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1. Introduction

BC health authorities are facing the challenge of increasing demand and budget pressures. The geographic proximity of the three participating health authorities headquartered in the lower mainland presents the opportunity to look for efficiencies within departments that are common across the four organizations. Although some work on consolidation has been done by some of the organizations, the potential for more integration and alignment has been identified as a way of creating greater efficiencies.

In the summer of 2009 the Ministry of Health Services directed that the Lower Mainland Consolidation (LMC) project be initiated to ensure full consolidation of all corporate, clinical support and back office functions. Efficiencies gained through consolidations were to net an overall target of 10% of the $1B “non—clinical budget”. The overall objective of the LMC initiative was to consolidate as many corporate, clinical supports and back office functions to achieve these targeted savings and efficiencies across Fraser Health (FHA), the Provincial Health Services Authority (PHSA), Vancouver Coastal Health (VCH,) and their affiliate Providence Health Care (PHC) in order to achieve the 10% savings target. The initiative also envisioned that in the longer term, additional benefits would be achieved as the entities function as an integrated system. Direct clinical services and services for which there is a definitive and undeniable reason for exclusion were deemed to be out of scope.

This report is a result of a due diligence assessment of the 12 in-scope Lower Mainland Consolidation projects that occurred over an eight week timeframe. The first four weeks were dedicated to interview LMC stakeholders at all levels of the governance structure including Board Chairs, CEOs, CFOs and LMC Project Leads across all Health Authorities. 30+ group and individual sessions were conducted to gather insights and answers to specific questions on respective progress, plan and overall project health. Subsequently, dozens of follow-up discussions were performed.

All available project documentation was collected and reviewed by Accenture subject matter experts for the respective LMC area. Additionally, results to date, governance processes as well as issues and barriers have been reviewed. Accenture was specifically asked by the Ministry of Health Services to contribute private sector perspectives. Thus, industry benchmarks, best practices and project management mechanisms were researched.

In this report, we have summarized our analysis for each LMC project as well as the overall program.
2. Executive Summary

In August 2009, British Columbia embarked on the Lower Mainland Consolidation ("LMC") initiative to consolidate its corporate, clinical support and back office functions with the objective to capture synergies and improve efficiency across the four participating organizations which comprised three Health Authorities ("HA") plus Providence Healthcare.

British Columbia is a pioneer in demonstrating this type of leadership in comparison to other jurisdictions that have not been as successful in progressing with their consolidation or amalgamation plans.

As a jurisdiction, British Columbia has a track record of pursuing shared services to optimize their service delivery and focus on providing quality public services. Moving forward with Lower Mainland Consolidation is a natural extension to prior efforts to drive the type of savings that have been achieved in core Government.

Transformational savings initiatives (e.g., Shared Services) in the public sector environment, with multiple organizations, cultures and heterogeneous systems is challenging but can be successfully accomplished with the right leadership and collaboration at all levels (e.g. timely decision-making).

2.1 Achievements To-Date

Health Authorities have continuously worked in the past to reduce budgets and improve efficiency. Work has been accomplished both, within and across the organizations, including consolidated services and initiatives such as integrated support service contracts, security, and a common pharmacy formulary.

The LMC initiative had 2 key goals: achieve virtual consolidation by March 31st 2010, and identify and make progress towards savings. Since the inception of LMC, project teams have worked very hard. To date, they all have nominated and established project leads as well as the organization structure to support the service delivery across Health Authorities. Furthermore, savings plans have been developed and approval has been obtained by the Steering Committee. All projects have successfully achieved virtual consolidation.

Achievements to-date present a solid foundation and catalyst for future initiatives and to capitalize on more significant savings.

2.2 Financial Results

The Lower Mainland Consolidation initiative has not achieved its target savings of $103M. In Mid FY 09/10, the Ministry of Health Services set a savings target of $100M across all of the in-scope functions, equating to a 10% reduction off a $1,043M budget. The Ministry of Health Services and Health Authorities subsequently collaborated to establish target savings by initiative with the objective to meet the overall target.

To date, $76M in gross, annualized savings of the total $103M target have been identified to be achieved by the end of FY 12/13. $6M in annualized savings was achieved in FY 09/10 and $33M is targeted for FY 10/11.

The Health Authorities have identified additional collaboration and non-LMC initiatives totaling $44.2M to close the gap to the overall target, including savings from establishing a shared services organization for Procurement and Transactional Finance. Optimizing Legal spend has generated an additional $2.5M. Other concurrent initiatives also include consolidation efforts with Northern and Interior Health Authorities which address synergies based on common IT platforms. The scope of Accenture’s assessment neither included reviewing the details of these initiatives nor the likelihood of achieving the identified savings.

Our project assessment substantiates that target savings are not being achieved in a reasonable amount of time. Overall, our findings demonstrate that the identified project initiatives are mainly targeting incremental improvement opportunities which will contribute less than 10% in savings of the spend. Furthermore, the projects do not target or exploit all sources of potential
opportunity and spend. For example, Pharmacy has focused their initiatives on a small portion of their overall budget, i.e. non-clinical operations. Also, HR and IT have excluded scope and budgets that lie within Fraser Health Authority thereby significantly reducing the potential for savings.

There are risks associated with achieving the future year identified savings due to a combination of lack of detail and thoroughness of project plans, risk and issue management and mitigation as well as underlying assumptions that require additional investment.

In addition to the $76M in savings identified by the LMC project teams, there are additional opportunities to increase the overall savings. We have identified additional savings opportunities based on our experience in comparative environments, benchmarks and best practices. With modest investments and effort, combined with structured program management and enforced mechanisms, savings targets could be enhanced and achieved within a shorter timeframe.

2.3 Execution Challenges

Projects have completed structural and organizational consolidation tasks as well as selected a leader for each function and next level leadership that has assumed its new roles and responsibilities.

Across all LMC projects, teams struggle with limited baseline data. Financial baselines are just now close to being signed off. Additional visibility on fact-based service levels and quality as well as workload drivers is minimal and deviates strongly by project. Until financial and service level baselines are resolved and documented, desired service level definition and agreement will be cumbersome and lengthy since it will be non fact-based and highly perception-based.

The lack of consistency in service delivery models across the projects strains the basis for a common governance approach, e.g. some projects embarked on a pursuit of virtual versus physical consolidation while some could not progress without physically transferring resources.

Being cognizant that the LMC initiative was set out to be a budget reduction and virtual consolidation, savings can still be pursued more diligently and aggressively. Budget reductions typically address savings levers that have little organizational impact, e.g. management delayering, procurement spend reduction, demand management etc. Most projects have successfully addressed these levers and reaped benefits. However, consolidation effectiveness remains suboptimal as service item, levels, quality and common governance issues are still unresolved and are hindering project progress and larger savings potential. The sustainability of some of these efforts is an area of risk.

There is universal agreement (i.e. HA and the Ministry of Health Services) that broader savings and systemic change will require investment. The HA view is that investments should come from the Ministry. The Ministry’s view is that the responsibility for running efficient operations is the HA’s and therefore the investment responsibility also resides with the HAs. Our observation is that alternative funding models do not appear to have been considered. For example, a typical model would achieve rapid cost reduction (~1-3 months) with minimal organizational and change impact to fund Operational Transformation (~3-6 months) initiatives which fund a Larger Scale (systems) Transformation (~1-2 years).
2.4 Project Evaluation Summary

We have summarized our assessment of all LMC projects based on a common set of evaluation criteria. We have evaluated the projects based on their overall results as well as consolidation effectiveness.

We have rated each project on a continuum ranging from ‘not established’ to ‘emerging’ to ‘established’. Characteristics of ‘established/fully in place’ Consolidation Effectiveness include the following by evaluation area:

- **New/Consolidated Organization Structure**
  - LMC Function lead selected
  - New organization structure established
  - Next level leadership structure in place

- **Formal Decision Making Model**
  - Formal issue escalation process in place
  - Formal, collective issue resolution process in place
  - Meeting cadence established
  - Timelines on issue resolution defined and adhered

- **Service Management Framework**
  - Service item and quality baseline established
  - Service item list developed
  - Targets/KPIs defined
  - Service levels agreed
  - Chargeback approach defined

- **Customer Interaction Management**
  - Customer and business needs segmented
  - Formal interaction tools/technology and input collection channel established
  - Approach to handling customers service requests /cases defined

- **Service Delivery Model**
  - Consolidation process scope defined
  - Physical vs virtual consolidation requirements defined
  - Service delivery location(s) defined
  - Process split determined, i.e. shared service centre, HA retained

Figure 1: LMC Project Evaluation Criteria
The table below depicts the high-level results and current status of the individual LMC projects. The project management capability has been assessed in detail in each project section and is only summarized in this table. We have taken the PMO assessment results into consideration for our conclusions.

**LMC Project Evaluation Summary**

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<th>Evaluation Criteria</th>
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<th>Mid-Office Functions</th>
<th>Infrastructure Functions</th>
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<td></td>
<td>Human Resources</td>
<td>IMIS</td>
<td>Health Information Mgt</td>
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**Project Results**

- Budget Baseline Established: 3 3 3 3 3 3 3 3 3 3 3 3
- Savings Targets Identified: 3 3 3 3 3 3 3 2 3 2 3 3
- Savings Target Achieved in FY09/10: n/a n/a n/a n/a n/a 3 n/a

**Consolidation Effectiveness**

- LMC Lead & New Organization Structure: 3 3 3 3 3 3 3 3 3 3 3 3
- Formal Decision-Making Model: 2 3 1 1 2 2 1 1 1 1 2 2
- Service Management Framework: 1 1 1 1 1 1 1 1 1 1 2 2
- Customer Interaction Management: 2 2 1 1 1 2 1 1 1 2 1 3
- Service Delivery Model: 2 2 2 2 2 2 1 1 1 2 2 3

**Project Management - PMO**


(1) On key issues such as Staff Transfers, Budget Mgt, SLAs, Baseline
(2) See detailed PMO Assessment in section 4.6. each Project Section
n/a: no targets set for FY09/10 - mainly due to late approval of plans

**Common Themes**

It is important to mention that all challenges and disconnects documented below are under the direct purview and authority of the Health Authorities and can all be resolved through collective decision making.

All projects have selected and put in place LMC project leads, established the future, consolidated organization structure and next level leadership positions. However, most projects do not have a formal decision making model established to facilitate the escalation of critical issues to the right level of executive attention which significantly stalled progress. Additionally, a formal, timely and collective issue resolution process and cadence has not been established to date. Another common characteristic across the majority of projects is the lack of a structured mechanism to interact with the customers, how to process customer requests and collect input. This is a very critical
component of maintaining and managing customer and service expectations as well as ensuring a sound business relationship.

Human Resources, IM/IS and Communications are very critical functions during any consolidation effort as the support of these functions are a key enabler for a sound transformation. Their concurrent consolidation goal has placed challenges on the rest of the LMC projects. Customer interaction management is increasingly important for these projects and has not been formally developed.

As opposed to the majority of other LMC projects, IM/IS was able to successfully navigate LMC leadership decision-making and HR processes and was able to move forward with the required organizational restructuring and staffing issues in a timely fashion. A relatively basic but solid project management approach was a key enabler. Furthermore, the IM/IS team established a structured approach to prepare and escalate key issues to executive attention and agenda.

The lack of a formal decision making model poses significant challenges for the progress of the HIM project. 50% of cost savings are left on the table until the staff consolidation is completed (dependent upon results of Section 54 and related union discussion). Physical consolidation is assessed to be a key enabler to manage staff effectively across HAs.

The Biomedical Engineering project can improve the likelihood to achieve its savings through a better service management framework. Definition and monitoring of performance metrics (e.g. for equipment) will provide better transparency and timely mitigation for their self-insured model.

The mid-office clinical support functions (Pharmacy, Diagnostic Imaging, Laboratory & Pathology Medicine) all unveil a lack in utilization of best practices.

Pharmacy struggles to establish a solid factbase to apply and measure their efficiency gap to relevant benchmarks. Furthermore, Pharmacy is not achieving its savings targets timely since their consolidation plan obtained Steering Committee approval in February 2010 which puts the project team at its infancy of identifying comprehensive initiatives to support the savings target. A better project management approach with regards to scope and work plan/timeline would be beneficial to mitigate the late approval and lack of dedicated savings initiatives to support the goal.

Diagnostic Imaging has a good handle on its workload drivers, however, is not fully applying benchmarks to identify and close efficiency (i.e. utilization capacity) gaps. A portion of the targeted savings ($3M-$4M) requires a structured approach to consolidation of operations and significant participation by the radiologists and clinicians. Thus, leveraging the project management capabilities particularly in Workplan Management and Stakeholder engagement will be crucial. Furthermore, additionally recommended actions are required to improve performance of planned initiatives.

Laboratory & Pathology, in particular, has to better manage its stakeholder engagement process to ensure clinician community support and collaboration on initiatives. Furthermore, a structured self-funding approach for the required LIS investment has to be developed in order to ensure feasibility of targeted savings.

Parking & Protection services has achieved its savings targets despite rudimentary project management and lack of applying consolidation effectiveness levers. This project was able to default to revenue generation as a savings lever which requires little project or change management mechanisms. Additional consolidation synergies were not explored and possibly left on the table.

The BISS project has largely exploited outsourcing as a major service delivery option. The project is integrating relatively advanced project management mechanisms and has a solid handle on workload driver and demand. Additional savings to achieve their target should be explored through collaboration with other functions (e.g. Facilities) in centralizing some of their services (e.g. call centre). The BISS team has developed some critical expertise, e.g. in contract management, service level definition and management as well as performance measurement which should be leveraged across projects as an internal centre of expertise.
The Facilities project is lagging in applying an optimized service delivery model with minimized vacancy across all 100+ buildings. Several key, larger consolidation savings opportunities are still being developed where improving their work plan and scope management disciplines would provide a structured basis.

In conclusion, teams are committed and working hard to instill success for their projects and with appropriate tools and support can achieve sustainable results.

### 2.5 Leadership Challenges

Health Authority executives have not seized collective accountability on key decisions that are within their direct purview, e.g., staff transfers, financial and service level baselines and targets, collective budget management. All issues brought to our attention as an obstacle to LMC project progress are under the direct authority and decision rights of the Health Authorities' leadership. As a direct outcome of this, LMC project leads do not feel empowered to execute their plans across the HAs on account of repeated blocking and stalling when it comes to working with HAs that have not previously fallen under their jurisdiction. Furthermore, the lack of enforced accountability for results has placed the likelihood of savings achievement at risk.

### 2.6 Recommendations Going Forward

We have derived opportunities moving forward that will help LMC capitalize on savings faster and more effectively.

#### 2.6.1 Option 1: Drive LMC to be more aggressive

Option 1 requires Health Authority Executives to work together and exercise collective accountability to achieve more aggressive timelines and savings. In order to achieve higher savings, self-funding mechanisms have to be pursued and instilled, e.g. improving strategic sourcing, span-of-control, and project elimination. Stakeholders, particularly in the clinical community, need to be engaged in a dedicated and timely way to gain buy-in and mitigate future disagreement. The overall risk is shared between Health Authorities. The option is also extensively focused on back-office support as opposed to the core mission.

#### 2.6.2 Option 2: Drive to Shared Services – Captive or Outsource

Option 2 addresses the opportunity to pursue an alternate service delivery model. Contract non-core, highly transactional and repetitive functions/activities (e.g. IT, Transactional HR and Finance, Procurement) for guaranteed savings and service levels. This option can be combined with aggressively driving retained activities (e.g. Diagnostics Imaging, Pharmacy)
through a captive shared service centre to a high-performing model. Under this option the risk is shared with a strategic partner (e.g., SLA management) and HAs can focus on their core mission to deliver quality health care to the Lower Mainland.

2.6.3 Option 3: Hybrid (recommended)

Option 3 is about systematically reviewing each LMC project as well as other support function areas to determine the most effective approach, i.e. moving forward driving savings more aggressively and evaluating captive or outsourced shared services delivery models.

The following section examines immediate next steps which should be applied towards the chosen path.

2.7 Next Steps

Moving forward, LMC success is contingent on resolving a number of key issues.

1. Collectively across HAs, establish a comprehensive **financial and headcount baseline** for each function. In order to ensure a more fact-based approach to establishing and agreeing on common standards, develop current service delivery performance and quality baseline by function and by service item and define desired, standard service levels and performance targets.

2. Collectively agree on a **decision-making model** to drive issues to conclusion for:
   - budget approval
   - issue /exception resolution
   - performance management (SLA adherence)
   - chargeback model

3. Understand the nature of forecast demand and collectively agree on **service cost allocation** as well as **cost/risk and surplus/savings allocation**
   - historical cost
   - FTE based budget
   - operating unit size
   - transaction volume
   - time to complete
   - fixed vs. variable

4. Develop a 90-day plan to accomplish the above tasks and mobilize for the path forward (Options 1-3)
3. The LMC Project Due Diligence Review

3.1 Background

In February 2010, the B.C. Ministry of Health Services issued a Request for Proposals to select a management consulting firm to provide due diligence on the Lower Mainland Consolidation (LMC) initiative. The due diligence services were to include reviewing current project plans, gathering and assessing baseline project and financial information related to the consolidation projects and establishing a framework for monitoring project performance against planned outcomes.

3.2 Project Objective

The purpose of the LMC Due Diligence project was to validate the current state of the LMC projects, assist in the identification of additional opportunities for generation of savings, recommend next steps as well as provide guidance on standardizing status reporting across projects. To achieve these results, Accenture worked collaboratively with the LMC project teams to:

- Review existing project plans and deliverables
- Gather and assess related baseline project and financial information
- Establish and recommend mechanisms for ongoing project management monitoring and evaluation of progress against both plan and targeted savings
- Recommend any further actions necessary to ensure the achievement of consolidation efficiencies
- Provide advice on additional areas for consideration based on best practices, potential for improvement and experience with other jurisdictions and organizations

3.3 Project Scope

The scope of the due diligence assessment encompasses the 12 Phase 1 LMC projects assigned to FHA, PHSA, VCHA and PHC, i.e. Health Authority businesses that are considered corporate, clinical support and/or back-office.

Phase 1 LMC Projects encompass:

- Human Resources - Transactional
- IM/IS (excl. Technology Services)
- Health Information Management
- Biomedical Engineering
- Interpretation Services (PLS)
- Communications
- Diagnostic Imaging
- Pharmacy
- Pathology & Laboratory Medicine
- Facilities Management
- Protection Services – Security & Parking
- Housekeeping Food Laundry (BISS)

Direct clinical services are defined as out of scope for this assessment.
3.4 The Accenture Team

We leveraged our breadth and depth in the health care industry and functional expertise to create a team that would deliver the best value. Subject Matter Experts with deep experience in each of the LMC project areas were brought in to analyze the status of each project. Extensive years of experience in their relevant areas combined with exposure to a diverse set of project situations allowed the SME’s to bring comparative examples of how additional savings and efficiencies could be achieved within British Columbia.

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<td>Accenture Client Partner: Owen Taylor</td>
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<th>Subject Matter Experts</th>
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</thead>
<tbody>
<tr>
<td>Facilities Management: John Thoennes</td>
</tr>
<tr>
<td>IT/IMIS/Health Information Mgt/BioMed Engineering: Clare Peterson</td>
</tr>
<tr>
<td>Pharmacy: Jennifer Malen</td>
</tr>
<tr>
<td>HR/Communication/Interpretation Services: Giselle Comissiong</td>
</tr>
<tr>
<td>Laboratory: Jeff Hawley</td>
</tr>
<tr>
<td>Diagnostic Imaging: Deniese Chaney</td>
</tr>
<tr>
<td>PMO: Cedric Brossard</td>
</tr>
<tr>
<td>BC Health Advisor: Deborah Shera</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Project Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analytics, Modeling &amp; Reports: Eva Munro</td>
</tr>
</tbody>
</table>

Figure 3: Accenture LMC Assessment Project Team
3.5 **Project Timeline**

**Assessment High-Level Work Plan**

<table>
<thead>
<tr>
<th>Tasks</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
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<tbody>
<tr>
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<td>W 0 W 1 W 2 W 3 W 4 W 5 W 6 W 7 W 8 W 9</td>
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</tr>
</tbody>
</table>

- **Project Mobilization**
- **LMC As-Is Assessment**
  - Conduct Board Chair & CEO Interviews
  - Conduct LMC Lead/CFO Interviews
  - Conduct LMC Project Team Interviews
  - Perform Governance & PMO Assessment
- **Document Findings & Derive Recommendations**
- **Prepare Interim Deliverable**
- **Review Findings & Recommendations with Stakeholders**
  - Present Interim Deliverable at LMC Leadership Meeting
  - Present Final Deliverable to Minister & Deputy Minister
  - Present Final Deliverable at SteCo

![Figure 4: Assessment Work Plan & Timeline](image)

After a short project mobilization to set up interviews and agree on periodic reporting, the Accenture team utilized the first 4 weeks in interviewing key stakeholders across the LMC projects. Subsequent to that, initial hypotheses and findings were validated with respective project leads. An interim deliverable was developed to demonstrate initial findings and depth of project assessment based on Pharmacy and HR. The final 2-3 weeks were dedicated to drafting the final deliverable report.

To date, high-level findings have been shared with the Ministry of Health Services as well as with the Minister and Deputy Minister (April 29th, 2010).
3.6 **Stakeholders & Interviewees**

A comprehensive interview process was undertaken and included Board Chairs, Health Authority CEO’s, LMC Health Authority Leads, Project Leads, selected members of the actual project teams and Project Management resources – where available.

### Figure 5: Interviewees across all Health Authorities

<table>
<thead>
<tr>
<th>Board Chairs</th>
<th>CEOs</th>
<th>LMC Leads</th>
<th>LMC Project Leads</th>
<th>PMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gordon Barefoot</td>
<td>Dr. Nigel Murray</td>
<td>Brian Woods</td>
<td>Dr. Shellen Letwin</td>
<td>Maurie Maitland &amp; Eric De Mer</td>
</tr>
<tr>
<td>David Thompson</td>
<td>Dr. David Ostrow</td>
<td>Duncan Campbell</td>
<td>Mike Nader</td>
<td>Sean Parr</td>
</tr>
<tr>
<td>Wynne Powell</td>
<td>Lynda Cranston</td>
<td>Michael Marchbank</td>
<td>John Andruschak</td>
<td>Stephen Barbazuk</td>
</tr>
<tr>
<td>Kip Woodward</td>
<td>Dianne Doyle</td>
<td>Mary Procter</td>
<td>Barry Rivelis</td>
<td>NA</td>
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</table>

<table>
<thead>
<tr>
<th>LMC Project Leads</th>
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</thead>
<tbody>
<tr>
<td>Peter Goldthorpe</td>
<td>Anne Harvey</td>
<td>Clay Adams</td>
<td>John Andruschak</td>
<td>Barry Rivelis</td>
</tr>
<tr>
<td>Facilities</td>
<td>Human Resources</td>
<td>Communications</td>
<td>Pathology &amp; Laboratory</td>
<td>IT/IMS</td>
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</tr>
<tr>
<td>Don MacAllister</td>
<td>Mike Nader</td>
<td>David Handley</td>
<td>Susan Barclay</td>
<td></td>
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<tr>
<td>Protection, Parking,</td>
<td>Diagnostic Imaging</td>
<td>BISS</td>
<td>Interpretation</td>
<td>Services</td>
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<tr>
<td>Security</td>
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<table>
<thead>
<tr>
<th>LMC Project Leads</th>
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3.7 Project Management Evaluation Methodology

The Accenture Project Management Office Assessment methodology was leveraged to evaluate the execution effectiveness of the 12 LMC projects as well as the overarching project management.

The tool is typically used to identify strengths and weaknesses associated with program/project management practices within an organization. The results of the assessment are used to provide recommendations to improve overall project delivery.

The tool is adapted for each specific client situation. We have narrowed our assessment to 8 core and essential PMO disciplines including:

- Scope Management
- Issue & Risk Management
- Workplan & Time Management
- Resource Management
- Performance Management & Reporting
- Financial Management
- Stakeholder Management
- PM Support Tools

These 9 discipline areas are evaluated against a standard set of quality criteria categorized based on levels of maturity as defined by the Accenture PMO Assessment Methodology (see Figure 4 below).

![PMO Assessment Maturity Model](image)

The size, magnitude and stage within the project lifecycle generally determine the sufficient and reasonable level of maturity. Not all projects need to target benchmark levels to successfully execute against their targets. Based on our experience, a ‘Basic’ level of maturity is often sufficient with projects of comparable size to the LMC initiatives.
4. Current Situation

4.1 LMC Project Financial Baseline

The following figure shows both the FY 09/10 and FY 10/11 Lower Mainland Health Authority ‘in scope’ consolidation budgets as confirmed by the Finance Working Group. The 09/10 budget forms the baseline for the consolidation savings initiative.

Source: Finance Working Group for FY09/10 & FY 10/11 Budget Baselines; CFOs for Savings Targets

Figure 7: FY 09/10 & FY 10/11 Budget Baseline

4.2 LMC Initiative Grouping

After concluding our LMC project interviews, we found that three types of project groupings emerged with like-characteristics. We noted that overall (1) Back-Office projects do not fully exploit applying best practices and benchmarks against industry peers, (2) clinical support projects lack effective and timely engagement of key clinician stakeholders to support more systemic change and favour rapid cost reduction approaches whereas (3) Infrastructure projects default into procurement savings and revenue generation. One example is Facilities where other than the Surrey-Vancouver consolidation, no further vacancy opportunities have been explored within the given timeframe.
4.3 **Individual Project Targets**

The savings targets associated with each of the individual LMC projects within these three groupings are defined in the figure below. Clinical support functions are targeted to contribute ~50% of the overall savings which further underlines the criticality of these projects.

**Figure 8: LMC Initiative Groupings by Functional Area**

**Table: LMC Initiative Groupings**

<table>
<thead>
<tr>
<th>Back-Office Functions</th>
<th>Mid-Office Functions</th>
<th>Infrastructure Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Human Resources</td>
<td>• Pharmacy</td>
<td>• Protection Services</td>
</tr>
<tr>
<td>• IT/IMIS</td>
<td>• Pathology &amp; Laboratory Medicine</td>
<td>• Facility Management</td>
</tr>
<tr>
<td>• Health Information Management</td>
<td>• Diagnostic Imaging</td>
<td>• BISS - Housekeeping, Food, Laundry</td>
</tr>
<tr>
<td>• Biomedical Engineering</td>
<td></td>
<td></td>
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<tr>
<td>• Interpretation Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Communication Services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Figure 9: LMC Functional Area Budget & Savings**

*Source: Finance Working Group for FY09/10 & FY 10/11 Budget Baselines; CFOs for Savings Targets; LMC Project Leads for Achieved Savings FY 09/10*
4.4  Project ‘Pain-Gain’ Analysis

One of our conclusions is that the majority of LMC initiatives appear to be relatively high in effort and complexity and relatively low in savings value.

The Health Authority and LMC Project Leads have articulated the following beliefs, which they perceive to be attributing to the current results:

- Lack of investments to pursue larger, systemic changes that would yield higher value
- Perceived mixed messages around virtual vs physical consolidation goals – despite a clear mandate to achieve virtual consolidation by March 31<sup>st</sup>, 2010
- Lack of clarity on scope
  - The initial scope description for the project described that the savings would accrue from ‘non clinical’ initiatives yet the baseline budget of $1B includes such clinical cost centres as drugs
- Inability to ‘count’ prior consolidation effort savings
  - E.g. Fraser and Vancouver Coastal pre-LMC consolidations had already harvested savings from elimination of inefficiencies

The Ministry of Health Services has made it clear in their messaging that HAs are responsible for the transformation cost related to implementing their assigned consolidated departments. Furthermore, it was communicated that additional funding or one-time investments are not available and have to be self-funded through administrative savings.

Our Accenture perspective is that none of the projects have neither considered nor employed any alternative funding mechanisms.

Rapid cost reduction serves as a fast and impactful first step provides funding necessary for an overall organizational transformation through strategic fiscal management.

Our clients see the value Rapid Cost Reduction, both in its immediate impact as well as its ability to more than pay for itself. With the savings realized during Rapid Cost Reduction, clients are able to fund Organizational & Operations Transformation initiatives. Initial efforts position the client to achieve longer term strategic vision and objectives.

The consolidation goal to achieve virtual consolidation by March 31<sup>st</sup>, 2010 was stated as a project mandate. Clarity on scope was provided as part of the LMC Project Charter. Attributing prior consolidation savings and efforts to LMC was cumbersome in the absence of an agreed and signed-off baseline. Furthermore, the decision to include or not to include savings could have been made by the 4 HA CEOs collectively.
The following figure depicts the LMC projects by value and complexity.

![LMC Project Value vs Complexity Assessment](image)

**Figure 10: LMC Project Value vs. Complexity**

In summary, most LMC projects are assessed to be high in effort/complexity and relatively low in value. Emphasis should be placed on more aggressively addressing savings levers for those projects to improve the business case (higher value) and justify the efforts spent so far and in the future. Potentially freed up capacity should be focused on enhancing benefits realization for high value and high effort projects, i.e. Laboratory, Diagnostic Imaging.

The Back-Office functions are primarily in the lower-right-hand quadrant (high effort/low value) since total addressable spend is not fully exploited and practices and benchmarks are only minimally utilized to target higher efficiency levels. Clinical support functions, whilst relatively high in value (except Pharmacy due to agreed minimized scope), are at higher risk if buy-in from the clinician community is not ensured in a timely manner and some savings are based on substantial capital investment. Infrastructure Functions are relatively low in complexity and value since majority of services are already outsourced and main levers addressed are contract price renegotiations (BISS) or even revenue generation (Parking & Protection Services) whereas Facilities has not addressed and identified the full consolidation potential pre and post LMC.
4.5 **Summary of LMC Initiatives**

Our analysis has concluded that the existing projects plans will not achieve the targeted savings of $103M even when stretched out to the end of FY 2012/13. Almost 50% of savings are projected for FY11/12 and FY12/13.

The total savings targets are net of capital investments, however, each project has a component of transformational ‘cost’ (e.g. project effort) that has to be identified and incorporated into the overall benefits tracking approach to better managed funds.

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>FY 09/10 Baseline $M</th>
<th>Savings Achieved $M</th>
<th>FY 10/11 Target $M</th>
<th>FY 11/12 Target $M</th>
<th>FY 12/13 Target $M</th>
<th>Total Target $M</th>
<th>% of Baseline</th>
<th>Gap to Target $M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infrastructure</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protection Services</td>
<td>6.4</td>
<td>1.5</td>
<td>3.59</td>
<td>1.40</td>
<td>0.00</td>
<td>6.5</td>
<td>101%</td>
<td>5.0</td>
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<tr>
<td>Facility Management</td>
<td>193.9</td>
<td>3.3</td>
<td>3.76</td>
<td>2.91</td>
<td>0.00</td>
<td>10.0</td>
<td>5%</td>
<td>6.7</td>
</tr>
<tr>
<td>BISS</td>
<td>191.9</td>
<td>0.0</td>
<td>2.38</td>
<td>3.48</td>
<td>0.00</td>
<td>5.9</td>
<td>3%</td>
<td>5.9</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>152.9</td>
<td>0.0</td>
<td>1.60</td>
<td>1.60</td>
<td>0.00</td>
<td>3.2</td>
<td>2% (10%)</td>
<td>3.2</td>
</tr>
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<td>Mid-Office</td>
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</tr>
<tr>
<td>Pathology &amp; Laboratory</td>
<td>187.0</td>
<td>0.0</td>
<td>5.40</td>
<td>8.40</td>
<td>9.80</td>
<td>23.6 ($5.9 Inv.)</td>
<td>13% (9%)</td>
<td>23.6</td>
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<td>Diagnostic Imaging</td>
<td>118.8</td>
<td>0.0</td>
<td>3.70</td>
<td>4.20</td>
<td>2.60</td>
<td>10.5</td>
<td>9%</td>
<td>10.5</td>
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<tr>
<td>Back-Office</td>
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<tr>
<td>Biomedical Engineering</td>
<td>27.5</td>
<td>0.09</td>
<td>1.85</td>
<td>0.67</td>
<td>0.00</td>
<td>2.6</td>
<td>9%</td>
<td>2.5</td>
</tr>
<tr>
<td>Health Information Mgt</td>
<td>55.3</td>
<td>0.02</td>
<td>1.16</td>
<td>1.98</td>
<td>0.00</td>
<td>3.6</td>
<td>6%</td>
<td>3.1</td>
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<tr>
<td>Interpretation Services</td>
<td>2.1</td>
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<td>0.24</td>
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<td>0.00</td>
<td>0.2</td>
<td>12%</td>
<td>0.2</td>
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<tr>
<td>IT/IMIS</td>
<td>55.0</td>
<td>0.15</td>
<td>6.10</td>
<td>0.00</td>
<td>0.00</td>
<td>6.3</td>
<td>11%</td>
<td>6.1</td>
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<tr>
<td>Communication Services</td>
<td>7.8</td>
<td>0.3</td>
<td>1.20</td>
<td>0.00</td>
<td>0.00</td>
<td>1.5</td>
<td>19%</td>
<td>1.2</td>
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<tr>
<td>Human Resources</td>
<td>31.2</td>
<td>0.7</td>
<td>2.17</td>
<td>0.00</td>
<td>0.00</td>
<td>2.8</td>
<td>9%</td>
<td>2.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,030.4</strong></td>
<td><strong>6.1</strong></td>
<td><strong>33.14</strong></td>
<td><strong>24.65</strong></td>
<td><strong>12.40</strong></td>
<td><strong>76.7 (70.8)</strong></td>
<td><strong>7%</strong></td>
<td><strong>76.1 (82.1)</strong></td>
</tr>
</tbody>
</table>

**Table 1: Summary of LMC Initiatives**

Source: Finance Working Group for FY09/10 & FY 10/11 Budget Baselines; CFOs for Savings Targets; LMC Project Leads for Achieved Savings FY 09/10

The HAs have identified additional, non-Phase 1 or non-LMC initiatives totaling $44.2M to close the gap to the overall target (e.g. $21.7M in total savings from SSO). Additionally, $2.5M in savings was achieved through business design changes in the Legal function and is included as peripherals to LMC.
4.6 Project Management Maturity

All 12 LMC projects were assessed with regards to their Project Management maturity based on the Accenture methodology. Each project was evaluated based on eight, core PM disciplines as outlined in section 3.7 and rated against predefined maturity level criteria. In summary, the LMC projects reveal an ‘Ad-Hoc’ approach to project management. Key characteristics at this level suggest ad-hoc project management with independent versus integrated and standardized processes across the initiative.

Despite the fact that LMC projects were not asked or required to produce and instill some of the project management tools and mechanisms, we were still compelled to recommend basic project management principles and areas for improvement.

It is also important to note that a ‘heroic’ rating for projects which larger organizational impact such as Laboratory, Diagnostic Imaging or IT and HR is more severe than for projects with relatively small impact and projects that pursued more ‘rapid cost reduction’ levers such as procurement/contract savings, eliminating vacant positions of revenue generation.

<table>
<thead>
<tr>
<th>Human Resources</th>
<th>IT/IMS</th>
<th>Health Information Management</th>
<th>Biomedical Engineering</th>
<th>Interpretation Services</th>
<th>Communication Services</th>
<th>Diagnostic Imaging</th>
<th>Pharmacy</th>
<th>Pathology &amp; Laboratory Medicine</th>
<th>Facility Management</th>
<th>Protection Services</th>
<th>BISS - Housekeeping, Food, Laundry</th>
</tr>
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<tbody>
<tr>
<td>Scope Management</td>
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<tr>
<td>Issue &amp; Risk Management</td>
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<td>Workplan &amp; Time Management</td>
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<tr>
<td>Resource Management</td>
<td></td>
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<tr>
<td>Performance Management &amp; Reporting</td>
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<tr>
<td>Financial Management</td>
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<td>Stakeholder Management</td>
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<td>PM Supporting Tools</td>
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<tr>
<td>Overall Project Summary</td>
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Table 2: PM Maturity Assessment Summary

4.7 LMC Program Level Issues

4.7.1 Ineffective Collective Decision Making

The lack of seizing collective accountability to resolve program level issues at the Health Authority leadership level has significantly impacted project progress and realization of savings. As a result of our stakeholder interviews, we have observed the following key factors that contribute to the current results:

- Lack of collaboration, communication and timely decision making across Health Authorities
- Disagreement amongst Health Authority leadership and general lack of progress in resolving such cross-Health Authority issues as staff transfers, joint budget management and standardized service levels
- Majority of LMC project leads do not feel empowered to execute across Health Authorities - blocking and stalling occurs frequently when trying to execute across authorities
- Lack of enforced accountability for results has placed the likelihood of savings achievement at risk
4.7.2 Absence of Comprehensive Baseline & Workload Drivers

The lack of a solid, comprehensive baseline across Health Authorities has led to increased ‘emotional’ versus fact-based discussions. A dedicated Finance Working Group was established in December 2009 to develop a clean budget baseline for FY10/11 and establish a benefits tracking mechanism and LMC savings attribution going forward. The financial (budget) baseline for FY10/11 is about to be signed off which is critical to be able to measure benefits realization going forward.

The following areas are predominantly impacted:

- addressing and assigning joint budget responsibility
- establishing standard service items and service levels
- internal and external benchmarking

Key issues with benchmarking revolve around the fact that there are multiple systems with diverse accounting methods and aggregation logic, e.g. Pharmacy drug costs are in some cases centralized and in others distributed which distorts the data retrieved from systems for comparative analysis. Substantial lack of workload drivers and metrics further hinder developing and addressing business challenges.

4.7.3 Management of Interdependencies

The deficiency of a unified approach to critical, program-wide issues, e.g. Section 54 discussions, job classifications, privacy issues is causing delays and duplication of efforts. Furthermore, interdependencies are not dedicatedly addressed and effectively managed i.e. key support functions such as HR, IT and Communications are consolidated concurrently and are thus challenged to provide sufficient LMC project support and service.

Additionally, the lack of an integrated approach has not allowed the program to identify the optimal sequencing of activity to address the interdependencies.

The next section examines each of the twelve projects in detail. The assessment is then followed by an evaluation of the project as a whole and the overall effectiveness of existing governance processes.
5. **LMC Project Assessments**

5.1 **Human Resources**

For the purposes of the LMC Initiative the Human Resources function has been split into separate Strategic and Transactional functions. The scope of this project is limited to Transactional HR. Fraser Health Authority is also out of scope with the stated rationale that their information system is different than that of the other Authorities.

5.1.1 **Baseline Budget, Savings Targets and Approach**

![Figure 9: Transactional HR - Combined Baseline Budget](image)

*Source: Finance Working Group for FY09/10 & FY 10/11 Budget Baselines; CFOs for Savings Targets*

The overall consolidated budget for the ‘in scope’ Transactional HR function is $31.8M. The team has a target of $2.84M in savings approximating 9% of their addressable spend. If Fraser were to be included in scope then the target budget would increase by an additional $15.5M.

The Transactional HR team has identified a number of initiatives to meet their targeted savings of $2.84M as well as additional savings possible through working with the broader clinical workforce. The initiatives identified are comprised of a combination of HR department related and Healthcare Workforce cost reductions. If FHA were included, these savings would potentially increase by an additional $1.80M in healthcare workforce savings. However, benefits outside the HR function budget were not attributed to LMC savings as per latest decision of the Finance Working Group.
5.1.1.1 The Savings Initiatives

Transactional HR identified five initiatives to reduce costs between fiscal years 2009/10 and 2012/13. The following table summarizes these initiatives and their timeline, opportunity and rationale. Note that the Table 3 below encompasses all savings (affecting budgets beyond HR Function) by the Transactional HR team. HR Function Savings depicted in Figure 10 above are thus a subset of the potential savings identified below.

<table>
<thead>
<tr>
<th>LMC Transactional HR Initiatives</th>
<th>Strategy</th>
<th>Timeline</th>
<th>Opportunity</th>
<th>Rationale</th>
</tr>
</thead>
</table>
| Labor Relations & HR | Attendance Management & Promotion  
Overtime management | Milestones within timeline to be confirmed | Estimated at $2.068M total by 2012/13 | Improved LR/HR practices |
| Disability Management & Safety | Increased focus on disability management as a means of savings vs. safety, prevention & wellness | By 2010/11 | Estimated reduced DM&S costs $1.693M, Healthcare workforce savings $2.375M | Standardization of approach leveraging VCH practice to improve effectiveness |
| Recruitment & Compensation | Standardized job descriptions, titles, pay rates for similar work  
Recruiting process standardization | Timeline to be confirmed | Estimated at $0.539M | Standardization of practice to improve service efficiency |
| HR Technology & Employee Records | Consolidated practices and technology, BI / EDW initiative across all HAs to integrate and standardize metrics | To be confirmed | Opportunities for efficiencies in consolidation, however $0.650M investment required | Management efficiency to deliver consistent services |
| Employee & Family Assistance | Standardized service contracts | To be confirmed | Reduce EFAP costs through contract consolidation | Consistency in practice to improve efficiency |

Table 3: Transactional HR - Initiatives

As previously mentioned, healthcare workforce cost reductions are also embedded in the HR team plans representing an additional potential of $3.2M. These savings neither impact the Transactional HR budget nor its targets. Finally, additional longer-term efficiencies resulting from the consolidation of technology are being assessed.
5.1.1.2 Observations

HR Function Savings

The $2.84M targeted savings in HR specific cost reductions seem reasonable and achievable corresponding to an 11% budget reduction. FHA is not a part of the consolidated service but accounts for an additional potential $15.5M to the baseline budget. If we assume the 90% of the FHA HR budget is transactional and a similar savings potential of 9%, inclusion of FHA would net a further $1.25M in LMC Transactional HR savings.

HR cost savings will primarily be achieved through reductions in HR labor costs and have largely been realized; $0.65M (24%) was achieved in FY09/10 – another $2.19M is planned to be saved in FY10/11. Additional longer-term efficiencies are likely to be achieved through the consolidation of technology. The investment for this initiative has been identified but the savings not yet quantified.

Observations on Transactional HR Savings Initiatives

As mentioned above, the initiatives identified by HR have the potential for significant efficiencies, beyond the already identified savings. The following Table contains our assessment of each of the initiatives in this group.

<table>
<thead>
<tr>
<th>Transactional HR Initiatives</th>
<th>Observations</th>
</tr>
</thead>
</table>
| Labor Relations & HR        | • Leading practice exists at VCH to be rolled out to other HAs  
• Requires collaboration at front line in order to achieve |
| Disability Management & Safety | • Resource reallocation has placed a greater emphasis on disability management vs. prevention and safety, as VCH has had success in improved cost management in disability management  
• Need to closely monitor metrics and consider the implications of enhancing focus on disability management vs. prevention in order to ensure that areas like mental health, safety, injuries remain protected |
| Recruitment & Compensation  | • Although there is a source of significant savings in this areas that may not have been completely quantified, this is likely to be challenging to implement and one would expect to encounter labour relations challenges  
• There will also be a need to avoid the unintended consequences of unmanaged attrition by maintaining focus on employee engagement as changes are rolled out |
| HR Technology & Employee Records | • Likely savings to be had here but requires investment to achieve  
• Currently 3 instances of Oracle that should be integrated – unsure whether to build on existing platform or consider net new  
• Cost has been quantified but benefits have not been – anticipate there could be some process/additional HR labour cost reductions associated with this |
| Employee & Family Assistance | • Consolidation of service contracts – savings not quantified but would not expect much here |

Table 4: Transactional HR Initiatives – Observations

Observations on Service Level Agreements

It is likely that the individual health authorities will, at least in the short term, have varying service level expectations that will need to be managed and formalized through service level agreements. Currently these are not formally in place. An interim service listing and service levels should be established collaboratively with both PHSA and PHC in the short term to assist in managing the transition until more permanent agreements can be negotiated. Finally, we suggest that improvements could be made in the formal engagement of both Strategic HR as well as the front line as the speed of integration of the LMC initiative in general and Transactional HR may have resulted in a mismatch of expectations with some stakeholders who were not able to be fully engaged in the process.
5.1.2 Maturity of Project Management

While the HR team is well on the way to realizing their target savings the scale, duration and complexity of these initiatives require a “basic” level of project management capabilities to improve stakeholder engagement. As we will discuss later in this report there are a number of areas where key process partners could be better engaged with the HR LMC project. Improvements in project management will become increasingly critical as the team moves forward with the broader Healthcare workforce initiatives.

<table>
<thead>
<tr>
<th>Maturity</th>
<th>Process Area</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Ad-hoc</td>
<td>Scope Management</td>
<td>What Works Well: Initial scope has been defined initially, list of initiatives is part of the initial plan. Area to Look At: Rationale to exclude FHA Transactional HR.</td>
</tr>
<tr>
<td>2 Ad-hoc</td>
<td>Issue &amp; Risk Management</td>
<td>What Works Well: Risks have not been formally documented but are embedded in the plan. Area to Look At: No evidence of risk and issue tracking log</td>
</tr>
<tr>
<td>1 Heroic</td>
<td>Workplan &amp; Time Management</td>
<td>What Works Well: A basic high level Project Plan exist with phases and dates. Area to Look At: Lack of detailed tasks, milestones definition and tracking</td>
</tr>
<tr>
<td>2 Ad-hoc</td>
<td>Resource Management</td>
<td>No estimate of resource needs, no dedicated PM, relying on internal resources only, on top of their daily job.</td>
</tr>
<tr>
<td>2 Ad-hoc</td>
<td>Performance Management &amp; Reporting</td>
<td>What Works Well: Regular meetings. Report project progress up to the LMC steering committee. Area to Look at: No evidence of minutes and decision log. Consider joint reporting with strategic HR to build the full picture. This would enable HR as a whole to take action at right level between both groups.</td>
</tr>
<tr>
<td>2 Ad-hoc</td>
<td>Financial Management</td>
<td>What Works Well: Financial savings are tracked by project team. Area to Look at: Project cost is not tracked, Improve reporting up to the LMC. Improve consistency with official finance team numbers.</td>
</tr>
<tr>
<td>1 Heroic</td>
<td>Stakeholder Management</td>
<td>What Works Well: Starting to have more regular touch-points with strategic HR and the clinical stakeholders. Area to Look at: Consider more proactive engagement with stakeholders, document their requirements, needs, potential negative impact on the project.</td>
</tr>
<tr>
<td>1 Heroic</td>
<td>PM Support Tool – Documents &amp; Knowledge Management</td>
<td>Static PowerPoint documentation. The team do not leverage a central repository or standard template/tools.</td>
</tr>
</tbody>
</table>

Table 5: Transactional HR - PM Maturity Assessment
5.1.3 Accenture Assessment of Additional Opportunities

5.1.3.1 Optimizing the ratio of HR support to employee FTEs

We assessed the proposed post consolidation ratios of HR to employee FTE counts. It should be noted that combining qualitative and quantitative information yields a more meaningful assessment as quantitative benchmarks alone can be misleading and out of context. Such ratios within leading practice organization are highly variable and depend on a number of factors.

As a starting point, expected service levels are not well accounted for in quantitative data. One organization may provide bare minimum of HR services needed to meet regulatory requirements while another strives for comprehensive delivery. Strategic and Transactional HR typically are considered together when benchmarking HR functions.

Efficiencies of scale that can be achieved with a 10,000 or 20,000 person organization are not typically achieved with 1,000 person organization. The Lower Mainland Health Authorities have a heavy reliance on casual workers which increases the ratio of actual employees to FTEs, while Labour Relations may require additional attention in a unionized environment. Moreover, certain activities may be executed and/or paid for either within Strategic HR or within the business areas and are not accounted for within the Transactional HR budget (examples: training, leadership coaching, employee engagement). In addition, the skill level and capabilities of individuals are not reflected in quantitative benchmarks. If an organization has very experienced individuals and highly effective processes and technology, they will have a higher HR FTE ratio.

Within the LMC context, such comparisons therefore have limited weight due to the limited data available and limited scope of this assessment. At a high level the integrated Transactional HR function ratios demonstrate favourable comparison with industry benchmarks, although this is likely not a “like to like” comparison. As noted earlier there may be opportunities to optimize both Transactional and non-transactional HR FTE costs through more comprehensive benchmarking analysis that includes both qualitative and quantitative factors, in order to identify the most likely sources of savings.

This is demonstrated in the following figure:

<table>
<thead>
<tr>
<th>HR Functional Category</th>
<th>Pre-LMC Ratio (employees)</th>
<th>Consolidated Ratio (employees)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labor Relations / Human Resources</td>
<td>0.19</td>
<td>0.16</td>
</tr>
<tr>
<td>Occupational Health &amp; Safety</td>
<td>0.25</td>
<td>0.21</td>
</tr>
<tr>
<td>Records &amp; Benefits</td>
<td>0.13</td>
<td>0.13</td>
</tr>
<tr>
<td>HR Technology</td>
<td>0.03</td>
<td>0.04</td>
</tr>
<tr>
<td>JDs and Compensation</td>
<td>0.05</td>
<td>0.05</td>
</tr>
<tr>
<td>Recruitment</td>
<td>0.14</td>
<td>0.14</td>
</tr>
<tr>
<td><strong>Total LMC Transactional HR</strong></td>
<td><strong>0.60</strong></td>
<td><strong>0.73</strong></td>
</tr>
<tr>
<td>Other LMC HR functions embedded in Strategic HR or the business (e.g., Training, Leadership Development, Engagement)</td>
<td>TBC*</td>
<td>TBC*</td>
</tr>
<tr>
<td><strong>Total LMC end-to-end HR</strong></td>
<td><strong>TBC</strong></td>
<td><strong>TBC</strong></td>
</tr>
<tr>
<td>Leading HR Organizations</td>
<td>0.60 – 1.25</td>
<td></td>
</tr>
<tr>
<td>Target LMC end-to-end HR ratio</td>
<td>TBC*</td>
<td></td>
</tr>
<tr>
<td>Estimated Additional HR Savings (Transactional + non-Transactional)</td>
<td>STBC</td>
<td></td>
</tr>
</tbody>
</table>

Figure 11: Transactional HR - Ratio of HR Support/FTEs
5.1.3.2 Enhancing the effectiveness of the current initiative

Overall it is our observation that this LMC initiative can be enhanced through better definition of the touchpoints between transactional and strategic HR as well as between transactional HR and their stakeholders. Moreover, program delivery between these two groups needs to be “untangled” in order to achieve optimal effectiveness in HR service delivery and eliminate potential sources of confusion to the front lines.

1. Link with Strategic HR
   - Strategic HR and Transactional HR need to collaborate through the consolidation in order to ensure a smooth interface and transition with front line staff
   - Separating these functions early in the LMC process has resulted in challenges in managing both the ongoing integration as well as setting the longer-term HR strategy. Leading practice provides for a more measured approach to HR consolidation while the other LMC projects are in transition and require HR support
   - There is a need for a more formalized HR governance structure between Transactional and Strategic HR, and definition of the overall HR operating model in order to ensure optimal continuing services to the front line business. This operating model should be reviewed once the LMC initiative has stabilized.

2. Long Term Strategy
   - While Transactional HR has reasonably focused on tactical opportunities to consolidate there still needs to be a strategic view of Transactional HR grounded in a broader overall HR strategy that incorporates all stakeholders
   - An overarching HR strategy planning initiative with Strategic HR would enable both groups to operate toward a common vision and shared set of priorities

3. Technology Planning
   - The IT group needs to be more effectively engaged with the HR initiative in both identifying the plan and areas of opportunity
   - The business case for technology integration requires further investigation and formalization

5.1.3.3 Improving the effectiveness of Transactional HR in supporting the LMC transformation

Areas for improvement in the area of HR as it relates to the LMC initiative as a whole include ongoing integration and change management/communications.

1. Ongoing integration
   - The entire LMC initiative is highly dependent on support from Transactional HR, however the dependencies between HR and the other projects have neither been fully mapped nor understood. This is critical to ensuring that the HR consolidation objectives can be achieved effectively.
   - There is not yet a multi-year staff transfer plan for the other 11 projects, this means HR cannot practically plan out its workload
   - Without an integrated cross LMC HR Plan that looks across the entire LMC initiative, other projects may continue to be challenged in executing their reduction initiatives
   - It is recommended that more formalized and ongoing planning between HR and the other projects take place to better manage the ongoing process
2. Change Management/Communications

- The speed of the HR integration in particular, and the LMC overall has resulted in a limited ability to focus on change management and communications,
- Moving forward, it is recommended that a more formalized proactive approach be taken to change management and communication and further that this be done in collaboration with Strategic HR and the front lines, as achieving many of the follow on savings will be dependent upon the degree to which stakeholders are engaged and committed.

5.1.4 Conclusions – The Transactional HR Initiative

Although the current LMC scope has been limited to Transactional HR, there are opportunities to broaden the scope and by extension the savings. FHA is not within the current project scope but accounts for approximately 32% of HR costs if its budget is added to the consolidated baseline.

1. The direct HR savings target is realistic, but additional opportunity lies in the implementation of Transactional HR programs to achieve Healthcare workforce savings
   - The Transactional HR savings program accounts for Healthcare Workforce savings which do not directly impact the Transactional HR budget but do result in overall cost savings (beyond the LMC $1B scope)
   - The HR team has achieved successfully reduced its FTE/Workforce ratio overall from 1:36 to 1:24 FTEs per 100 FTEs (or from 0.80 to 0.73 FTEs per 100 employees), enabling it to achieve its labour-related savings targets.
   - While these achievements compare favourably with high-level benchmarks, a full comparative analysis was not feasible given the high level nature of this assessment, which did not address HR-related activities such as leadership coaching, and training that may take place either within Strategic HR or the actual business. A like to like assessment would help identify further HR savings opportunities.

2. Separation of program responsibilities and execution between Transactional and Strategic HR is not clear and the touch points, as well as program responsibilities between the two groups should be better defined and disentangled.
   - There is significant opportunity to engage with both Strategic HR and the front line workforce in delivering savings through Transactional HR program efficiencies
   - Improved joint HR strategy planning and priority setting with Strategic HR would enable a more integrated approach to managing Human Resources as a whole, and improve service delivery to the front lines

3. The overall LMC initiative and attainment of objectives are highly dependent on HR involvement; however dependencies with the other projects have not been fully mapped resulting in potential confusion and mismatched stakeholder expectations
   - A greater focus on integration with other LMC projects is recommended in order to manage people-related risks
   - Finally, joint priority setting and planning, stakeholder engagement, and a proactive communications agenda are recommended in order to increase effectiveness of these touchpoints
5.2 IM/IS (excluding Technical Services)

The scope of the LMC IM/IS project includes VCH, PHC and PHSA. Fraser has been excluded due to organizational capacity and since they utilize a different clinical information system platform (Meditech). Technical Services has been transitioned to the Shared Services Organization (SSO).

5.2.1 Baseline Budget, Savings Targets and Approach

The overall consolidated budget for the ‘in scope’ IM/IS function is $54.96M. The team has a target of $6.25M in savings approximating 11.4% of their spend. While Fraser is not in scope for this savings initiative their budget is $13.7M. If FHA is added to the scope and is able to save half the 11.4% targeted savings for the other Health Authorities, an additional savings an $800,000 could be achieved.

The savings target of $6.25M is projected to be achieved over a 2 year time frame, beginning in fiscal 09/10 and ending in this current fiscal year.
5.2.1.1 The Savings Initiatives

The IM/IS team has identified several cost reduction initiatives to meet their targeted savings as shown in the following figure:

Source: Finance Working Group for FY09/10 & FY 10/11 Budget Baselines; CFOs for Savings Targets
A $2.25M savings will be achieved through implementation of a new organizational structure and staffing rationalization. $2.0M will be achieved through the renegotiation of contracts, with 50% of those savings coming from five key vendors. $1.1M in savings will be achieved through reduction in supply expenses and finally $900k will be saved through consolidating staff into two sites.

The following table describes these initiatives in more detail:

<table>
<thead>
<tr>
<th>IM/IS Initiatives</th>
<th>Details</th>
<th>Strategy</th>
<th>Timeline</th>
<th>Opportunity</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour</td>
<td>• IMITS new organization created FY09/10</td>
<td>• Create new IT organization</td>
<td>FY09/10, FY10/11</td>
<td>$2.5m</td>
<td>• Consolidation of all but FHA at this time due to capacity and variance in platforms</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Consolidate staff from PHC, PHSA &amp; VCH</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non Labour: Contracts &amp; Obligations</td>
<td>• Renegotiate service contracts</td>
<td>• Identify key vendors and renegotiate</td>
<td>FY10/11</td>
<td>$2.0m</td>
<td>• Combined buying power &amp; volume, unused licenses</td>
</tr>
<tr>
<td></td>
<td>• Five vendors account for approx. 50% target savings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non Labour: Sundries &amp; Supplies</td>
<td>• Reduce spend in preparation of FY10/11 fiscal year</td>
<td>• Gain better wireless contracts with larger volume and reduction to single vendor</td>
<td>FY10/11</td>
<td>$1.1m</td>
<td>• Added buying power with single vendor</td>
</tr>
<tr>
<td></td>
<td>• Reduce training &amp; education budget to $2000/person</td>
<td></td>
<td></td>
<td></td>
<td>• Reduce discretionary spend on education</td>
</tr>
<tr>
<td>Non Labour: Facilities</td>
<td>• Consolidation complete for FY10/11</td>
<td>• Reduce space footprint</td>
<td>FY10/11</td>
<td>$900,000</td>
<td>• Lease expiration, staff reduction, cost savings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Consolidate team</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The overall total projected savings is $6.25M exclusive of any capital expenditure on infrastructure or other dependent improvements. The principal source of savings comes from reduction in labour and contract expenses. Maximum savings occurs in this fiscal (year 2 of the two year program).

5.2.1.2 Observations

Overall our analysis shows that the IM/IS plan is feasible but contains a number of challenges that will need to be managed. As we will describe in a later section, we believe that implementation of additional utilization and efficiency opportunities could increase and extend the savings/benefit curve.

Labour – It was interesting to note, unlike many other LMC projects, through a structured approach and effective leadership, the team was able to make organizational structure decisions and change without experiencing decision delays or impediments from HR.

While the new organizational structure is substantively in place, key management positions are still in process of being finalized so overall the leadership has not yet reached full efficiency.

As mentioned previously, Fraser is currently out of scope for this initiative. Inclusion of FHA could create additional savings opportunities. Fraser’s budget is $13.7M. If FHA is added to the scope and is able to save half the 11.4%
targeted savings for the other Health Authorities, an additional savings of $800,000 could be achieved. Savings are subject to alignment of Fraser IM resources with ITIMS

**Non Labour: Contracts and Obligations** – While the targeted savings of $2M is conceptually feasible the details of the implementation/negotiation strategy were not clear. Typically a vendor will not consider a major reduction in annual maintenance fees unless there is a license swap or an identifiable future sales target. Historically, contract signature/extension does not solely reside in IT. Therefore, there is a risk of a different department signing the contract outside the bounds of what IT plans to negotiate. To minimize this risk, ITIMS should continue to build the contract inventory and determine responsibilities for the contract process.

**Non Labour: Sundries and Supplies** – While “sundries” savings of $1.1M (through wireless fees, education and training) is feasible within a given year, it does not appear to be a sustainable approach over the longer term. Risks exist in cutting the education and training budget. Although the move to $2000 per person is still within “typical” levels, the reduction in budget may hinder the ability to support appropriate skills as the new organization evolves. Employees are likely to experience uneasiness as they see these types of cuts in addition to staff reductions.

The wireless strategy was to consolidate to a single vendor and have monthly fees set by the end of fiscal 09/10 so the annualized savings are indeed possible for 2010/11. This vendor consolidation has been completed as planned. Proactive monitoring of wireless usage and wireless industry pricing will indicate if adjustments become appropriate.

**Non Labour: Facilities** – Consolidation to the two facilities was completed by the end of 2009/10 so the annualized savings targeted for this fiscal are achievable.
5.2.2 Maturity of Project Management

While the IM/IS team is well on the way to realizing their target savings the multiple interdependencies with the other LMC projects lead us to recommend that this function should move to “Advanced PM Capabilities”. This would improve IM/IS’s resource and stakeholder management capabilities and enable more agility in responding to service needs.

<table>
<thead>
<tr>
<th>Maturity</th>
<th>Process Area</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Basic</td>
<td>Scope Management</td>
<td>What Works Well: Initial scope and plan has been properly defined, a list of initiatives is part of the plan. Area to Look At: No evidence of scope change tracking log.</td>
</tr>
<tr>
<td>3 Basic</td>
<td>Issue &amp; Risk Management</td>
<td>What Works Well: Risks and issues have been formally documented and are log-tracked on a weekly basis.. Area to Look At: May benefit from a stronger issue resolution mechanism, define the due date, effort needed, impact details. Implement a consolidated workflow-enabled tool to track and report on risk &amp; issues in a real-time manner, that will help to escalate issues to management as appropriate.</td>
</tr>
<tr>
<td>3 Basic</td>
<td>Workplan and Time Management</td>
<td>What Works Well: A basic high level Project Plan exist with phases and dates. A detailed MS Project plan has been built, describing the main tasks of the project, task duration etc. Area to Look At: No evidence of detailed tasks, specifically in terms of resources need. The dependencies between tasks are not described. The team could benefit from a central MS Project server.</td>
</tr>
<tr>
<td>2 Ad-Hoc</td>
<td>Resource Management</td>
<td>What Works Well: An estimation resource needs tool exists. A prioritization process is being established. Area to Look at: No consistent use of estimation tool for resources needs, no dedicated PM, relying on internal resources only, on top of their daily job. Establish a demand management process.</td>
</tr>
<tr>
<td>3 Basic</td>
<td>Performance Management and Reporting</td>
<td>What Works Well: Regular meetings. Report project progress up to the LMC steering committee. Area to Look at: N/A</td>
</tr>
<tr>
<td>2 Ad-Hoc</td>
<td>Financial Management</td>
<td>What Works Well: Financial savings are tracked by project team. Area to Look at: Project cost is not tracked, improve reporting up to the LMC. Improve consistency with official finance team numbers.</td>
</tr>
<tr>
<td>3 Basic</td>
<td>Stakeholder Management</td>
<td>What Works Well: There is an initial stakeholder list and documented assumptions, including a communication plan. Area to Look at: the stakeholder management plan could benefit from periodic verification of expectations and identification of new stakeholders, their expectations and potential impact.</td>
</tr>
<tr>
<td>3 Basic</td>
<td>PM support tool – Documents &amp; Knowledge management</td>
<td>What Works Well: The team use a central SharePoint and specialized Project Management tools as well as mostly static documentation. Area to Look at: The team could benefit from a more structured project documentation repository and a central MS Project server.</td>
</tr>
</tbody>
</table>

Table 7: IM/IS – PM Maturity Assessment
5.2.3 Accenture Assessment of Further Opportunities

LMC IM/IS Initiatives

<table>
<thead>
<tr>
<th>IM/IS Initiatives</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour</td>
<td>• Structured approach and effective leadership led to organization structure decisions and change with no major HR execution or Leadership decision-making delays or impediments</td>
</tr>
<tr>
<td></td>
<td>• While new organization structure is in place, key management positions are still in process or being finalized or have recent additions, so leadership has not reached full efficiency</td>
</tr>
<tr>
<td></td>
<td>• Fraser Health Authority is excluded from the current scope of work. Inclusion of FHA could create additional savings opportunities.</td>
</tr>
</tbody>
</table>

Non Labour: Contracts & Obligations

<table>
<thead>
<tr>
<th>IM/IS Initiatives</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• The $2m savings IM/IS expects to achieve may be feasible conceptually, it is unclear as to how these savings objectives are going to be met. Typically, a vendor will not consider a major reduction in annual maintenance fees unless there is a license swap or an identifiable future sales target.</td>
</tr>
<tr>
<td></td>
<td>• Contract signing &amp; extension risk outside of IT control currently possible. Continue building inventory and determine authority and responsibilities for contract process.</td>
</tr>
</tbody>
</table>

Table 8: IM/IS - Additional Opportunities

Note 1: 5.7% savings factor used for FHA due to unique applications environment from PHC, PSHA, VHC
5.2.4 Conclusions – The IM/IS Initiative

IM/IS will achieve $6.25M savings from an overall budget of $55M by the end of fiscal 2010/11.

- The team successfully navigated LMC leadership decision-making and HR processes and were able to move forward with the required organizational restructuring and staffing issues in a timely fashion. They were able to transfer employees to a common employer.
- $511,000 in savings achieved in FY09/10 through creation of the IM/IS organization as well as reduction in management staff.
- $2.1 in labour savings will be achieved in FY10/11 through a combination of staff consolidation as well as reduced spending on external consultants.
- Service contracts will be renegotiated with a projected savings of $2M, of this $1M will come from 5 vendors.
- Facility consolidation efforts will provide $900K in savings in this fiscal year and as well $1.1M in savings will result from a combination of renegotiation of wireless contracts and reductions in training and education budgets.

Some high risk areas exist within the plans for staff restructuring and renegotiation of key service contracts:

- We view the service contract targets as at high risk as a result of two main factors:
  - The team does not have vendor commitment to the renegotiation/reduction targets. Industry leading vendor targets will not be met unless detailed negotiation tactics include a 'win-win' for vendors.
  - The potential exists for non-IT departments extending service contract terms without consideration of the IM/IS plan until appropriate accountability is established and the complete inventory of existing contracts is put in place.
- The elapsed time to complete staff contract negotiations will dictate achievement of the savings targets in the 2010/11 FY.

Additional savings of up to $3.3M are feasible through additional related IT initiatives:

- Including FHA in the consolidation could yield further savings of $.8M, assuming achievement of ½ of the planned 11.4% savings targeted for PHC, PHSA and VCH. Savings are subject to alignment of Fraser IM resources with ITIMS.
- An application and portfolio rationalization exercise could help the organization achieve up to an additional $2.5M savings through reduction of unused or low value applications and projects. Rationalization success depends upon business leadership support of business process standardization and applications retirement.
5.3 Health Information Management

The LMC Health Information Management (HIM) consolidation initiative encompasses all the lower mainland health authorities: Fraser, PHC, PHSA and VCH. HIM services include such functions as health records, transcription services, registration and health data.

5.3.1 Budget Baseline, Savings Targets and Approach

The HIM project identified $3.16M in savings from an “in scope” budget of $55.28M or 5.7%.

Source: Finance Working Group for FY09/10 & FY 10/11 Budget Baselines; CFOs for Savings Targets
5.3.2 The savings initiatives

The $3.2M in targeted savings is going to be generated through a combination of both cost reduction and revenue generation initiatives.

**Figure 18: Health Information Management – Saving Sources**

These savings will be realized over a three-year timeline and in the following manner:

- $1.0M will be achieved through revenue generation in transcription services
- $883K will be saved through labour consolidation within HIM
- $500K will be achieved through reduction in radiology/voice recognition expenses
- $250K savings will be achieved through the reduction of outsourced contract expenses
- $200k will be saved a change in the record retrieval practice to eliminate automatic retrieval of records over 5 years of age
- The remaining $330K savings will be achieved through the reduction of a number of other expenses such as voice recognition ($75K); autofaxing ($140K); coding software ($40K) and other ($75K)
Six initiatives have been identified and are described in the following table:

<table>
<thead>
<tr>
<th>Health Information Management Initiatives</th>
<th>Details</th>
<th>Strategy</th>
<th>Timeline</th>
<th>Opportunity</th>
<th>Rationale</th>
</tr>
</thead>
</table>
| Outsourcing Contract                     | • 40% transcription services outsourced to single vendor  
  • Vendor discussions in progress & progress as planned  
  • Alternative to issue RFP for lower pricing  
  • If go to RFP, consideration of service provider option  
  • Renegotiate vendor contract for more favourable terms | • FY10/11 | $250k | Combined buying power and volume levels |
| Change Retrieval Practice                | • Change in retrieval practice to eliminate automatic retrieval when over 5 years of age  
  • Vendor notification process initiated | • FY10/11 | $200k | Guideline to rationalize when charts provide saves retrieval costs |
| Autofaxing                               | • Begin autofax at VCH, PHSA, FH sites not currently utilized  
  • Use existing servers so no investment needed (if needed, would be $15k)  
  • Need small level support from IMITS to implement  
  • Add autofaxing at sites not utilizing to increase productivity | • FY 10/11 | $140k | Increase efficiencies in sites not currently utilizing |
| Organization Structure                   | • Create new organizational structure supporting FHA, PHC, PHSA, VCH  
  • Staff reduction of 17 FTEs  
  • Consolidation across HA  
  • Support all HA through services  
  • Transfer staff to one organization | • FY10/11, FY11/12 | $883k total | Consolidate HIM structure and reduce staff |
| Transcription                            | • Confirmation of service offerings  
  • Identified as high risk initiative  
  • Restructure transcription services  
  • Include fee for service | • FY10/11, FY11/12 | $1m | Productivity gains of 20-30%  
  • Revenue generation  
  • Support EHR |
| Voice Recognition                        | • FHA initiated & funded prior to LMC consolidation  
  • FHA radiology speech recognition tool RFP in process  
  • 30% FHA transcription volume from radiology  
  • Move FHA radiology to voice recognition. Transfer responsibility to DI.  
  • Enable remaining FHA sites.  
  • Q4 FY10/11 | • Q4 FY10/11 | $500k FHA Radiology  
  • $75k other FHA | DI in PHC, PHSA & VCH executed - thus no need for HIM support |

Figure 19: Health Information Management – Initiatives
5.3.3 Accomplishments to date:

So far HIM has achieved $0.02M of their $3.16M target. The bulk of savings are projected to occur in the third year, FY 2011/12.

Figure 20: Health Information Management – Savings by Year

Source: Finance Working Group for FY09/10 & FY 10/11 Budget Baselines; CFOs for Savings Targets; LMC Project Leads for Achieved Savings FY 09/10
5.3.4 Observations

In summary, the total projected savings for HIM total $3.16M, exclusive of any capital spend on infrastructure or other dependent improvements. As can be seen in the preceding figures, the principal sources of savings are reductions in labour expenses, radiology/voice recognition expenses and an increase in revenue for transcription services. The majority of savings are projected to occur in Year 3 of the program.

Our analysis concludes that the HIM plan is feasible overall, but there are a number of challenges that the team will need to address to ensure success. We will now discuss these challenges at the individual initiative level.

**Organization Structure** – We observed that the management team works cohesively in structuring the organization. 50% of cost savings will not be realized until the staff consolidation is completed - so the team’s ability to move forward with Section 54 and related union discussion is critical to meeting their target. We feel that additional staff reductions may be feasible with a process standardization effort.

**Transcription** – Sound reasoning for the identification and expectation of savings is evidenced in this area. The initiative plans to charge physicians (fee-for-service) for transcription services. While the team received initial positive feedback, we see these revenue generation targets as high risk due to the assumption that physicians will pay transcription fees. If this proceeds, higher adoption of transcription would also provide a foundation for the E.H.R. For this initiative to succeed the senior executive and VP of Medicine must provide strong and visible support for this approach.

**Voice Recognition** – While the FHA goal to increase the use of speech recognition is appropriate, the decision as to the actual tool should be driven by the broader Lower Mainland speech recognition requirements. The investment funding is already in place for this initiative. It is important to note that strong user adoption within the Diagnostic Imaging group is necessary to in order for that department to manage the process, thus removing the manual transcription process from HIM’s responsibility.

**Outsourcing Contract** – It appears that the savings target in this area is achievable based upon current vendor discussions. If the discussions with the vendor do not result in the desired savings HIM still has the option of initiating an RFP process. At that time consideration should be given to selecting a service provider that completes the processing and as well manages the solution. HIM could source both components to an external vendor. A decision date should be established to ensure completion of an RFP process and implementation before the end of this fiscal year to gain the savings as planned.

**Change Retrieval Practice** – Moving to automatic retrieval for records within five years is a low risk opportunity. A typical retrieval process in the industry leverages 2-5 years.

**Autofaxing** – Autofaxing has shown productivity improvements during previous LMC implementations. The savings appear appropriate based on implementation history. HIM should work with IM/IS to ensure that they are in the priority queue to receive support on this initiative.
5.3.5 Maturity of Project Management

We applied the PMO methodology as described in Section 3.7 and have assessed the HIM project as “Basic” in its PMO maturity. HIM would benefit from stronger basic PM capabilities to improve most of the project management processes and thus ensure better visibility and tracking.

<table>
<thead>
<tr>
<th>Maturity</th>
<th>Process Area</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 - Basic</td>
<td>Scope Management</td>
<td>What Works Well: Initial scope and plan has been properly defined, a list of initiatives is part of the plan. Dependencies have been identified and documented as part of the project charter. The IT impact and IT strategy has been properly defined. Area to Look At: No evidence of scope change tracking log. Lack of cross-Health authority PMO may hinder the project success and timely progress.</td>
</tr>
<tr>
<td>3 Basic</td>
<td>Issue &amp; Risk Management</td>
<td>What Works Well: Risks and issues have been formally documented and are log-tracked on a weekly basis. Area to Look At: Implement a consolidated workflow-enabled tool to track and report on risk &amp; issues in a real-time manner, that will help to escalate issues to management as appropriate.</td>
</tr>
<tr>
<td>3 Basic</td>
<td>Workplan and Time Management</td>
<td>What Works Well: A detailed MS Project plan has been build, describing the main tasks of the project, task duration, resources need and dependencies between tasks. Area to Look At.: The team could benefit from a central MS Project server.</td>
</tr>
<tr>
<td>2 Ad-Hoc</td>
<td>Resource Management</td>
<td>What Works Well: The current project management team claims to handle the LMC project workload with an appropriate level of efficiency. “It’s no pure PMO, but all components are here” Area to Look At.: List roles and responsibilities at the project &amp; program level to facilitate task allocation and workload evaluation process. Produce a time based resource plan to forecast demand over time, including dependent resources.</td>
</tr>
<tr>
<td>3 Basic</td>
<td>Performance Management and Reporting</td>
<td>What Works Well: Regular meetings with formal meeting notes and action list. Report project progress up to the LMC steering committee. Area to Look at: Formalize escalation process and identify accountable person, indicate issue impacts on overall project, (timeline, results, costs, etc)</td>
</tr>
<tr>
<td>2 Ad-Hoc</td>
<td>Financial Management</td>
<td>What Works Well: Financial savings are somehow tracked by the project team, but without a clear initial baseline. ne. Area to Look at: Project cost not tracked, Improve reporting to LMC. Improve consistency with official finance team numbers.</td>
</tr>
<tr>
<td>3 Basic</td>
<td>Stakeholder Management</td>
<td>What Works Well.: There is a very detailed list and analysis of stakeholders current and desired engagement status, including a precise communication plan. Area to Look at: The stakeholder management plan could benefit from periodic verification of expectations and identification of new stakeholders, their expectations and potential impact.</td>
</tr>
<tr>
<td>3 Basic</td>
<td>PM support tool – Documents &amp; Knowledge management</td>
<td>What Works Well: The team use a central SharePoint and specialized Project Management tools as well as mostly static documentation. Area to Look at: A more structured project documentation repository and a central MS Project server would be beneficial.</td>
</tr>
</tbody>
</table>

Table 9: Health Information Management – PM Maturity Assessment
5.3.6 Accenture Assessment of Further Opportunities

We see a number of additional activities HIM could undertake to achieve further cost savings/benefits. We have outlined these in the following table.

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Action</th>
<th>Rationale</th>
<th>Benefits</th>
<th>Benchmark Improvement Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Standardization</td>
<td>Create standard processes for each functional area across the HAs.</td>
<td>Standard processes allow additional efficiencies in training, execution</td>
<td>• Common processes enabling personnel to work effectively across all HA units.</td>
<td>Organizations focused on process reengineering efforts typically save up to 5%. For HIM, this could mean additional savings up to $2.5M</td>
</tr>
<tr>
<td></td>
<td>Review best practices in organizations and adopt LMC-wide</td>
<td>and support costs</td>
<td>• Streamlined training and additional cross training opportunities</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Higher productivity, leading to additional savings or work uptake</td>
<td></td>
</tr>
<tr>
<td>Voice Recognition</td>
<td>Consider the broader Lower Mainland Radiology needs when making</td>
<td>Will be managed in DI and with DI consolidation efforts, using common voice</td>
<td>• Common systems platform</td>
<td>Organizations understanding potential impact of decisions on organizational strategy are more effective when making decisions regarding tool usage and affecting cost of ownership</td>
</tr>
<tr>
<td></td>
<td>vendor decision for RFP.</td>
<td>recognition will be advantageous</td>
<td>• Lower support &amp; maintenance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Cross training skills</td>
<td></td>
</tr>
<tr>
<td>Document scanning</td>
<td>Expand the scanning capabilities in support of records management</td>
<td>Provides costs savings and enables further deployment of electronic health</td>
<td>• Reduced paper chart storage and retrieval costs</td>
<td>Best practices in HIM include centralized scanning with established work flow processes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>records</td>
<td>• Timely record availability</td>
<td>Scanning cost and benefit dollars, yet to be determined, vary significantly based on volumes,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Standardization of documentation practices</td>
<td>automation and application</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Reduction in turnaround time for CIHI (Canadian Institute for Health Information) data</td>
<td></td>
</tr>
<tr>
<td>Performance Metrics</td>
<td>Start measuring performance in each functional area. Create baseline</td>
<td>Identify key metrics for internal and stakeholder use, then study the</td>
<td>• Factual basis for measuring performance</td>
<td>Organizations striving for efficiencies gain insights and productivity improvements through managing the right metrics.</td>
</tr>
<tr>
<td></td>
<td>of current performance to use as indicator of efficiency uptake</td>
<td>drivers and outcomes, making adjustments along the way</td>
<td>• Transparency of performance</td>
<td>“What gets measured gets done”</td>
</tr>
<tr>
<td>Service Level Agreements</td>
<td>Develop a SLA process to be utilized with the stakeholders for each</td>
<td>Sets performance expectations for both parties. Provides transparency</td>
<td>• Gained understanding and buy-in from both parties</td>
<td>SLAs are cornerstone to strong working relationship across service departments and those</td>
</tr>
<tr>
<td></td>
<td>function within HIM</td>
<td>throughout organization</td>
<td>• Shared expectations for availability and performance</td>
<td>they service. Organizations structured with shared services have stronger working</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>relationships when appropriate agreements are in place</td>
</tr>
</tbody>
</table>

Table 10: Health Information Management – Additional Opportunities

5.3.7 Conclusions – the Health Information Management Initiative

HIM will achieve $3.16m savings target from an overall budget of $55m by end of FY2011/12

- Transcription cost savings of $1m through revenue generation to be gained by end of FY2011/12
- Labor savings of $883,000 planned for FY10/11 through reduction of 17 FTEs
- Transcription outsourcing contract renegotiation and voice recognition completion to provide another $825,000 in savings through FY2011/12. Voice recognition also includes transfer of responsibilities to Diagnostic Imaging once operational
- Policy change in automatic chart retrieval process (5-year history) to gain $200,000 in FY2011/12
- Initial savings for all these initiatives to begin in 2009/10
- Implementation projects received funding prior to LMC initiative, so no investment funding needed

Overall, the target is achievable. However some higher risk components are included

- While the FHA goal to increase the use of speech recognition is appropriate the decision as to the actual tool should be driven by the broader Lower Mainland speech recognition requirements. The investment funding is already in place for this initiative.
- Strong adoption of FHA radiology voice recognition is necessary to gain HIM savings of $500K. Consistent technology will enable lower total cost of ownership.
- Transcription $1M savings through charging fee-for-service physicians has been identified as high risk. Physicians must adapt to paying a fee for additional services provided (beyond those provided through hospital agreements). It is critical to have senior executive and VP of Medicine provide strong and visible support for this initiative. The opportunity for increased continuity of care creates a strong foundation for this cost savings initiative.

Additional savings of up to $2.5m are feasible through additional HIM initiatives

- Organizations focused on process reengineering efforts typically save up to 5%. For HIM, this could mean additional savings up to $2.5M.
- Other activities including document scanning, tracking of performance metrics and service level agreements will increase HIM departmental effectiveness thus providing additional benefits.
5.4 BioMedical Engineering

In Phase 1 of the BioMedical Engineering LMC Project, the following sites are in scope:

- Fraser Health Authority;
- Providence Healthcare;
- Provincial Health Services Authority;
- Vancouver Coastal Health;
- All DI equipment service contracts and staff to transfer to BioMedical Engineering; and,
- Riverview and FPH equipment services.

In Phase 1, Radiation Therapy Service Techs and Linear Accelerators are excluded from the project scope.

In Phase 2, the follow areas will be reviewed within six months of the implementation of the new organization structure:

- Lab equipment service;
- Pharmacy equipment service and
- SPD equipment service

5.4.1 Baseline Budget, Savings Targets and Approach

The BioMedical Engineering Budget for FY 09/10 is $27.5M. The agreed saving target for BioMedical Engineering is $2.6M or 9% of the budget. The breakdown by region is as follows:

Biomedical Engineering FY09/10 Budget

<table>
<thead>
<tr>
<th>Region</th>
<th>Budget in $M</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHC</td>
<td>$11.6M</td>
</tr>
<tr>
<td>PHSA</td>
<td>$2.7M</td>
</tr>
<tr>
<td>FHA</td>
<td>$10.7M</td>
</tr>
<tr>
<td>VCH</td>
<td>$2.5M</td>
</tr>
<tr>
<td>Total</td>
<td>$27.5M</td>
</tr>
</tbody>
</table>

Figure 21: BioMedical Engineering – Baseline Budget

Source: Finance Working Group for FY09/10 & FY 10/11 Budget Baselines; CFOs for Savings Targets

The total projected savings is exclusive of any capital spend on infrastructure or other dependent improvements. Maximal savings are expected to occur in the second year of this three-year program. The breakdown of savings through FY2012/13 is depicted below.
Figure 22: Biomedical Engineering – Savings to Date

Source: Finance Working Group for FY09/10 & FY 10/11 Budget Baselines; CFOs for Savings Targets;

Figure 23: Biomedical Engineering – Savings by Source

Source: LMC Biomedical Engineering Cost Savings Report (received during 4/1 meeting) & LMC 2010/11 Draft Budget
The $2.6M in savings is generated through two distinct cost reduction initiatives, Service Contracts and Labour Consolidation (Vacancies; Staff Reductions, Reduce on Call), with the majority of savings occurring through a reduction in Service Contract expenses.

### 5.4.1.1 The savings initiatives

The LMC team identified two initiatives that are listed in the following table:

<table>
<thead>
<tr>
<th>Biomedical Engineering Initiatives</th>
<th>Details</th>
<th>Strategy</th>
<th>Timeline</th>
<th>Opportunity</th>
<th>Rationale</th>
</tr>
</thead>
</table>
| **Service Contracts**             | • VCH and FHC are bulk of usage  
  • Majority of VCH contract savings realized prior to LMC project. Additional small savings identified  
  • CT MRI savings belong to DI  
  • Other DI maintenance savings belong to Biomedical Engineering  
  • Productivity gained through added maintenance support without added staff | • Implementing self-insurance model assuming 50/50 investment / savings model  
  • 94% of contract savings to come from four vendor contracts | • Negotiations in progress  
  • Savings planned for FY10/11 | • $1.8m savings  
  • 10% cancellation penalty estimated | • Reduced maintenance spend by in-house management |
| **Labour Consolidation**          | • Staff & vacancy reduction total 7.1 FTE  
  • On-call reduction, primarily for FHC and VCH | • Reduce through vacancies and limited staff  
  • Reduce on-call hours  
  • Consolidate labour to single HA  
  • Manage cross-HA funds as one budget | • Savings did not occur in 2009/10 as planned due to lack of HR support in job structuring | • Vacancy closure of $389,000  
  • Staff reduction of $220,000  
  • $181,000 savings through on call reduction | • Small FTE reduction due to more work in house  
  • Staff increase not planned  
  • On-call has over coverage |

Table 11: Biomedical Engineering – Savings Initiatives

### 5.4.1.2 Observations

Overall, the savings targets for both Service Contracts and Labour Consolidation are achievable, although operational risks to exist.

A self-insured model of services contracts has proven effective at VCH. The LMC project director has experience with the self-insured model through work at VCH which lends credibility to the view of the benefits and funding model. The targeted 50% saving can be reasonably removed from future budgets. However, the remainder of the operating budget must remain through future years, regardless of utilization, to manage the risk of equipment failure.

A 10% penalty for the cancellation of service contracts has been included in the budget. Actual penalties may exceed the estimate and negatively affect the overall savings.

Productivity has been gained due to added maintenance support without added staff. In the future, performance metrics and tracking will be key to managing budgetary issues.

Labour Consolidation includes $0.4M in Vacancies, $0.2M in Staff Reductions and $0.2M in On Call Support Reductions. The ability to fully execute on this plan has been delayed due to job reclassification and description of BioMedical Engineering management in the new organization.
Labour Consolidation has also been delayed due to issues with system access policies across the HAs. Employees within one HA are limited in their ability to access other HA’s systems which is inhibiting the ability of employees to provide support.

Implementation of additional utilization and efficiency opportunities could increase and extend the savings/benefit curve.

5.4.2 Maturity of Project Management

The PMO methodology described in 3.7 was applied to the LMC BioMedical Engineering project. Overall, the BioMedical Engineering work plan is managed on an “Ad Hoc” basis. BioMedical Engineering would mainly benefit from a “Basic” level of workplan management with specific focus on managing dependencies.

The overall assessment of the Project Management Office maturity is below:

<table>
<thead>
<tr>
<th>Maturity</th>
<th>Process Area</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Ad Hoc</td>
<td>Scope Management</td>
<td>What Works Well: High level scope has been defined initially, list of initiative are part of the initial project charter. Area to look at: Short planning window may result in incomplete or inaccurate forecasts. Leverage stronger project control and nominate a dedicated Project Manager to create more comprehensive impact analysis faster.</td>
</tr>
<tr>
<td>2 Ad Hoc</td>
<td>Issue &amp; Risk Management</td>
<td>What Works Well: Risks have been formally documented including developed mitigation strategies but are lacking accountable lead and expected closure date. The risks are part of the plan and the report up to the LMC committee. Area to Look At: Unable to identify all risks and cost saving opportunities due to short planning window. Risk and issue are based on a static file. No evidence on risk tracking log. An integrated tool with workflow capabilities will help to track closely the issue until final resolution.</td>
</tr>
<tr>
<td>1 Heroic</td>
<td>Workplan and Time Management</td>
<td>What Works Well: A basic high level Project Plan exists with list of tasks but no specific dates are documented due to short planning window. Area to Look At: Development of a more detailed work plan including task work breakdown structure and dependencies mapping, milestones definition and progress tracking. Dedicated project manager should develop &amp; maintain a detailed plan.</td>
</tr>
<tr>
<td>1 Heroic</td>
<td>Resource Management</td>
<td>What Works Well: Although a BME target org chart has been defined, there is no project resource management plan in place and the resource needs has not been identified. Area to Look At: Resource Management Plan should include how and when project team members will be allocated during all phases. Confirmation of resources availability is a common challenge across projects.</td>
</tr>
<tr>
<td>2 Ad Hoc</td>
<td>Performance Management and Reporting</td>
<td>What Works Well: Project status and risks are reported up to the LMC steering committee. Area to Look at: Minimal or no quantitative metrics are reported, Analyze improved information to refocus status activities on corrective action to improve proactive decision making. Compare project activities to baseline and trigger corrective actions to avoid further deviation.</td>
</tr>
<tr>
<td>2 Ad Hoc</td>
<td>Financial Management</td>
<td>What Works Well: financial savings have been defined and planned by the project team. Area to Look at: Project cost not tracked. Improve reporting to LMC &amp; consistency with official finance team numbers.</td>
</tr>
<tr>
<td>3 Basic</td>
<td>Stakeholder Management</td>
<td>What Works Well: There is a draft list (in construction) and analysis of stakeholders current and desired engagement status, including a change management and communication plan. A dedicated change management person has been assigned. Area to Look at: Finish the stakeholder analysis, this plan could benefit from periodic verification of expectations and identification of new stakeholders, their expectations and potential impact.</td>
</tr>
</tbody>
</table>

Table 12: Biomedical Engineering - PM Maturity Assessment
5.4.3 Accenture Assessment of Further Opportunities

5.4.3.1 Process Standardization and Increased Productivity

One additional opportunity is to create and adopt standard processes, based on best practices in the organization, across the LMC HAs. Standard processes allow additional efficiencies in training, execution and support which result in increased productivity and additional savings. Common processes enable personnel to work effectively and cooperatively across the HAs. There is also a cost rationalization opportunity through streamlined training and cross-functional area training.

Organizations focused on process standardization and productivity efforts typically realize savings up to 5%. For Biomedical Engineering, this could mean additional savings of approximately $1.3M.

5.4.3.2 Performance Metrics

A second opportunity is to transparently measure performance in each functional area. Identifying key metrics, including equipment maintenance, and creating a baseline of current performance will allow the use of indicators as a measure of efficiency uptake in the future. Having a baseline will allow the project team to study the drivers and outcomes, making adjustments as needed and tracking progress over time.

Organizations striving for efficiencies gain insights and productivity improvements through managing the right metrics. It is an old axiom that “what gets measures, gets done.”

5.4.3.3 Service Level Agreements

A third benefit opportunity is to develop a service level agreement (“SLA”) process to be utilized with the stakeholders which will set performance expectations for all parties and provide transparency through the organization. A SLA process will improve buy in from stakeholders who will gain clear understanding of the process and expectations.

SLAs are the cornerstones to strong working relationships across service departments and those they serve. Organizations with structured shared services have stronger and more productive relationships when SLAs are in place.

5.4.3.4 An Example: A productivity increase by one hour per day shows additional opportunity for rationalization

The example below indicates that savings of $1.4M could be the result of one hour increase in productivity for 60% of the staff. Biomedical Engineering has the ability to impact the budgetary numbers through capture and proactive monitoring of staff productivity. *(Actual Biomedical Engineering metrics not available)*:

- When productivity monitoring is formalized, Biomedical Engineering will be able to identify baseline and identify targets for improved productivity;
- Actual targeted savings dollars may be identified;
- Process standardization will also lead to more staff rationalization
5.4.4 Conclusions – the BioMedical Engineering Initiative

Biomedical Engineering will achieve $2.6M savings from an overall budget of $27.5M by end of FY11/12, a reduction of 9%:

- $1.8M service contract savings anticipated through use of self-insured model;
  - 94% of those savings come from four contracts
  - $1.4M of those savings planned in FY2010/11;
- Estimate of 10% cancellation penalty is accounted for with service contracts savings target; and,
- $0.6M savings is planned through staff rationalization and reduced on-call support.

Biomedical Engineering is positioned to meet the savings target, although operational risks must be proactively monitored:

- Discussions have begun with the four vendors;
  - Targeted completion date is May 31, 2010
- Vacancies and minimal staff reductions will meet the labour savings target;
- Reduced on-call coverage is being evaluated and a execution plan with contingencies developed;
- Performance metrics, including equipment monitoring metrics, must be proactively monitored to confirm self-insured model will not lead to negative budget situation; and,
- Even with annual surpluses, the budget must continue to provide the established funding model to ensure sufficient budget for maintenance occurrences.

Additional savings of up to $1.3M are feasible through additional initiatives:

- Up to an additional $1.3M could be saved through standardization of processes across the Lower Mainland (5% of budget); and,
- Other activities will increase departmental effectiveness through performance management and SLAs.

Table 13: Biomedical Engineering - Productivity Increase

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Hrs/Day Current</th>
<th>Hrs/Day Future</th>
<th>FTE</th>
<th>$/Hr</th>
<th>Daily Savings</th>
<th>Annual Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scenario 1</td>
<td>5.5</td>
<td>6.5</td>
<td>170</td>
<td>$39</td>
<td>$6,545</td>
<td>$2,388,925</td>
</tr>
<tr>
<td>Scenario 2</td>
<td>5.5</td>
<td>6.5</td>
<td>102</td>
<td>$39</td>
<td>$3,927</td>
<td>$1,433,355</td>
</tr>
</tbody>
</table>

Assumptions:
1. Assumes $80K/year annual avg. salary
2. Assumes 2080 hrs/year
3. Scenario 2 assumes only 60% of staff can increase productivity

Note: Numbers above do not represent actual metrics. Numbers are illustrative for example purposes only.
5.5 **Interpreting Services**

As a result of the growing cultural and linguistic diversity of the lower mainland population there is a constant challenge of meeting growing demand for Language Services as a clinical support service within current fiscal constraints. Provincial Health Services Authority is leading the Lower Mainland Interpreting Services consolidation. PHSA’s Provincial Language Services (PLS) has been providing Interpreting Services to VCH since FY2009. All the lower mainland health authorities as well as the existing PLS function of the PHSA are in scope. The LMC scope of Language Services is limited to face-to-face and telephone Interpreting Services across the in-scope authorities. However, PLS also provides Translation, Consulting, and Training services which could be future areas of consolidation for language-related services.

5.5.1 **Baseline Budget, Savings Targets and Approach**

The consolidated Interpreting Services budget for FY10/11 is $2.50M. The agreed savings target to meet this budget for 2010/11 is $0.24M or 12% of the budget. The Interpreting Services budget is highly dependent on demand across the different HAs. The breakdown of the total budget by organization is:

![Interpreting Services FY10/11 Budget](image)

**Addressable: $2.5M (Consolidated Labor + non-Labor)**

Source: Finance Working Group for FY09/10 & FY 10/11 Budget Baselines; CFOs for Savings Targets

The total projected saving of $0.24M is exclusive of any capital spend on infrastructure or other dependent improvements. Cost savings are being achieved primarily through reductions in labour costs (FTEs), increased management efficiencies, and an increased surplus from Provincial Language Services (“PLS” is able to generate some revenue by providing services to other non health authority organizations). The savings are generated through four initiatives.
5.5.1.1 The savings initiatives

The LMC team identified four main initiatives to achieve their savings and they are listed in the following table:

<table>
<thead>
<tr>
<th>Interpreting Services Initiatives</th>
<th>Strategy</th>
<th>Timeline</th>
<th>Opportunity</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced Staff Compensation Costs</td>
<td>Share positions between LMC and PLS business model</td>
<td>By 2010/11</td>
<td>Estimated at $0.098M</td>
<td>Reduce management overhead and replace with more operational roles</td>
</tr>
<tr>
<td></td>
<td>Introduce Regional Advisor role</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduction of Non-Labour Operating Costs</td>
<td>Streamline technology by consolidating to single database and scheduling system</td>
<td>By 2010/11</td>
<td>Estimated at $0.010M</td>
<td>Centralize operations to take out redundant costs</td>
</tr>
<tr>
<td></td>
<td>Centralize budget for billing</td>
<td></td>
<td></td>
<td>Consolidation of contracts and interpreter management key to sustainability</td>
</tr>
<tr>
<td></td>
<td>Centralize intake and dispatch of interpreters</td>
<td></td>
<td></td>
<td>Transformational approach to service delivery</td>
</tr>
<tr>
<td></td>
<td>Standardize and consolidate contracts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Investigate alternative modes of service delivery</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5.5.2 Observations

The $0.24M savings to be achieved through Interpretations Services efficiencies appears reasonable given the final FY09/10 budget spend of $2.50M. The savings approach is highly dependent on accurate cost allocations and care needs to be taken to ensure that savings are actually sustainable.

The greatest risk to achieving the planned savings will be due to increased service demand which will have a proportional negative impact on the overall budget.

Additional longer term efficiencies could be achieved through the consolidation of contracts and technology.

5.5.2.1 Interpreter Labour Relations

The changes being contemplated to support the consolidation initiative have the potential to result in increased labour issues with interpreters. The potential loss of interpreters, due to strikes and work-to-rule campaigns, would necessitate the use of higher cost resources thus negating savings.

A proactive strategy with HR, with Legal support, is needed to ensure the contractor relationship is healthy and well-maintained as the LMC initiative proceeds.

5.5.2.2 Realization of Benefits and Actual Savings

Some of the identified savings, such as the labour reallocation and PHSA/PLS subsidies, appear to be more dependent on resource cost or revenue allocation rather than “real” changes. These savings sources should be re-examined to ensure that true savings and subsidies are being realized rather than merely being re-allocated.

Projected PHSA/PLS subsidy savings should be vetted to ensure that they can feasibly be realized. A transparent benefits tracking mechanism will be essential to keep savings realization on track.
5.5.3 Maturity of Project Management

The PMO methodology described in Section 3.7 was applied to the LMC Interpreting Services project. Overall, the Interpreting Services work plan is managed on an “Ad Hoc” basis. Interpreting Services should improve its Stakeholder Management and Risk & Issue Management capabilities to better manage resistance during the execution phase.

This assessment was completed prior to the entry of the project into execution mode where the project team planned to implement additional processes were planned. The overall assessment of the Interpreting Services Project Management maturity is below:

<table>
<thead>
<tr>
<th>Maturity</th>
<th>Process Area</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Ad-hoc</td>
<td>Scope Management</td>
<td>What Works Well: Initial scope has been defined initially, list of 9 initiatives are part of the project charter. Area to Look At: A dedicated project manager would look at any scope change, should document them and will integrate resulting impact on the project plan. (i.e., resources, timeline, budget, etc.)</td>
</tr>
<tr>
<td>2 Ad-hoc</td>
<td>Issue &amp; Risk Management</td>
<td>What Works Well: Risks have been documented part of the briefing note but could benefit from additional details on the mitigation strategy, accountable person, timeline, tracking log, etc. Area to Look At: No evidence of risk and issue tracking log. Non-published risk resistance from the other HA’s.</td>
</tr>
<tr>
<td>2 Ad-hoc</td>
<td>Workplan &amp; Time Management</td>
<td>What Works Well: A basic high level Project Plan exists with phases and dates in a static excel file. Area to Look At: Lack of detailed tasks, definition and tracking.</td>
</tr>
<tr>
<td>1 Heroic</td>
<td>Resource Management</td>
<td>No estimate of resources needs, no dedicated PM, relying on internal resources only, on top of their daily job.</td>
</tr>
<tr>
<td>2 Ad-hoc</td>
<td>Performance Management &amp; Reporting</td>
<td>What Works Well: Report project progress up to the LMC steering committee. Area to Look at: No evidence of minutes and decision log.</td>
</tr>
<tr>
<td>2 Ad-hoc</td>
<td>Financial Management</td>
<td>What Works Well: Baseline is established and financial savings are planned to be tracked by the project lead. Area to Look at: The project cost is not tracked. Savings are theoretical based on accounting practices and there is no clear link between planned actions and financial savings.</td>
</tr>
<tr>
<td>1 Heroic</td>
<td>Stakeholder Management</td>
<td>Area to Look at: Consider a more detailed documented approach to stakeholders identification and impact analysis, also consider a more proactive engagement with stakeholders, document their requirements, needs, potential negative impact on the project.</td>
</tr>
<tr>
<td>1 Heroic</td>
<td>PM Support Tool – Documents &amp; Knowledge Management</td>
<td>Area to Look at: Static documentation. The team should consider using a specialized Project Management tool and a SharePoint to share project documentation.</td>
</tr>
</tbody>
</table>

Table 15: Interpreting Services – PM Maturity Assessment
5.5.4 Accenture Assessment of Further Opportunities

5.5.4.1 Interpreter Scheduling Optimization

Optimized interpreter scheduling will be an effective approach to managing costs and could result in significant additional savings.

Current face-to-face Interpreting Services across the LMC represent approximately 58,000 hours annually, with each appointment lasting approximately 75 minutes out of a scheduled 120 minute block. Potential savings were modeled based on decreasing the standard scheduling block to 90 minutes. Scenarios were modeled involving scheduling efficiencies ranging from 5% to 25% of appointments being scheduled in 90 minute blocks. Based on an average industry hourly rate of $30, this optimization generated savings of $0.033M to $0.225M.

<table>
<thead>
<tr>
<th>Percentage of 1.5 hour blocks</th>
<th>45,000</th>
<th>50,000</th>
<th>55,000</th>
<th>60,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>5%</td>
<td>$33,750</td>
<td>$37,500</td>
<td>$41,250</td>
<td>$45,000</td>
</tr>
<tr>
<td>10%</td>
<td>$37,500</td>
<td>$41,250</td>
<td>$45,000</td>
<td>$48,750</td>
</tr>
<tr>
<td>15%</td>
<td>$41,250</td>
<td>$45,000</td>
<td>$48,750</td>
<td>$52,500</td>
</tr>
<tr>
<td>20%</td>
<td>$45,000</td>
<td>$48,750</td>
<td>$52,500</td>
<td>$56,250</td>
</tr>
<tr>
<td>25%</td>
<td>$48,750</td>
<td>$52,500</td>
<td>$56,250</td>
<td>$60,000</td>
</tr>
</tbody>
</table>

Figure 26: Interpreting Services – Scheduling Optimization

Source: VCH Budget Analysis, Accenture Benchmarks

The savings generated would be proportional to the actual realized average hourly interpreter cost rates for the Lower Mainland Health Authorities. It is recommended that PLS actively and aggressively pursue this strategy as a means of managing and controlling costs.

5.5.4.2 Addressing Growth

The use of Interpreting Services is directly proportional to health service demand and, therefore, proactive cost management will be necessary for savings in this area to be sustainable. Moreover, if service volume increases without a proportionate increase in the supply of interpreters, this may place upward pressure on interpreter hourly rates. Specifically:

- Initiatives to better manage interpreter downtime should be a significant area of ongoing focus
- Focus should also be placed on consolidating contracts to enable provision of a uniform set of services to the HAs
- PLS should continue to move toward lower hourly phone interpreter rates as contracts are consolidated

In short, a key to sustainability of savings in interpreter management, in the face of service volume growth, will be to actively manage and maximize interpreter productivity.
5.5.4.3 Consolidation of Additional Language Services

While the scope of the LMC initiative for Language Services is limited to Interpreting Services which has a relatively small baseline budget of $2.42M, there are additional opportunities to consider consolidation of other PLS services such as Translation and other Language-related services, which account for a significant portion of HAs’ language service-related budget beyond Interpreting Services.

5.5.5 Conclusions – the Interpreting Services Initiatives

The scope of the LMC initiative for Language Services is limited to the budget for Interpreting Services ($2.50M – FY09/10 final budget). Given the relatively low baseline budget, savings of $0.24M is realistic. Although there are additional opportunities to consider for the consolidation of Translation and other Language-related services, Interpreting Services is not likely to be a significant source of future additional savings. However, there are additional opportunities to look more broadly at consolidating some of the additional services provided by PLS, such as Translation and Consulting services.

The savings target of $0.24M will be achieved through a combination of labour reductions and reallocations, workspace savings, improved interpreter time management, and an increase in revenue activities allocated back to the program. Some savings are dependent on an alternative allocation of budgets. Because some of the savings are “soft” as they depend on the use of lower-cost resources, a savings tracking mechanism will help ensure that actual savings are achieved.

Significant future savings will be achieved through streamlining of internal processes to improve interpreter management and downtime. It should be noted that utilization of Interpreting Services is likely to increase with health services growth, leading to budget increases, which will result in a need for the HAs to implement a funding model that accounts for growth in Language Services as a clinical support service.

Although the move to a single contract for interpreters across all of the HAs has the potential to generate future additional savings, there is also an increased risk for labour challenge to the contract nature of these roles that will need to be managed to ensure sustainability of the targeted savings.
5.6 Communications

5.6.1 Introduction

The purpose of the project is the immediate and full consolidation of communication services across the Lower Mainland.

The in-scope organizations are:

- Fraser Health Authority;
- Providence Healthcare;
- Provincial Health Services Authority; and,
- Vancouver Coastal Health.

5.6.2 Budget, Targets and Approach

The scope of the expenditures of this project is the consolidated communications budget of $7.8M (Labour and Non-Labour):

The breakdown of the budget is seen below:

**Consolidated Communications**

**FY09/10 Budget**

*in $M*

- **Non-labour savings not yet quantified**
- **Consolidated Non-Labour**: $1.2M
- **Consolidated Labour**: $6.6M

**Addressable: $7.8M (Labour+ non-Labour)**

*Figure 27: Communications – Baseline Budget*

*Source: Finance Working Group for FY09/10 & FY 10/11 Budget Baselines; CFOs for Savings Targets*
The agreed savings target for Communications in the LMC was $1.5M or 19% of the budget. Given that labour costs represented 80% - 90% of Communications budgets across the four HAs, the initial savings approach was largely based on FTE reductions:

![Communications Savings Diagram](Image)

**Figure 28: Communications – Savings Sources**

Source: Finance Working Group; for FY09/10 Baseline; CFOs for Savings Targets; LMC Project Leads for Achieved and Planned Savings FY 09/10

Of the $1.5M of identified savings, $1.2M has been identified and will be implemented in FY10/11. The remaining $0.3M in savings will be achieved through a combination of labour and non-labour efficiencies.
5.6.3 The savings initiatives

The philosophy for the consolidation was to standardize the approach to Communications across the in-scope HAs given that, historically, the respective HAs had significantly different approaches. The consolidated Communications functions were reorganized into three main portfolios: Corporate Communications, Public Affairs and External Relations.

The LMC team identified four initiatives to achieve their savings, listed in the following tables:

<table>
<thead>
<tr>
<th>Communications Portfolios</th>
<th>Mandate</th>
<th>Timeline</th>
<th>Staffing</th>
<th>Mandate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate Communications</td>
<td>• Internal communications</td>
<td>In place</td>
<td>• Led by an Executive Director</td>
<td>Internal communication elements for each organization</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Supported by writers, corporate communicators and generalists</td>
<td></td>
</tr>
<tr>
<td>Public Affairs</td>
<td>• Media relations, issues management and event planning</td>
<td>In place</td>
<td>• Three directors for PA to support for each HAs, PHC support to be</td>
<td>Ensure individual organization entities are maintained while</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>provided by VCH director</td>
<td>integrating the support team</td>
</tr>
<tr>
<td>Stakeholder Relations</td>
<td>• Government, stakeholder and community relations</td>
<td>In place</td>
<td>• Overseen by one director</td>
<td>External stakeholder communications elements for each organization</td>
</tr>
<tr>
<td>Consolidation</td>
<td>• Communication Support for LMC consolidation and integration initiatives</td>
<td>In place – to be phased out as LMC initiatives move beyond implementation</td>
<td>• Stakeholder relations directed to oversee portfolio</td>
<td>Focus on change management and operational support for consolidation initiatives</td>
</tr>
</tbody>
</table>

Table 16: Communications – Savings Initiatives

The VP Communications believes that further labour and non-labour savings are potentially feasible, and will be considered once the LMC initiative has stabilized, the scope of customer needs has been fully assessed, and service level agreements have been established.
5.6.4 Observations

The $1.5M savings in Communications functional cost reductions that have been identified are reasonable given the projected year-end FY 2010/11 budget of $5.8M, and FY 2009/10 baseline of $7.8M.

However, there is a concern that shadow communications groups may still exist within other functional areas within the HAs, given the previous nature and scope of communications support within the various HAs. However, identification of these resources would require a more extensive evaluation of remaining role and responsibilities across the HAs. In this case, the baseline budget and savings target could be expanded.

5.6.4.1 Integration Approach

The entire LMC initiative is highly dependent on Communications; however the dependencies and requirements from the other projects have not been fully mapped and understood. This is a risk to the successful execution of all 12 LMC initiatives as communications is critical to stakeholder buy-in and employee engagement.

It is recommended that more formalized and proactive engagement occur between Communications, HR and the other projects to better manage the ongoing process.

5.6.4.2 Change Management

The speed of the Communications integration has resulted in a lack of explicit focus on change management and communications. This poses another high risk to successful execution.

Moving forward, it is recommended that a more formalized approach to proactive change management and communications be established in collaboration with both HR and the front lines, as the success and sustainability of the LMC initiative are dependent on effective change management.

5.6.5 Maturity of Project Management

The PMO methodology described in Section 3.7 was applied to the LMC Communications project. Overall the Communications project demonstrates “heroic” capabilities in project management. Based on the nature of the function, Communications requires “basic” project management capabilities mainly in Scope, Issue & Risk management to avoid and manage ‘shadow’ communication activity.

The overall assessment of the Project Management Office maturity is below:
There is an opportunity to explore additional savings by organizing the Communications function around internal customer requirements.

Leading practices for a streamlined Communications operating model categorize communications and public affairs activities into one of three areas: ‘strategic advisor’, ‘strategic communication’, and ‘communication execution’. Strategic advisors define requirements while the majority of resources reside in a “shared” model and can be deployed to specific projects as needed. This model is flexible and can respond to individual customers’ varying levels of need.
5.6.6.2 Optimize Resource Allocation

There may be additional opportunities to re-assess the allocation of resources within an optimized operating model to find further labour savings.

Reconsidering the mix of staff required to support the strategic and tactical communication requirements within each of these portfolios may present additional reduction opportunities; and,

Shifting more generalist type resources into a “Shared” pool, possibly across all portfolios, while increasing the specialization of strategic resources may result in further cost reductions.

### Table 18: Communications – Resource Allocation Optimization

<table>
<thead>
<tr>
<th>Communications Resource Allocations</th>
<th>VP</th>
<th>Corporate Communications</th>
<th>Public Affairs</th>
<th>Stakeholder Relations</th>
<th>Consolidation</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>VCH</td>
<td>1</td>
<td>11.5</td>
<td>2.5</td>
<td></td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>PHSA</td>
<td>9</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>PHC</td>
<td>1.5</td>
<td>1.5</td>
<td>4</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>FHA</td>
<td>10</td>
<td>4</td>
<td></td>
<td>14</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>Shared</td>
<td>9</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>Total FTE per portfolio</td>
<td>41</td>
<td>15</td>
<td>4</td>
<td>2</td>
<td></td>
<td>63</td>
</tr>
</tbody>
</table>

| Total Labour Budget (estimated)    | $6.197M |
| Cost/resource (estimated)          | $0.098M |

Further changes should not be undertaken prior to establishment of final Service Level Agreements, and must be accompanied by a specific and detailed change management plan.
5.6.6.3 Corporate Culture

Although the concept of consolidation of undifferentiated services is sound, care should be taken to maintain within the new Communications group an understanding of the distinct cultures and associated needs of each organization, to improve service effectiveness and reduce the reliance on “shadow” communications resources. In the short term, support to PHC specifically should be re-evaluated.

5.6.6.4 Synergies with Human Resources

There are potential synergies between Human Resources and Corporate Communications with respect to internal communications planning which could be explored for additional synergies.

5.6.6.5 Service Levels

It is likely that each HA will have, at least in the short term, varying service level expectations which will need to be managed and formalized through service level agreements. Interim Service Listing and Service Levels should be established collaboratively with both PHSA and PHC in the short term to manage the transition until more permanent agreements can be negotiated.

It is recommended to improve the formal engagement of key leaders within the HAs as the speed of consolidation appears to have resulted in a mismatch of service expectation among stakeholders.

5.6.7 Conclusions – the Communications Initiative

The high-level scope of services for the LMC Communications Service project includes Public Affairs, Corporate Communications, and Stakeholder Relations. The savings of $1.5M in Communications services will be achieved primarily through workforce consolidation.

Although the focus to date has largely been on defining the future organization structure and headcount reduction, the next steps should include a detailed needs assessment for each HA to determine the appropriate set of services and associated service levels for each group. The focus on headcount reductions may be leading to the perception of reduced service levels, which can be countered through an increased focus on stakeholder engagement in the definition of SLAs.

SLAs with each HA need to be negotiated and agreed before making any additional headcount /structural changes.

Communications may benefit from an operating model that balances the need for customization (e.g. executive support) vs. standardization (e.g. intranet support) to achieve greater flexibility for growth. There will be additional opportunities to provide more efficient day-to-day service delivery through the provision of technology tools (e.g. self service intranet publishing tools).

While the strategy is to eliminate the use of Communications resources outside of the shared Communications group, given the nature of the function there is a significant risk that “shadow” Communications resources will continue to exist within the HAs, masking the true cost of Communication services: this can be mitigated by improving linkages and developing a shared vision with the HAs.
5.7  **Diagnostic Imaging**

The LMC Diagnostic Imaging Project encompasses all the lower mainland health authorities: Fraser, PHC, PHSA and VCH. The LMC consolidation plan seeks to significantly improve management oversight by consolidating the LMC under a single radiology director with regional directors reporting to him for each Health Authority.

5.7.1  **Budget Baseline, Savings Targets and Approach**

The Lower Mainland DI initiative has a consolidated “in scope” FY 09/10 budget of $118.4M. Their target is to save 8.9% of this budget which equates to $10.5M. The following figure shows the breakdown of the overall budget by categories of non-labour, physician compensation and salaries and benefits.

![Diagnostic Imaging FY09/10 Budget](image)

*Figure 30: Diagnostic Imaging – Baseline Budget FY09/10*

*Source: Finance Working Group for FY09/10 & FY 10/11 Budget Baselines; CFOs for Savings Targets*
5.7.2 The savings initiatives

The DI LMC determined they would achieve their targeted savings with ten individual initiatives. These are described in the following tables with the initiative plan by the project team for each in “italics”. We have also included our specific recommendations for each initiative.

<table>
<thead>
<tr>
<th>Initiative Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Technical Staff Productivity Improvements</td>
</tr>
<tr>
<td>• Eliminate positions based on productivity review to achieve targeted performance</td>
</tr>
<tr>
<td>• Recommend targeting reductions in areas where significant capacity exists and eliminate or greatly curtail equipment resource utilization to a few sites to improve productivity</td>
</tr>
<tr>
<td>• Staffing reductions will fail if equipment resources remain as configured</td>
</tr>
<tr>
<td>2. Management Restructuring</td>
</tr>
<tr>
<td>• Eliminate supervisory layers within sites, develop regional management structures and a single director level position</td>
</tr>
<tr>
<td>• These changes are dependent upon Section 54 union concessions currently beginning</td>
</tr>
<tr>
<td>• Anticipate union demands for merged certification and a single employer—establishes single seniority pool and job security across the LM</td>
</tr>
<tr>
<td>3. LEAN Workflow Improvements</td>
</tr>
<tr>
<td>• Use internal Green Belt Lean Six Sigma team to define streamlined workflows</td>
</tr>
<tr>
<td>• Required support structure for productivity improvements and needs to be accomplished</td>
</tr>
<tr>
<td>• Standardization of workflow across LM is critical and needs to precede staff reductions</td>
</tr>
<tr>
<td>4. Supply Cost Reduction</td>
</tr>
<tr>
<td>• Standardization of supply practices and implementation of supply tracking/management system</td>
</tr>
<tr>
<td>• Inventory management system required to control inventories and manage PAR levels</td>
</tr>
<tr>
<td>• Implementation of IT system in process</td>
</tr>
<tr>
<td>5. Equipment Maintenance Contract renegotiations and/or transition of service to Biomedical Engineering (BME)</td>
</tr>
<tr>
<td>• Transition first level equipment diagnostics and repair to BME</td>
</tr>
<tr>
<td>• Transition vendor service contracts for high-tech imaging equipment (CT, MRI, NM, PET, etc.) to time and materials. Proposed strategy would take $5M of the $6M of current spend to fund a self-insured pool to support repairs</td>
</tr>
<tr>
<td>• Recommend taking all of the contract savings and establishing an estimated repair pool for the first year. Use experience to budget subsequent years and maintain a contingency fund for emergent repairs</td>
</tr>
</tbody>
</table>


Table 19: Diagnostic Imaging – Savings Initiatives

As can be seen from the preceding list, cost reductions are focused across the full DI operation – labour, non-labour, clinical and non-clinical. However, addressing labour costs is a primary focus of the project with between $5M and $8M in reductions planned across the life of the project. Addressing labour costs is complex due to the differing union certifications across the participating health authorities. Key features of the labour savings in DI are regional management restructuring to eliminate management layers and targeted productivity savings for the technical staff in each Health Authority. Union concessions will be required to achieve the restructuring.

Non-clinical cost reductions account for $2M of the planned savings and include reducing supply costs and eliminating long-term vendor equipment maintenance contracts. Equipment maintenance contracts with the vendors are planned to be exchanged for Level 1 diagnostics and service management by Biomedical Engineering (BME) and Time and Materials agreements with the vendors for repairs and parts (such as specialty x-ray tubes) outside the scope or purchasing power of BME.
The remaining $3.0M - $4.0M in savings required to achieve the Total DI savings target is pending identification.

The analysis below, contrary to customary understanding, shows significant capacity across most imaging modalities. However, to achieve improved equipment utilization especially in high-tech areas, the LMC will be required evaluate consolidation of equipment resource scheduling and staffing. Where significant capacity exists (based on the standards utilized), a rationalization of equipment resources will be needed with perhaps decommissioning of excess capacity.
Equipment Utilization analysis shows significant capacity exists in most modalities

<table>
<thead>
<tr>
<th>Equipment Utilization Analysis - High Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Equipmen</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>General Radiography &amp; Fluoroscopy</td>
</tr>
<tr>
<td>Interventional Radiology</td>
</tr>
<tr>
<td>CT</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
</tr>
<tr>
<td>Bone Density</td>
</tr>
<tr>
<td>MRI</td>
</tr>
<tr>
<td>Mammography</td>
</tr>
<tr>
<td>Ultrasound</td>
</tr>
</tbody>
</table>

*Based on 51 weeks/year IP and 50 weeks/year OP

- **Green** Significant Capacity Exists
- **Red** Nearing or at Capacity Today

Table 20: Diagnostic Imaging – Equipment Utilization Analysis

Source: 2009 American Health Care Radiology Administrators Staff Utilization Survey; Numbers represent 50th percentile performance for all organizations included in the study.
5.7.3 Observations

We have provided specific observations and recommendations related to each of the savings initiatives in the preceding sections. At a more summary level we believe the targeted savings are achievable if the planned and recommended initiatives are undertaken. Significant clinical program risk is possible if staffing reductions are taken without commensurate equipment utilization realignment, workflow standardization and IT systems standardization.

The ‘TBD’ savings will be difficult to achieve without structured consolidation of operations and significant participation by the radiologists and clinicians in this LMC area as outlined above.

5.7.4 Maturity of Project Management

We applied the PMO methodology as described in Section 3.7 and have assessed the DI project overall as “Ad-Hoc” in its PMO maturity. DI would benefit from improved project management practices particularly in developing a more structured work plan for the ‘TBD’ savings as well as improved stakeholder engagement strategy for the radiologists and clinicians.

<table>
<thead>
<tr>
<th>Maturity</th>
<th>Process Area</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Ad-Hoc</td>
<td>Scope Management</td>
<td>What Works Well: Scope has been defined initially with a list of sites and services. A list of saving areas are part of the initial briefing note. Area to Improve: Formal detailed project charter and project plan missing. Consider formally engaging IT as there is a documented dependency and a strong alignment needed for mission critical activities.</td>
</tr>
<tr>
<td>2 Ad-Hoc</td>
<td>Issue &amp; Risk Management</td>
<td>What Works Well: Issues and risks have been initially documented, though still require evidence of detailed mitigation strategy, key responsible dates etc. Area to Improve: Issues need to be consistently escalated, communicated and driven to closure. Consider implementing regular tracking and review in weekly meeting to drive issue ownership and resolution.</td>
</tr>
<tr>
<td>2 Ad-Hoc</td>
<td>Workplan &amp; Time Management</td>
<td>What Works Well: A 3-phase high level plan has been developed, together with a detailed presentation of the approach, challenges and a cost savings plan over the 10/11 through 12/13 fiscal years. Area to Improve: Develop a more detailed work plan including task work breakdown structure, milestones definition and progress tracking. Define the integrated plan to analyze schedule slippage and time tracking and realign savings targets by year using earned vs burned.</td>
</tr>
<tr>
<td>1 Heroic</td>
<td>Resource Management</td>
<td>Area to Improve: No estimate of resources needs, no dedicated PM, relying on internal resources only on top of their daily job. The Resource Management Plan should include how and when project team members will be allocated during all phases.</td>
</tr>
<tr>
<td>1 Heroic</td>
<td>Performance Management &amp; Reporting</td>
<td>Area to Improve: Immediately implement regular LMC reporting and weekly project meetings with minutes and decision logs. Institute reporting against quantitative targets once plan is approved. Analyze improved information to re-focus status activities on corrective action to improve proactive decision making. Compare project activities to baseline and trigger corrective actions to avoid project slippage.</td>
</tr>
<tr>
<td>2 Ad-Hoc</td>
<td>Financial Management</td>
<td>What Works Well: Financial savings are planned and tracking is begun by the project lead. Area to Improve: Lack of estimating methodology and discipline. Project costs not tracked. Improve reporting up to the LMC. Cash flow projections unavailable given preliminary assessment.</td>
</tr>
<tr>
<td>2 Ad-Hoc</td>
<td>Stakeholder Management</td>
<td>What Works Well: The list of stakeholders has been documented. Close work across HA’s is identified to develop a process to align the RIS/PACs strategies. Area to Improve: Extended stakeholder requirements, needs, potential negative impact on the project. Stakeholders expectations should be verified and documented.</td>
</tr>
<tr>
<td>1 Heroic</td>
<td>PM Support Tools</td>
<td>Area to Improve: Static word and Excel documentation. Consider managing the projects using standard and centrally stored project management tools – such as sharepoint.</td>
</tr>
</tbody>
</table>

Table 21: Diagnostic Imaging – PM Maturity Assessment
5.7.5 Accenture Assessment of Further Opportunities

We see a number of additional initiatives DI could undertake to achieve further cost savings/benefits. These include:

<table>
<thead>
<tr>
<th>Diagnostic Imaging Initiatives</th>
<th>Rationale and Recommendations</th>
</tr>
</thead>
</table>
| 1. Imaging IT support consolidation and realignment | • Bring all imaging IT team members under one leadership structure. Realign responsibility to comply with organizational strategy  
• Recommend bringing DI IT support under a single central IT organization  
• Improve team performance resulting in a potential reduction of 1-2 FTEs |
| 2. Consolidate staffing by function and operate each function across the lower mainland using regional directors and supervisors | • Consolidate staffing by coverage group (single and/or multi-specialty teams) and improve cross-modality training and certification  
• Cross-cover across the lower mainland (within geographic proximity) to provide adequate coverage and improve staff performance  
• Requires staff planning, labor certification realignment and management restructuring |
| 3. Consolidate imaging budgetary management across the lower mainland | • Provide the radiology director purview and authority to utilize capital and operating budgets to benefit the entire Lower Mainland communities  
• Manage limited resources effectively across lower mainland to benefit the entire DI function |
| 4. Identify and implement centralized OP scheduling for the Lower Mainland | • Eliminate the need for imaging to require a third party system with poor interface capability to existing clinical information systems (Cerner/MediTech)  
• Implement one of the existing central scheduling systems (Cerner or MediTech) across imaging  
• Increase equipment utilization across the lower mainland by adequately utilizing available slots |
| 5. Select one of the incumbent PACS vendors and implement across the lower mainland | • Provide maximum radiologist coverage options and minimize reading turnaround by utilizing similar PACS  
• Improve team performance resulting in a potential reduction of 1-2 FTE radiologists or capacity for immediate growth in reading volumes  
• An internal cross-LM team is currently developing a strategy |
| 6. Review the productivity of the employed radiology group and determine best course of action to cover cancer services | • Employed Group volume per radiologist is low  
• Additional analysis is required to establish the best strategy for cancer services and a savings target  
• Primary goal is to eliminate duplicate readings for BCCA studies |
| 7. Select one of the two incumbent clinical systems vendors and implement the RIS from that vendor across the lower mainland | • Supports need for standardized clinical workflow across sites and increases staff performance in the proposed consolidated operating model  
• Facilitates staffing consolidation and cross-coverage  
• An internal cross-LM team is currently developing a strategy |
| 8. Implement rigorous IVR supply consignment program with required items and PAR levels and secure supply area | • Reduce total costs for interventional radiology supply items  
• Limit inventories by continuously reviewing PAR levels  
• Use vendors to manage stocking and refresh of items nearing expiration to limit budgetary impact  
• Control items in stock by policy and limit vendor choices to 2 per supply type  
• Secure supply areas to eliminate unauthorized borrowing |

Table 22: Diagnostic Imaging – Additional Opportunities

Source: Accenture Health Sector Experience

We believe that these additional opportunities would net a further potential savings between $3.6M and $5M primarily through DI IT staff consolidation, utilization management, supplies and radiologist payment/staffing.
Utilization management as a new program would require initial investments of approximately $1M. However, the long-term benefit of clinician and radiologist collaboration on appropriateness of exams will be significant.

5.7.6 Conclusions – the Diagnostic Imaging Initiative

Diagnostic Imaging plans to achieve a total of $10.5M in savings against a budget of $118M.

- Savings will be taken from current operations without additional investment
- Cost reductions are planned across the operation including non-clinical and clinical projects
- Demand pressures continue with volume growth projected at 8% to 10% per year
- Opportunities for additional savings are strongly recommended for further practice consolidation, additional restructuring of operations, improved utilization of equipment resources and utilization management programs

Achievement of targets will require:

- Planned initiatives with additional recommended actions to improve performance of planned initiatives
- A portfolio of additional initiatives targeted at broader lower mainland consolidation of resources and budgets
- Significant stakeholder and general clinician participation and education to attain the utilization management goals
- Policy and procedure enhancements to ensure compliance with the go-forward strategy
- Union concessions to achieve restructuring
- Significant equipment resource capacity exists. Alternative operating structures will be required to take advantage of this capacity and control costs

Accenture has identified additional opportunities with estimated net savings of between $3.6M and $5.0M over the life of the project.
5.8 Pharmacy

The Pharmacy budget consists of 3 main cost buckets including:

- Drug Expenditures
- Clinical Operations
- Non-Clinical Operations

As per Steering Committee approval, the Pharmacy project excluded Clinical Operations from the overall spend and scope primarily based on the assumption that clinical pharmacists monitor drug utilization which in return drives efficiencies in overall medical cost.

Furthermore, the Health Authorities allowed for a 1% increase in pharmacy drug budget. The pharmacy team aimed at capping drug cost at 3%, based on the underlying assumption that drug costs will grow at a higher rate i.e. 5-8%. It will have to be determined how to ‘make up for the difference’ in another area. Consequently, any savings identified for drug cost containment were not attributed to LMC savings.

The only budget addressed for savings is non-clinical operations.

The Pharmacy plan was approved in early February 2010. The Pharmacy team was not authorized to proceed with project tasks until formal approval of the plan. The Pharmacy project team informed Accenture that the scope of the pharmacy consolidation project was in flux up until February 2010 and it was therefore difficult for program leadership to effectively plan as in-scope tasks fluctuated.

This relatively late approval was further communicated as a primary driver to us that the consolidation efforts were at its infancy, i.e. only one third of savings target initiatives have been identified to date. Based on feedback as part of our review sessions, we understand that the Pharmacy lead had been working (partly in parallel) on establishing a common formulary as well as engaging the P&T Committee to ensure agreement. The resulting successes of this work provided the basis required for a sound shared services model.

The Pharmacy team initially worked under the assumption that savings as a result of FHA consolidation efforts would be attributable to LMC savings. Per latest Finance Working Group decision, these savings were deemed not attributable towards LMC. A total of $1.2M had been identified as consolidation savings for which alternative savings initiatives had to be derived to meet the agreed target.
5.8.1 Baseline Budget, Savings Targets and Approach

The Pharmacy project has targeted $3.2M (10%) in savings from its “in scope” budget of $32.6M in non-clinical operations. As stated at the beginning of this section, clinical operations ($42.7M) were approved by the Steering Committee to be out of scope. The project team added a caveat that in case savings cannot be achieved through non-clinical operations, clinical operations will be addressed and revisited for opportunities.

Drug expenditures at $77.6M account for the largest of pharmacy related expenditures. The breakdown in budget categories is illustrated in the following figure:

![Figure 33: Pharmacy – Baseline Budget](source)

Source: Finance Working Group for FY09/10 & FY 10/11 Budget Baselines; CFOs for Savings Targets; LMC Project Leads for Achieved Savings FY 09/10

The LMC pharmacy team identified approximately $1.1M (one third) in savings initiatives towards their targeted goal of $3.2M. The main sources of savings are a set of rapid cost reduction mechanisms with minimal organizational impact, e.g. management consolidation, reduction in discretionary spend, salary reduction, eliminating vacant positions etc. The following diagram illustrates the team’s planned savings over 2 years.

![Figure 34: Pharmacy – Planned Savings](source)
5.8.1.1 The savings initiatives

The table below depicts the currently identified initiatives totaling $1.1M (towards the total target of $3.2M) to achieve their savings which were assessed by the Accenture team.

Five initiatives were identified to reduce the non-clinical operations costs.

<table>
<thead>
<tr>
<th>Pharmacy Initiatives</th>
<th>Strategy</th>
<th>Timeline</th>
<th>Opportunity</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>FTE reductions, decrease in salaries, sick/OT reduction, surplus pharmacist budget</strong></td>
<td>Elimination of pharmacist, technician and administration positions</td>
<td>Expected to achieve savings in timeline</td>
<td>$467K savings calculated fiscal date April ’10; $180K fiscal start May ’10; $230K fiscal start June ’10;</td>
<td>No investment required to implement initiatives</td>
</tr>
<tr>
<td>2. <strong>HealthPro transition to SSO (Deletion of BCHS membership fees)</strong></td>
<td>Consolidation purchasing</td>
<td>Achievable savings in timeline</td>
<td>$76K savings calculated fiscal start date April ’10</td>
<td>No investment required to implement initiatives</td>
</tr>
<tr>
<td>3. <strong>Decrease pharmacist residents salary</strong></td>
<td>Excess spend cut</td>
<td>Expected to achieve savings within timeline</td>
<td>$165K savings calculated fiscal start date June ’10</td>
<td>No investment required to implement initiatives</td>
</tr>
<tr>
<td>4. <strong>License consolidation</strong></td>
<td>Consolidation of services</td>
<td>Expected to achieve savings within timeline</td>
<td>$4.5K savings calculated fiscal start date April ’10</td>
<td>No investment required to implement initiatives</td>
</tr>
<tr>
<td>5. <strong>Reduce travel and education funds</strong></td>
<td>Reduction in continuing education travel</td>
<td>Expected to achieve savings within timeline</td>
<td>$20K savings calculated fiscal start date April ’10</td>
<td>No investment required to implement initiatives</td>
</tr>
</tbody>
</table>

| Table 23: Pharmacy – Non-Clinical Pharmacy Initiatives |

Drug Cost Containment Initiatives

Savings addressing the drug budget centered on the following three initiatives with minimal quantification of savings opportunity:

1. **Drug Utilization** – the stated objective of this initiative is to contain increased demand utilization. There are a number of dependencies and challenges that will need to be addressed such as physician buy-in. Savings quantification still needs to be determined (KPI’s, baselines, tracking tools).

2. **Consolidation of GPO and Non GPO drug procurement** – while this approach to savings through leveraging contract pricing is standard practice, the complexity is driven by the multiple ordering systems across the Health Authorities. A plan to address this barrier has yet to be developed collectively since Pharmacy alone cannot initiate a systems consolidation effort. GPO procurement savings of $0.6M have already been realized. Savings from non-GPO procurement initiatives are in progress to being identified.

3. **Standardize Pharmaceutical production** – the objective of this approach is to maximize efficiencies and decrease waste. This still requires detailed analysis for savings quantification.
5.9.1.1 Observations

Non – Clinical Operations

After our project review, we concluded that the overall savings target for the LMC Pharmacy of $3.2M representing a 10% reduction of the non-clinical operations budget is reasonable and achievable particularly as the initiatives are comprised of rapid cost reduction measures with minimal organizational impact and requiring no capital investment.

As mentioned in Section 5.8.1, only $1.1M of the total $3.2M in savings have been identified and backed by documented initiatives. No plans were in place during the time period of our due diligence assessment for the remaining $2.1M. The Pharmacy lead has recently tasked his team of directors to derive respective initiatives to close the gap to target.

Drug Spend

The overall approach in this area is to control projected growth (estimated between 5-8%) through a combination of both cost and utilization control measures. The team’s stated objective is to contain overall budget increases to 3% for FY 10/11. However, as stated in Section 5.8., the Health Authority has capped budget increases at 1%. It is at the discretion of the Health Authority to allow an increase of 3% where the delta is ‘made up for’ in other areas within Pharmacy. From a Finance Working Group perspective the result is an unfunded 2% cost increase and as a result not attributable as savings towards LMC.

As we analyzed the three proposed savings initiatives identified in Section 5.8.1.1., we have identified two main concerns; firstly there are no detailed implementation plans to support the high level initiatives and secondly no quantification of cost/savings have been developed to date.
5.9.2 Maturity of Project Management

We applied the PMO methodology as described in Section 3.7 and assessed the Pharmacy project as “Ad hoc” in its PMO maturity. While the Pharmacy project has access to select skilled, central PMO support resources, they currently do not appear to have availed themselves of this support. As this team moves forward in articulating their plans we recommend that they add solid project management expertise to their team.

<table>
<thead>
<tr>
<th>Maturity</th>
<th>Process Area</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Ad-hoc</td>
<td>Scope Management</td>
<td>What Works Well: Scope has been defined; list of initiatives are part of the project plan. Area to Look At: Changes to savings attribution should be mitigated and additional initiatives developed in a timely manner.</td>
</tr>
<tr>
<td>2 Ad-hoc</td>
<td>Issue &amp; Risk Management</td>
<td>What Works Well: Issues and risks are tracked and reviewed regularly in weekly meeting. Area to Look At: Drive issue ownership and resolutions.</td>
</tr>
<tr>
<td>2 Ad-hoc</td>
<td>Workplan and Time Management</td>
<td>What Works Well: A comprehensive project plan has been developed Area to Look At: Define integrated plan to analyze schedule slippage, time tracking to understand earned versus burned value.</td>
</tr>
<tr>
<td>1 Heroic</td>
<td>Resource Management</td>
<td>No estimate of resource needs; no leverage of PM resources or delegation. Mainly relying on internal resources in addition to their daily operational responsibilities.</td>
</tr>
<tr>
<td>2 Ad-hoc</td>
<td>Performance Management &amp; Reporting</td>
<td>What Works Well: Weekly meeting with minutes and decision log. Area to Look at: Report up and feed progress into program level tracking for better comparability across authorities.</td>
</tr>
<tr>
<td>2 Ad-hoc</td>
<td>Financial Management</td>
<td>What Works Well: Financial savings are tracked by project lead. Area to Look at: Project costs are not tracked.</td>
</tr>
<tr>
<td>2 Ad-hoc</td>
<td>Stakeholder Management</td>
<td>What Works Well: Strategic partnership has been defined initially as part of the initial project plan. Area to Look at: Engage extended/director stakeholder groups to avoid potential negative impact on project, e.g. lack of physicians buy-in for new policies</td>
</tr>
<tr>
<td>2 Ad-hoc</td>
<td>PM Support Tool – Document &amp; Knowledge Management</td>
<td>Static MS Word and MS Excel documentation. No evidence of a central repository.</td>
</tr>
</tbody>
</table>

Table 24: Pharmacy – PM Maturity Assessment
5.9.3 Accenture Assessment of Further Opportunities

5.9.3.1 Drug cost per admission

We started our analyses by comparing the Lower Mainland Health Authority pharmaceutical expenses per admission to Accenture’s Health Sector client database benchmarks. The following two figures show pharmaceutical cost per admission by hospital, grouped by Average Daily Census (ADC) compared against their relevant benchmark levels.

![Figure 35: Pharmacy – Pharmaceutical Expense per Admission](image)

*Source: Drug spend – Finance Working Group; Total beds - Quantum Analyzer, April 1, 2010; Accenture Health Sector client database Benchmarks*

The above analysis has to be viewed with a set of caveats. Discussions with Pharmacy project leadership revealed that drug expenditure data are stored in multiple ways across Health Authorities, e.g. centralized vs decentralized, different accounting principles across hospitals. As a result, we were not able to obtain data that provided a solid basis for comparison. Looking at the analysis more indicatively, a potential savings opportunity by applying best practice and moving towards benchmark levels ranges from $100 per admission to $200 per admission. We have identified significant outliers such as Powell River and Queen’s Park Fellburn which may be attributed to demographic and/or level of care factors as well as distorted baseline data.
It is also important to note that the in-scope hospitals vary across characteristics and demographics such as small and non-urban, long-term care, high number of acute patients etc. All these factors may impact the level of expense for admission.

5.9.3.2 Clinical Pharmacists per total beds

While clinical operations were approved to be excluded from the scope of addressable budgets, the Accenture team applied their evidence-based client database benchmarks to the ratio of clinical pharmacists to total bed count. The results suggest a fairly consistent excess of clinical pharmacists per facility.

Analogous to the benchmarking situation above, the absence of clean, comprehensive data hinders any valuable comparative analysis. A time ladder analysis would also be beneficial to provide better transparency on clinical pharmacists’ daily tasks and responsibilities.

In general, clinical pharmacists provide value to health care contributing both to positive patient outcomes as well as appropriate drug ordering and thus managed medical costs. As can be seen indicatively by the preceding figure, the Lower Mainland clinical pharmacy services staffing levels are well above comparative Accenture Health Sector client database benchmarks. This could be due to the following factors:

a) The Lower Mainland provides “high intensity” clinical pharmacy services such as:
   - Medication reconciliation
• Medication error monitoring/reporting
• ADR monitoring/reporting
• Pharmacokinetic dosing & monitoring
• IV to PO program
• Protocol management

b) The LM shares clinical pharmacists across facilities and outpatient clinics and/or provide distributive functions in addition to facility based clinical services thus skewing the ratio comparisons
c) LM may have excessive clinical staff, i.e. staff not performing at optimal productivity levels, spend too much time on non-core tasks, extensive monitoring of suboptimal drug ordering by physicians. In order to determine the actual drivers, a current state analysis of clinical pharmacist activities (‘time ladder’) is required to determine gaps to future desired state

5.9.3.3 Medication Use Management

The application of best practices and evidence based medication use management strategies can significantly impact drug expenditures. The following table provides selected examples of the savings that can accrue from application of Medication Use Management (MUM) Initiatives. The savings opportunities depicted in the table below are based on Accenture experience with a large portfolio of health care clients.

<table>
<thead>
<tr>
<th>MM Task Force</th>
<th>MUM Initiative</th>
<th>MUM Action</th>
<th>Expense Opportunity</th>
<th>Cost Reduction Opportunity</th>
<th>% Cost Reduction</th>
<th>Low Range</th>
<th>High Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology/Med/Ortho</td>
<td>Low Molecular Weight Heparin* (enoxaparin/dalteparin)</td>
<td>Establish dosing criteria</td>
<td>$1,734,981</td>
<td>$173,498</td>
<td>10%</td>
<td>$147,473</td>
<td>$182,173</td>
</tr>
<tr>
<td>Hema/Onc</td>
<td>Colony-Stimulating Factors (Filgrastim)</td>
<td>Adhere to ASCO (1) guidelines for indications; develop consensus for ANC endpoint ~ 1500-2500. Assumes reduction of Tx days. Rationalize inpatient vs outpatient use of pegfilgrastim.</td>
<td>$227,331</td>
<td>$18,186</td>
<td>8%</td>
<td>$15,459</td>
<td>$19,096</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>Carbapenems* (imipenem, ertapenem, meropenem)</td>
<td>Patient selection/use criteria (dosing, duration, streamlining)</td>
<td>$3,995,275</td>
<td>$998,819</td>
<td>25%</td>
<td>$848,996</td>
<td>$1,048,760</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>3rd Gen cefas (ceftriaxone)</td>
<td>Preferential 1g dose. Increase utilization of 1g dosing.</td>
<td>$295,381</td>
<td>$136,839</td>
<td>46%</td>
<td>$116,313</td>
<td>$143,681</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>IV to PO (levofloxacin, ciprofloxacin, azithromycin)</td>
<td>Patient selection/use criteria (dosing, duration, streamlining); IV-PO switches (assumes target of 20% IV and 80% PO)</td>
<td>$365,395</td>
<td>$109,619</td>
<td>30%</td>
<td>$93,176</td>
<td>$115,099</td>
</tr>
<tr>
<td>Anesthetics</td>
<td>Anesthetic Gases (desflurane, sevoflurane)</td>
<td>Change product mix and flow rates</td>
<td>$800,056</td>
<td>$120,008</td>
<td>15%</td>
<td>$102,007</td>
<td>$126,009</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>$7,418,419</strong></td>
<td><strong>$1,556,969</strong></td>
<td>21%</td>
<td><strong>$1,323,424</strong></td>
<td><strong>$1,634,818</strong></td>
</tr>
</tbody>
</table>

Table 25: Pharmacy – Medication Use Management Initiatives

(1) Accenture Health Sector Client Database

Source: Top Drug Spend FY 2009-2010 FHA & PHC; * Initiative has been implemented across LM; further analysis of harvestable savings is underway

Successful MUM requires high-level strategic planning and effective and extensive stakeholder engagement. The following guiding principles are critical to success in this area:

- Patient safety and quality of patient care are essential when selecting and implementing cost savings strategies
• Effective planning for medication utilization management must provide the health system with a roadmap for continuous improvement in pharmaceutical expense management with specific goals and outcome measures of success with quality and safety of patient care as the primary driving focus
• Medication Utilization Management opportunities will typically require 3-6 months implementation timeline to develop infrastructure (overarching P&T Committee, physician champions, formulary consolidation, KPI's, tracking tools and application of evidence based medicine) to drive and achieve cost containment
• Detailed work plan and timeline for short term and long term strategies need to be developed
• Data must underlie all types of planning to manage medication expenditures
• Systems should be established to have ready access to data and continually monitor and review progress for cost containment
• Several steps are required to achieve stakeholder collaboration. Initial task of stakeholder identification is in its infancy stage

5.9.3.4 Increasing Inventory Turns

We have also identified additional opportunities to reduce drug costs through increasing inventory turns. Applying best practices in this area, we estimate an additional one-time savings in drug reduction of approximately $0.5M-$2.5M across Health Authorities.

![Figure 37: Pharmacy – Increasing Inventory Turns](Source: Finance Working Group; for FY09/10 Baseline; Hospital Pharmacy in Canada Report 2007/08 [www.lillyhospitalsurvey.ca](http://www.lillyhospitalsurvey.ca))
5.9.4 Conclusions – the Pharmacy Initiative

Pharmacy is tasked with savings target of $3.2M which represents 10% of the non-clinical operations budget of $32.6M

Recent confirmation that cost reductions achieved in FY09/10 (FHA consolidation efforts) cannot be counted towards LMC savings created a recent shift in the pharmacy savings strategy. In order to compensate for the shortfall, the Pharmacy lead recently tasked his directors to derive initiatives to achieve $1.6M by the end of FY10/11 – a total of $3.2M by end of FY11/12. The plans for these savings are currently under development. To date, the source of $1.1M in savings has been identified and quantified. These savings are planned to be achieved primarily through reduction in discretionary spend across Health Authorities, organizational de-layering and management streamlining and elimination of vacant positions. We see these targets as achievable. The lack of additional, comprehensive initiatives and quantification prevent us from completing a solid feasibility and due diligence assessment of the remaining $2.1M in savings.

Clinical pharmacy budget of $42.7M is deemed “out of scope” for additional savings opportunities

- Clinical pharmacists are essential to the healthcare team for improving patient outcomes and decreasing overall medical costs
- Comparison against Accenture Health Sector client data suggests an uneven distribution of clinical pharmacists and/or excess employment of clinical pharmacists
- General lack and availability of baseline and workload driver data hinder more detailed analysis. Outlier facilities should be evaluated through time ladder analysis and comparison to adequate levels of “clinical” pharmacist staffing
- Above Accenture client database benchmark values for pharmaceutical expense per admission further underline that the lack of appropriate infrastructure (overarching P&T Committee, physician champions, formulary consolidation, KPI’s, tracking tools and application of evidence based medicine) creates inefficiencies in medication use management

The Accenture team has identified specific additional opportunities with indicative savings ranges that can increase the overall efficiency of Pharmacy operations

- Medication utilization management (MUM) initiatives demonstrate a cost containment opportunity of $1.3-$1.6M targeting six drug initiatives based on “top” drug spend dollars
- Savings are based on Accenture client experience with implementation of MUM initiatives
- Based on comparison to Hospital Pharmacy in Canada Report an estimated one time savings opportunity of $0.5M to $2.5M through drug inventory reduction and increased inventory turns
5.10 **Pathology and Laboratory**

The purpose of the project is to optimize through standardization, integration and/or consolidation, the delivery of Pathology and Laboratory ("lab") Medicine services in the Lower Mainland and to maximize existing resources, gain efficiencies and minimize cost. The long term goals are to manage technology and laboratory test growth, to reduce redundant infrastructure and to develop a single operating entity for laboratory medicine. This is especially critical as the demand for Lab testing has grown at a rate four to six times higher than population growth. Varying degrees of lab services integration has occurred within the HA regions since 2004 but there has been little cross-region consolidation.

Provincial Health Services Authority is leading the Lower Mainland lab consolidation. The in-scope authorities are:

- Fraser Health Authority (12 facilities);
- Providence Healthcare (2 facilities);
- Provincial Health Services Authority (6 facilities); and,
- Vancouver Coastal Health (11 facilities).

The staffing at these sites includes 142.3 lab physician FTEs, 11 separate physician contracts and 1865.8 lab staff FTEs.

### 5.10.1 Baseline Budget, Savings Targets and Approach

The total budget for lab expenditures in the Lower Mainland in 2008/2009 was approximately $240M out of a total provincial spend of $591M. The scope of the expenditures of this project is limited to the global and MSP-funded, publicly delivered services, excluding revenue in the Lower Mainland, which was $186.9M in 2008/2009.

The breakdown of the budget, by region, is seen below:

![Laboratory Budget FY 2009/10](image)

**Figure 38: Laboratory – Baseline Budget**

*Source: Finance Working Group for FY09/10 & FY 10/11 Budget Baselines; CFOs for Savings Targets; LMC Project Leads for Achieved Savings FY 09/10*

The agreed savings target for lab services in the LMC was $23.6M or 13% of the budget. The LMC Lab Team identified a number of initiatives to meet its $23.6M savings target.
The breakdown of savings through to FY12/13 is depicted below.

![Figure 39: Laboratory & Pathology - Savings Achieved to Date](image)

The total projected savings is $23.6M net of any capital spend on infrastructure or other dependent improvements. However, an anticipated capital investment of $5.9M to achieve these savings results in net savings of $17.7, short of the $23.6M target. The breakdown of savings by LMC initiative, including capital spend is depicted below:

![Figure 40: Laboratory & Pathology – Savings Targets by Source](image)
## 5.10.1.1 The savings initiatives

The LMC team identified five initiatives to achieve their savings and they are listed in the following tables.

<table>
<thead>
<tr>
<th>Laboratory Initiatives</th>
<th>Strategy</th>
<th>Timeline</th>
<th>Opportunity</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Discipline Consolidations:</strong></td>
<td><strong>Disciplines:</strong> Chemistry; Haematology; Microbiology; Virology; Flow Cytology; Neuropathology; Electron Microscope; Renal pathology; Cytogenetics; Non-gynecytology; Anatomical pathology/histology</td>
<td><strong>Consolidate disciplines to reduce:</strong> Duplication in administrative staff &amp; equipment Varying practices Varying workload/technologist ratios Accreditation &amp; site-related costs</td>
<td>By FY 2012/2013</td>
<td>$9.8M estimated</td>
</tr>
<tr>
<td><strong>Non-contract Administrative and Support Reductions</strong></td>
<td>New leadership structure including a 20% reduction of non-contract and leadership support</td>
<td></td>
<td>By FY 2012/2013</td>
<td>$500K estimated</td>
</tr>
<tr>
<td><strong>Supply Reductions</strong></td>
<td>Use Shared Services Organization to reduce supply costs by 10% over 3 years Supply contract renegotiation Equipment standardization Process optimization</td>
<td></td>
<td>By FY 2012/2013</td>
<td>$4.6M estimated</td>
</tr>
<tr>
<td><strong>Equipment Contract Reductions</strong></td>
<td>Reduction of redundant and out-of-date equipment Concomitant reduction in maintenance contracts Biomedical assuming maintenance on certain equipment</td>
<td></td>
<td>By FY 2011/2012</td>
<td>$900K estimated</td>
</tr>
<tr>
<td><strong>Utilization Management</strong></td>
<td>Standardization of test ordering criteria and increased access to lab test results to reduce duplicate and unnecessary testing</td>
<td></td>
<td>By FY 2012/2013</td>
<td>$5M estimated</td>
</tr>
</tbody>
</table>

Table 26: Laboratory & Pathology – Savings Initiatives
5.10.1.2 Observations

The targeted savings for the Lower Mainland Laboratory Consolidation project is $23.6M out of a budget of $187M. The project team developed a three year plan, ending March 2012, with the bulk of the savings occurring in year two. The savings are primarily based on test volume reductions, staff reductions and equipment contract renegotiations or reductions:

- HA imposed reductions ($2.8M)
- Discipline consolidation: staff and equipment ($9.8M)
- Non-contract admin and support reductions ($500K)
- Supplies reductions through contract renegotiations, volume discounts and retirement of some contracts ($4.6M)
- Maintenance contract reductions ($900K)
- Utilization management: reduction in test volume ($5M)

A capital investment of $5.9M is required to realize the Utilization Management and Discipline Consolidation savings outlined in the plan, bringing the total net savings to $17.7M, below the target level of $23.9M. The capital investment is critical, however, as the Laboratory Information System (“LIS”) and other infrastructure initiatives are essential components of the proposed consolidation solution. In particular, significant process change and technical and operational infrastructure is required to achieve the planned savings in Utilization Management.
5.10.2 Maturity of Project Management

The PMO methodology described in 3.7 was applied to the LMC Lab project. Overall the Lab project demonstrates "advanced" capabilities in project management; however, stakeholder engagement requires a more diligent pursuit. Additionally, project management support tools, including an integrated issue and risk tool should be considered.

The overall assessment of the Project Management Office maturity is below:

<table>
<thead>
<tr>
<th>Maturity</th>
<th>Process Area</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Advanced</td>
<td>Scope Management</td>
<td>What Works Well: Scope has been defined initially, list of initiative are part of the initial project charter. Area to Look At: N/A</td>
</tr>
<tr>
<td>3 Basic</td>
<td>Issue &amp; Risk Management</td>
<td>What Works Well: Risks have been formally documented Area to Look At: Risk and issue tracking is based on static files. An integrated tool with workflow capabilities will help to track closely the issue until final resolution. Dependencies should be documented as part of the risk matrix.</td>
</tr>
<tr>
<td>4 Advanced</td>
<td>Workplan and Time Management</td>
<td>What Works Well: A high level Project Plan exists with phases and dates. Currently entering the planning phase. Area to Look At: Development of a more detailed work plan including task work breakdown structure, milestones definition and progress tracking</td>
</tr>
<tr>
<td>3 Basic</td>
<td>Resource Management</td>
<td>What Works Well: The project director has built a high-level work-plan, describing the project management structure, one project manager per initiative. Area to Look At: Confirmation of resources availability is a common challenge across projects</td>
</tr>
<tr>
<td>3 Basic</td>
<td>Performance Management and Reporting</td>
<td>What Works Well: Report project progress up to the LMC steering committee. Area to Look at: An integrated tool to report on issue progress and escalation needs with integration across multiple projects</td>
</tr>
<tr>
<td>4 Advanced</td>
<td>Financial Management</td>
<td>What Works Well: Financial savings are tracked by project team. Area to Look at: Project cost is not tracked. Improve reporting up to the LMC. Improve consistency with official finance team numbers.</td>
</tr>
<tr>
<td>3 Basic</td>
<td>Stakeholder Management</td>
<td>What Works Well: Stakeholders have been identified properly. Area to Look at: Proactively engage stakeholders; documenting their requirements, concerns and issues. Stakeholder engagement is critical to the success of this program</td>
</tr>
<tr>
<td>3 Basic</td>
<td>PM support tool – Documents &amp; Knowledge management</td>
<td>What Works Well: Static documentation. The team does not use specialized Project Management tools with integration capability. SharePoint is used, with controlled access. Area to Look at: Consider managing the projects using specific project management software with multi-project integration and roll-up reporting capability. Ability to provide status dashboards is desirable.</td>
</tr>
</tbody>
</table>

Table 27: Laboratory & Pathology – PM Maturity Assessment
5.10.3 Accenture Assessment of Further Opportunities

5.10.3.1 Operational Efficiency – Autoverification

An additional opportunity for savings is to implement autoverification where practical. Autoverification allows the release of test results automatically under guidelines and strict rules without manual intervention or review. This reduces the number of FTEs required to review and release test results, results in faster turnaround times for test results and reduces errors arising from technologists having “review fatigue” looking at high volumes of normal results. This process is typically applied to the high-volume areas of chemistry, haemotology and coagulation.

The LMC Lab team can expect savings of up to three hours per day per technologist in high-volume laboratories. Studies have suggested that autoverification will allow an 80% reduction in manual review of results and a three to five percent reduction in FTEs.

5.10.3.2 Operational Efficiency – Reference Ranges

A second additional savings opportunity is standardization of reference ranges, which allow physicians to easily compare results across disparate platforms and deters physicians from reordering tests specifically for comparison purposes. This lowers the overall test volume with concomitant savings. From a reporting perspective, a standardized reference range enables cross-enterprise data sharing and analytics.

Although improvement varies by level of heterogeneity of existing test platforms and methods, the LMC Lab team can expect savings in range of 4-18% in accordance with reported savings.

5.10.3.3 Operational Efficiency – Workflow Analysis

A third additional opportunity for savings is to conduct a workflow analysis and implement process changes that eliminate the waste in process execution. Eliminating waste in execution will lower the FTE requirements to execute on common processes and will improve the quality in test delivery.

Implementation of LEAN and Six Sigma protocols can assist the labs in removing waste and improving efficiency.

5.10.3.4 Operational Efficiency – Duplicate Orders/Standardized Order Sets

Checking for duplicate orders and standardizing order sets will reduce cost and enable test economies such as larger batch runs. Standardized order sets will lower the test volume by eliminating non-necessary testing or testing by exception.

Implementing duplicate order-checking on existing LIS platforms yields immediate opportunities to reduce test volumes if tests are cancelled under appropriate guidelines established by the Laboratory Medical Directors and the medical community. This can have a profound impact on test volume and consequently, operational expense. In the long term, creating alerts in a computerized provider order entry system (CPOE) is ideal to impact test volume and order appropriateness.
5.10.4 Conclusions – the Pathology and Laboratory Initiatives

Although $17.7M in gross savings should be realized through the initiatives (adjusted for the $5.9M LIS/infrastructure spend), the savings target is only achievable with the right infrastructure and stakeholder management. Technical infrastructure, including the LIS interface/integration is critical to the success of the program. FHA’s Meditech platform will require interfacing to the Sunquest platform to achieve an appropriate level of interoperability. Approval of the LIS improvement is required to proceed. Robust service level agreements, an agreed-upon test stratification model and other operational infrastructure must be in place.

Executive leadership, including the Health Authority (HA) CEO’s and Ministry of Health Services are critical to project management and stakeholder management. Executive leadership must make timely decisions, support the project approach and engage the physician/stakeholder community in order to achieve the outlined savings. Physician and pathologist engagement must be actively pursued.

It is estimated that $5.9M in IT and operational infrastructure costs are necessary to realize the savings. This infrastructure spend brings the net savings to $17.7M, well below the target ($23.6M).

Additionally, the $5.9M allocated for requisite infrastructure spend must first be generated in savings to self-fund the LIS. There is an estimated implementation timeline of 18 months for the LIS, which will prolong the start of savings realization into FY12/13.

Savings through consolidation are primarily in staff and equipment reduction. $0.9M in savings have already been achieved through reductions in non-contract administrative and support FTE’s. An ageing population of technologists coupled with the introduction of significant changes in structure of the workforce could introduce threats to the success of the program.

In summary, there are additional opportunities to reduce cost and improve operations over and above the initiatives proposed by the LMC team through three different operational efficiency initiatives:

1. Autoverification;
2. Test Range Standardization; and,

Checking for duplicate orders and standardizing order sets will reduce cost and enable test economies such as larger batch runs. Autoverification on high volume testing will reduce test turnaround time, lower error rates and mitigate staffing/resource issues. Using a standardized reference range will reduce unnecessary testing which identifying candidates for automation will reduce manual testing and accompanied labour effort, cost & variability.
5.11 **Facilities Management**

The purpose of the project is to consolidate capital projects, real estate departments and facilities departments. This project includes all major P3 capital projects and environmental sustainability portfolios. The overall mandate is to create a single consolidated department providing services to all four lower mainland health organizations.

The in-scope organizations are:

- Fraser Health Authority;
- Providence Healthcare;
- Provincial Health Services Authority; and,
- Vancouver Coastal Health.

5.11.1 **Baseline Budget, Savings Targets and Approach**

The total budget for Facilities expenditures in the Lower Mainland in FY09/10 was $193.7M.

The breakdown of the budget is seen below:

![Facilities Budget FY 09/10](image)

*Figure 41: Facilities – Baseline Budget*

Source: Finance Working Group for FY09/10 & FY 10/11 Budget Baselines; CFOs for Savings Targets; LMC Project Leads for Achieved Savings FY 09/10

The agreed saving target for facilities in the LMC was $10.0M or 5% of the budget. The LMC Facilities Team identified a number of initiatives to meet its $10.0M savings target. The breakdown of savings through to FY2012/13 is depicted below.
The Facilities team is working as one team to manage their business and improve cost controls across all authorities. Some longer term plans to optimize vacancy will continue to drive down cost, however, require detailed analysis. The key drivers to achieve savings in Facilities Operations & Maintenance are:

- In-sourcing resulting from economies of scale
- Knowledge transfer and adoption of the best/most efficient practices across the Lower Mainland
- Lean operations compared to industry benchmarks, i.e. Operations & Maintenance $s per square foot

The breakdown of savings, by source, is depicted below:

Figure 43: Facilities – Savings by Source

Source: Facilities Team – Collaboration 2010 04 15 - All Directors and EDs FINAL.xlsx
### 5.11.1.1 The savings initiatives

The LMC team identified five initiatives to achieve their savings and they are listed in the following table.

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Strategy</th>
<th>Timeline</th>
<th>Estimated Savings</th>
<th>Opportunity Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Global</td>
<td>Organizational consolidation structure</td>
<td>By 2011/12</td>
<td>$1.4M</td>
<td>Consolidation of all HA Facilities teams into one support function is complete; Miscellaneous non-labour cost reductions possible; Time to implement may be a barrier</td>
</tr>
<tr>
<td>2. Utilities</td>
<td>Procure gas on the futures market</td>
<td>By 2011/12</td>
<td>$3.0M</td>
<td>Since these utilities are being purchased on the futures market savings will not be known until the procurement of the utility is made; A hedging strategy is mentioned to be in place to mitigate the risk of increased costs due to market fluctuations</td>
</tr>
<tr>
<td>3. Leasing – Real Estate Programs</td>
<td>Consolidate leases and relocate into lower cost portfolios; Take tax credits where applicable</td>
<td>By 2011/12</td>
<td>$3.3M</td>
<td>Utilize technology to reduce the real estate footprint and costs; Implement Integrated Workplace Management System (IWMS) with Archibus; Gain all tax advantages available; Reduce the number of leases and gain full control of all new lease negotiations to increase leverage and occupancies of existing space; Projected savings for the Surrey office and future space consolidation are only estimates at this time; Without a direct study on number of personnel, vacancy rates and optimal work arrangements, savings from leasing – real estate programs will be smaller scale</td>
</tr>
<tr>
<td>4. Facilities O&amp;M</td>
<td>Optimize maintenance staffing, insourcing, outsourcing and shared services; Bulk purchase of maintenance supplies and optimization of inventory</td>
<td>By 2011/12</td>
<td>$1.6M</td>
<td>Optimization to improve efficiency and staffing ratios; Savings from shared services may not be able to be realized until 2011/12; Inventory optimization to decrease holding costs; Increased risks of “just-in-time” issues</td>
</tr>
<tr>
<td>5. Projects</td>
<td>Optimize capitalization and resourcing of project staff; Centralize and standardize procurement</td>
<td>By 2010/11</td>
<td>$0.7M</td>
<td>Reduce underutilization of planning staff; Reduce contractors if possible; Standardization of procurement to improve efficiency; Centralizing procurement may result in budget transfers rather than actual savings</td>
</tr>
</tbody>
</table>

Table 28: Facilities – Opportunity Assessment
5.11.2 Observations

5.11.2.1 Overview / Facilities O&M

There may be opportunities for FTE reductions based on improved operational efficiencies and leaner overall management structure.

Despite the fact that Facilities operations account for 32% of total budget, the project team has focused mainly on Utilities and Leasing as levers for savings:

- Utilities is projected to produce 30% of the savings; and,
- Leasing is projected to produce 33% of the savings.

Facility O&M savings initiatives were focused on:

- Maintenance staffing level reductions;
- Bulk purchase of maintenance supplies and equipment & furnishings;
- Charge backed client-requested overtime costs; and,
- Investment in maintenance replacements with ROI of < 2-3 years.

5.11.2.2 Leasing

Leasing savings are derived from reassessment of exempt opportunities for property taxes, increasing lease revenue such as rooftops (cell transmitters) and reduced operating costs from sale/lease of redundant assets. Lease contracts’ savings will depend on leveraging real estate and/or sale of redundant assets once an assessment is done and contracts are consolidated. A detailed assessment of all buildings is still to be performed to estimate vacancy levels and assess cross Lower Mainland consolidation opportunity across all HA locations.

Additional lease consolidation efforts are projected to produce savings over 12 years.

5.11.2.3 Utilities

One third of the total savings is utilities benefits. These savings are achieved through bulk purchases of natural gas on the Futures market. This approach cannot be guaranteed going forward and is not a sustainable approach. Further assessment on the risk-return profile is required.

5.11.3 Maturity of Project Management

The PMO methodology described in 3.7 was applied to the LMC Facilities project. Overall the Facilities project demonstrates “ad hoc” capabilities in project management. Facilities and real estate projects would benefit from leveraging in-house project management capabilities to reach “Basic” level, especially to increase visibility in Performance Management and Reporting.
The overall assessment of the Project Management Office maturity is below:

<table>
<thead>
<tr>
<th>Maturity</th>
<th>Process Area</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Basic</td>
<td>Scope Management</td>
<td>What Works Well: Scope has been defined initially, list of initiative are part of the initial project charter, but not completely signed off by all stakeholders. Area to look at: Control and execution of approved CRs to communicate result, update deliverables and manage revisions. Leverage stronger project control and embedded PM resources to create more comprehensive impact analysis faster.</td>
</tr>
<tr>
<td>3 Basic</td>
<td>Issue &amp; Risk Management</td>
<td>What Works Well: Risks have been formally documented including developed mitigation strategies. Area to Look At: Risk and issue tracking is based on a static file. An integrated tool with workflow capabilities will help to track closely the issue until final resolution. Dependencies should be documented as part of the risk matrix.</td>
</tr>
<tr>
<td>2 Ad Hoc</td>
<td>Workplan &amp; Time Management</td>
<td>What Works Well: A high level Project Plan exists with phases and dates, a documented list of activities to execute the project but not consistent level of detail necessary to monitor execution. Area to Look At: Development of a more detailed work plan including task work breakdown structure and dependencies mapping, milestones definition and progress tracking.</td>
</tr>
<tr>
<td>2 Ad Hoc</td>
<td>Resource Management</td>
<td>What Works Well: Although target org chart has been defined, the Resource management plan is not in place and their resource needs have not been identified. Area to Look At: The Resource Management Plan should also include how and when project team members will be allocated during all phases, confirmation of resources availability is a common challenge across projects.</td>
</tr>
<tr>
<td>2 Ad Hoc</td>
<td>Performance Management &amp; Reporting</td>
<td>What Works Well: Status, risk and financial project progress are reported up to the LMC steering committee. The projects risks are not in the proper section. Area to Look at: Minimal or no quantitative metrics are reported. Analyze improved information to refocus status activities on corrective action to improve proactive decision making. Compare project activities to baseline and trigger corrective actions to avoid further deviation.</td>
</tr>
<tr>
<td>2 Ad Hoc</td>
<td>Financial Management</td>
<td>What Works Well: Financial savings are tracked by the project team, but on a on-demand basis. Area to Look at: Project cost is not tracked. Improve reporting up to the LMC. Improve consistency with official finance team numbers.</td>
</tr>
<tr>
<td>2 Ad Hoc</td>
<td>Stakeholder Management</td>
<td>What Works Well: Stakeholders have been identified. Area to Look at: It is unclear as to the authority held by the director to make decisions that impact other authorities.</td>
</tr>
<tr>
<td>Basic</td>
<td>PM Support Tool – Documents &amp; Knowledge Management</td>
<td>What Works Well: Facilities team utilizes a detailed workplan which included a task work breakdown structure, dependency mapping, milestones, and tracking timelines. Area to Look at: Consider managing the projects using specific project management software with multi-project integration and roll-up reporting capability. Ability to provide status dashboards is desirable. This tool will enable more effective analysis of the impact of deliverables/dependency slip page.</td>
</tr>
</tbody>
</table>

Table 29: Facilities - PM Maturity Assessment

5.11.4 Accenture Assessment of Further Opportunities

5.11.4.1 Real Estate Savings

The draft real estate savings plan with a flexible real estate model is dependent on a successful implementation. It takes time to implement so cost reductions should be limited to lower cost real estate and increased density. To ensure accurate cost estimates, the project team should:

- Gain full program approval before estimating cost savings;
- Determine the audience for flexible work arrangements, along with each departments headcount, to determine if the program worth the effort; and
- Evaluate current space utilization and review customer space requirements to better estimate cost savings.

5.11.4.2 Flexible Work Space Model

The vision and current plan to reduce the overall real estate footprint and relocate to lower cost locations is well conceived and will reduce cost. The plan to move to a flexible workspace model can also reduce the need for workspace and capture significant cost savings.
A new work space model is difficult to implement and it may be hard to realize savings. For example, the IT department currently does not have the capacity to develop the infrastructure needed to support the flexible workspace model. The project team will need to work closely with the IT to permit more flexible work environments.

Stakeholder engagement is critical to the success of flexible workspace models. The project team should ensure it has the explicit support of executive leadership and work to gain approval from all stakeholders. It is vital to develop a communication plan to review the desired direction of the new workspace model and inform leadership and affected departments how the new model may impact on their operations. The communication plan will also ensure that there is no miscommunication of the purpose of a flexible workspace model.

### 5.11.4.3 Surrey Consolidation

The projected savings for the Surrey office and future space consolidation are only estimates. Any number of issues could affect the Surrey plans:

- Flexible work space models are both a cultural and physical change. Push back from employees could hinder execution of the flexible workspace model
- Current Surrey location is not a head count reduction but a 1 to 1 seat count exchange - savings are generated only by increasing the density of the workplace
- Lease termination will result in FTEs moving to Surrey and other flexible work spaces and occupying any excess space

To mitigate these risks, the project team should get the explicit support of executive leadership as early as possible.

There are additional opportunities that the project team could consider. Executive support roles should be assessed to determine if a centralized support model would maximize efficiencies and thus reduce cost. Additional savings and operational efficiencies can be realized through a well organized and planned workspace model that maximizes workspace utilization.

Efforts on exploring and pursuing Facilities consolidation and space management opportunities are still at an infancy stage. High-level plans and estimates have been started by the project team. In the absence of relevant vacancy, occupancy rates by building etc. we were only able to apply indicative quantification of consolidation opportunity ranges. These ranges are based on our Accenture experience in comparable environments.

Based on our large client portfolio, we have observed the following savings ranges where IWMS was utilized to optimize footprint/occupancy cost:

- Lease Administration: 5-8%
- Space Management: 10-15%
- Project Management: 3-5%
- Process Improvement: 5-8%
- Tax Management: 3-5%

We also recommend revisiting the following additional opportunities:

- Develop a business case to replace inefficient boilers based on improved utilities costs
- Develop an energy conservation program based on current use of electricity and opportunities to reduce consumption
- Implement a customer connection program where all HA people can participate in reducing energy waste

Facilities Management is in the process of implementing a subset of the recommended actions. On a high-level we understand that a number of business cases for energy efficient boilers have already been completed as part of health authority capital planning. Additionally, each health authority appears to have an energy conservation program. The
GreenLeaders+ program (originally a PHSA initiative) as part of environmental sustainability and waste reduction is rolling out across the lower mainland under the leadership of FM.

5.11.5 Conclusions –Facilities Initiatives

The Facilities teams have been consolidated into one capability and are working as one team to manage their business and improve cost controls across all authorities.

Facilities’ plan has identified targeted savings of $10M, based on a $194M budget. The targeted savings are mainly sourced from the Utilities and Leasing budgets – very minimal savings from Facilities Operations & Maintenance. A full 1/3 of these savings are Utilities benefits. Utilities saving are not fixed year to year because they are purchased on the Futures Market. The team has put in place hedging strategies to mitigate risk, however, savings underlying a volatile Futures Market are not sustainable in the long term.

Significant incremental savings are achievable in the Leasing, Real Estate and Property Management operations. One third of the savings should be realized based on the consolidation of leases and relocation of various portfolios. Over the course of this review, a very high-level, 12-year Cost Recovery Summary Draft Plan was developed to analyze different scenarios of real estate cost reductions. A detailed analysis by building and FTEs still needs to be performed.

The Facilities team should focus on formalizing a 5 to 10 year program with comprehensive, supporting quantitative analysis to help achieve Facilities’ objectives and gain stakeholder approval.

The concurrent Integrated Workplace Management Systems (IWMS) implementation will help the Facilities team to derive the actual footprint consolidation/vacancy optimization opportunity. Additionally, the system will enable establishing the flexible workspace model (e.g. hotelling for select job functions). Close collaboration with HR is critical to understand capabilities feasible for remote work. Furthermore, IT has to be closely integrated to facilitate secure, remote infrastructure.
5.12 Protection Services, Security & Parking

The LMC Protection Services Initiative encompasses all the Lower Mainland Health Authorities. The existing scope for Integrated Protection Services includes:

- Protection Security, including security contract management, loss prevention, people protection, investigations, and security systems & technology
- Parking, including contract management, financial management, designated technology, pass controls and transportation demand management
- Photo identification services are in scope for the four organizations as is fire safety for PHSA and FH and Emergency Management/Business Continuity for FH

Integrated Protection Services program has three core objectives:

- To create and maintain a secure and accessible environment allowing the highest standard of quality care to be made available across the four organizations.
- To create an integrated program that will provide quality service to all four organizations.
- To identify cost-saving and revenue enhancements from consolidation, standardization, collaboration and integration.

The Lower Mainland Consolidation Steering Committee (LMC SC) approved the business case creating Integrated Protection Services and formalized the program on September 17, 2009. As we will describe in more detail, the 60-day savings business plan approved by the CEOs was completed on time and the LM Integrated Protection Services service delivery model was implemented on November 17, 2009.

5.12.1 Baseline Budget, Savings Targets and Approach

The Lower Mainland Protection Services Initiative consolidated “in scope” 2009/10 budget is pictured in the following figure:

![Parking & Protection Services Baseline Budget](image)

**Figure 44: Parking & Protection Services – Baseline Budget**

*Source: Finance Working Group for FY09/10 & FY 10/11 Budget Baselines; CFOs for Savings Targets; LMC Project Leads for Achieved Savings FY 09/10*

The consolidated security budget for 09/10 is $17.6M and for 10/11 $17.36. Parking Services has a target revenue of $11.1M for FY 09/10 and $14.5M for FY 10/11. The net of cost and revenue for Protection Services comes to a ‘budget’ of $6.5M in 09/10 and $2.9M in 10/11. There are approximately 43 excluded FTE in the new Public Safety model, down nearly 10 percent from the pre-consolidation period. Security contracts account for more than $15 million of the budget.
The savings target for this LMC project is $6.5M of which $6M comes from increases in parking revenue and $0.5M cost reductions from security operations.

5.12.2 The Protection Services Initiatives

The planned savings and revenue generation targets are to be achieved through the three initiatives listed and described in the following table.

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Strategy</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Consolidate multiple contracts into one</td>
<td>Move from 3 guard companies to 1 Integrate security services/guards currently being performed by Facilities Department</td>
<td>Drive down costs by renegotiating three contracts into one large contract Reduce operational risk through reassessed and renegotiated terms and conditions The team is waiting for the contracts to expire - not for another two years In all 3 contracts, contract minimum spends are on a fixed management fee (no percentage participation)</td>
</tr>
<tr>
<td>2. Centralized Operations Call Centre</td>
<td>Single number contact for all customers All security and emergency services consolidated</td>
<td>Provide one number service for both emergency contact and security services. Single after hour on-call number for LM IPS Security call centre for VCH/PHC finalized to provide 911 like connectivity as FH and PHSA have in place. Material cost reduction by staffing one location vs. multiple locations. Develop common metrics in key areas between HA’s – Aggression, Theft, Fire Alarms, Calls for Service Significant cost savings and efficiency benefits if other project groups can use Protection Services current model to stay consistent with operational benchmarks and standards, and ongoing management and tracking for all operations and security work This requires the CEO committee to make the decision with regard to integrating emergency services</td>
</tr>
<tr>
<td>3. Increase Revenue from parking</td>
<td>Raise rates Increase payment compliance Eliminate staffed parking booths for automated service</td>
<td>Rates have been raised for visitor and excluded staff parking and the revenue targets for this initiative have been met Increasing rates for staff covered by collective agreements will require consultation processes Automate the process of paying for parking – eliminate the cost of paying for someone to collect parking fees. Personnel handling ticket transactions only offering minimal service interaction due to their location and setup of the booths, Current parking lot setups have barrier gates controlling access to the entry and exit lanes. Impeded access generates vehicle congestion and excessive wait times especially during peak periods, therefore having standalone, self serving meters would adds space by dismantling parking control equipment, enlarging entrance/exits, facilitating increased vehicle flow, convenience and visitors</td>
</tr>
</tbody>
</table>

Table 30: Parking & Protection Services – Savings Initiatives

5.12.2.1 Project Status

As of February 2010, the 2009/10 parking revenue commitment of $1.8M, annualized to $5.6M in 2010/11 was on target. The 2009/10 targets were also met so the parking revenue target of $6M will be achieved. These increases currently have been realized through increases in rates to the public and to management staff. The team is working closely with HR to address increases to unionized staff to ensure that any future increases are in compliance with collective agreements.

The original business case, approved by the LMC SC in September, included the following approved assumption:
"Fire Safety and Emergency Management/Business Continuity for PHSA and VCH/PHC will be consolidated in this program after the 2010 Olympic Games in March 2010, and form the Integrated Public Safety program for health in the Lower Mainland in the final phase of this project".

The team’s work to date has been completed in a manner that will allow the relatively seamless on boarding of the EM/BC functions for VCH/PHC and PHSA, as well as Fire Safety for VCH/PHC. The non parking cost efficiencies are tied to effective consolidation and built on the assumption that the EM/BC and fire safety services from VCH/PHC and PHSA would be on boarded after the 2010 Olympics. The plan has 3 associated financial commitments:

- PHSA: Reduce EM/BC excluded staffing by 1 FTE - savings approximate $90K
- VCH: Reduce EM/BC excluded staffing by 1 FTE - savings approximate $80K
- VCH: Consolidate fire safety contracts - savings approximate $30K

The projected $200K savings in this phase of the plan will allow the team to meet their overall target. They are however at risk if the Steering Committee does not confirm the post Olympic onboarding described above. The Protection Services team noted that these are minimum targets and based on limited budget information available for the services to be on boarded. As we have found in the LM Integrated Protection Services phase of consolidation, further cost savings opportunities can be anticipated beyond that committed in the cost savings plan.

A Service Level Agreement (SLA) has been produced for Integrated Protection Services and submitted to the HAs through the LMC SC for review SLA sign off. The team has been waiting several months for response from the various Health Authority executives.
5.12.2.2 Further Planned Efficiencies

The Protection Services team has identified a number of efficiencies beyond their current target.

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Observation</th>
<th>Opportunity</th>
</tr>
</thead>
</table>
| 1. Addressing non payment of parking passes through moving to badge strategy | - Revenues are being lost from both from non payment of parking fees as well as ex employees who continue to use parking when they are no longer authorized.  
  - Non authorized parkers are pushing up costs without contributing to the revenue. They also are taking space for people who need the parking space.  
  - Currently there are limited means to stop this non compliant behaviour particularly with medical staff or ex employees | - Work with HR to ensure cancellation of parking is enforced for those no longer working with the HA  
  - Move forward with badge strategy that will enable cancellation of parking access as appropriate |
| 2. Ensure appropriate levels of security across all sites – complete all site assessments | - Risk assessments to determine ratio of guards have been completed across some but not all LM sites  
  - A fair degree of variation still exists | - The belief is that there are still opportunities to cut costs by rationalizing current coverage  
  - Need to finish conducting the risk assessments and then staff accordingly  
  - Need to move the sites still being covered by the Facilities team over to the Protection Services Team |

Table 31: Parking & Protection Services – Further Planned Efficiencies

5.12.3 Maturity of Project Management

We applied the PMO methodology as described in Section 3.7 and have assessed the Parking & Protection Services project “ad hoc” in its PMO maturity. The Protection Services Team has mostly achieved their targets without utilization of a PMO, but further initiatives in this area would benefit from improved basic capabilities to ensure sound execution.
Maturity | Process Area | Observations
--- | --- | ---
2 Ad-hoc | Scope Management | What Works Well: Initial high level scope has been defined initially, list of initiatives is part of the initial plan. Area to Look At: A more formal list of initiatives and potentials savings for each initiative. Dependencies on contract existing expiration date. Track scope change impact on savings (i.e. automatic parking machine to replace parking guard will require capital investment)
1 Heroic | Issue & Risk Management | What Works Well: only 2 risks have been formally documented as part of the plan in January 2010. Area to Look At: Not all risks have been documented (i.e. consolidation one single facility for centralized support center may be denied by the HA). No follow-up on mitigation strategy.
2 Ad-hoc | Workplan & Time Management | What Works Well: A high level Project Plan exists with phases and dates. Progress is tracked within this plan (IPS action list) Area to Look At: Inadequate workplan tracking, preventing from quantitatively determining schedule and savings achieved Lack of detailed tasks, milestones definition and tracking. Define link and dependencies between tasks to actively manage the critical path.
2 Ad-hoc | Resource Management | Although a list of key contact exists, there is no estimate of project resources needs, no dedicated PM, relying on internal resources only, on top of their daily job. Project Management organization is not formally established, the project lead is acting as the project manager. They should involve the existing PMO support structure within Fraser and nominate a dedicated Project Manager.
2 Ad-hoc | Performance Management & Reporting | What Works Well: Report project progress up to the LMC steering committee. Area to Look At: No evidence of regular meetings, no evidence of minutes and decision log. The project lead is managing all parts of the project in an autonomous way.
2 Ad-hoc | Financial Management | What Works Well: Financial savings are tracked by project lead. Area to Look At: Improve reporting up to the LMC. Improve consistency with official finance team numbers. Savings and additional revenue plan would benefit from additional details, there is no clear link between planned actions and financial savings.
2 Ad-hoc | Stakeholder Management | What Works Well: There is a communication plan that is currently being built. Limited discussions with the HA to get approval for the centralized support center. Area to Look At: Consider more proactive engagement with stakeholders document their requirements, needs, potential negative impact on the project.
1 Heroic | PM Support Tool – Documents & Knowledge Management | Static documentation. Project plan lacking proper structure and level of details. The project lead does not use a central tool or any specialized Project Management tools.

Table 32: Parking & Protection Services – PM Maturity Assessment

5.12.4 Conclusions – Integrated Protection Services

The Integrated Protection Security Function has achieved most of their consolidation targets through increases to parking rates. The LMC team feels they can achieve further efficiencies through reducing security guard FTEs and consolidating contracts but require a decision from the Steering Committee on on-boarding some key programs as well as transferring security functions from Facilities to Protection Services.

Progress in this area has been hampered by delays in the area of HR and Finance, which they attribute to the pressures these organizations are facing as a result of consolidation demand. A further $200K of savings can be achieved if the team can open their planned centralized call centre and as well centralize and standardize badge issuing. Progress on this front is dependent upon the Steering Committee approving the recommended decisions.

The Accenture team has only two observations on this team’s initiatives. Firstly the team should begin discussions with the security contractors prior to contract expiration to potentially move savings forward. The second observation is in relation to the current badge distribution process – presently badges allowing access to health authority sites such as hospitals are distributed by mail. We feel this introduces unnecessary risk of the badges getting into the wrong hands and recommend badges be given to individuals in person.
5.13 **BISS: Housekeeping, Food and Laundry**

Vancouver Coastal Health (VCH) was selected as the LMC Lead Health Authority in the planning, implementation and delivery of consolidation savings from the Lower Mainland (LM) Business Initiatives & Support Services (BISS). BISS primarily manages a portfolio of Non-Clinical Support Services, namely Food, Housekeeping, Laundry, and Waste Management on behalf of the partner organizations of VCH, Providence Health Care (PHC), Fraser Health (FHA), and most recently, Provincial Health Services (PHSA). On the clinical side, BISS is charged with effectively managing the Patient Transport (Ambulance) programs at VCH & FHA.

In March of 2008 VCH/PHC and FHA were consolidated under a single leadership and the new organizational structure put in place by May of the same year. In Phase 2, the LMC Initiative, PHSA was included in this structure in October of 2009.

While the majority of BISS services have been contracted out to various vendors, some of the services are managed and delivered by in-house staff, and there are a variety of service delivery models in place across the different organizations, reflecting the differences in the available infrastructure, staffing practices, and negotiated agreements between the organizations, among other factors. Presently, BISS manages over 20 major contracts.

### 5.13.1 Baseline Budget, Savings Targets and Approach

![BISS Budget Baseline](Image)

*Figure 45: BISS – Baseline Budget*

*Source: Finance Working Group for FY09/10 & FY 10/11 Budget Baselines; CFOs for Savings Targets; LMC Project Leads for Achieved Savings FY 09/10*

As per the Finance Working Group, the 09/10 base budget for the BISS team is $191.9M. Within the different lines of operations (Housekeeping, Food, Laundry, Waste Management, Patient Transportation, and Corporate), there are a total of 686.19 HA FTEs across all of BISS services, with 2304.3 FTE's contracted to 3rd party providers (72%).

- Housekeeping and Waste Management has been fully outsourced. Note that FHA operates an in-house service model and an RFP is underway to outsource 5 smaller sites for Housekeeping
- Patient transportation is provided through BC Ambulance Service as well private operators
• RFPs are underway to outsource remaining in house laundry services

BISS has an LMC savings target of $5.9M mainly driven by FTE reductions and contract consolidation.

**BISS Savings Targets FY09-12**

(in $M)

- **Patient & Retail Food**: 34%
- **Patient Transportation**: 31%
- **Housekeeping**: 16%
- **Waste Management**: 2%
- **Laundry**: 1%
- **Corporate Admin**: 16%

**Total Savings Target: $5.9M**

*Figure 46: BISS – Savings Targets*
5.13.2 The BISS Savings Initiatives

Savings of $5.9M are projected over a 3-year timeframe with no targets for fiscal 09/10. As BISS is heavily outsourced large additional gains are challenging to obtain. The following table describes the LMC savings initiatives and their status.

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Strategy</th>
<th>Timeline</th>
<th>Opportunity (1)</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient &amp; Retail Food</td>
<td>FTE reductions</td>
<td>2010/2011</td>
<td>$2.9 M</td>
<td>Contract out services to companies where the service is their core responsibility and can provide expertise in the field. Consolidating contractors will also drive efficiencies. Estimate</td>
</tr>
<tr>
<td>Housekeeping</td>
<td>Move laundry cleaning to specialized companies</td>
<td>2010/2011</td>
<td>$1.5 M</td>
<td>Eliminate the need for capital requirements and operating expenses and drive down cost by moving to a vendor who offer reduces costs from increased volumes. Contractor solution not implemented but in final stage of RFP process</td>
</tr>
<tr>
<td>Laundry</td>
<td>Reduce FTE headcount</td>
<td>2010/2011</td>
<td>$0.08M</td>
<td>With contracted services elimination of any work duplication results in cost savings</td>
</tr>
<tr>
<td>Patient Transport</td>
<td>Reduce FTE headcount</td>
<td>2010/2011</td>
<td>$0.83M</td>
<td>Cost avoidance and rate increase in patient pay revenues. New revenues are estimates of expected volumes could see variance if raise in rates is unfavourable to the public</td>
</tr>
<tr>
<td>Waste Management</td>
<td>Reduce FTE headcount</td>
<td>2010/2011</td>
<td>$0.23M</td>
<td>Reductions have been completed</td>
</tr>
<tr>
<td>Corporate Administration</td>
<td>Reduce FTE headcount</td>
<td>2010/2011</td>
<td>$1.5M</td>
<td>Reductions have been completed  Plan to continue to not fill vacant positions if possible and execute reductions in Corporate functions FTE through consolidation and reduction in duplication of work effort</td>
</tr>
</tbody>
</table>

Table 33: BISS – Savings Initiatives
5.13.3 Observations

The BISS team is also working on applying relevant enablers for their set of identified initiatives where considerable success has already been achieved. We have additionally commented on potential risks associated with some of the initiative enablers. Our observations are provided in the following table:

<table>
<thead>
<tr>
<th>Initiative Enablers</th>
<th>Achievements to-date</th>
<th>Risks going forward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater clarity of Roles and Responsibilities</td>
<td>Delivered on a significant number of initiatives, and created new, incremental value for organizations</td>
<td></td>
</tr>
<tr>
<td>Reduced Management</td>
<td>– Developed common tools, integrated reports, common KPIs, SharePoint; good PMO approach to manage projects</td>
<td></td>
</tr>
<tr>
<td>One BISS contact person at smaller and mid-sized sites</td>
<td>– Structure implemented quickly – defined roles leveraging the wide variety of skill sets available within teams</td>
<td></td>
</tr>
<tr>
<td>Increasing scope of some FHA Food Managers</td>
<td>– Some relationships work really well – good team work on some initiatives</td>
<td></td>
</tr>
<tr>
<td>Strengthen Customer Service function at 4 Organizations</td>
<td>– confirmed that vacant 7.8 FTE positions would not be filled</td>
<td></td>
</tr>
<tr>
<td>Expand Contract Optimization function that will serve other organizations with the HAs</td>
<td>HAVE managed service continuity, maintained quality without major overarching issues</td>
<td></td>
</tr>
<tr>
<td>Refine quality audit function; change focus to customer service, shift more quality work to vendors</td>
<td>– Have managed to overcome infrastructural barriers, and made the virtual integration work well</td>
<td></td>
</tr>
<tr>
<td>Promote geographic responsibility</td>
<td>– Integrated performance management on FHA PerformanceLink</td>
<td></td>
</tr>
<tr>
<td>Centralizing Directors in same offices</td>
<td>More consistent contract management</td>
<td></td>
</tr>
<tr>
<td>Drive to standardization and integration</td>
<td>– Improved cooperation between contract team and BI team</td>
<td></td>
</tr>
<tr>
<td>Allow successful accomplishment of projects</td>
<td>– 77% of all FTE’s have either been consolidated and contracted out, or in the midst of being renegotiated to better contract terms</td>
<td></td>
</tr>
<tr>
<td>Delivered on a significant number of initiatives, and created new, incremental value for organizations</td>
<td>Difficult to communicate and reach out to the organization:</td>
<td></td>
</tr>
<tr>
<td>– Developed common tools, integrated reports, common KPIs, SharePoint; good PMO approach to manage projects</td>
<td>– Not fully utilizing Innovation &amp; Integration Team that they have hired and dedicated for their reorganization plans (eg. They invested in adding a new director role to assist with standard contract language &amp; risk management)</td>
<td></td>
</tr>
<tr>
<td>– Structure implemented quickly – defined roles leveraging the wide variety of skill sets available within teams</td>
<td>– Lack of integrated approach to problem solving</td>
<td></td>
</tr>
<tr>
<td>– Some relationships work really well – good team work on some initiatives</td>
<td>– Future development planning is not viewed as enabling or supporting</td>
<td></td>
</tr>
<tr>
<td>– confirmed that vacant 7.8 FTE positions would not be filled</td>
<td>– 4 organizations with different priorities that sometimes don’t align with BISS’ own strategies – eg. BI not fully integrated with FH, PHC</td>
<td></td>
</tr>
<tr>
<td>– Have managed service continuity, maintained quality without major overarching issues</td>
<td>– Lack of high level financial support</td>
<td></td>
</tr>
<tr>
<td>– Have managed to overcome infrastructural barriers, and made the virtual integration work well</td>
<td>– Senior team still not acting as a mutually supportive team</td>
<td></td>
</tr>
<tr>
<td>– Integrated performance management on FHA PerformanceLink</td>
<td>– Perception that we “over manage” the vendors</td>
<td></td>
</tr>
<tr>
<td>More consistent contract management</td>
<td>– Some question classification of Quality Manager</td>
<td></td>
</tr>
<tr>
<td>– Improved cooperation between contract team and BI team</td>
<td>– Role confusion at times (Confusion remains between contract performance and quality)</td>
<td></td>
</tr>
<tr>
<td>– 77% of all FTE’s have either been consolidated and contracted out, or in the midst of being renegotiated to better contract terms</td>
<td>– Lack of capacity on contract management – resources appear weighted to quality management / operations</td>
<td></td>
</tr>
<tr>
<td>IT access has been very challenging</td>
<td>– IT access has been very challenging</td>
<td></td>
</tr>
</tbody>
</table>

Table 34: BISS – Observations on Initiative Enablers
5.13.4 Maturity of Project Management

The BISS function reached an ‘Advanced’ level in project management maturity effectively leveraging their in house support team.

<table>
<thead>
<tr>
<th>Maturity</th>
<th>Process Area</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Advanced</td>
<td>Scope Management</td>
<td>What Works Well: With dedicated Project Manager and Project management support team, the project scope has been defined initially, including the list of initiative and contract list are part of the initial project charter. There is extensive evidence of a proper management of the scope. Area to look at : N/A</td>
</tr>
<tr>
<td>4 Advanced</td>
<td>Issue &amp; Risk Management</td>
<td>What Works Well: Risks have been formally documented including developed mitigation strategies. The risks are part of the plan and the report up to the LMC committee. Risk and issue are shared on the internal sharepoint. Area to Look At: An integrated tool with workflow capabilities will help to track closely the issue until final resolution.</td>
</tr>
<tr>
<td>3 Basic</td>
<td>Workplan &amp; Time Management</td>
<td>What Works Well: A detailed Project Plan exists with list of tasks, and documented specific dates, resources etc Area to Look At: Development of a more detailed work plan including task work breakdown structure and dependencies mapping, milestones definition and progress tracking, ideally in a PM specialized dynamic tool, so that tasks with dependencies would be dynamically moved together in case of modification.</td>
</tr>
<tr>
<td>3 Basic</td>
<td>Resource Management</td>
<td>What Works Well: The project resource management plan is in place and the resource needs has been identified. Area to Look At: The Resource Management Plan should also include confirmation of resource availability.</td>
</tr>
<tr>
<td>4 Advanced</td>
<td>Performance Management &amp; Reporting</td>
<td>What Works Well: Project status and risks are reported up to the LMC steering committee. Financial metrics are reported. Compare project activities to baseline and trigger corrective actions to avoid further deviation Area to Look at: N/A</td>
</tr>
<tr>
<td>4 Advanced</td>
<td>Financial Management</td>
<td>What Works Well: Financial savings have been defined, planned and tracked properly by the project team. Area to Look at: No evidence of project cost tracking.</td>
</tr>
<tr>
<td>3 Basic</td>
<td>Stakeholder Management</td>
<td>What Works Well: There is a list and analysis of stakeholders current and desired engagement status, including a documented change management and communication plan. A dedicated change management person has been assigned. Area to Look at: This plan could benefit from periodic verification of expectations and identification of new stakeholders, their expectations and potential impact.</td>
</tr>
<tr>
<td>3 Basic</td>
<td>PM Support Tool – Documents &amp; Knowledge Management</td>
<td>What Works Well : Extended and template based project documentation.. Area to Look at: The team does not use specialized Project Management tools with integration capability. Consider managing the projects using specific project management software. This tool will enables more effective analysis of the impact of deliverable/dependency slippage.</td>
</tr>
</tbody>
</table>

Table 35: BISS – PM Maturity Assessment

5.13.5 Accenture Assessment of Further Opportunities

We believe that some innovative collaboration could further streamline the BISS budget and improve operations. For example, housekeeping could evaluate partnering with Facilities with regards to their plan to centralize their services as a single call centre for their customers, which follows the same principles as the Facilities team is pursuing. This could help drive down start-up costs and capitalize on some headcount synergies setting up the shared centre.

As well, once all contractor decision are made and implemented, further savings could be achieved by providing incentives for contractors to realize additional cost savings through continuous improvement activities or partnering with the contractors to develop cost initiatives such as labour management efficiencies, leveraging vendor purchasing power and supply’s cost controls.

5.13.6 Conclusions – The BISS Initiative

As part of BISS’ Phase 1 initiatives (VCH/PHC/FHA) several contractual and operational efficiencies, including extensive standardization, were achieved. This provided for a leaner going-in position to Phase 2 (LMC) where the PHSA operations were also on-boarded.
Savings in BISS are driven primarily from 2 sources:

- **Excluded management reductions**: BISS has significantly reduced its administrative management overhead (21.5% total admin) delayering and streamlining its organizational structure.
- **Services budget savings**: 72% of the total pre-consolidated budget is currently contracted out to 3rd party providers. Thus the scope for additional opportunities is confined to contract renegotiation and/or retendering. Furthermore, BISS has already established a new, consolidated and streamlined organizational structure, processes and designs which also leave less room for further optimization with the exception of driving synergies from onboarding PHSA.

A savings target of $5.9M (3%) of a FY09/10 budget baseline of $191.9M appears reasonable since most additional efficiencies must come from synergies of onboarding PHSA and further optimizing vendor relationships and managing contract pricing.

Having contract cost pressure mitigation as a core focus within BISS’ strategies towards maximizing value bears the risk of potential contract price increases and saturated negotiation levers.

BISS previously experienced a 2.92% contract price increase over FY09/10 budget. Savings are sourced 70% + from contract price negotiations. The remainder is to come from in-house operational savings and outsourcing as well as Ambulance and BI savings.

**Innovative collaboration opportunities can further streamline the BISS budget and improve operations**

- Housekeeping could evaluate partnering with Facilities with regards to their plan to centralize their services as a single call centre for their customers, which follows the same principles as the Facilities team is pursuing. This could help drive down start-up cost and capitalize on some headcount synergies setting up the shared centre.
- Once all contractor decisions are made and implemented, further savings could be achieved by providing incentives for contractors to realize additional cost savings (through continuous improvement). Partnering with the contractors to develop cost initiatives such as labour management efficiencies, leveraging vendor purchasing power and supply’s cost controls.
6. LMC Program Assessment

6.1 LMC Governance Structure and Process

The LMC governance model is comprised of a four-tiered leadership structure. Per LMC Project Charter (Section 6), one of the key roles and responsibilities of the Health Authority CEOs is to remove barriers to project success. The key disconnects described in Section 4.6. (Program Level Challenges) including:

- Resource transfers
- Collective budget management
- Service items and services levels
- Funding/investment issues

can all be addressed, agreed upon and resolved at the CEO level without any additional authorization. The lack of agreement and collective ownership has significantly contributed to the slow project progress and minimal savings achievement.

Also anchored in the LMC project charter (Section 6), “the membership of the Steering Committee reflects the shared accountability of the Health Authority CEOs for the initiative success and project deliverables”. As the primary function of the Steering Committee, it is responsible for the feasibility and outcomes of the Lower Mainland Consolidation project.

Since official accountability and decision rights are defined, documented and assigned to each CEO as well as the Steering Committee in plenum, the key challenge is to develop a mechanism to enforce accountability.
6.2 LMC Program and Project Management

The LMC Project Charter (Section 6) also describes the roles and responsibilities of the dedicated program level project management support. The team had developed a standardized template and format to be utilized for preparing, reporting and monitoring individual and overall project status. This management process has not been diligently adhered to and collectively leveraged. Some projects chose not to submit any data on progress.

Our project management assessment resulted in an overall project maturity level of 'Ad-Hoc' across the 9 PMO disciplines and projects, which indicate that projects are managed with independent processes.

Select projects have dedicated PM resources whereas others employ very rudimentary project management mechanisms. As stated in Section 3.7 (Project Assessment Methodology), projects do not need to put in place extensive project management structures. Particularly in the case of the LMC initiative being more a budget reduction versus a larger scale transformation effort, it is critical to ensure savings are sustainable going forward.

6.2.1 Common Project Management Challenges

Our interview sessions with LMC leads as well as with PM resources revealed a set of common challenges:

- **Over-emphasis on tactical tasks and lack of longer-term planning**
  - Project plans were often too high-level and/or did not address mitigation strategies for risks and issues

- **Lack of timely issue resolution**
  - No defined, standard process in place for escalation and resolution
  - Approvals had to be sought from 4 separate Health Authorities as opposed to leveraging a collective resolution mechanism

- **Lack of dedicated PM resources**
  - Most projects were handling project management tasks in addition to their daily operational responsibilities
  - Some projects, however, had highly skilled dedicated PM resources on their teams

- **Concurrent consolidation of critical support functions HR, IT and Communications**
  - HR and IT resources are tied up in their function consolidation efforts which poses additional resource constraints to support the 12 LMC initiatives
  - Common tasks such as developing standard job descriptions take up to 2 months
  - Service levels are stretched
  - Some projects ended up hiring additional communication support to better meet demand and their particular business needs and circumvented the consolidated Communication function

6.3 Conclusion and Recommendations

Select projects have established very skilled and best practice level project management capabilities and resources, e.g. Steve Barbazuk’s team within PHSA and Sean Parr within VCH. We recommend the following:

- Leverage existing PM capabilities as a ‘Centre of Expertise’ across all LMC projects
- Establish a formal process on periodic engagement
- Define formal process on engaging with Ministry of Health Services program level management and agree on hand-offs
- Establish a formal process on project reporting, benefits tracking and monitoring (for Financials in collaboration with Finance Working Group)
- Agree and deploy common set of methodologies and templates
- Share and deploy best practices
7. Recommendations Going Forward

7.1 Evaluation of Options

We have developed 3 scenarios as options for LMC going forward. The options are mainly differentiated in the level of risk sharing, timing and magnitude of benefits realization.

7.1.1 Option 1: Drive LMC to be more aggressive in savings pursuit

<table>
<thead>
<tr>
<th>Option 1: Drive LMC to be more aggressive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Leadership:</strong> Boards and CEOs have to work together and exercise collective accountability to achieve more aggressive timelines and savings</td>
</tr>
<tr>
<td><strong>Investment:</strong> Pursue self-funding initiatives (e.g., strategic sourcing, span-of-control, project elimination) to achieve higher savings</td>
</tr>
<tr>
<td><strong>Stakeholders:</strong> Engage clinical community and include all potential scope</td>
</tr>
</tbody>
</table>

In option 1, risk is shared with the Health Authorities. An extensive focus on back-office support minimizes the time and effort to invest in core mission to deliver healthcare to the Lower Mainland.

7.1.2 Option 2: Drive towards Shared Services – Captive or Outsource

<table>
<thead>
<tr>
<th>Option 2: Drive to Shared Services – Captive or Outsource</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outsource:</strong> Contract non-core activities (e.g., IT, HR transactional, procurement) for guaranteed savings and service levels</td>
</tr>
<tr>
<td><strong>Shared Services:</strong> Aggressively drive retained, activities (e.g. Labs, DI, Pharmacy) to a high-performing shared services model</td>
</tr>
</tbody>
</table>

In option 2, benefits are typically seen as early as in year 1. Risk is shared with the strategic partner and managed through Service Level Agreements (SLAs). By alleviating the Health Authorities of back-office support, focus can be shifted towards the core mission.

7.1.3 Option 3: Hybrid Approach (our recommendation)

The hybrid approach is about systematically reviewing each LMC project as well as other support function areas to determine the most effective approach, i.e. moving forward driving LMC to pursue savings more aggressively and concurrently evaluating captive or outsourced shared services delivery models.
For all back-office and infrastructure functions we recommend to maximize contracting non-core activities.

With regards to clinical support functions, we have provided a deeper perspective by selected sub-functions with regards to scalability, i.e. the ability to support the required quality of service as the workload increases and impact on clinical operations (i.e. level of change and effort required as well as initial disruption) based on our experience with Health Sector clients and current capabilities in the private sector.

There are transactional components within Diagnostic Imaging, Laboratory & Pathology and Pharmacy that lend themselves for centralization and shared services/outsourcing. The following three tables provide additional insights by function.

### Laboratory

<table>
<thead>
<tr>
<th>Function/Process</th>
<th>Potential for Shared Services /Outsourcing</th>
<th>Scalability</th>
<th>Impact on Clinical Operations</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory Test Catalog</td>
<td>Shared Services</td>
<td>☐</td>
<td>☈</td>
<td>Standardizing test catalogs provides an opportunity for normalization between disparate systems and could reduce duplicate testing</td>
</tr>
<tr>
<td>Laboratory Testing Systems</td>
<td>Shared Services</td>
<td>☐</td>
<td>☈</td>
<td>Standardizing test platforms reduces overall cost per test, reduces complexity of training and provides overall reduction in operating costs through high-volume buying of reagents and services</td>
</tr>
<tr>
<td>Laboratory Supplies</td>
<td>Shared Services</td>
<td>☞</td>
<td>☇</td>
<td>Provides opportunity to garner volume discounts, standardize test platforms and create common testing methodologies</td>
</tr>
<tr>
<td>Laboratory Equipment</td>
<td>Outsourcing</td>
<td>☞</td>
<td>☐</td>
<td>Outsource maintenance of common, low-complexity equipment; should provide cost savings over providing similar service in-house.</td>
</tr>
<tr>
<td>Laboratory &amp; Pathology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Discipline Consolidation - high volume testing | Outsourcing (1) / Shared Services (2) | ☞           | ☇                           | Developing centralized test capability and capacity for non-critical tests to increase quality, consistency and economies of scale, reducing the current cost per test. Options for centralization: (1) Outsourcing:  
  • Lower cost due to scale  
  • Leverages existing testing capability and capacity  
  • Leverages existing results distribution network (Excelleris)  
  • Lack of end-to-end specimen tracking capability – add as qualifier for provider to ensure/establish this capability (2) Shared Services  
  • Leverages excess capacity of existing labs/PHSA  
  • Investment required to upgrade LIS systems and enable specimen tracking  
  • Plan/design/build specimen tracking system |
| LIS Systems Application Support, enhancement, break/fix | Outsourcing                              | ☞           | ☇                           | LIS systems including Meditech and Sunquest. Reduces cost and can be provided locally and remotely to enable 24 x 7 staffing during critical implementations. Does require maintenance of two separate systems with concomitant skill sets in both systems. |

## Diagnostic Imaging

<table>
<thead>
<tr>
<th>Function/Process</th>
<th>Potential for Shared Services/Outsourcing</th>
<th>Scalability</th>
<th>Impact on Clinical Operations</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standardize Clinical Practice</td>
<td>Shared Services</td>
<td>●</td>
<td>●</td>
<td>Clinical practice standards proliferated across the organization reduces costs and allows staff mobility.</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>Shared Services</td>
<td>●</td>
<td>●</td>
<td>Streamlines clinical processes and speeds up delivery of care by agreeing in advance on study acceptance standards and study protocols to be utilized for most diagnoses.</td>
</tr>
<tr>
<td>Budget Management &amp; Staff Productivity Standards</td>
<td>Shared Services</td>
<td>●</td>
<td>●</td>
<td>Establishing budgets across the LMC and managing them across the structure will assure resources are prioritized for best use and best utilized across the region.</td>
</tr>
<tr>
<td>RIS</td>
<td>Shared Services</td>
<td>●</td>
<td>●</td>
<td>System selection would ideally be consistent across the LMC to provide better data integration and streamline staff training.</td>
</tr>
<tr>
<td>IT Systems Application Support, enhancement, break/fix (non-PACS)</td>
<td>Outsourcing</td>
<td>●</td>
<td>●</td>
<td>All IT systems except PACS initially due to multiple vendor platforms in use and lack of vendor training available to third parties for PACS. Reduces cost and can be provided locally and remotely to enable 24 x 7 staffing during critical implementations.</td>
</tr>
<tr>
<td>IT Help Desk support (Level I &amp; II) with referral for Level III to vendor</td>
<td>Outsourcing</td>
<td>●</td>
<td>●</td>
<td>Provides readily available 24 x 7 staff at reduced costs with training across application platforms.</td>
</tr>
<tr>
<td>Centralized OP Scheduling system implementation</td>
<td>Shared Services</td>
<td>●</td>
<td>●</td>
<td>Required to assure cross-HA scheduling of patients in multiple departments. Allows equipment resource utilization across sites needed to properly serve demand with existing or fewer resources over time.</td>
</tr>
<tr>
<td>IVR supply</td>
<td>Outsourcing</td>
<td>●</td>
<td>●</td>
<td>Consolidate supply inventory for LMC and leverage vendor pricing by outsourcing supply management to a wholesaler who would supply &lt; or = to 2 vendors per supply type and manage the supply sites based on par levels established and vendors agreed upon by the LMC. This is an IVR recommendation that could also apply to other major supply use areas such as the OR, Cath Lab, Central Sterile Supply, etc.</td>
</tr>
</tbody>
</table>

- Red Circle for **High Scalability/Impact on Clinical Operations**
- Blue Circle for **Low Scalability/Impact on Clinical Operations**
## Pharmacy

<table>
<thead>
<tr>
<th>Function/Process</th>
<th>Potential for Shared Services/Outsourcing</th>
<th>Scalability</th>
<th>Impact on Clinical Operations</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy: Remote physician medication order entry</td>
<td>Shared Services</td>
<td>☀</td>
<td>☀</td>
<td>Manage wide swings in order entry flow; planned periods of reduced staffing; if pharmacist order entry, allows more clinical pharmacy services performed</td>
</tr>
<tr>
<td>Medication Use Management (reporting adverse drug events, formulary management, other clinical programs)</td>
<td>Shared Services</td>
<td>☀</td>
<td>☀</td>
<td>Pharmacists, physicians, nurses and ancillary health professionals are required for implementation across all HA’s</td>
</tr>
<tr>
<td>Unit dose repackaging, Intravenous preparations</td>
<td>Outsourcing</td>
<td>☀</td>
<td>☀</td>
<td>Determine business case for current state repackaging/intravenous preparations; Consider vendor outsourcing for repackaging and/or compounded sterile product preparation</td>
</tr>
</tbody>
</table>

- **High Scalability/Impact on Clinical Operations**
- **Low Scalability/Impact on Clinical Operations**
### 7.2 Next Steps

The following section examines immediate next steps which should be applied towards the chosen path.

Moving forward, LMC success is contingent on resolving a number of key issues.

<table>
<thead>
<tr>
<th>Baseline</th>
<th>Decision-making</th>
<th>Financial Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Collectively across HAs:</td>
<td>- Agree on decision-making model to drive issues to conclusion for:</td>
<td>- Understand nature of forecast demand</td>
</tr>
<tr>
<td>- establish comprehensive financial and headcount baseline for each function</td>
<td>- budget approval</td>
<td>- Collectively agree on cost allocation:</td>
</tr>
<tr>
<td>- develop current service delivery performance and quality baseline by function and by service item</td>
<td>- issue/exception resolution</td>
<td>- historical cost</td>
</tr>
<tr>
<td>- define desired, standard service levels and performance targets</td>
<td>- performance management (SLA adherence)</td>
<td>- FTE based budget</td>
</tr>
<tr>
<td></td>
<td>- chargeback model</td>
<td>- operating unit size</td>
</tr>
<tr>
<td></td>
<td>- Identify cross-HA collaboration beyond executive level SteCo (e.g., functional leadership)</td>
<td>- transaction volume</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- time to complete</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- fixed vs. variable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Agree on cost/risk and surplus/savings allocation</td>
</tr>
</tbody>
</table>

**Figure 48: Immediate Next Steps**

These critical tasks are strongly recommended to be resolved within the next 90 days to minimize further stalling of project progress and savings realization. A 90-day workplan is recommended to establish to support the strategic and tactical tasks in pursuit of the Option chosen.
8. Appendix – LMC Project Charter
Project Charter

Project: Lower Mainland Consolidation (corporate, clinical support and back office functions)

<table>
<thead>
<tr>
<th>Version</th>
<th>1.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Carl Roy</td>
</tr>
<tr>
<td>Start Date</td>
<td>July 27, 2009</td>
</tr>
</tbody>
</table>

Approvals/Reviews

<table>
<thead>
<tr>
<th>Executive Project Sponsor(s)</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Dyble, Deputy Minister</td>
<td>Original Signed by John Dyble</td>
<td>September 23, 2009</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Project Sponsor(s)</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gordon Barefoot</td>
<td>Original Signed by Gordon Barefoot</td>
<td>September 26, 2009</td>
</tr>
<tr>
<td>Wynne Powell</td>
<td>Original Signed by Wynne Powell</td>
<td>October 2, 2009</td>
</tr>
<tr>
<td>David Thompson</td>
<td>Original Signed by David Thompson</td>
<td>October 2, 2009</td>
</tr>
<tr>
<td>(Kip Woodward)</td>
<td>Original Signed by Kip Woodward</td>
<td>October 5, 2009</td>
</tr>
</tbody>
</table>
Project Charter

This Project Charter is a formal statement of the purpose, objectives and scope of the Lower Mainland Consolidation (LMC) project. The Charter also represents a commitment to dedicate the necessary time and resources to the project. The Charter provides the basis for approval to proceed with detailed project planning and serves as an agreement between the various stakeholders that the project will be planned and executed in accordance with the content of this document.

The Charter has four important functions:

1. Provides a high level and common understanding of the project.
2. Establishes the partnership between the project sponsor, steering committee, project director, project team and stakeholders.
3. Provides input to necessary project planning documents.
4. Identifies the project structure, roles and responsibilities.

Document History

As many individuals contribute to the development of a business it is recommended that changes be identified using this table. Versions can be upgraded as determined by the owner of the document.

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Author</th>
<th>Description of Changes / Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>August 23, 2009</td>
<td>Carl Roy</td>
<td>First draft</td>
</tr>
<tr>
<td>1.1</td>
<td>August 25, 2009</td>
<td>Carl Roy</td>
<td>Incorporation of feedback from Nigel Murray</td>
</tr>
<tr>
<td>1.2</td>
<td>August 26, 2009</td>
<td>Carl Roy</td>
<td>Input from all CEOs, MOHS &amp; reflect Board Chairs discussion</td>
</tr>
<tr>
<td>1.3</td>
<td>Sept 4, 2009</td>
<td>Carl Roy</td>
<td>Steering committee final review</td>
</tr>
</tbody>
</table>
# Table of Contents

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2. Background..................................................................................................................................... 4  
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1. Project Purpose

To consolidate as many corporate, clinical support and back office functions to achieve savings and efficiencies across Fraser Health (FH), the Provincial Health Services Authority (PHSA), Vancouver Coastal Health (VCH,) and their affiliate Providence Health Care (PHC) in order to address the HA’s budget deficits in the short term.

In the longer term, additional benefits will be achieved as the entities function as an integrated system.

2. Background

Although health authorities have received significant funding increases over the last few years, demand continues to grow. To varying degrees, all health authorities are currently facing projected deficits. The geographic proximity of the three health authorities headquartered in the lower mainland presents the opportunity to look for efficiencies within departments that are common across the four organizations. Although some work on consolidation has been done by some of the organizations, the potential for more integration and alignment has been identified as a way of creating greater efficiencies. The Ministry of Health Services has directed that the “LMC” project be initiated to ensure full consolidation of all corporate, clinical support and back office functions unless there is a definitive and undeniable reason for exclusion.

Given the current economic environment, the continuing demand, and the percentage of the provincial budget already allocated to health care, additional funding is not an option. In order to ensure clinical services are funded appropriately with the available resources, back office and corporate functions must be reduced if health authorities are to balance their budgets. As a result of these actions, in some areas there will be reductions in service.

3. Objectives

The strategic level objectives of the project are:

<table>
<thead>
<tr>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) By the end of August, undertake a review of all common departments (except direct clinical services) to identify the feasibility of consolidation for efficiency.</td>
</tr>
<tr>
<td>(2) Prioritize departments to be consolidated based on potential savings, time to implement and effort required. This objective will leverage collaboration work that has already been implemented by FH and VCH.</td>
</tr>
<tr>
<td>(3) Utilize the existing health authority structure and expertise to assign accountability to each CEO for specific departments and delivery of the project deliverables related to their areas of accountability.</td>
</tr>
<tr>
<td>(4) Implement consolidation plans that include savings and timelines for all in scope departments.</td>
</tr>
<tr>
<td>(5) Develop basic service level agreement for each LM service.</td>
</tr>
</tbody>
</table>
4. Principles

The Steering Committee agreed to the following guiding principles:

1. **Scope:** All non-clinical services should be considered in-scope for this project unless there is a compelling business case for exclusion. All resources (FTEs, Supplies, Projects) related to an area targeted for Lower Mainland consolidation are included in scope and subject to the business model. The starting point for consolidation is Health Authority budgets / activity effective July 27, 2009.

2. **Provincial Scope:** Consolations will be expanded to Northern Health, Interior Health and VIHA once the value is demonstrated in the lower mainland.

3. **Participation:** Participating health authorities are: Vancouver Coastal, Fraser and Provincial Health Services Authority. Providence Health Care is included under the umbrella of Vancouver Coastal Health Authority. For all intents and purpose, the approach will be as though the three organizations act as a single corporate entity.

4. **Financial Benefit:** Initiatives must have a reasonable expectation of returning financial benefit by fiscal 2009/10 year end.

5. **Budget Plan Impacts:** Consolidation activities must not jeopardize other budget management activities or health authority clinical services delivery capacity.

6. **Pace is Critical:** Comprehensive business cases will not be required for each initiative; the pace and magnitude of savings will drive flexibility in the business models. Leaders to be selected and savings targets set; it is understood that course correction may be periodically required as initiatives are implemented.
   - By end of September: major progress of implementation of 2 or 3 business lines
   - By end of November: major progress of implementation of remaining business lines

7. **Consistency:** Common templates and reporting methodologies should be used where possible to ensure comparability of evaluations and outcomes.

8. **Benefit Attribution:** Financial benefits resulting from consolidation will be distributed back to participating health authorities relative to their investment in the process (e.g. should a consolidation initiative net a 50% savings, each participating health authority will receive a 50% return on their investment in that consolidation initiative).

9. **Transformation Costs:** Health Authorities are responsible for the transformation costs related to implementing their assigned consolidated departments. Investment to drive further efficiencies from consolidated departments will be considered separately from transformation costs. Additional funding is not available for transformation or restructuring. Costs will be covered from administrative savings.

10. **Administrative Ownership:** Consolidated services will reside within an existing administrative structure (i.e. within one of the participating health authorities) and will report to the leadership of that health authority, while providing services to the other participating health authorities. Health Authority will be responsible for planning, implementing and delivering services for their assigned departments.

11. **Service Relationships:** Flexibility in the mechanisms and structures of service relationships will allow a common sense approach. Care and services will continue to receive appropriate support from the amalgamating departments.

12. **Staff Reductions:** Expectation that staff complement, including senior executive management, will be significantly reduced in all lines of business.
5. Scope

Objective 1: By the end of August, undertake a review of all common departments (except direct clinical services) to identify the feasibility of consolidation.

Within Scope

- Health authority business that is considered corporate, clinical support and / or back office
- Preliminary list includes:

<table>
<thead>
<tr>
<th>Human Resources - Strategic</th>
<th>FOI, Privacy &amp; Legal Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Resources – Transactional / Standardization</td>
<td>Patient Care Quality Office</td>
</tr>
<tr>
<td>Financial Services – Transactional (Payroll, Accounts Payable, Accounts Receivable)</td>
<td>Provincial Language Services</td>
</tr>
<tr>
<td>Financial Management - Strategic Communications</td>
<td>Health Records</td>
</tr>
<tr>
<td>IM/IT</td>
<td>Portering</td>
</tr>
<tr>
<td>Facilities Management</td>
<td>Transcription</td>
</tr>
<tr>
<td>Environmental Management</td>
<td>Switchboard</td>
</tr>
<tr>
<td>Security and Parking</td>
<td>Project Management</td>
</tr>
<tr>
<td>Emergency Planning</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>Business Initiatives</td>
<td>Laboratory Services</td>
</tr>
<tr>
<td>Patient Transport</td>
<td>Diagnostic Imaging.</td>
</tr>
<tr>
<td>Biomedical Engineering</td>
<td>Housekeeping</td>
</tr>
<tr>
<td>Sterile Processing</td>
<td>Food</td>
</tr>
<tr>
<td>Enterprise Risk Management</td>
<td>Laundry</td>
</tr>
</tbody>
</table>

Out of Scope

- Direct clinical services
- Service for which there is a definitive and undeniable reason for exclusion

Objective 2: Prioritize departments to be consolidated based on potential savings, time to implement and effort required. This objective will leverage collaboration work that has already been implemented by FH and VCH.

Within Scope

- Collaborations already implemented by FH and VCH.
- Confirm Immediate (end of September), Phase 1 (end of November) and Phase 2 (future) consolidation activity
### Out of Scope
- Areas identified to move to the BC Health Authority Shared Services Organization (SSO)
  - Supply Chain
  - Technology services
  - Payroll

### Objective 3: Utilize the existing health authority structure and expertise to assign accountability to each CEO for specific departments and delivery of the project deliverables related to their areas of accountability.

### Within Scope
- Confirm roles and responsibilities of governance committee, steering committee, project support and health authority executives
- Assign health authority CEO accountability
- Appoint project support to accomplish objectives
- Establish reporting and monitoring mechanism
- Identify a consolidation lead within each health authority to coordinate and align the plans for departments assigned to their health authority
- Select / appoint department consolidation leads. The consolidation lead, once chosen, must table a plan that includes, business model, savings, staffing and timeline to implement and achieve the deliverables

### Out of Scope
- Day-to-day operations of departments until accountability for the provision of the service has been assumed by a health authority
- Direct clinical services

### Objective 4: Implement consolidation plans that include savings and timelines for all in-scope departments

#### Within Scope
- Develop department plan (budget and staffing analysis, recommend consolidated organizational model, confirmation of savings potential)
- Identify potential barriers to consolidation and recommend strategies to remove them
- Implement department specific project plans
- Develop communication plan for the consolidated department
- Implement labour adjustment strategies (in consultation with HEABC)
- Status reporting on deliverables and timeline
**Objective 5: Develop basic service level agreement for each LM service.**

**Within Scope**
- Performance metrics and service levels for each service area
- Mechanism of support and service to direct care and service
- Dispute mechanism.

**Out of Scope**
- 

---

**6. Structure and Roles**

**Ministry of Health Services**

The Ministry, through Michael MacDougall, Chief Operating Officer, will provide facilitation and will have decision-making authority in the event that collaborative decision making is not possible. He will assist with issues resolution including support for health authority efforts to engage Providence Health Care. The Ministry of Health will also assume responsibility for performance monitoring and reporting support for the project.

**Governance Committee**

The Governance Committee holds responsibility for the overall performance of the Lower Mainland Consolidation project. The Governance Committee will ensure that each health authority provides leadership and assumes accountability for “designated” services by incorporating the expectation into individual health authority CEO performance plans. Specific Governance Committee roles include:
- Approval of the recommended business model including policy and decisions related to project funding, transformation costs and distribution of savings/reinvestment
- Sign-off on assignment of services and programs to the health authorities
- Performance reviews
- Issues resolutions

**Steering Committee**

The membership of the Steering Committee reflects the shared accountability of the Health Authority CEOs for the initiative success and project deliverables. The primary function of the steering committee is to take responsibility for the feasibility and outcomes of the Lower Mainland Consolidation project. The steering committee will monitor and review project status as well as provide oversight of the project deliverables.
The committee provides a stabilizing influence so that organizational directions are maintained with a visionary and strategic view for the Lower Mainland (Lower Mainland versus HA specific view). The steering committee also provides insight on long-term strategies in support of legislative mandates and requirements. Members of the steering committee ensure that business objectives are being adequately addressed and the project remains under control. These responsibilities are carried out by:

- Monitoring and reviewing the projects at regular steering committee meetings
- Establishing policies and guidelines for implementation of consolidation plans (i.e. labour adjustment)
- Controlling project scopes as issues arise that require changes to be considered by ensuring alignment with the business requirements
- Resolving project conflicts and disputes, reconciling differences of opinion and approach
- Formal acceptance of project plans, deliverables and targets
- Assumption of specific project responsibilities
- Revise benefit attribution methodology as required to ensure flexibility for future use.

The steering committee is responsible for approving major project elements such as:

- Prioritization of project objectives and outcomes
- Establishing savings targets
- Deliverables as identified in the project scope statement
- Departmental consolidation plans, including model, staffing, budgets, timing, transformation activities
- Communications strategy.
- Labour adjustment strategies.
- Risk management strategies - ensuring that strategies to address potential threats to the projects success have been identified and approved
- Project management and quality assurance practices
- Project lead

**Steering Committee Membership**
Michael MacDougall, COO Ministry of Health Services (Chair, appointed by Project Sponsor)
Lynda Cranston, President and CEO, PHSA
Dianne Doyle, President and CEO, PHC
Nigel Murray, President and CEO, FH
David Ostrow, President and CEO, VCH

Executive staff may be asked to attend steering committee meetings as required in order to advance the committee’s deliverables.

**Health Authority CEOs**
- Responsible for consolidation of assigned programs / services - overseeing, managing and resourcing the development of the plan for those consolidation initiatives assigned to them
- Remove barriers to project success.
- Champion business model in the context of the Lower Mainland.
• Bring forward well developed decision points related to department consolidation plans to the steering committee that are aligned with project principles and efficiency objectives, and achieve savings targets.
• Monitor project status.
• Resources and transformation activities, including implementation costs for assigned areas
• Regular reporting to the steering committee

Health Authority Consolidation Leads
• Project management
• Timelines
• Processes
• Deliverables and targets
• Service level agreements (simple format).

Project Support (Sandra Maxson and Carl Roy)
• Support and coordination of Governance and Steering Committee activities
• Document development and management
• Preparation of, and reporting on, an integrated project plan
• Monitoring of health authority department project plans and activities to ensure overall alignment with LMC project deliverables
• Reporting on project performance by using the Ministry of Health Services monitoring / reporting system
• Facilitation of inter-health authority discussions aimed at reaching consensus and recommendations for the Steering Committee. Identifying and removing barriers to ensure deliverables are achieved
• Identify issues that require policy or decisions by the Steering Committee

7. Measures & Metrics

A list of the quantifiable measures that this project will track or affect.

• Achievement of savings targets (by department, overall) including:
  o Budgeted expenditures by month, by health authority for each initiative
  o Actual expenditures by month, by health authority for each initiative
  o Total expenditure by month, by health authority
• Allocation of savings to meet budget targets and offset transformation costs
• % reduction in management and admin positions
• # of positions reduced by employment category
• Transformation costs
• Adherence to project schedules
• Key Performance Indicators to monitor quality impact (to be incorporated into specific consolidation plans)

8. Major Deliverables

• LMC integrated project plan (major activity areas, accountabilities, milestones, budgets) to achieve the project objectives.
• Detailed implementation plans for all departments approved for consolidation
o Approval and initiation of at least three project plans for departmental consolidation prior to the end of September 2009
o Approval and initiation of all other consolidated department project plans by the end of November, 2009
• Approved labour adjustment strategies

9. Key Milestones

A milestone is a marker in a plan that represents a significant event in a project such as the completion of a critical activity, a decision point, or the creation of a significant deliverable.

• Reporting on project performance and achievement of milestones will be done by using the Ministry of Health Services monitoring / reporting system

10. Links and Dependencies

Other projects or initiatives that could affect the outcome of project deliverables, cost or timeline and projects that depend on the output of this project and the nature of the relationship.

Projects that this initiative could be linked to or dependent on:

<table>
<thead>
<tr>
<th>Projects</th>
<th>Possible Impact (TIME COST SCOPE QUALITY, OTHER)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 BC Health Authority Shared Services (SSO)</td>
<td>Demands on resources, possible confusion between initiatives</td>
</tr>
<tr>
<td>2 eHealth, PHSA Clinical Information Systems</td>
<td>Requires significant IMIT resources</td>
</tr>
<tr>
<td>3 Pandemic Planning across the health authorities</td>
<td>Pandemic preparedness requires support of key corporate services, potential of lost time due to flu could slow implementation</td>
</tr>
<tr>
<td>4 Program Management at FH</td>
<td>Requires HR support and change support</td>
</tr>
<tr>
<td>5 Work force redesign and hours of care review at VCH</td>
<td>Requires HR support and change support</td>
</tr>
</tbody>
</table>

11. Project Resources & Structure

11.1 Overall Resources Required
<table>
<thead>
<tr>
<th>Resource Role</th>
<th>Project-Specific Knowledge and Experience</th>
<th>Time Estimate Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Project Director</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Project Secretariat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 CEOs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Health Authority</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consolidation Leads</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Health Authority</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consolidation Teams (HR, Finance, Analysts, Change, Communications, etc.)</td>
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### 11.2 Project Organizational Chart

**Draft Consolidation Structure**

**Lower Mainland Health Authorities**

- **Governance Committee**
  - Board Chair
  - COO MoH
  - Sign-off on Assignment of Services/Programs
  - Resolve Issues if Necessary
  - Regular Briefings from Steering Committee

- **Steering Committee**
  - Four CEOs
  - Four Senior Management Leads
  - COO MoH
  - Regular Steering Committee Meetings to
  - Ensure Efficiencies through Consolidation

- **Support Team**
  - C. Roy
  - S. Massen
  - Human Resources (including LR)
  - Communications (designated resources)

- **CEO**
  - Each CEO responsible for consolidation of services/programs
  - assigned and reporting to Steering Committee

- **Consolidation Lead(s)**
  - Project Management
  - Timeliness
  - Processes
  - Deliverables
  - Targets
  - Service Level Agreements (sample)

**HEABC will assign staff to support each of the CEOs as well as the Consolidation Lead**

August 26, 2000