Moving towards a new vision for healthcare

The McGill University health centre, Montreal

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In 1992, five hospitals affiliated with McGill University, in Montreal (Quebec), came together to explore how they might share services for the benefit of their combined communities. These included a children's hospital, two general (adult care) hospitals, a respiratory care hospital and a neurological hospital.[1] At this point in their evolution, each had to acknowledge signs that the health care system was rapidly changing in ways that would fundamentally challenge their survival.

Our initial goal had been to find ways in which services could be rationalized and redistributed across the sites to reduce duplication, ensure critical mass for patient care services and teaching programs, and improve efficiency to cope with budget reductions being imposed across the system. However, it quickly became clear that our physical facilities constituted a major obstacle in achieving our goal. In 1994, a preliminary feasibility study resulted in a recommendation to merge the institutions and to consolidate all activities onto a single, new site.

Since then, there have been more detailed studies and extensive consultation. The merger has been accomplished, under the new name of McGill University Health Centre. We have acquired a site and are beginning functional programming for the new facility.

However, the road to change is never easy or direct, and this project is no exception. In this paper, we present some of the challenges encountered and lessons learned as we worked to incorporate the interests of patients, staff, government and others into the overall plan, and to educate our key constituencies about modern health care design. We will describe strategies used to generate support for the project within the internal and external communities, where there have traditionally been strong attachments to the existing hospitals.

Major challenges

The challenges facing this project were numerous and complex. Some were a result of the cultural and political context, while others had to do with the inevitable change occurring in any merger of diverse corporate cultures. Still others were inherent in what we were trying to accomplish, which was to create a new paradigm of health care.

The first challenge was to ensure the continued viability of McGill's teaching hospitals in

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Ms Riley has worked for more than 20 years in hospitals both in the US and Canada. Having entered the McGill University hospital system at the Montreal Children's Hospital in 1985, she was instrumental in carrying out feasibility studies that led to the eventual merger of five hospitals into the McGill University Health Centre. She has been Director of Planning first for the Children's Hospital then the MUHC, for more than 12 years. She is actively involved in the Canadian College of Health Service Executives and serves as preceptor to residents in healthcare administration from a variety of university programs.

[1] These institutions were the Montreal Chest Hospital, the Montreal Children's Hospital, the Montreal General Hospital, the Montreal Neurological Institute and Hospital, and the Royal Victoria Hos-

the face of a shrinking donor base. The hospitals had traditionally enjoyed the generous support of Montreal's English-speaking community, and in particular a few well-to-do families. However, over the previous decade, a significant number of these families had moved out of Quebec to pursue opportunities in Canada's other, mainly English-speaking, provinces. Those remaining in Montreal found themselves faced with competing requests from the hospitals for expensive equipment and other needs, which they could no longer afford. They therefore called upon the hospitals to coordinate their requests so as to avoid duplication of services.

A decision by the Quebec government in the early 1990s to limit the number of officially designated *centres hospitaliers universitaires* (CHU), or teaching hospitals, in the province was similarly motivated. The Ministry of Health developed rigorous criteria to define a teaching hospital, specifying which services were to be available. Although McGill University was to be allotted one teaching hospital, none of its affiliated hospitals met all the criteria. At the same time, the hospitals were finding it increasingly difficult to maintain their teaching programs due to reduced numbers of residents resulting from a government policy intended to redistribute resources more equitably across the province. Clearly, a unified solution was needed.

This raised, however, another difficulty, which was that these hospitals had a long tradition of rivalry, which was not easily set aside. This became evident as soon as the various committees, work groups, planning panels – even the Interim Board of Directors – of the merged institutions began their work together. The challenge to planning has been to motivate the partners to recognize that their common interests, and those of the whole community, are more vital than individual positions. Nevertheless, many old rivalries are likely to persist until after the move.

Still, even when we move, some of these individual positions will have to be maintained for valid reasons. Both the Children's Hospital and the Neurological Institute and Hospital will have distinct facilities, as stipulated in the original agreement. In the case of the "Neuro", this independence is motivated by a desire to maintain its worldwide reputation and to ensure the protection of its generous endowment. The relative autonomy of the Children's is intended to ensure an appropriate environment for the care of children and adolescents, as well as to enhance their fund-raising ability. Because the MUHC is committed to providing care to patients across their entire lifespan, there is an ongoing commitment to ensure all planning includes pediatric as well as adult-care perspectives.

Another group of challenges arises from the uncertainty associated with any merger, and the length of the transition period between the old model and the new. The merger itself led to a significant reduction of management staff, resulting in the departure of some very good people. Certain key physicians also chose to move elsewhere rather than live through a period of profound transition. There were times when some senior administrative positions were occupied by interim appointments. Any change of the magnitude of the MUHC project requires strong leadership, and it was, at times, a challenge to ensure this.

The innovative nature of our project, its scope and its complexity have presented special challenges related to communications, both internal and external. In January of this year, the MUHC's francophone counterpart in Montreal, the *Centre hospitalier universitaire de Montréal* (CHUM), announced similar plans to consolidate the services of its three hospitals in a new facility. This has launched debate in some quarters on a range of issues including the need for investment in other parts of the healthcare system, the viability of two such large projects in Montreal, the preservation of heritage buildings, and the challenge of recycling the eight existing hospital sites.

The greatest overall communications challenge has been fear among the general public of having reduced access to services. Shortly after our first feasibility study in 1994, the government closed seven community-based hospitals

in Montreal as part of its reform of the health care system. Two of these were McGill hospitals. They were closed quickly, with little planning to ensure appropriate transfer of responsibility to other institutions. This abrupt change was disorienting to many long-time patients, particularly the elderly. Now, there is a fear that with our five English hospitals being reduced to one, regardless of its size, access to services will be even more restricted. This is exacerbated by the fact that the new hospital is projected to have fewer beds than the current total. While such fears can be allayed with information on the factors underlying the projections, the issues are complex, requiring a great deal of time and communications expertise.

Within the hospitals, support for the project has grown steadily, with concerns focused mainly on the transition period. There is an eagerness to move forward in the shortest possible time frame, but also a worry that activities on the existing sites will receive less support as the move approaches. There is also concern that the schedule may not be entirely within our control because some major decisions require government approval. Furthermore, some question whether the MUHC project will be tied to the same timetable as the francophone project, which is just getting off the ground.

Balancing all of these concerns has required enormous energy and vigilance, and careful strategies for involving and educating stakeholders at each stage of the process.

Strategies for developing buy-in

The fundamental premise of the project for a new MUHC is to create an environment that responds more fully to the needs of patients, staff, physicians, researchers, students, and the community altogether. For the project to succeed, each of these constituencies must be fully engaged. As well, the payers – in this case government and donors – must recognize the project as being not only economically *feasible*, but *imperative*.

To accomplish these objectives, many different strategies have been used. For purposes of this discussion, these can be broadly grouped into three categories: (1) stakeholder inclusion, (2) analysis and documentation, and (3) information exchange and education. These are described more fully in the following paragraphs.

1) Stakeholder inclusion

Our planning process has been designed from the start to include the people most directly concerned or who have the appropriate expertise, authority and credibility. It has also included patient representatives at every step of the way.

The MUHC springs from a voluntary process initiated by the partner hospitals. At all times, the partners have been fully represented and have called to the table other parties necessary to accomplish their objectives. The Steering Committee that commissioned the initial feasibility study in 1992-94 was made up of representatives of the hospitals, the University and the community. Then, each hospital Board and the University delegated representatives to an Interim Board created in 1994 to plan the merger and the new facility. Finally, with the merger in August 1997, and the dissolution of the multiple hospital Boards, a unified Board was created with the same pattern of representation.

In 1994, a Joint Planning Committee (JPC) was created, reporting to the Interim Board, whose mandate was to oversee planning for the new facility. In addition to representatives of the hospitals, the University, and the community, the JPC included members from the Ministry of Health, the Ministry of Higher Education, the Regional Board of Health and Social Services of Greater Montreal, and the City of Montreal. This composition ensured the support, advice and assistance of each of these stakeholders at every step of the way.

To develop a vision for the new health centre, twenty planning panels were created (1996-97), each looking at the needs of a particular group of patients. Panel participants were selected based on strict criteria including their

availability and a strong personal commitment to the vision process. They included physicians, nurses, other health professionals, patients or family members, and representatives of community-based services, as appropriate. These panels worked under the guidance of the Patient Services Steering Committee (PSSC), which had similar representation, including patients. One innovation in the composition of this committee was that it did not include chiefs of services or senior administrators, but rather persons from the "next generation" of leaders, deemed to have a personal stake in the success of the new centre.

Once completed, the reports of these panels and the PSSC were the subject of broad-based consultation, whereby hundreds of groups and individuals from the hospitals, research institutes, University, and community-based services were able to voice their concerns and demonstrate their support for the directions proposed. A consultation process was designed by each site to suit its needs. Feedback was provided through written submissions, at open and closed forums, and in patient focus groups. In the next stages of the process, as we develop functional programs and a design for the new facility, we will continue to use this inclusive and iterative approach, to ensure the outcome is "owned" by all concerned.

Essential to our overall planning framework were Guiding Principles developed by the PSSC, which set out the attributes of the new MUHC in relation to its community and mission. These Guiding Principles were used as a constant reference by the planning panels, and later by other work groups. They have served us well, both as a unifying force and as an arbiter to avoid or settle conflict.

Other key stakeholders in our process are the provincial government and its various agencies, the municipal governments (because our proposed new site falls in two municipalities) and the federal government. It has been an essential feature of our process that these entities are consulted frequently, are regularly informed of our activities, and are invited to participate in committees or discussions whenever possible. The provincial government has publicly supported the project, including a significant financial pledge, while the federal government has indicated a willingness to fund research-related construction. Such demonstrations of support strengthen the community's overall confidence in the project's viability.

2) Analysis and documentation

Another key success factor in our approach to planning has been to ensure rigorous analysis and documentation of facts, assumptions, and processes. This rigour is applied to a wide range of activities such as assessing our current buildings and developing scenarios for their reuse, documenting assumptions underlying service forecasts, using evaluative tools to assess processes and improve them, and developing clear mandates for committees, consultants and others. Each of these activities could be the subject of a full presentation, but for the purposes of this paper, we will concentrate on the analyses related to the existing and new sites.

Of all the studies undertaken, the most compelling was the assessment of our buildings in 1996–97. The 1993 feasibility study, based only on the cost of known deficiencies and planned renovations, had concluded new buildings would be more cost-effective. However, our communities understandably had deep attachments to these buildings which were the scene of major life events in their families, and which they had supported over several generations. While the assessment of the buildings was very technical in nature, the analytical approach had to be easily accessible and credible so as to be clearly understood by the lay person.

First, we focused on fifteen of the most intensive service areas, such as operating rooms, imaging services, inpatient units and laboratories. Each area was rated against modern standards on a scale of 1 to 5. Scenarios for improvement were then developed, costed and rated against the same standards. This analysis illus-

trated very graphically the limits of "transformability" of our buildings. Faced with the fact that even renovations to these areas, occupying one third of our overall space, would cost as much as a new facility and still not achieve modern standards, the community began to rally around the concept of moving.

To embrace this idea, however, they required two other elements: feasible options for reuse of the buildings, and an acceptable new site. We consulted heritage groups and other stakeholders, both before studying the reuse potential of the existing sites, to ensure we were asking the right questions, and again following completion of the study to share the conclusions. They suggested exploring scenarios beyond the residential and office uses proposed in the study, and called for the preservation of heritage buildings. In the coming year, an independent group will carry out extensive public consultation on these issues and make recommendations on the ultimate disposition of the properties.

Meanwhile, several sites were evaluated by a small group of volunteers, whose work was kept confidential for nearly two years during negotiations with the owner, a railway company. These individuals are persons of standing in the community whose credibility compensated for the secrecy required and ensured a positive reception for their recommendation. The new site selected has many features which make it clearly more advantageous than our existing sites, in relation to topography, size, accessibility and location. The announcement of this decision therefore generated considerable excitement for the project.

More studies were required to evaluate the site before final acquisition. Neighbors of the site were consulted in assessing impacts of the project related to traffic, parking, noise, views, as well as socioeconomic and environmental matters. Because the site straddles two municipalities, and will require rezoning in both, it is essential that good communications be maintained with the citizens of the area, as well as with the municipal authorities. Further meetings with area residents are planned.

Throughout our planning, we have found that the use of objective data and rigorous analysis wherever possible has helped inform constituents, building their confidence in decision-making and increasing buy-in for the project and ownership of the process.

3) Information exchange and education

To be successful, a project of this scope requires a great many people to process an enormous amount of information and assimilate many complex concepts. The challenge is to ensure the appropriate information is collected, organized and presented to participants as needed to help them in their decision-making.

First, we ensured that all information collected, whether in the form of reports, books, videos or other material, was appropriately catalogued and entered into a computerized library management system. We also established protocols for documenting telephone contacts, surveys, conference notes, and other inputs in shared computer files accessible to all planning staff. This material has served as the foundation for many reports and discussion papers, and has been readily shared with government agencies, other institutions and interested citizens.

A striking example of how such information was used to stimulate creativity was seen early in the planning panels' work. Before the panels began meeting, planning staff contacted hundreds of international experts in all fields of healthcare to discern their vision of the future. As a prelude to developing service forecasts, each panel received a summary of these opinions for their area of study. They were then challenged to either validate these, or develop alternate future scenarios. This provocative experience allowed the group to develop a wider range of assumptions upon which to build their forecasts.

The sharing of information in this project has taken many forms. During the period when the planning panels were meeting, there was considerable frustration in the community because of uneven sharing of information. Although panel members were selected as repre-

sentatives of certain constituencies, and efforts were made to support them with newsletters and key messages they could share, not all of them were equally effective in communicating with their peers. Once the panel reports had been finalized, however, they were circulated widely during the consultation process referred to above and generally well received. We then made sure all reports, whether from the panels or from other committees, were widely accessible through our web site, libraries, public relations offices, and other outlets.

Project leaders have worked tirelessly to promote the benefits of this project. Certainly, the most effective means of sharing information and gaining the understanding and support of the community for this project has been the hundreds of encounters with both small and large groups held over the past eight years in church basements, schools, town halls, and other venues, supplemented by written materials such as a special insert in the local newspapers. We have seen that when questions are answered directly and frankly, the response is almost invariably positive. As the public becomes better informed about the project and more supportive of it, the media coverage is also becoming somewhat more favourable.

In September of this year, the MUHC will host a two-day conference on healthcare design, for the primary purpose of educating those who will be directly involved in planning the new facility. This conference will bring together some of the world's leading experts in health care facilities planning. Also invited will be a variety of external stakeholders from the government, universities, municipalities, media, and others whose understanding and support are vital. This occasion will mark a major milestone in our project, as it will be the prelude to the development of a master program and conceptual design for the new facility

Conclusion

In 1995, when the MUHC Planning Office was established after the first feasibility studies, it is probably safe to say most of the hospital community thought of this project as desirable but unattainable. At that time, there were a few identifiable champions, but the troops were not fully behind them. Within three years, the tide had shifted. Now, the community is impatient, eager to bring to life the vision they have developed.

Our challenge now is to maintain the confidence and collaboration of all stakeholders. We are committed to sharing information and to ensuring open and inclusive planning processes. In the next year, many of our staff will visit new hospitals elsewhere and return invigorated with ideas. As they become more knowledgeable, it will be important that this information make its way throughout the organization and the community. We will continue to use and further develop our communications media such as the website, newsletters, and group presentations. We will also need to develop other, more visual, tools such as models and videos. We will also conduct focus groups of patients to incorporate their expectations into the design of the new facility.

In summary, we believe the key building blocks in developing the current level of consensus on the MUHC project have been an inclusive approach encouraging full participation, intensive two-way communication, and innovation guided by principles and supported by carefully-designed processes.