

Assessment of project risks

Synthesis of Value Assurance interviews on the
Clinical Transformation Project (CST)



Discussion document
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Executive summary

- Vancouver Coastal Health Authority (VCHA), and Providence Health Care (PHC), and the Provincial Health Services Authority (PHSA) -- known as the “health organizations” (HOs) – along with British Columbia’s Ministry of Health are embarking on a multi-entity, multi-year effort called the Clinical and Systems Transformation (CST) Project to establish a “common standardized, integrated, end-to-end clinical information systems and environment” for 1.2m patient visits in British Columbia
- Given the complexity, and criticality for success, of CST, you had asked us to provide an independent perspective on potential risks in the project, highlighting the ones that could be “hidden” or especially detrimental to large “mega” projects

s. 13(1), s. 21(1)

- Against these, we launched a series of structured interviews of CST’s key stakeholders and believe that:
 - You have made great strides in launching CST, stabilizing the project where team members can work effectively, and having a better relationship with your key delivery partner, Team IBM
 - However, there are potential key risks that must be meaningfully addressed. In particular, a) lack of transparency/ buy-in on scope; b) inadequate level of granularity on objectives, unclear measures for success that are specific, time-based, and grounded on granular objectives; c) inadequate effort to include clinicians not just in design but change management; and d) insufficient understanding across the stakeholders that sufficient effort is made to ensure project delivers objective value (balanced by on time and on budget delivery)
- As next step, we suggest a deeper, more targeted set of interviews to confirm our initial hypotheses on the 5 risks the CST Project must address immediately

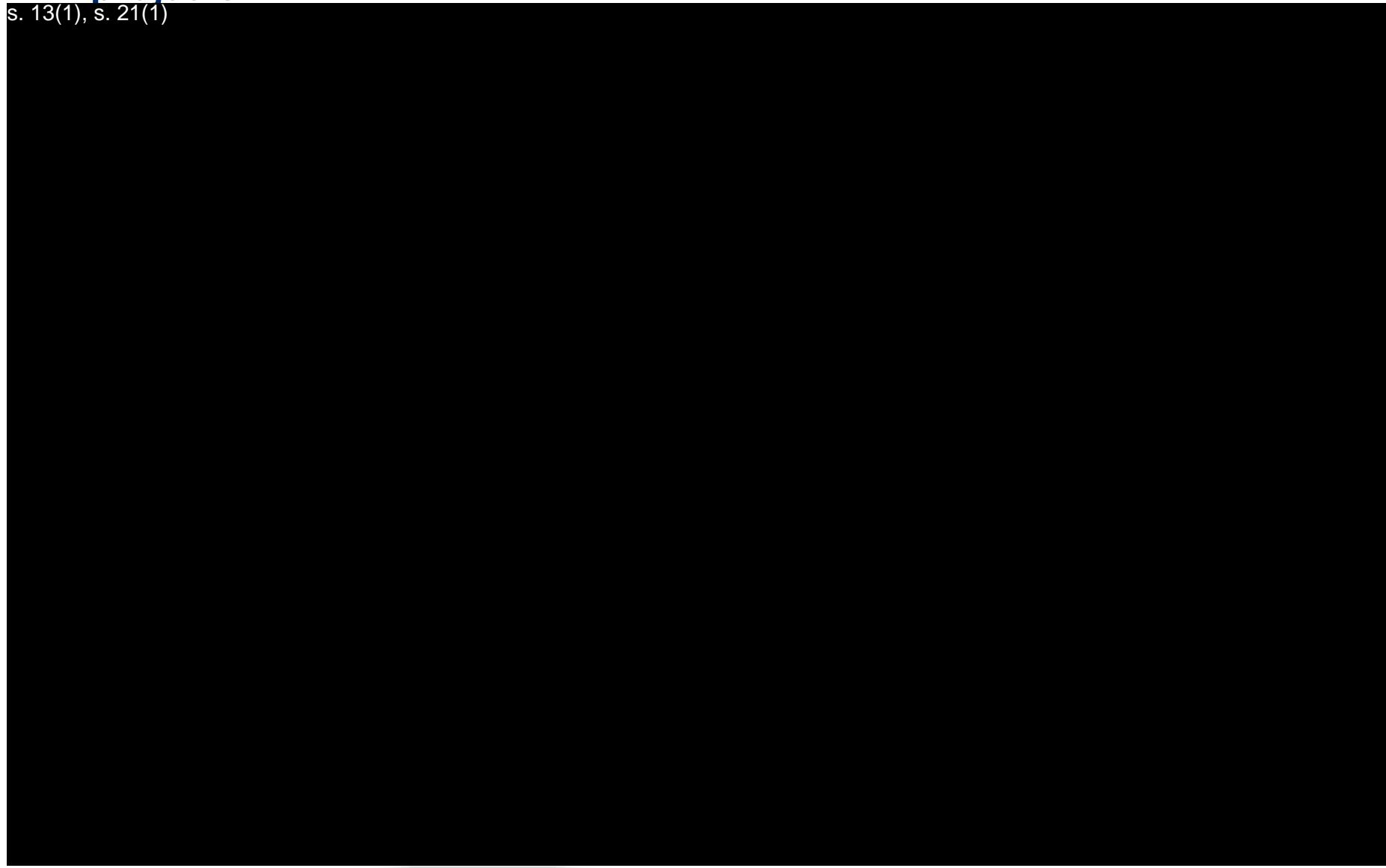
s. 13(1), s. 21(1)

Content

- 1 Playback of success factors and what we heard from you in the interviews
- 2 Preliminary hypotheses on project risks (against the Value Assurance categories)
- 3 Suggested next steps

1 McKinsey's Value Assurance: ^{s. 13(1),}_{s. 21(1)} key success factors for “mega” projects

s. 13(1), s. 21(1)



1 What we heard... (1 of 2)

Value Assurance categories

s. 13(1), s. 21(1)

Key points of agreement

- General agreement on CST objectives: standardize clinical practice and modernize IT infrastructure
- Scope could have been better defined before contract was signed with Team IBM
- Suboptimal start to working with IBM, but trajectory is improving
- Strong executive support for the project
- CEOs are working well together
- Aligned on who stakeholders are – and aligned on stakeholder group at most risk to be disappointed (physicians)

- Software technology and service partners are considered best in the business s. 13(1)
- General agreement on the importance of involving clinicians in design
- Clinicians are involved in design; “Everyone is participating and giving input during the design phase”

Key points of difference

- “True north” objective: Is it to be on time and on budget? Or should we index on achieving quality outcomes?
- Lack of scope clarity post Strategy and Verification phase
- s. 13(1)
- Sufficient status transparency : Consensus that things have gotten better, disagreement still lingers whether reports are effective
- Difference in opinion whether physicians are engaged sufficiently
- Opinions differ on whether we are positioned for success. “We just have to make it work” (vs. we’re doing all we can to make it work)

1 What we heard... (2 of 2)

Value Assurance categories



s. 13(1), s. 21(1)

Key points of agreement

- Team IBM, serving as project manager had a rough start – though getting better
- General opinion that shared IT service could be a risk area
- Teams are extremely motivated

- There were general issues with estimates, plans, and transparency at the beginning – but things are better
- Methodologies exist
- Change management must get better

Key points of difference

- Right mix of talent: everyone agrees at some level that we need more talent, however, there is difference on how critical stakeholders perceive this risk to be

- s. 13(1) [Redacted]

- Opinion on whether sufficient transparency exists vs. “we don’t really know what we’re getting in the end”
- Methodologies used are effective – “project plan has 3,000 lines! Not an effective way for us to communicate the really important things that must happen”

2 Synthesis of preliminary hypotheses of key/hidden risks in CST project

- Several “simple practices” have been neglected. No single one is particularly troublesome, but taken together, the negative impact could be substantial
 - *Lack of transparency on scope* – No good understanding of what functionality are exactly expected by when. Difficult to know “must have” vs. “nice to have” elements. Difficult to measure true risk if there is a lack of specific objectives
 - *Lack of alignment on granular business case, and KPIs reflecting clinical improvement objectives* -- Overall objective is clear, but not sufficiently broken down to objectives that can be tracked and managed. Interviews and document review did not suggest that there is clarity on granular enough time-based KPIs to measure adoption/uptake (e.g., % Rx via CPOE, % adherence to order sets, % physician to physician chart sharing via CST) that stakeholders can assess
 - *Insufficient physician involvement* -- The user group with the highest relevance for participating is involved in decision making, but have not been adequately included in strategy (e.g., scoping) and change management activities (e.g., user adoption). Fixing this requires massive communication effort and focus
 - *Uninformed decision making by Steering committee* – Decisions were made under time pressure, without: a) being fully informed about the underlying facts; and b) understanding the full implications of the decision. “We’re making design decisions without anticipation of effects on workflow and impact, such as [changes to operations and] requirement in additional downstream personnel”
 - s. 13(1)
[REDACTED]
- Imbalance between leading for project value versus leading for specification. There is clear agreement that we have a goal to deliver project on time and on budget. However, can we get comfortable that after project is completed, we will have the needed capabilities enabled¹?(e.g., s. 13(1), s. 21(1) [REDACTED])
- Realizing full value of investment presupposes maximum user adoption, especially with clinicians. Are we investing sufficiently in this area? Do we have sufficient focus on change management?

s. 13(1), s. 21(1)
[REDACTED]

2 Hypotheses on critical and/or hidden risks you face (1 of 2)

Most critical risk which need to be resolved to ensure project success

Potential key / hidden risks you face

- Lack of clarity and granularity of objectives: Objectives are not granular enough. Consistent acknowledgment that ultimate goal is to improve clinical care, but there is no granular enough articulation (e.g., % CPOE, % images shared via HIE); consequently value capture is hard to track and measure. Further, “cost and timeline are the only things measured”
- Downstream, non-IT activities are not sufficiently planned nor budgeted: To be successful, CST requires transformation and change in operations beyond IT. However, there seems to be insufficient budget for clinical transformation or user adoption activities
- Balance between clinical and IT modernization benefits: Not everyone is aligned on the balance between (a) infrastructure-led benefits (IT modernization) vs. (b) clinical benefits (workflow standardization) – is this acceptable, since (a) is a (necessary?) enabler while (b) delivers the value to the health system
- Ambiguity in the project scope creates confusion, hampers communication, and results in disappointment for stakeholders who do not get what they expect from the system. “Some people communicate their aspiration”
- No model for on-going collaboration after implementation across the HOs
- Lack of alignment on scope among stakeholders, especially clinical staff. They have not understood the implications of what is going to be created. “Only those who participated in the ‘design phase’ really understand it, but they have not effectively communicated this– and the implications – back to clinical staff yet”

1 Physicians are involved; did not get information on whether nurses are involved as well

2 Hypotheses on critical and/or hidden risks you face (2 of 2)

Most critical risk which need to be resolved to ensure project success

Potential key / hidden risks you face

- Lack of support from physicians, a key stakeholder : While clinicians¹ are involved in design, there is strong doubt among key stakeholders whether they are ready to adopt the solution
- s. 13(1) [REDACTED]
- s. 13(1) [REDACTED] clinical leadership, communications expertise, clinical informatics, others
- s. 13(1) [REDACTED]
- Speed of communication and the preparation for decision making is improving, but still insufficient. Executive stakeholders are not always fully aware of status and key activities, nor do they know communication outside the project team
- “We are not aware of the ramifications of the decisions we are taking on how the system is going to work and how the workflow is going to look like. This is our most significant risk”
- Root cause and risk assessment lacking – executive stakeholders are not comfortable about true project status, scope, plan, and downstream clinical transformation needs

¹ Physicians are involved; did not get information on whether nurses are involved as well

3 Suggested next steps

- Review our current perspective and hypotheses with the 4 key stakeholders (*today*)
- Hold a more targeted set of interviews to confirm hypotheses; list of interviewees¹ to be jointly determined with you
- Outline potential activities to mitigate key risks after hypotheses are either refuted or confirmed

¹ Potentially includes clinicians (physicians, nursing), IM/IT, CST Project Manager, CFO, Team IBM

Getting started: Initial interviews

Name	Function	Status
▪ Mary Ackenhusen	▪ CEO Vancouver Coastal Health	▪ Completed
▪ Carl Roy	▪ President and CEO, Provincial Health Services	▪ Completed
▪ Dianne Doyle	▪ President and CEO, Providence Health	▪ Completed
▪ Elaine McKnight	▪ Associate Deputy Minister, BC Ministry of Health	▪ Completed

- We estimate each interview to take 1 hour
- If needed, interviewees can bring one additional person who may provide additional details during the interview