
the planning and approval process
for health major capital projects



Health Capital Planning Manual

3rd Edition - Revised April 2005

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Introduction

Alberta's nine regional health authorities and the Alberta Cancer Board work within an overall accountability framework that includes needs assessment, service planning, business planning and capital planning. Health authorities are responsible for assessing the impact of



operational strategies contained in their Business Plans and Health Plans on their capital assets and formulating appropriate capital plans to implement those strategies based on an analysis of the full costing of alternatives, both capital and operating.

The Government of Alberta has made strong commitments to sound fiscal management, public accountability and achieving value for taxpayers' dollars. This

means delivering effective public services, including capital assets that meet the needs of Albertans at an affordable cost.

Health authorities have a key role to play in ensuring that health infrastructure is acquired and managed in the most cost-effective manner possible. Achieving this goal in an environment of technological, demographic and economic change calls for new ideas and approaches. Health authorities and their government partners must think and plan creatively and apply fresh solutions to their infrastructure challenges.

Alberta's Provincial Capital Plan

Alberta has implemented a number of government-wide initiatives to ensure more effective and innovative capital planning and funding decisions and to strengthen accountability to Albertans. For example, the Alberta Sustainability Fund has helped bring more predictability to capital spending. Other fundamental changes have been made to the way the government manages and accounts for capital spending. The objective is to improve the government's business planning processes so that the most cost-effective solutions can be implemented and priority infrastructure requirements met.

In 2003, as part of this new fiscal framework, the Government of Alberta implemented a more systematic approach to addressing Alberta's infrastructure needs with the creation of the Capital Account and the use of alternative capital financing. For the first time, a rolling three-year provincial Capital Plan was published, setting out the government's commitment to capital projects.



The provincial Capital Plan includes:

- Infrastructure projects, capital programs and purchases of equipment by school boards, post-secondary institutions, health authorities, municipalities and other local authorities and institutions, and
- Capital investment in government-owned infrastructure, equipment and inventories as well as operating funding to rehabilitate government infrastructure.

The provincial Capital Plan is funded from three sources:

- **Current-Year Revenues.** This used to be the only source of funding for capital.
- **The Capital Account.** The Capital Account helps increase the predictability of capital spending by allowing unexpended money appropriated for government-owned projects to be carried forward from one year to pay for projects in future years. For projects constructed by local authorities, including health authorities, provincial capital grants can be fully advanced in the year the grants are budgeted even if there are project delays. Additional funds can be transferred to the Capital Account when the balance of the provincial Sustainability Fund exceeds \$2.5 billion.
- **Alternative Capital Financing,** including public-private partnerships (P3s). The provincial Capital Plan assumed that alternative financing would be used to fund a portion of approved public sector capital projects, starting in 2005-06. The government will pay the financing costs for alternatively financed projects.

Purpose of the Health Capital Planning Manual

This revised manual incorporates several important changes to the health capital planning process. These changes resulted from the government's fiscal framework and approach to capital budgeting, planning, decision-making and funding.

Decisions on the approval of health sector major capital projects continue to be made at the provincial level within the context of government's annual budget cycle and based on provincial priorities. However, this manual reflects significant changes in accountability mechanisms and funding policies designed to provide health authorities with greater responsibility and autonomy for spending decisions using funds allocated to them for capital projects and programs.

This manual supersedes the document entitled *Capital Planning Manual: the planning and approval process for health capital projects* dated June 2001. It is intended to serve as a guide for Alberta's health authorities, Alberta Infrastructure and Transportation, Alberta Health & Wellness, consultants, and others involved in health sector capital planning by:

1. Providing a convenient reference for policy and processes applicable to the planning and approval of health sector infrastructure projects.
2. Providing guidelines and minimum standards for the preparation of capital funding requests, capital plans and associated planning documentation.



3. Encouraging health authorities to find the best infrastructure solutions and to apply the best capital management practices when planning for capital assets.
4. Supporting health authorities in finding innovative and efficient ways to meet their infrastructure needs.

The manual will be updated on an ongoing basis, in consultation with the health authorities, to support efficient and accountable planning. The most recent version is posted on the Alberta Infrastructure and Transportation web site. Future revisions will be made to the web site copy located at <http://www.infras.gov.ab.ca>.

Guiding Principles

The identification, assessment, planning and prioritization of infrastructure needs are the key components of the health capital planning process. The process outlined in this manual is based on principles, guidelines and minimum standards, which health authorities are encouraged to exceed.

Five broad principles provide direction and accountability for health capital spending and ensure that expenditure decisions are based on relative merit and health care benefit.

Principle 1: An Emphasis on Service Delivery

Capital investment decisions and practices must be based, first and foremost, on meeting service delivery needs (e.g., patient care). Health authorities are encouraged to challenge traditional service delivery assumptions and explore a full range of options for effectively and efficiently meeting their service delivery and infrastructure needs.

In support of this principle, the health capital planning framework requires that alternative service delivery options be assessed as an alternative to capital investment. This includes:

- ✓ Assessing whether there is another way to meet service delivery needs that could reduce or avoid new capital spending;
- ✓ Making more efficient use of existing assets to reduce or avoid the need for additional capital spending;
- ✓ Entering joint-use or joint-venture arrangements with partners in the public, private or non-profit sectors (for example, sharing services or space with other public or private-sector agencies, thereby reducing the need for capital expansion); or
- ✓ Applying demand-management techniques to minimize the need for capital expansion.

Principle 2: Sound Fiscal & Risk Management

The health capital planning process supports consolidated provincial capital planning - wherein health authority capital plans are "rolled up" into a single, provincial health capital plan. The health capital plan is, in turn, incorporated into the provincial Capital Plan. This process strengthens the Province's ability to assess and manage risks across all government



infrastructure programs, allows trade-offs amongst competing government priorities and supports the province in managing within its fiscal targets.

The health capital planning framework is structured to ensure that:

- ✓ Spending on health infrastructure is managed within fiscal limits.
- ✓ Health capital asset management decisions are supported by an appropriately rigorous programming and/or business case analysis.
- ✓ Risks are allocated to the parties best able to manage them at the least cost while serving the public interest. Those parties may be in the public, private or non-profit sector - or a combination of the three.

In support of the principle of consolidated capital planning, the health capital planning framework:

- ✓ Provides guidance to health authorities for developing multi-year capital plans, based on their service plans, and identifies the key issues that should be addressed in those capital plans, including inventory information and project ranking.
- ✓ Sets minimum standards for analytical due diligence (i.e., for developing programming studies and business cases);
- ✓ Sets out the guidelines and rating criteria that government ministries use to evaluate and prioritize proposed major capital projects; and
- ✓ Outlines an introduction to the process followed for identifying and planning alternative capital financing (ACF) approaches (such as public-private partnerships) and describes the principles, financial arrangements and reporting requirements applicable to long-term care facility infrastructure partnerships.

Principle 3: Strong Accountability in a Flexible Process

Alberta Infrastructure and Transportation and Alberta Health and Wellness use a risk-based approach to oversight. Degrees of rigour in approval requirements, monitoring, reporting and other checks and balances increase in proportion to the cost, complexity and level of risk associated with capital projects.

Health authorities have appropriate autonomy and flexibility to carry out their capital mandates. At the same time, they are held fully accountable for managing their capital assets efficiently.

The health capital planning framework has sufficient flexibility to:

- ✓ Accommodate differences in project complexities and health authority experience in planning and project management;
- ✓ Allow health authorities to be innovative and consider a full range of options to best meet their service delivery needs; and
- ✓ Respond to the many factors that affect service delivery needs, such as demographic shifts, emerging technologies and changes in provincial priorities.



In support of this principle, the health capital planning framework:

- ✓ Outlines the core capital responsibilities of government ministries and draws clear lines of accountability between those responsible for service planning and delivery and those responsible for oversight.
- ✓ Articulates clear funding and project approval processes; and
- ✓ Offers guidance in measuring and assessing asset performance.

Principle 4: Value for Money

Value for money in the health sector is assessed through an appropriately rigorous examination of options and business case analysis. A key aspect of achieving value for money requires health authorities and their supporting ministries to demonstrate efficient use of resources to meet their service delivery goals.

The principle of value for money may be enhanced through the strategic and appropriate use of public and private sector resources. In support of this principle, the health capital planning framework does not assume that any one sector is inherently more efficient in building public assets. Instead, it emphasizes that capital decisions should be based on a practical, project-specific assessment of a range of options to determine which will provide the best value for money while serving the public interest.

Principle 5: Protecting the Public Interest

Safeguarding the public interest will be paramount in determining the preferred project delivery option. Public interest issues such as service effectiveness, health and safety and access will be carefully assessed in making capital decisions.

Eligibility for Provincial Capital Grants



Publicly funded health care services in Alberta are delivered using a wide variety of arrangements for infrastructure. The health authorities or the Province itself owns the greatest proportion of health sector infrastructure. However, a significant proportion is leased by the health authorities from, or operated under contractual arrangements with, a private, voluntary or other public sector owner.

Any infrastructure used for the delivery of publicly funded health care services is usually eligible for provincial capital funding. However, provincial capital grants from Alberta Infrastructure and Transportation may only be requested by and paid to a Health Authority. Provincial capital grant funding provided to a Health Authority may, in turn, be used to support leased and/or contracted infrastructure arrangements. However, there must be an



appropriate form of longer-term contractual agreement or arrangement that adequately protects the provincial capital investment.

Generally, the following categories of infrastructure are eligible to receive provincial capital grants:

- Hospitals owned by the Province, leased to a Health Authority or voluntary organization and operated under the Hospitals Act or Mental Health Act;
- Hospitals owned by a Health Authority and operated by the Health Authority under the Hospitals Act or Mental Health Act;
- Hospitals owned and operated by voluntary societies under the Hospitals Act and having an Equity Agreement with the Minister of Health & Wellness;
- Nursing homes owned by the Province and operated by a Health Authority under the Nursing Homes Act;
- Nursing homes owned by a Health Authority and operated by the Health Authority under the Nursing Homes Act;
- Infrastructure owned by the Province and leased to a Health Authority to accommodate or support the delivery of health programs and services operated under health legislation.
- Infrastructure owned by a Health Authority and used to accommodate or support the delivery of health programs and services operated under health legislation.
- Infrastructure leased by a Health Authority to accommodate or support the delivery of health programs and services operated under health legislation.
- Nursing homes owned by a private corporation or voluntary society that will be developed under an infrastructure partnership arrangement between a Health Authority and the private or voluntary sector organization and that will be operated by the private or voluntary sector organization under the Nursing Homes Act. Eligibility for Infrastructure Maintenance Program grants for such facilities is subject to conditions outlined in a Master Agreement between the Health Authority and the partner organization (refer to Part 1, Section 6 of the manual).

Organization of the Manual

Provincial capital funds are allocated for health infrastructure in two streams – major capital projects and infrastructure maintenance projects.

The manual is organized into the following four parts:

Part 1 describes the planning and approval process for major capital projects. It provides guidance for preparing multi-year capital plans, programming studies and business cases; sets out the guidelines and rating criteria that ministries use to evaluate and prioritize proposed major capital projects; articulates the government project approval process and provides an introduction to alternative capital financing (ACF) approaches.



Part 2 describes Infrastructure Maintenance Program (IMP) procedures and reporting requirements.

Part 3 provides convenient access to various provincial policies, procedures, and guidelines for health infrastructure and property management.

Part 4 provides templates for preparing various planning documents.

Ministry Resources Available to Health Authorities

Alberta Infrastructure and Transportation and Alberta Health & Wellness staff can provide assistance, as needed and requested, to health authorities with their ongoing capital planning activities, the submission of funding requests, project management, technical advice, tendering, and cost analysis.

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Alberta Infrastructure and Transportation Support Services

To access any of the following professional and technical support services offered by Alberta Infrastructure and Transportation, initial contact should be made through the Regional Director responsible for the health region.

1. Project Management Services

Depending on the size, risk profile and complexity of a capital project and the technical capabilities of the health authority, the Health Facility Projects Branch can arrange to provide project management services. Project management services would vary according to need, ranging from a complete "hands-on" approach through to a simple resource/monitoring service to providing support on an "as-required" basis during the planning, design, and construction stages.

2. Technical Services Branch (TSB)

The Technical Services Branch offers services to health authorities in the following disciplines upon request and subject to availability of personnel:

- Architectural
- Mechanical
- Electrical
- Structural
- Building envelope
- Hazardous materials
- Air quality
- Energy conservation
- Specifications documentation and standards
- Facility evaluation
- Drafting and records maintenance
- Interior Design



3. The **Site Development Branch** provides advice regarding municipal and environmental engineering services, including:
 - Environmental site assessments
 - Remediation of contaminated sites
 - Site management and landscape development
 - Legal surveys for land transactions

4. The **Cost Management Section (CMS)** provides advice regarding cost estimating, cost planning and control services and value planning and management. CMS can provide assistance with determining the scope of services required for a specific project, developing a Request for Proposal (RFP) for cost consultant services if necessary, selecting and contracting with a cost consulting firm, and monitoring the firm's activities.





PART 1
Section 1

Overview



Part 1 of the Manual outlines the process and procedures followed by Health Authorities to propose and plan for major capital projects that are considered essential to the communities they serve. A major capital project is a project that will require a provincial capital expenditure exceeding \$2.5 million.

The process illustrated below takes each proposed new major capital project through several progressively more detailed planning stages to develop the documentation needed to describe the project, as it should ultimately be designed.

When the project is approved by the government to proceed to the design and construction stages, the project scope of work, cost, and any conditions for implementing the project are communicated to the Health Authority in a Letter of Approval from the Ministers of Health and Wellness and Infrastructure and Transportation.

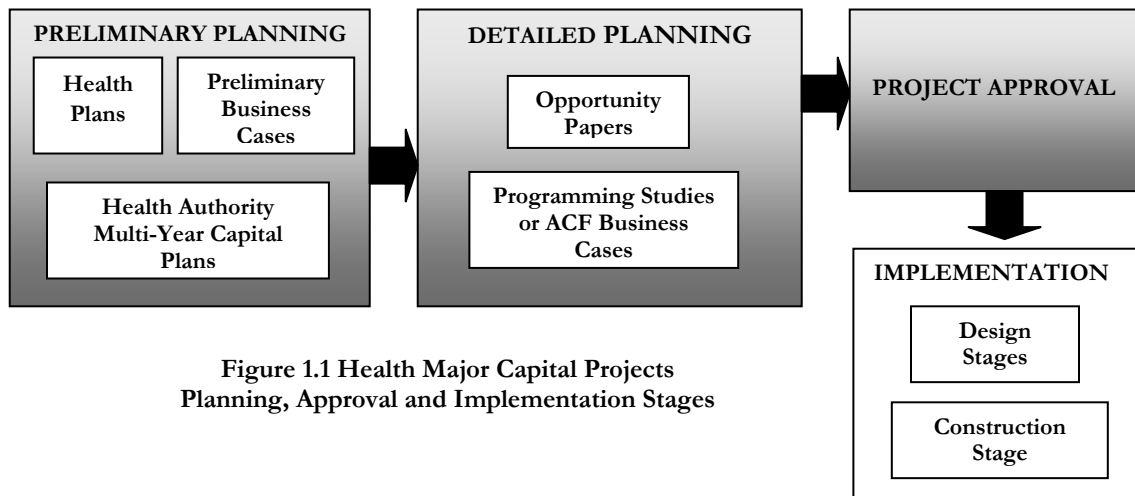


Figure 1.1 Health Major Capital Projects Planning, Approval and Implementation Stages

Legislative Authority

The process and procedures described in this part of the Manual are authorized under Sections 2.7(1) and (2) of the Regional Health Authorities Regulation, AR 15/95, which state:



“(1) No regional health authority shall without the written consent of the Minister enter into a capital development project that has a value in excess of an amount specified by the Minister in a directive.

(2) A regional health authority that enters into a capital development project referred to in subsection (1) shall comply with written policies and rules issued by the Minister for the purpose and given to the regional health authority.”

Overview of Planning Process for Major Capital Projects

This part of the Manual:

- ✓ Provides guidance for developing multi-year capital plans and identifies the key issues that must be addressed in these capital plans;
- ✓ Sets out minimum standards and information requirements for the preparation of preliminary business cases and programming studies;
- ✓ Sets out the guidelines and rating criteria that government ministries use to evaluate and prioritize proposed new capital projects;
- ✓ Provides an introduction to the process for identifying and planning alternative capital financing (ACF) approaches (such as public-private partnerships) and describes the specific principles, financial arrangements and reporting requirements applicable to long-term care infrastructure partnerships; and
- ✓ Articulates the government funding and project approval processes.

It is organized into the following seven sections:

Section 1 - Overview. This overview of the process.

Section 2 - Health Authority Multi-Year Capital Plan. Health Authorities request provincial capital funds for major capital projects by submitting a multi-year capital plan to Alberta Infrastructure and Transportation and Alberta Health and Wellness by June 30th each year. The plan will identify, justify and prioritize major capital projects needed over the next three years and in the longer term.

Section 3 - Preliminary Business Case. Every proposed major capital project identified in the Health Authority’s multi-year capital plan must be supported by a preliminary business case.

Section 4 - Provincial Capital Guidelines. Every proposed major capital project must comply with provincial capital guidelines before it can be considered for approval. Compliance with these guidelines is generally assessed using information provided in the preliminary business case.

Section 5 - Programming Study. Preliminary business case recommendations with respect to a preferred procurement approach will determine the next steps in the planning and approval process. If a traditional procurement approach is recommended, a programming study, approved jointly by the Ministers of Infrastructure and



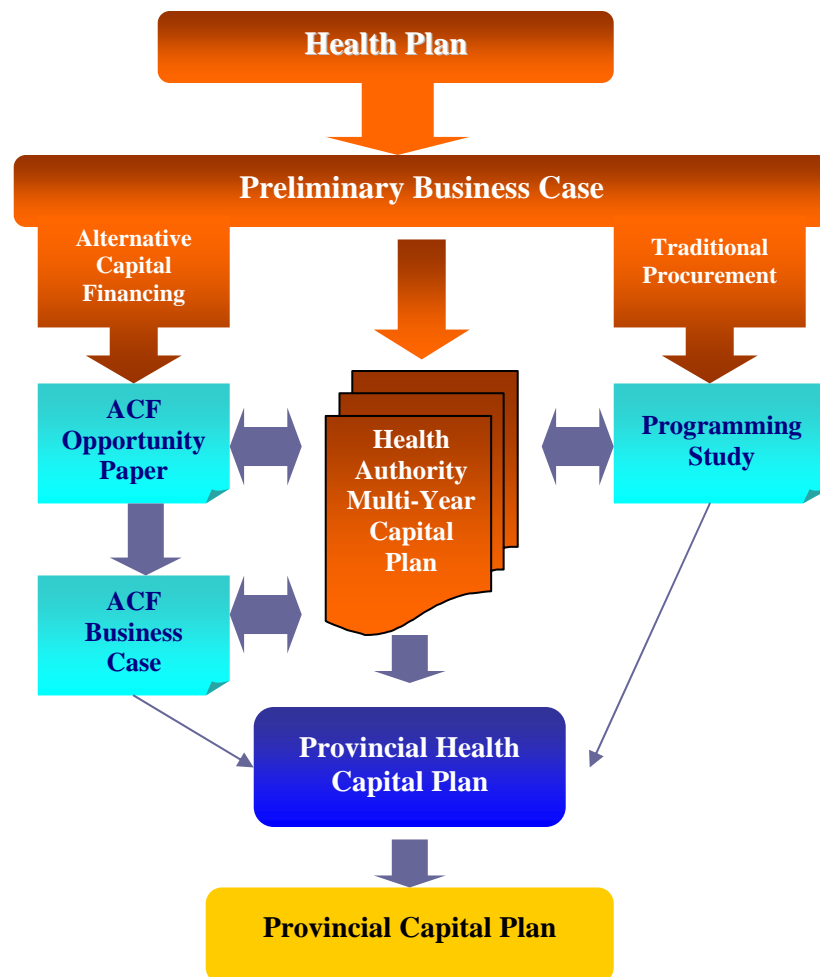
Transportation and Health and Wellness, will need to be completed before a major capital project can be considered for approval.

Section 6 - Alternative Capital Financing. If an alternative capital financing (ACF) approach is recommended in the preliminary business case, the Health Authority will prepare an ACF Opportunity Paper to establish that the project meets the fundamental requirements for an ACF project.

If, based on the assessment of the ACF Opportunity Paper, it is agreed that the project has sufficient potential to provide value for money when compared to a traditional procurement model, a full ACF Business Case will be developed. This section introduces the process for planning and assessing alternative capital financing of health infrastructure projects.

Section 7 - Consolidated Provincial Capital Plan. A provincial plan for health major capital projects is prepared, annually, by the Minister of Health and Wellness, in consultation with the Minister of Infrastructure and Transportation. New major capital projects may be recommended for approval each year, based on their provincial priority, determined using a set of capital rating criteria. Provincial capital priorities are determined using a cross-ministry capital rating methodology.

The basic steps in the capital planning and approval process are illustrated below.



**PART 1**
Section 2**Health Authority Multi-Year Capital Plan**

Multi-year capital planning is the process of identifying current and future capital needs and developing strategies and projects to address those needs. Alberta uses a consolidated capital planning process whereby health authority capital plans are “rolled up” into a single, provincial health capital plan. The health capital plan is, in turn, incorporated into a provincial capital plan.



As part of this process, health authorities must develop a multi-year capital plan that flows from and supports their Health Plan. Alberta’s process for health capital budgeting and decision-making relies on information provided in these multi-year capital plans to recommend appropriate future budget allocations for health infrastructure and to determine which specific

projects should proceed within those allocations.

Each health authority must submit its multi-year capital plan to the Ministers of Health and Wellness and Infrastructure and Transportation by June 30th each year. The annual updating of the multi-year capital plan will involve broad consultation within each health region, with other health authorities and with Alberta Health and Wellness and Alberta Infrastructure and Transportation. The process is ongoing and continuous.

Multi-year capital plans have four primary purposes:

1. To improve the overall planning and management of health infrastructure.
2. To communicate future capital expenditures needed to effectively maintain the existing asset base and to modify that asset base to support service delivery strategies. Multi-year capital plans provide the Ministers of Health and Wellness and Infrastructure and Transportation with the information needed to recommend appropriate future funding levels for health infrastructure.
3. To provide a rational context for assessing provincial capital project priorities as the basis for annual decisions on individual project approvals.
4. To provide a preliminary estimate of the operating cost implications of proposed capital investment.



Format and Information Requirements

Within the five broad general sections outlined below, the multi-year capital plan may be presented in whatever format is most meaningful to the health authority. At a minimum, the following information is required:

Part 1: Executive Summary

Part 1 provides an overview of the capital plan in a format appropriate for Health Authority senior management and Board review and approval.

Part 2: Overview of the Health Plan



To provide a proper context for the strategic capital priorities that will be outlined in Part 4, the multi-year capital plan should begin with an overview of key program and service delivery strategies and objectives for the next three years or longer. The capital plan must show evidence that capital strategies are directly linked to operational strategies. It should also identify and briefly describe the most significant factors underlying the health authority's need for capital expenditures (e.g. demographics, technological change, program change).

The objective of capital investment, and all capital projects, is ultimately to meet or support service delivery needs. Every health authority is responsible for delivering a range of core health services, as set out in its Health Plan. This should be the central factor driving the capital planning process.

The link between the health authority's capital plan and its Health Plan should be clearly articulated by including:

- ✓ A descriptive overview of the mandate, core services and priorities in the Health Plan;
- ✓ An explanation of how the capital plan supports the health authority's Health Plan; and
- ✓ Where relevant, a summary of how the health authority's capital plan links to broader government strategic priorities.

This information is important to government decision makers, ensuring that they view the Health Authority's capital plan in its proper context. It can also help the Health Authority to stay "on course" throughout the capital planning process.

Part 3: Overview of Infrastructure Asset Base

Part 3 provides an inventory of all infrastructure used by the health authority, including owned, leased and contracted facilities. This inventory information:

- ✓ Allows for more meaningful comparisons between assets;
- ✓ May help form the basis for ranking or prioritizing projects;



- ✓ Helps determine the nature, cost and timing (urgency) of work required; and
- ✓ Supports the development of capital strategies that meet service needs in the most cost effective and efficient manner (i.e., by identifying and capitalizing on excess capacity).

Every health authority should develop and maintain (e.g., update on an annual basis) a comprehensive asset inventory that includes a current assessment of the physical condition, functionality (i.e. ability to support current program delivery) and utilization (capacity) of its capital stock.

The following table outlines the type of information that will be included for each asset:

ASSET INFORMATION	DESCRIPTION
Inventory Information	Information on land and buildings, tracking such factors as: <ul style="list-style-type: none"> ▪ Ownership status (e.g. owned or leased) ▪ Location ▪ Structural types ▪ Size (land area, square footage, capacity) ▪ Age (year of original construction for each component structure) and history (e.g., significant rehabilitation, repairs, additions, renovations) ▪ Replacement value ▪ Current use ▪ Any other significant issues
Physical condition	An assessment of the physical condition of the asset stated in terms of provincial performance criteria (see Part 3, Section 3).
Functionality	An assessment of how effectively each asset meets existing program or service needs, stated in terms of provincial performance criteria (see Part 3, Section 3).
Utilization	An assessment of how much each asset is being used; this is sometimes measured by comparing forecast service demand against an asset’s current capacity to determine whether there is excess or a shortage of capacity (see Part 3, Section 3).

Appendices may be included to provide additional descriptive or statistical detail for Part 3.

Part 4: Strategic Capital Priorities

Part 4 sets out the health authority’s strategic capital priorities, clearly indicating linkages between each capital strategy and service delivery strategies described in Part 2. The strategic capital plan should include both capital investment and disposal initiatives.

The purpose of Part 4 is to clearly communicate the health authority’s strategic capital priorities over a longer time frame. The timing for implementation of each strategy must



reflect, as much as possible, only what could be managed within realistic forecasts of future operating revenues.

Information provided for each capital asset strategy should include, at a minimum:

- An indication of its priority in relation to other strategies;
- Its relationship to service delivery strategies;
- An implementation plan (timing); and
- The implications for service delivery of delays in implementing the strategy.

Part 4 of the multi-year plan should be updated whenever there are significant changes in service strategies and priorities.

The following statements represent examples of typical capital strategies that might appear in this part of the Capital Plan:

- Additional capital spending will be targeted, over the next five years, to meet projected increases in service demands for the following specific program areas ...
- Deterioration of existing infrastructure will be slowed and, if possible, reversed. Deterioration is most apparent in older long-term care facilities constructed before 1970. Over the next ten years, approximately 40% of proposed capital expenditures will be directed to correcting physical and functional deficiencies at existing long-term care facilities. It is proposed to upgrade or replace (subject to further investigation) up to 30% of owned long-term care infrastructure. Priority will be given to correcting situations where the greatest potential risks to resident safety have been identified, as follows...
- Capital assets will be rationalized by disposing of two surplus properties and examining possible alternate uses for three underutilized facilities. Proceeds from the disposal of surplus infrastructure will be used to help offset capital expenditure needs in subsequent years. Over the next two years, other redundant assets will be identified and a plan developed for disposal or alternate use.
- Proposals will be invited from private and voluntary sector organizations to develop new long-term care and supportive living capacity identified in the regional continuing care service plan. Where cost-effective, partnership arrangements with the private and voluntary sectors will be used to replace up to 200 existing long term care beds over the next five years and to develop up to 75 additional long term care beds and 250 supportive living units over the next ten years.
- Pressures on hospital emergency departments due primarily to increased non-urgent cases will be partially addressed through the establishment of a fast-track urgent care centre pilot project to be located

Part 5: Capital Project Profiles and Priorities

Part 5 translates the health authority's strategic capital plan into a specific project plan by providing information on the major capital projects and divestiture initiatives needed to



implement the strategies outlined in Part 4. This part of the multi-year plan must be updated annually. It should be organized into three sections.

Section 1 – Five Year Major Capital Project Plan.

This section describes all major capital projects being proposed for some form of provincial capital funding approval within the next five fiscal years. The projects must be listed in priority order. The following summary information should be provided for each proposed project:

- 1. Project Identification:** The location and name of the facility or proposed location of a new facility. The legislative status of the facility (i.e., the health legislation under which the facility will be operated).
- 2. Priority Rank:** The project's rank relative to other projects in the plan.
- 3. Project Description/Scope of Work:** A brief description of the proposed scope of work – identifying the physical and/or functional problems to be corrected and service objectives to be addressed. Information should be based on key elements in the preliminary business case or programming study.
- 4. Relationship to Strategic Capital Priorities:** Description of the link between the project and the capital strategies stated in Part 4.
- 5. Procurement Method:** Description of how the project is to be procured (e.g. by a traditional or an alternative capital financing approach).
- 6. Capital Requirements:** The total estimated capital cost of the project and the provincial contribution required (stated in constant dollars). Explain the impact on provincial capital funding requirements of any proposed alternative sources of funds or financing (i.e., partnership with private, voluntary or public sector organization).
- 7. Operating Expenditure Impact:** An estimate of the additional annualized operating cost, the reasons for the increase and an indication that the health authority can support the increased expenditure in future years' operating budgets. Alternately, an estimate of annualized operating savings following completion of the project and the reasons.
- 8. Current Status of Project:** Any investigative analyses or planning completed to date (master plan, feasibility study, preliminary business case, etc.) and related reports available for review.
- 9. Specific Approval Requested:** If a programming study has not yet been completed or if some other type of investigative study is needed, identify the funds required and the year in which funds are needed. If all necessary planning is complete, indicate the year in which approval for the project is being requested.



Section 2 – Ten Year Capital Project Plan.

This section provides an overview of any future capital projects that may need to be initiated beyond the next five fiscal years. As much as possible, the information provided for each future project should be the same as that provided for projects in Section 1, above. It is understood that this information may lack detail and will be subject to significant change.

Section 3 – Asset Divestiture Plan.

This section provides an overview of any surplus or underutilized infrastructure and describes plans for its disposition or alternate use.

Part 6: Appendices

The capital plan must include, at a minimum, a Preliminary Business Case for each project identified in Part 5, section 1. Supporting reports or studies for projects identified in Part 5, section 2 may also be included.

Project Ranking Methodology



Project ranking is a systematic way of indicating capital priorities. It is particularly useful to health authorities examining a broad range of proposed projects since it provides a means to assess and prioritize competing demands, based on consistent and measurable criteria.

Health authorities are encouraged to use specific and quantifiable project-ranking criteria when setting their project priorities. These criteria may reflect:

- Service needs - for example, projects may be ranked on the basis of their potential to improve program delivery immediately as measured by quantity, quality or other standards, or their potential to change program delivery to improve quality or increase volume;
- Legislative, legal or contractual requirements;
- Protection of people, including the need to comply with building codes or health and safety standards;
- Protection of existing assets, taking into consideration the cost of renovating existing assets versus the cost of replacement, with facility assessments substantiating the scope of work and budget;
- Cost savings or cost implications; these may be calculated to show the budget implications of implementing a capital project, or the future implications if the project is not undertaken;
- Health Plan targets and strategic fit; and/or
- Local conditions (physical, economic or demographic).

Health authorities may decide to use the provincial rating criteria outlined in section 7 of this Manual. If another methodology is adopted, provide a brief description of the criteria and methodology used to establish health authority priorities.



Submission and Review Process

Board Approval and Submission of Plan

The multi-year capital plan should be approved by the Health Authority Board and formally submitted, by the Board Chair, to the Ministers of Infrastructure and Transportation and Health and Wellness by June 30th each year.

- The Ministers will jointly respond to the Board Chair to acknowledge receipt of the plan. The Ministers may provide comments on the general acceptability of the plan and whether all information requirements have been met.
- The Ministers may also comment on individual projects included in the capital plan.
- Where the Ministers indicate that information requirements have not been met, the specified information should be forwarded as soon as possible to the party specified by the Ministers.

Review of the Plan



Upon receipt of the plan, Alberta Health and Wellness and Infrastructure and Transportation staff will initiate an assessment and review of the specific projects identified in Part 5, Section 1. The primary objective of this review process will be to determine or update the current status of the project and to reach consensus on the appropriate next step.

1. The Preliminary Business Case for the project is reviewed in consultation with health authority staff. Consensus is reached on the most appropriate next step (i.e., further investigative analysis, programming study, P3 Opportunity Paper, ACF Business Case or project approval)
2. New projects in the plan, not previously identified by the Health Authority, will be assessed for compliance with provincial capital guidelines based on information provided in the Preliminary Business Case.
3. Projects that comply with provincial capital guidelines will be prioritized using capital rating criteria.
4. For higher priority projects, recommendations will be prepared to proceed with the appropriate next step in the planning process.

The timing for proceeding with the appropriate next step for an individual project may involve the consideration of issues that are not contemplated in the Health Authority's capital plan. It is possible that the arguments for proceeding with a project are well documented and compelling, but other provincial infrastructure priorities need to take precedence.

**Part 1
Section 3****Preliminary Business Case**

Each proposed new major capital project included in a Health Authority's multi-year capital plan must be supported by an appropriately rigorous Preliminary Business Case justification. By focusing on both the financial and non-financial aspects of a proposed project, a



Preliminary Business Case is particularly well suited to the analysis and justification of health care sector projects.

An effective Preliminary Business Case is a multi-purpose document that transforms operational problems and needs into specific project requirements. It clearly communicates the service delivery objectives of a project and confirms that stakeholders have been consulted. It analyzes

a full range of service options by examining their feasibility and cost and demonstrates the benefits of the project in terms of financial and other factors.

The Preliminary Business Case gives all parties the information they need to make informed decisions based on a clear initial understanding of alternatives, feasibility, implications and preliminary costs. It must meet the standards of objectivity and impartiality. Claims of need and benefits must be substantiated to help decision-makers to reach fair and balanced conclusions based on the merits and demerits of the proposed project.

Evolution of a Business Case

When a major capital project is identified in Part 5, Section 1 of the Health Authority's capital plan (see Section 2), a Preliminary Business Case for that project must be prepared. Information from the Preliminary Business Case will be subsequently updated and incorporated into either a programming study or a full ACF Business Case.

A thorough Preliminary Business Case will provide sufficient information to confirm the proposed project's compliance with provincial capital guidelines (see Section 4) and to make a preliminary assessment of the relative provincial priority of the proposed capital project (see Section 7). It also provides adequate preliminary analyses and assumptions to assess the potential for an alternative capital financing or delivery (ACF) strategy (see Section 6).



- The Preliminary Business Case must contain detailed background information, a rigorous identification and analysis of strategic service options and a good initial analysis of potential costs and benefits associated with those options.
- Physical requirements and cost estimates at this stage will normally be based on guidelines rather than detailed space planning and professional costing. The analysis of operational impacts and risks will also be at a relatively high-level.
- For most projects, the Preliminary Business Case will become the foundation for a programming study. The information provided in the Preliminary Business Case will be updated and expanded later following more detailed study, usually with the assistance of professional consultants.
- For some projects where it is not yet possible to identify a preferred development option in the Preliminary Business Case, it will be necessary to undertake an appropriate investigative study with the assistance of professional consultants to confirm project feasibility and the scope of work.
- The Preliminary Business Case recommendations with respect to alternative capital financing/delivery potential will determine the appropriate next steps in the planning and approval process. If a traditional procurement approach is recommended, a programming study will need to be developed to provide the information outlined in Section 5 of this Manual.
- If it is determined in the Preliminary Business Case that the project may have potential for an alternative capital financing/delivery approach, the health authority may be asked to prepare an ACF Opportunity Paper to establish that the project meets the fundamental criteria for alternative capital financing or delivery.
- If, based on a review of the Opportunity Paper, it is determined that an alternative financing or delivery approach will meet program delivery needs and has sufficient potential to provide value for money when compared to the traditional procurement model, a full ACF Business Case will be developed in the format described in Section 6.

Depth of Analysis Required

Health authorities are responsible for determining the depth of analysis required for each element in a Preliminary Business Case - based on the project's size, complexity and risk.

The overall length of the Preliminary Business Case should be kept to a minimum (usually no more than 25 pages), ensuring that it stays on topic, presents only relevant information in a clear and concise manner, and remains focused on supporting the specific approval decision requested.

All sections of the Preliminary Business Case template will normally be completed. However, the information provided in each section is scalable to the nature and impact of the project. The following Table provides some additional guidance in making these decisions.



PROJECT DESCRIPTION & COMPLEXITY

<i>Larger, more complex projects such as new acute care facilities or major expansion of urban and regional acute care facilities</i>	A more detailed Preliminary Business Case analysis is needed that includes a substantive evaluation and comparison of strategies and options. All elements would be included, with detailed background information and project description.
<i>Medium-sized projects of moderate complexity such as the expansion of rural acute care facilities, new long-term care, or primary health care facilities.</i>	A less detailed Preliminary Business Case analysis is needed. Detailed background information and project description would still be provided. However, the focus would be on the elements associated with the areas of highest risk.
<i>Smaller, less complex projects such as the expansion of long-term care or primary health care facilities.</i>	A simplified Preliminary Business Case analysis is sufficient. A strategic options analysis may not be needed. Only selected (relevant) elements are included and levels of analysis are commensurate with risk.

Funds to Complete a Preliminary Business Case

Preparation of a Preliminary Business Case does not require the approval of the Ministers of Infrastructure and Transportation or Health and Wellness. It is anticipated that the Preliminary Business Case for most projects can be prepared by the Health Authority without the assistance of professional planning consultants. However, if needed, funds for any consultant assistance may be allocated by the Health Authority within its annual Infrastructure Maintenance Program budget.

Preliminary Business Case Elements

The remainder of this section offers a guide for preparing each element of the Preliminary Business Case template provided in Appendix 1. A Preliminary Business Case is comprised of the following six elements:

- | | |
|------------------------|---|
| 1. Executive Summary | 4. Strategic and environmental analysis |
| 2. Background | 5. Strategic options analysis |
| 3. Project description | 6. Conclusions and recommendations |

Section 1: Executive Summary

The Executive Summary is a stand-alone section highlighting the key findings and recommendations of the Preliminary Business Case. It captures and reports the information and results that decision-makers need in a minimum number of pages (maximum of 3 pages in length).



The reader should be able to understand what the project is about, the contribution of the project to the Health Authority's Health Plan and its operational benefits.

The information should be presented without detailed justification (which can be found in the body of the Preliminary Business Case document itself), focusing on the information needs and concerns of an executive-level audience.

Section 2: Background

The Background section describes the current situation and operational problems that the project is intended to address, summarizes any planning work done to date and describes the opportunities that the project presents.

Current Situation

This sub-section provides an overview of what is currently happening within the health facility or in that area of the health region in which the facility is located, what has led to the current situation and what is likely to happen if the current situation is maintained. The current situation should be described in terms of program and service strategies and targets, activity and workload and the condition of the infrastructure that will be directly affected by the proposed capital investment.

Finally, this section should provide an assessment of possible non-asset solutions to the identified operational problems, such as alternative service delivery options.

Description of Service Context

Begin with a clear and concise description of the facility's current and proposed future role in the community and the health region. Describe the health programs currently delivered at the facility, indicate why and how these programs need to be modified, describe any new programs that need to be introduced and indicate the specific improvements expected upon completion of the project.

Service relationships or dependencies between the facility and others should be described to convey the larger, regional or provincial health system context. It is important to demonstrate the relationship between the service plan for the facility and the Health Authority's Health Plan.

Activity Analysis

Current and projected service activity must be documented. Activity projections should generally be based on historical data for each service or program affected by the project and expressed in as much detail as possible.

Assessment of Existing Infrastructure

Where a project may involve the redevelopment or replacement of existing infrastructure, the Preliminary Business Case should describe the condition of



the infrastructure in which services are currently provided and outline the key physical and functional deficiencies to be addressed by the project.

Functional deficiencies relate to the ability of the building to accommodate current and/or future operational requirements.

Physical deficiencies are facility characteristics that detract from the safety and comfort of occupants, efficient physical plant operation and code compliance issues that must be rectified.

Analysis of Alternative Service Delivery Options

To find the best ways to meet their service delivery needs, Health Authorities are encouraged to think creatively and challenge historical service delivery assumptions. Before proposing capital investment, Health Authorities should have considered the possibility of changing the way health or support services are currently delivered to avoid or reduce the need for capital spending. This means considering key questions, such as:

- Is there a way to meet our service needs without new capital spending?
- Is there a way to better use or manage existing assets that could reduce the need for additional capital expenditures?
- Is there a way to share the cost and risk of capital acquisition with, for example, another public-sector organization?

Examples include:

- Adopting or developing new service delivery methods or models;
- Outsourcing;
- Improving asset utilization by, for example, extending hours, more efficient use of space, introducing different scheduling strategies or changing approaches to managing the service (i.e. catchment) area;
- Enhancing technology;
- Reconfiguring programs; or
- Sharing services with other health regions.

This is not a complete list of alternative service delivery strategies. Health authorities are encouraged to use their own creativity to identify as many options as may be feasible - bearing in mind that all decisions should be based, first and foremost, on effectively achieving the desired service delivery outcomes.

Note that the analysis required in this sub-section does not involve examining alternative physical development options.

Summary of Work to-Date

This sub-section describes what planning work has been done so far on the project and the status of any commitments or agreements negotiated.



Problems/Opportunities

This sub-section provides a brief descriptive summary of the problems or opportunities that the project is trying to address.

Section 3 Project Description

The Project Description section provides a clear definition of what the project will and will not include (scope of work), the expected results (outcomes) and the key stakeholders.

Scope of Work

This sub-section defines the preliminary physical parameters of the project. Specifically, it describes the preferred time frames and estimated physical requirements.

Time Frames: Indicate when the project would ideally start and end.

Physical Requirements: The space plan included in a Preliminary Business Case may be based on Alberta Infrastructure and Transportation guidelines. The document entitled *Space and Cost Guidelines for Health Care Facilities Construction* available on the Alberta Infrastructure and Transportation web site located at <http://www.infras.gov.ab.ca> provides a useful reference for determining the areas for various types of health facilities. This is sufficient for developing an order-of-magnitude space estimate for a new free-standing facility or an addition to an existing facility.

A more detailed space plan will be developed in the programming study or full ACF Business Case using a logical methodology such as the one described in the document entitled **“Evaluation and Space Programming Methodology”** produced by Health and Welfare Canada.

Anticipated Outcomes

This sub-section itemizes the specific and measurable deliverables of the project. Each outcome should include an estimated time frame for when the outcome/deliverable will be needed (in terms of elapsed time).

Stakeholders

This sub-section should identify all parties that may be impacted (positively or negatively) by the project and indicate how they are affected. For each stakeholder, include an overview of any consultation that has taken place and the outcome of that consultation.

Some common stakeholder groups are:

The public. Health authorities exist to provide services for the public. The project will likely exist to benefit the public in some way, either through direct service improvements or indirectly, by allowing the Health Authority to provide more efficient services than would otherwise be possible.



Staff within the organization. Many projects serve the needs of internal staff.

Other Health Authorities. While the project may not directly benefit other Health Authorities or health delivery organizations, it may affect them in other ways.

Municipalities. The project may affect the municipality in which the facility is located in terms of, for example, transportation issues or development restrictions.

Community organizations. Community organizations serving the same members of the public may also be affected by the project.

Government departments. A health project may have a program or policy impact on other government ministries such as Seniors and Community Supports, Education or Children’s Services.

Section 4 Strategic & Environmental Alignment

This section provides the reader with an understanding of how the project strategically aligns with the current Health Authority Health Plan, how it will support key service delivery strategies and how it may impact other initiatives. It should be clear what is driving the capital investment and what the impact of the investment will be.

The Environmental Analysis provides the reader with an understanding of what other health authorities or jurisdictions have done or are doing to address similar types of problems or to meet similar objectives. The reader can use this information to compare the proposed preliminary business case direction to that taken by other organizations.

Factors Driving Capital Needs

Health authority capital needs can be influenced by many different factors, but every Preliminary Business Case should include an analysis of the most significant factors driving the capital need. Some of the most common factors are as follows:

FACTORS	DESCRIPTION
Demographics	Current and future indicators of population change by age cohort; impacts of births, deaths, and other issues specific to program areas.
Program changes	These include new initiatives, program terminations or changes in program parameters.
Technological changes	Examples include advances in medical or diagnostic equipment or building systems obsolescence.
Financial pressures	Current and projected revenue and cost trends.
Environmental factors	The impact of any potential changes to consumer expectations or service standards
Social changes	Any trends that could affect service delivery needs.
Legislation	Any statutory requirements affecting the Health Authority.
Infrastructure condition	Any physical or functional factors affecting the ability to effectively deliver appropriate health care services.



Strategic Alignment

Capital projects are one means of achieving a health authority's service objectives. The Preliminary Business Case must, therefore, show the direct relationship between program and service strategies and the proposed investment in infrastructure. Each proposed investment in a capital project must clearly be justified in terms of benefits to the Health Authority and to the health system.

It is essential to set clearly defined objectives for capital projects. Where applicable, clear policy, regulation, or legislation impact statements are also essential. Capital initiatives undertaken without a clear definition of the desired service outcomes are likely unnecessary.

Project Objectives



Outline what the project will accomplish, in clear and measurable terms and within the specified time frame by stating a clear set of project objectives that show what the capital investment is intended to deliver.

The project objectives should be stated broadly enough that meaningful strategic options will not be ruled out, and narrowly enough that only viable strategic options need be considered. Objectives should be focused on outputs, not inputs.

Review the current Health Plan and identify specific service changes, expectations, strategic objectives and significant actions that the project will help achieve. Identify the level of impact that the project will have on achieving these various strategic objectives or actions by scoring the impact high, medium, or low, using the following guidelines:

- High indicates that the project is critical to achieving the objective or action.
- Medium indicates that the project directly impacts the objective or action but is not critical to its attainment.
- Low indicates an indirect impact to achieving the objective or action.

Environmental Analysis

The Environmental Analysis should address what is happening in other health regions, other provinces and, if applicable, the private sector, that directly relates to the scope of the project. This section also includes any findings from research or studies that identify relevant health sector trends and best practices.

Section 5 Strategic Options Analysis

The Strategic Options Analysis section provides an assessment of the realm of development possibilities that are available to address the identified problems or opportunities. It explains the rationale as to why some should be eliminated as viable options. It provides a description of the viable development options that could address



the operational problems or opportunities. Finally, it provides a preliminary recommendation on the potential for alternative capital financing or delivery.

This section is the technical core of a Preliminary Business Case. Strategic option analysis (SOA) is a systematic approach to determining the best way to meet service delivery needs. Preparing an SOA ensures a thorough strategic level screening of the widest possible range of project development options. The options examined must include a “do nothing” option (status quo) or “do minimum” option.

Since an SOA is a higher-level analysis, it is typically based on preliminary cost and benefit estimates and only a qualitative assessment of risks. It is primarily focused on setting the groundwork and direction for the programming study or full ACF Business Case analysis.

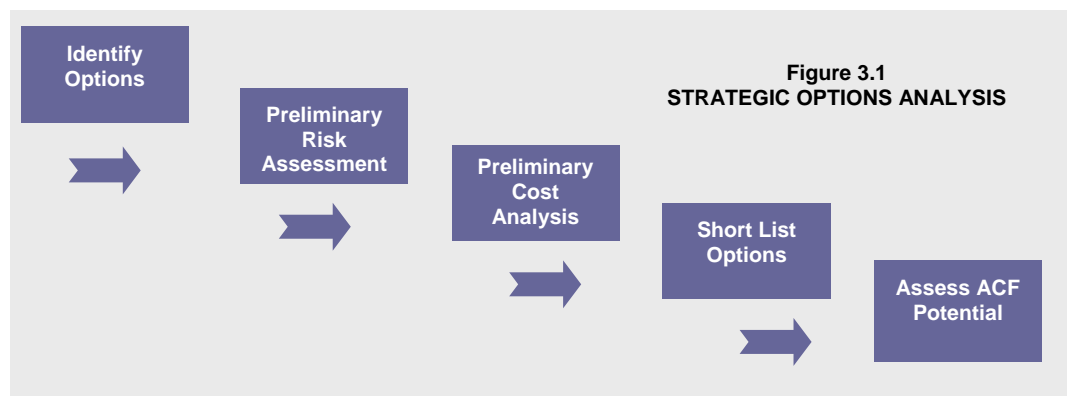
For some projects, it may not be possible to clearly decide on the preferred development option at the Preliminary Business Case stage of planning. For these projects, it may be necessary to undertake a feasibility study to develop the most viable options in fuller detail. For larger, more complex acute care facilities, it may be appropriate to prepare a master plan prior to proposing any specific project or development approach. Feasibility studies or master plans are also a means of working out a logical phased approach to meeting service needs that would be more operationally and financially sustainable.

The SOA will help the Health Authority to:

- Identify any critical legislative or public policy issues that need to be resolved;
- Identify and examine the financial and other advantages, disadvantages, risks and benefits of each option;
- Identify and provide a clear rationale for a short-list of viable options and, if possible, the preferred option;
- Determine the appropriate depth and type of further analysis needed; and
- Provide a sound basis for making key strategic decisions to meet service objectives, provide value for money and protect the public interest.

Steps in Strategic Options Analysis

Generally, a Strategic Options Analysis should follow the following five steps:





Step 1: Identification of Options: Describe a spectrum of realistic options, based on a traditional procurement approach, possibly including:

- A reference or base-case scenario indicating, for example, the most likely outcome if the recommended solution is not adopted (i.e., do nothing);
- An option exploring opportunities for partnering with other public sector agencies;
- An option that delivers the maximum (but not *all* of) the benefits at the minimum capital cost;
- An option that delivers the maximum benefits;
- A phased approach option where there is a choice of implementing and funding the project all at once or in phases.

At this stage, the range of potential development options that could meet the project objectives stated in Section 4 is being identified. These options should all assume a traditional project implementation approach (i.e., provincial financing and service delivery). The potential for alternative financing or delivery is assessed later.

Where the Health Authority jointly proposes a capital project in collaboration or partnership with another publicly-funded organization(s) such as a local school board or post-secondary institution, describe the specific nature of the partnership, including:

- The proposed sources of capital funds and cost-sharing arrangement;
- The proposed asset ownership arrangement;
- The degree of commitment of the partner organization and its sponsoring (funding) ministry to the project;
- The objectives of the partner organization(s);
- The benefits of the proposed partnership;

Step 2: Preliminary Risk Assessment: For each option identified in Step 1, provide a high-level analysis of potential risks including an assessment of their likelihood and consequences. The degree of rigour required in carrying out this type of risk assessment will vary depending on the nature of the service challenge and the nature of the options under consideration. Potential risk mitigation strategies should also be identified.

Risk is the possibility that things may turn out different from what is expected at the beginning of the project. Risk is inherent in all projects. In almost all circumstances, there will be more than one possible outcome. There is a possibility that things will turn out worse than expected – the downside risk, or better than expected – the upside risk.

The risk assessment carried out in a Preliminary Business Case need not weight and score all the risks. Instead, the risks can be grouped into broad groups and assessed at a high-level. Examples of project risks could include:



- Availability of operating funds
- Human resources availability
- Dependent but unfunded infrastructure maintenance or major capital projects
- Advancements in technology
- Appropriateness of the service delivery model
- Immediate capacity and future longer term capacity
- Impact on other health regions or on province-wide services

For each project risk, identify the probability of the risk occurring and the impact it may have on each option, using the following guidelines:

Probability of Risk

High indicates that the event is highly likely to occur

Medium indicates that the event is likely to occur

Low indicates that the event is not likely to occur

Impact of Risk

High indicates that the event will have a significant impact on the project

Medium indicates that the event will impact the project

Low indicates that the impact on the project is relatively minor

Step 3: Preliminary Cost Analysis: Provide a preliminary estimate of the costs associated with each option. The reader should be able to easily understand and compare the estimated initial capital cost and the initial and ongoing operating costs for each viable option.





To make recommendations on the best option(s), the Health Authority needs to determine which will likely achieve the best value for money. In the broadest sense, this will always be the option that uses the fewest resources to achieve the most desirable service outcomes. Resources include the initial capital cost, facility operating and maintenance costs over the life of a project, and ongoing program operating costs.

Operational (Ongoing) Costs

The operating cost implications of each short-listed option (including the operating costs of the do nothing or status quo option) must be compared. This comparison should be based on the total operating cost of the options rather than an incremental cost approach.

If it is not possible or practical to fully analyze the total operating cost of the facility or where the incremental project costs are relatively small compared to the total cost, an incremental approach may be used. The intent is to identify the differences between each option, using the projected costs of the status quo option as the benchmark.

For each viable option, indicate any significant changes in the staffing mix or productivity resulting from the project.

Capital (One Time) Costs

Estimate the capital cost of each short-listed option as well as the proposed funding sources.



The document entitled *Space and Cost Guidelines for Health Care Facilities Construction* available on the Alberta Infrastructure and Transportation web site provides useful reference guidelines for estimating the capital costs for various types of health facilities. These guidelines are suitable for developing an order-of-magnitude capital cost estimate for a new free-standing facility or an



addition to an existing facility. The document also provides elemental cost guidelines for main building elements as well as escalation and location factors.

Another document entitled *Elements of Budgeting for Health Care Facilities Construction*, also available on the Alberta Infrastructure and Transportation web site, outlines the basic elements that should be used in calculating total provincial support required for a project. These include the following elements:

Capital Funding Requirements:	Option 1	Option 2	Option 3
Construction	\$	\$	\$
Planning costs	\$	\$	\$
Design Fees	\$	\$	\$
Physical Plant Commissioning	\$	\$	\$
Furnishings & Equipment	\$	\$	\$
Consultant Fees	\$	\$	\$
Project Administration	\$	\$	\$
Contingencies	\$	\$	\$
Total:	\$	\$	\$

Funding Commitments/Sources:	Option 1	Option 2	Option 3
Alberta Infrastructure and Transportation	\$	\$	\$
Foundation/Fundraising	\$	\$	\$
Health Authority (specify Source)	\$	\$	\$
Other	\$	\$	\$
Total:	\$	\$	\$

Do not include any project-related costs that were or will be incurred and funded prior to project approval, such as the costs of preparing a master plan, feasibility study, programming study, Opportunity Paper or ACF Business Case.

The total construction cost estimate should be based on separate estimates for new construction work and renovation/upgrade work.

The budget allowance for project administration costs refers to costs that will be incurred by the Health Authority for general supervision of a capital project during the design and construction stages. The kinds of costs included in the project administration budget vary with the nature of the project. Eligible project administration costs may include travel and honoraria for special meetings associated with the project, office overhead, salaries of project management staff engaged for the project and legal fees.

The estimated eligible cost of equipment and furniture may, at this stage, be based on a percentage of the construction cost estimate.

Step 4: Short-List of Options: Develop a short-list of the most promising or viable options and, if possible, make a recommendation to senior decision-makers on one or more preferred options. Describe the major features of each option and discuss how each addresses the operational problems and meets the objectives of the project stated in Section 4.



The evaluation of options usually entails identifying a set of quantitative and qualitative criteria for screening the options identified in Step 1. At a minimum, a qualitative, common sense description of advantages and disadvantages of the options, relative to each screening criteria, is usually sufficient. Information on comparative results can be summarized in a table format where columns are used to list the options, and rows to list the criteria used in the evaluation.

Generally, this type of multiple criteria approach is sufficient when preparing a Preliminary Business Case. Analytical methodologies focused on financial or quantitative analysis, such as cost/benefit analysis or cost effectiveness analysis are not expected at this stage.

State the reasons for excluding an option. Valid options should not be simply excluded due to funding constraints.

Step 5: Identifying the Potential for Alternative Capital Financing or Delivery:

Alternative capital financing/delivery (ACF) involves the acquisition of capital assets:

- Without direct purchase by the Province;
- By transferring some or all of a project's costs and risks to outside parties; and/or
- Financed with or without recourse to the Province.

ACF encompasses a wide range of models with varying implications for issues such as risk transfer, ownership, operations, accounting and debt reporting. Each model has different service delivery potential and is predicated on different levels of risk being transferred or allocated to a partner organization. The most common ACF models include:

- Operating leases;
- Self-supporting projects (e.g., ancillary operations);
- Internal payback (e.g., energy efficiency) projects; and
- Partnership approaches such as joint ventures and public-private partnerships (a variety of models).

ACF can offer a range of potential benefits, including the opportunity for public-sector organizations to make use of private-sector ideas and innovations. However, the chief advantage of ACF is its potential for risk transfer.

Assessing the Potential for ACF

The Health Authority should develop criteria to identify whether the project has alternative capital financing or delivery potential. ACF can have advantages, but it is not appropriate in every situation. It may be a potential option where:

- A market for bidders can be identified or can be reasonably expected to develop;
- Significant opportunities exist for private sector innovation in design, construction, service delivery and/or asset use;



- The private sector has an ability, under legislation, to provide health care services (e.g., nursing home services);
- Clearly definable and measurable service output specifications can be established, suitable for payment on a services-delivered basis;
- There is potential to transfer risk to the private sector;
- The private-sector partner has an opportunity to generate non-health care delivery streams of revenue; and/or
- Projects of a similar nature have been successfully procured using a similar method.

Generally, projects that appropriately address the following questions may be potential candidates for ACF:

Financial: Can an ACF approach accommodate financial terms acceptable to both parties?

- ✓ Can the project be viable on a stand-alone basis (i.e., will returns to the private partner reflect their efforts and be commensurate with the risk transferred)?
- ✓ Is it possible to establish an equitable and effective payment mechanism that includes appropriate incentives and controls based on clear outcomes?

Technical: Could ACF result in a better technical solution to meeting service delivery needs?

- ✓ Does the project have technical constraints or risks that cannot be addressed by the private sector?
- ✓ Can clear and adequate technical specifications for the project be established?
- ✓ Can appropriate mechanisms/measures be established to monitor technical performance?

Operational: Could operational barriers undermine an ACF approach?

- ✓ Can the health authority establish clear and measurable operating standards for a private partner to meet?
- ✓ Can a private partner be held accountable for performing to those standards?
- ✓ Are there operational issues or risks that could not realistically be managed by the private sector?

Public policy: Will the public accept private sector involvement?

- ✓ To what extent do various stakeholders such as the public, local elected officials and other service users (all of whom may affect the viability of a project) accept involvement of the private sector?

Implementation: Could implementation barriers prevent the use of ACF methods?



- ✓ Is it possible to generate meaningful private sector competition?
- ✓ Can a successful transition plan be implemented that addresses such issues as labour adjustments?

Timing & Schedule: Could time constraints pre-empt ACF?

- ✓ Are the timelines adequate to pursue a partnership (e.g. time to develop appropriate operational specifications)?

Section 6 Conclusions & Recommendations Section

Summarize the conclusions reached regarding a preferred option or short-listed options in terms of operational impact, risk, and costs. Present specific recommendations to move the project forward. These recommendations will vary depending on whether a traditional or ACF approach is being recommended.

Conclusions

Recap each of the options based on factors such as operational impact, risks and costs. Based on these results, draw conclusions on which alternative should be chosen. Identify the recommended option, selecting the one that maximizes effectiveness and efficiency while minimizing risk and cost.

Recommendations

Make specific recommendations on proceeding with the project. The extent of the recommendations may range from recommending approval of the project to initiating a programming study based on a traditional procurement model, preparing an ACF Opportunity Paper, or recommending some form of more detailed master planning or investigative analysis to validate some key Preliminary Business Case elements.

Investigative Studies

If, the Preliminary Business Case has not been able to identify the most appropriate redevelopment approach, it may be necessary to study the feasibility of the project in greater detail prior to requesting funds for a programming study. For larger, more complex health facilities, it may be appropriate to complete a master plan before initiating detailed programming for the redevelopment of specific components of the facility.

The specific objectives of investigative studies may vary but will usually focus on confirming the most reasonable and cost-effective redevelopment approach – thereby demonstrating compliance with provincial capital guidelines.

Funding to complete these types of investigative studies will usually be funded from the Health Authority's Infrastructure Maintenance Program budget allocation.

**Part 1
Section 4****Provincial Capital Guidelines**

Government will only consider funding major capital projects that comply with provincial capital guidelines. These guidelines are the key requirements that any proposed major capital project must meet before ministerial approval will be granted to complete a programming study or an ACF Opportunity Paper.

Compliance with provincial capital guidelines will be assessed based on information provided by the Health Authority in the Preliminary Business Case for the project.

Each project included in a Health Authority's multi-year capital plan must:

1. Focus on Needs – Not Wants.

Service delivery needs must form the basis of any proposed infrastructure expenditure and the proposed expenditure must be proportionate to the resultant benefits or improvements. The Health Authority must demonstrate the relationship between the proposed capital investment and specific objectives, strategies and performance targets in its Health Plan.

- ✓ Capital strategies must be linked to specific service strategies that are, in turn, based on regional needs analyses, service plans and financial plans.
- ✓ Capital strategies should, whenever possible, be directly linked to the achievement of specific performance targets and health outcomes.

2. Consider Alternatives to Infrastructure Solutions.

Capital investment must be preceded by an evaluation of strategic service alternatives (non-infrastructure solutions). For example, community-based service delivery alternatives should be considered to reduce inappropriate use of facility-based health services. Long-term care infrastructure strategies must ensure that consideration is given to shifting from long-term care bed capacity to supportive living capacity.

3. Ensure Operating Cost Effectiveness or Economy.

All projects should take advantage of opportunities to achieve operational efficiencies by shifting service emphasis or rationalizing programs. If the primary objective of a proposed project is to achieve operating cost savings, the capital expenditure must



provide a good return on investment in terms of operational savings. The proposed project must not perpetuate fragmentation or duplication of health services.

4. Represent the Most Reasonable Capital Solution.

The proposed project, based on an analysis of options outlined in the Preliminary Business Case, must represent the most reasonable capital solution. When necessary, it may be necessary to complete an appropriate investigative study if it is apparent that additional information and analysis is needed to demonstrate compliance with this guideline.

5. Ensure That Infrastructure is Appropriately Preserved and Maintained to Ensure Safe Operating Conditions and Continued Service.

The age and condition of the facilities must warrant the proposed capital investment. Health infrastructure that is in relatively poorer physical and/or functional condition should receive priority attention to ensure acceptable and safe operating conditions. Capital investment decisions should be based on a consideration of infrastructure performance measures, including physical condition and functionality.

6. Align With Provincial Strategic Directions.

Capital investment strategies should align with, and support provincial health strategies and initiatives described in the most current Alberta Health & Wellness Business Plan.

7. Optimize Utilization of Infrastructure and Service Capacity.

The Health Authority must demonstrate that the proposed capital investment will optimize utilization of its existing health infrastructure.

- Before proposing to construct, upgrade, or replace a facility, reasonable consideration must be given to using other facilities in better condition.
- Conversion or re-designation of facilities or relocation of programs, on an interim or permanent basis, should be considered as an alternative to the construction of new facilities.
- Capital strategies should maximize infrastructure efficiencies through joint use and multiple user occupancy.
- Services should be reduced or eliminated where utilization is low or where economies of scale do not permit safe and/or cost-effective service delivery

8. Ensure Reasonable Distribution of Health Services.

The proposed project must represent a practical approach to delivering health services in the health region and/or the province. If the proposed project is intended to improve access to services, reasonable access must not already exist in terms of factors such as travel distance within the health region or to adjacent regions.



9. Recognize Health Authority Obligations for Cost Recovery.

Provincial funds are not provided for a project, or components of a project, that could be financed from revenues generated by the project. Capital costs incurred for the provision of accommodation for private sector health practitioners or commercial activities must be financed through future revenues generated from occupancy of that space.

10. Ensure Commitment of Financial Sustainability.

Capital strategies must be sustainable within reasonable forecasts of health authority operating revenues. Funds for operational commissioning of the proposed project, equipping the facilities, for ongoing operations and for any capital contribution being offered by the Health Authority towards the project must be allocated in the health authority's financial plan. Capital contributions from external sources (fundraising, donations and development partners) must be confirmed.



As a condition for government approval of a major capital project, the Health Authority must provide, in its Preliminary Business Case for the project, an estimate of any incremental operating costs that will be incurred because of the proposed project. The Health Authority must provide a clear commitment that these incremental operating costs can be accommodated within the regional financial

plan. Alberta Health & Wellness does not adjust health authority operating budgets for the impact of infrastructure projects.

**PART 1**
Section 5**Programming Study**

The Programming Study is a multi-purpose document that transforms operational needs into a specific physical plan describing the project, as it should be designed and implemented.

A Programming Study must be completed before seeking Government approval for any health major capital project that will be implemented using a traditional procurement approach.

If an alternative capital financing (ACF) approach is recommended in the Preliminary Business Case, the Health Authority may be asked to prepare an ACF Opportunity Paper rather than a Programming Study. However, if the consensus reached following review of the Preliminary Business Case is that the proposed project would be best implemented using a traditional procurement approach, a Programming Study will need to be completed before the project can be recommended for approval.

Joint approval of the Ministers of Infrastructure and Transportation and Health and Wellness is required before proceeding with the preparation of a Programming Study. This approval decision is normally made following the review of the Health Authority's multi-year capital plan and the Preliminary Business Case for the proposed project.

The timing for a decision to approve or not approve proceeding with a Programming Study may sometimes involve the consideration of issues that are not contemplated in the Preliminary Business Case. It is possible that the Preliminary Business Case is well written and compelling, but other infrastructure priorities must take precedence. It may also be that the government is well informed by the Preliminary Business Case but does not agree with its conclusions.

While the Programming Study provides the foundation for design of the project, it does not impose rigid constraints that cannot be altered during the design process when additional information becomes available.

This section offers a guide for preparing a Programming Study for a major capital project that will be implemented using a traditional procurement model. It includes:

- ❑ Guidance on determining the appropriate depth of analysis;
- ❑ Funding sources available to complete a Programming Study; and
- ❑ An overview of the elements to address.



Funds to Complete a Programming Study

A health authority undertakes the work needed to produce a Programming Study with the assistance of professional consultants. Alberta Infrastructure and Transportation will provide a grant to cover reasonable costs that will be incurred by the Health Authority to engage consultants to prepare an approved Programming Study.

When ministerial approval to proceed with preparation of a Programming Study is received, a Request for Proposals is prepared by the Health Authority and sent to at least three qualified consulting firms. Proposals are reviewed, a consultant is selected and an agreement drawn up and awarded to the consultant of choice.

Alberta Infrastructure and Transportation staff may be consulted for assistance in preparing a Request for Proposals and/or negotiating the resultant consultant agreement or contract. Both Alberta Infrastructure and Transportation and Alberta Health and Wellness staff should be kept involved and informed as preparation of the Programming Study progresses.

Depth of Analysis Required

All Programming Study elements described in this section will not normally need to be completed for every project. Moreover, the information provided for each element is scalable to the nature and impact of a project. The overall length of the Programming Study should be kept to a minimum, ensuring that it stays on topic and presents only relevant information in a clear and concise manner.

Health Authorities are responsible for determining the depth of analysis required for each element of a Programming Study - based on the project's size, complexity and risk. However, it is recommended that the Health Authority discuss requirements with their primary contact person at Infrastructure and Transportation and Health and Wellness prior to issuing a Request for Proposals for Programming Study consultant services that significantly alters the standard information requirements.

Programming Study Elements

The Programming Study will typically be comprised of the following ten elements:

- | | |
|--------------------------------|--------------------------|
| 4. Executive Summary | 6. Site Development Plan |
| 5. Background | 7. Equipment Plan |
| 3. Functional Components | 8. Project Cost Plan |
| 4. Space Summary | 9. Operational Impact |
| 5. Conceptual Development Plan | 10. Implementation Plan |

Most consulting firms engaged to prepare a Programming Study will have developed their own format. Within the above broad general elements, a Programming Study may be organized and presented in whatever format is best suited to the specific project and most meaningful to the Health Authority.



Executive Summary Section

The Executive Summary is a stand-alone section highlighting the key findings and recommendations of the Programming Study. Information is presented without detail (which can be found in the body of the Programming Study document itself), focusing on the information needs of an executive-level audience.

The Executive Summary should contain the following information:

- ✓ **Background.** An overview of the key reasons for initiating a Programming Study and the current situation that led to proposing the project.
- ✓ **Project Description Summary.** A summary of the following information taken from the Programming Study:
 - The opportunity or challenge that the project is addressing
 - The strategic alignment between the project’s goals and objectives and those of the health authority
 - The major features of the project, its scope of work, space requirements and technical scope
 - The impact of the project on current operations
 - The financial operating requirements of the project
 - The financial capital requirements of the project and funding sources
- ✓ **Recommendations.** A summary of key recommendations and next steps.

Background Section

The Background Section contains much of the same information provided in the Background and the Strategic & Environmental Alignment sections of the Preliminary Business Case for the project. However, it will be necessary, if considerable time has passed since the Preliminary Business Case was prepared, to update the program and service strategies and targets as well as the project drivers and objectives – especially if the Health Authority’s Health Plan and Business Plan have been updated since the Preliminary Business Case was completed.



The Background Section should contain a clear and concise description of the facility’s current and future role in the community and the health region. Describe the health programs currently delivered at the facility, indicate why and how these programs will be modified by the project, describe any new programs being introduced and indicate the specific improvements expected upon completion of the project.



Service relationships or dependencies between the facility and others should be described to convey the larger, regional or provincial health system context. It is important to demonstrate the relationship between the role of the facility and the Health Authority's regional service plan.

Provide a brief descriptive summary of the problems or opportunities that the project is intended to address as well as the most significant factors driving the need for the project. Describe the specific and measurable deliverables or outcomes of the project, including the impact the project will have on achieving Health Plan objectives or strategic actions.

Finally, provide a description of planning work completed so far on the project.

Functional Components Section

The basic 'building block' for physically organizing the project is the Functional Component. A functional component is a grouping of activities and assigned spaces that are physically related by their common purpose to satisfy a specific group of functions or operations. A functional component may or may not be synonymous with a department since the term "department" refers to an administrative organization and not a physical organization.

The description of each functional component of the project can be formatted according to the following headings:

Functional Description, providing information on the future general services of the component and its basic features or characteristics.

Operational Description, providing information on the proposed operation of the component internally, as well as in relation to other components.

Workload, summarizing the existing and projected future workload in appropriate work units, including assumptions used in developing the projections. This information will be used to estimate both the staffing and space requirements of the component. Workload projections should be based on historical data for each service or program affected by the project and should be expressed in as much detail as possible.

Staffing, summarizing the existing staff complement in terms of fulltime equivalents (FTEs), unique work patterns and peak day shift staffing as well as providing estimates of future FTEs, including assumptions used in developing the projections. These estimates are used to develop space requirements and operating costs. The figures are also useful to the architect in estimating maximum room occupancy loads.

The staffing estimates must be presented for the same years used for workload projections in order to see the direct correlation between workload and staffing.

Design Criteria, outlines external (or inter-component) relationship criteria and internal relationship/concepts to be incorporated into the design of the component. The following definitions are normally used to prescribe these relationships:



- 'Direct access by internal circulation' means components that are horizontally contiguous or linked internally.
- 'Direct access by general_circulation' means a minimal amount of horizontal general circulation.
- 'Convenient access by general circulation' means components linked by substantial horizontal and/or vertical general circulation.

All relevant physical and operational relationships required between component areas should be specified as well as any proximity needs critical to communications, sharing of equipment or circulation of patients, staff and materiel. The project may not be able to satisfy all of these specified relationships. However, at this point, they should be stated clearly. Compromises come later.

Capacity Requirements, outlining the capacity requirements for the functional component. The calculation of clinical capacity involves determining the number of beds, rooms or support spaces required to accommodate the future workload - taking into account factors such as staffing, room utilization or occupancy rates, average case time, and routine hours of operation. All assumptions used in developing the capacity requirements should be stated.

Space Requirements, outlines the net space requirements for the component based on its capacity requirements.

The space schedule should indicate the number of rooms or spaces (units), the net square metres (nsm) allocated to the unit, the total net square metres for each unit type and provide supplementary remarks that help explain the use of the space.

Wherever possible, the space planning criteria used for clinical spaces should be based on a 'standardized model', modified only to the extent necessary to meet the needs of each individual care program. This approach promotes the principle that space should be designed in a flexible manner to support future changes resulting from maturation of the programs and services.

SAMPLE SPACE REQUIREMENTS:

Room Name	No. Of Rooms	Net Room Area (metres ²)	Total Net Area	Comments
Reception Area	6	4.5	27.0	6 work stations
Information Desk	2	4.5	9.0	2 work stations
Waiting Area	1	125.0	125.0	75 seats
Public washroom	2	31.0	62.0	4 stalls each
Wheelchair storage	1	6.0	6.0	
Exam/Treatment Rooms	18	11.2	201.6	
Phlebotomy	10	4.5	45.0	10 stations
Specimen Processing	1	9.3	9.3	



Space Summary Section

This section summarizes the space requirements for all functional components to be included in the project.

The space summary should be presented in the form of a Schedule of Accommodation that summarizes the net areas, gross component areas and gross building area for the project. The Schedule of Accommodation should clearly distinguish between new space and renovated space.

Every space element included in the project should be listed on the Schedule of Accommodation indicating its net area and the total net component area for each functional component.

The grossing factor applied to the net component area to determine gross component area is referred to as Grossing Factor 1 as defined in the document entitled “**Evaluation and Space Programming Methodology.**” This factor allows for circulation, partitions, ducts and mechanical services within the department. The grossing factors used in the Programming Study must not exceed those recommended below.

FUNCTIONAL COMPONENT	GROSSING FACTOR	FUNCTIONAL COMPONENT	GROSSING FACTOR
Ambulatory Care Areas	1.40	Administration Services	1.30
Cardiology Services	1.30	Ambulance Garage	1.25
Day Medicine	1.35	Auxiliary/Volunteers	1.25
Day Surgery	1.40	Education & Training	1.30
Diagnostic Imaging	1.50	Facilities Maintenance	1.20
Electrodiagnostic Services	1.30	Food Services	1.20
Emergency Department	1.50	Housekeeping	1.20
Gymnasium	1.15	Information Technology	1.20
Hemodialysis	1.40	Laundry & Linen Services	1.10
Inpatient Unit – Bedroom Areas	1.50	Materiel Management	1.15
Inpatient Unit – Support Areas	1.30	Pastoral Care	1.20
Intensive Care Units (Adult)	1.60	Pharmacy	1.25
Intensive Care Unit (Neonatal)	1.50	Recreation Therapy	1.30
Laboratory (Open Design)	1.30	Research - Lab	1.25
Laboratory (Compartmentalized)	1.40	Research - Support	1.30
Labour & Delivery Suite	1.50	Security	1.20
Pulmonary Function Lab	1.30	Social Services	1.25
Rehabilitation Medicine	1.30	Staff Facilities	1.15
Respiratory Therapy	1.30	Medical Records	1.30
Surgical Suite	1.45	Public Areas	1.15

Grossing **Factor 2** is then applied to the sum of the gross component areas (for new space only) to allow for main horizontal and vertical circulation, mechanical and electrical service spaces, structures and external walls. The result is the gross building area. Grossing Factor 2 guidelines currently recommended by Alberta Infrastructure and Transportation are as follows:



Facility Type	Bed Range	Total
Acute Care	Up to 100	1.27
	100 +	1.29
Long Term Care	Up to 50	1.22
	50 to 200	1.26
	200 +	1.29
Community Health	N/A	1.20

When a project includes a mix of acute care, long term care and community health space, Grossing Factor 2 should be weighted based on the relative proportion of gross component area programmed for each type of space.

Wherever possible, the Schedule of Accommodation should include a column that allows for the comparison of current component area to proposed component area.

Conceptual Development Plan Section

The Preliminary Business Case for the proposed project or a subsequent feasibility study will have recommended the preferred development option based on a combination of practical and common sense analyses and specific criteria.

Normally, only the preferred development option recommended in the Preliminary Business Case or feasibility study will be carried forward and detailed in the Programming Study. However, in some instances, other options or variations of the

preferred option may arise as a result of more detailed analysis undertaken in preparing the Programming Study.



The Conceptual Development Plan section should describe the preferred development approach, explain its key features and restate how it addresses the operational problems and meets the objectives of the project as stated in the Background section.

Conceptual layouts of the preferred development approach or each alternative variation of the preferred scheme are helpful in

illustrating and assessing the strengths and weaknesses of options and assessing their feasibility. The preferred scheme should be described in sufficient detail to convey the scope of work, demonstrate feasibility and allow for a construction cost estimate to be prepared. The description should communicate, at a minimum, how existing areas of the building will be changed, the placement of any proposed new space and a schedule of renovation and modernization work for the building and its component systems.

For some more complex projects involving the redevelopment of an existing facility, it may be necessary to investigate development options in even more depth. The preparation of preliminary schematic design drawings showing the major functional



components, as they will relate to one another may be required to ensure that the components can adequately respond to functional and operational requirements.

Site Development Plan Section

It may be necessary for some projects to confirm that an existing site can accommodate the project as well as its access, servicing, traffic circulation and parking requirements. This will ensure that necessary budget allowances are in place for the provision of any required access and site servicing work needed to complete the project.



If land must be acquired, the specific requirements, costs and the preferred location must be identified along with some reasonable assurances of availability. The costs of land, site improvements, utility services and municipal charges are a provincial responsibility and must be included in the project cost estimate.

Among the key issues that may need to be addressed in the Programming Study are:

- ✓ Requirement for direct or indirect highway access
- ✓ Adequacy of road access
- ✓ Requirement for a Traffic Impact Assessment (T.I.A.)
- ✓ Availability and adequacy of public transportation
- ✓ Compliance with planning/zoning requirements
- ✓ Requirement for an environmental site assessment
- ✓ Suitability of the site topography for the project
- ✓ Location of site in relationship to 1:100 year flood plain (1:1000 for hospitals)
- ✓ Storm water management requirements
- ✓ Availability of offsite services such as power, gas, water, sanitary and storm sewers
- ✓ Consideration of geotechnical/foundation concerns

Equipment Plan Section

The Programming Study should include a schedule of all eligible program delivery equipment and furnishings required. The schedule should exclude any existing equipment that can reasonably be reused and any items that are typically included in the construction contract or will be funded by the Health Authority. Part 3, Section 1 of this Manual provides further information on equipment and furniture items that are eligible for provincial funding as a component of major capital projects.

The estimated cost of all eligible equipment and furniture on the schedule will be the amount included in the Project Cost Plan



Project Cost Plan Section

The total project cost should be broken down into construction and non-construction cost components. Each sub-component of the non-construction cost must be individually estimated with all assumptions noted.

The total construction cost estimate should be based on separate estimates for new construction and renovation/upgrade work – relating each to the gross area involved.



Operational Impact Section

The Programming Study must include a calculation of the operating cost implications of the project.

Where possible, a full total operating cost analysis is more informative than an incremental approach. However, if it is not possible or practical to analyze the full cost or where the incremental costs are small relative to the full cost, an incremental cost approach may be used.

Identify all relevant operating costs incurred by the Health Authority over the chosen project timeframe including initial start-up, operational commissioning costs, and on-going operating costs.

Implementation Plan Section:

The proposed implementation plan for the project should be outlined at a high level. Enough detail should be provided so that the reader can understand the recommended next steps of the project.

This section should include:

- ✓ A description of the major project phases.
- ✓ A preliminary schedule for the project with target dates for completion.
- ✓ A preliminary estimate of annual capital cash flow requirements.

**PART 1**
Section 6**Alternative Capital Funding**

In the past, major capital projects were funded almost exclusively on a current year basis within the Alberta Infrastructure and Transportation annual budget allocations. It is now be expected that ministries and supported agencies such as Health Authorities will consider Alternative Capital Financing (ACF) opportunities and assess their potential prior to seeking approval for a major capital project.

The primary interest in ACF for the government is to explore ways in which private sector involvement in projects could reduce the provincial capital outlay, reduce overall costs and share risks by taking advantage of core competencies in the private sector.

An Advisory Committee on Alternative Capital Financing (ACACF), comprised of private sector individuals with expertise in areas such as finance and investment management, real estate development and commercial law, has been established to evaluate capital proposals with ACF potential and their supporting business cases and to make recommendations to the Treasury Board.

The ACACF also oversees the development of provincial guidelines for alternative funding of capital projects and maintains an ongoing familiarity with public policy developments, both nationally and internationally, concerning various funding approaches for public sector infrastructure development.

This section outlines the steps that Health Authorities must follow to propose a project using an alternative approach to capital financing. These steps constitute a distinct sub-process within the overall government capital planning and approval process.

What Is Alternative Capital Financing?

Alternative capital financing/delivery (ACF) involves the acquisition of capital assets:

- Without direct purchase by the Province;
- By transferring some or all of a project's costs and risks to outside parties; and/or
- Financed with limited or no recourse to the Province.



ACF encompasses a wide range of models with varying implications for risk transfer, ownership, operations, accounting and debt reporting. Each model has different service delivery potential and is predicated on different levels of risk being transferred or allocated to the partner organization.

ACF can offer a range of potential benefits, including the opportunity for public sector organizations to make use of private sector ideas and innovations. However, the primary advantage of ACF is its potential for risk transfer.

Where the private sector is able to provide both an asset and a service, health authorities using ACF may be able to transfer some or all of the risks in areas such as site, design, construction, financing, non-health care services, labour relations and ownership (e.g., maintenance or technological obsolescence). With ACF, risks should always be allocated to the parties best able to manage them at the least cost while serving the public interest.

Application of the ACF Process to Health Projects

There is a wide range of alternatives to conventional, current year revenue funding of major capital projects. Health Authorities must consider and assess the potential value and benefits of these alternatives in the course of developing their project proposals - beginning when the preliminary business case for the project is prepared.

The process described in this section ONLY applies where an alternative to current year revenue financing is being proposed. This includes (but is not limited to):

- **Health Authority Borrowing** – The Health Authority borrows up front capital funds for specific projects, which Alberta Infrastructure and Transportation repays through future annual budget allocations.
- **Public Private Partnership (P3)** - A private/voluntary sector partner provides infrastructure and/or services that have been traditionally delivered by the public sector. A key component of P3 arrangements is the sharing of the project risks (e.g. design, construction and demand) between the public and private/voluntary sector partners according to who is better able to manage them.
- **User Charges** – Revenue mechanisms that can be used in combination with other ACF options, involving the collection of charges from the users of a particular capital project. Typically, these funds are used to repay borrowing or commitments under an ACF project.

The process applies ONLY to P3 projects that involve a private/voluntary sector investment. It does not include outsourcing (private partner provides infrastructure on a short term rental basis or operates and maintains Health Authority owned infrastructure) or design/build (fixed price contract for design and construction) options.

One special form of partnership that has been implemented in the health sector is also not required to follow the ACF planning and approval process. In this partnership arrangement, the Government provides a one-time, up-front capital grant to a Health Authority and the Health Authority uses this grant to make payments to its partner organization. Two models have been used:



- **The Supplementary Payment Model:** The Health Authority makes annual payments to the partner over the term of the partnership contract (usually the expected useful life of the infrastructure).
- **The Modified Mortgage Model:** The Health Authority provides a demand loan to the partner who uses the funds to construct the infrastructure. The loan is forgivable over the useful life of the infrastructure.

Public Private Partnerships (P3s)

A public private partnership (P3) is a legally binding contract between a Health Authority and a partner organization for the provision of assets and, possibly, for the delivery of services that allocates responsibilities and business risks between the partners. In a P3 arrangement, the Health Authority remains actively involved throughout the project’s life cycle. The partner is responsible for the more commercial functions such as project design, construction, finance and building operations.

- ❑ A P3 solution does not provide a miracle solution or a quick fix and should only be proposed where it can deliver clear advantages and benefits.
- ❑ A P3 structure must be selected according to project type and needs. There is no single perfect model.
- ❑ Each type of P3 has inherent strengths and weaknesses that need to be integrated into the project design.

At the core of a successful health infrastructure P3 is the risk transfer associated with this type of procurement. Long-term risk transfer is maximized when the partner is made responsible for some aspects of the ongoing operation of the physical asset over a significant period. Potential ongoing services that can be incorporated into an infrastructure P3 are those that can best trace their potential efficiencies back to the building's design and construction. These could include services such as maintenance, housekeeping, laundry and catering. The goal is to combine the best capabilities of the public and private sectors for mutual benefit.

Examples of P3 Models in the Health Sector

Focusing on the design and construction of the infrastructure itself, there are a wide variety of P3 arrangements with different levels of public and private sector involvement and risk. These differences can be illustrated using the following two P3 delivery models that have been used for the delivery of new health infrastructure.

- Design Build Operate (DBO); and
- Design Build Finance Operate (DBFO).

Each of these models is briefly described below.

Design-Build-Operate (DBO)

Under a DBO, the Health Authority would own and finance the project but would engage a partner to design, construct and operate the facility for a specified period. The logical services to include in a DBO would be those that relate to the design,



construction and operation of the building. At a minimum, this should include the maintenance of the building, but could also include any service where future operating efficiencies can be enhanced by design and construction decisions.



Under a DBO, the Health Authority would establish performance objectives and maintain ownership of the facility. The partner would not invest equity into the project and would be limited in its financial risk to the terms included in the contract with

the Health Authority. Payment would generally be made following commissioning of the infrastructure or at major milestones of the project, rather than on monthly progress.

One value driver behind DBO is the integration of design and construction that reduces the number of approval steps and facilitates concurrent design and construction. Depending on the environment in which a project is developed, the DBO model can usually deliver infrastructure faster and subject to fewer claims and cost overruns than traditional procurement.

As well, there can be more opportunity for creative freedom for the private sector partner through the use of a performance, rather than prescriptive, specifications. The key to this element is that the private sector is told what is required, but not how to achieve it.

The private partner would have an enduring stake in ensuring that the infrastructure will perform satisfactorily over the long-term. By having the partner take on operational responsibility for the facility after it is designed and constructed, the interests of the partner become more aligned with those of the Health Authority.

The competitive process for awarding a DBO is an important element of the arrangement. A DBO allows the partner to optimize the total cost of service delivery by trading initial capital investments against operational needs over a longer period. A competitive environment is the key to ensuring that the benefits of this optimization are realized by the Health Authority.

Design-Build-Finance-Operate (DBFO)

Under a DBFO, the partner would design, construct, finance and operate the facility for a specified time, known as the concession period. Like the DBO, the Health Authority would establish performance objectives. Although ownership of the infrastructure usually rests with the partner, there are ways to structure the transaction so that the Health Authority owns the facility. Unlike a DBO, the capital and operational costs in a DBFO would be blended together in a service payment to the partner over the operational period.

Although the Province usually could obtain financing at rates lower than those in the private sector, after the effects of risk transfer are accounted for, a successful P3

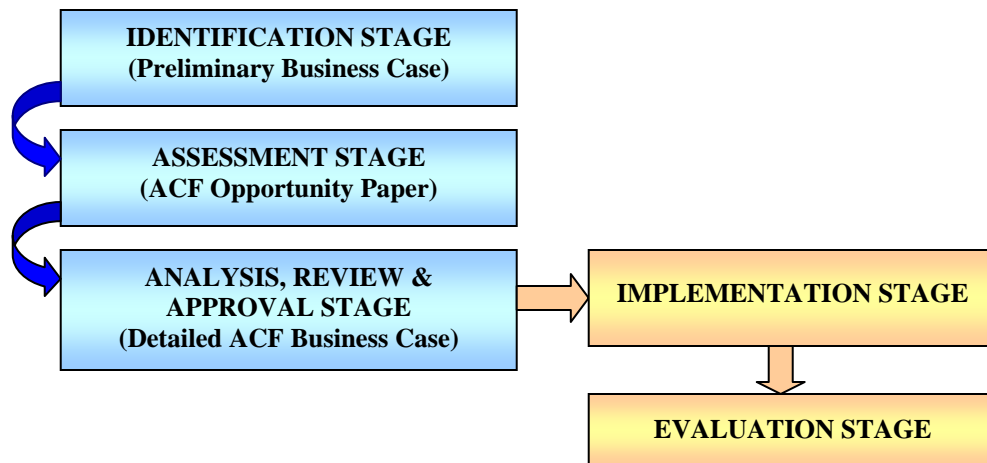


candidate should be able to demonstrate value for money. Value for money in a P3 occurs when the expected risk-adjusted costs of the P3 are less than the comparable expected risk-adjusted costs of the same project using a traditional procurement approach. Value for money is calculated against the public sector comparator and expressed in net present value terms. Should value for money from private sector involvement not exist, the Health Authority would be better off delivering the project itself.

DBFO has the potential to provide more savings to the public sector as it would have greater risk transfer than DBO and the most direct incentives for design and construction decisions that minimize whole life cost. A wide range of operational risks can be transferred to the private sector under a DBFO. Some financial risks are also transferable, the most important of which is responsibility for cost overruns during construction. These factors, combined with the disciplines that private financing imposes on project management can create a greater potential for cost savings. However, the Health Authority’s planning activities, the negotiation of terms and conditions of individual transactions and the implementation of the contract administration functions will determine the actual risk transfer and savings.

Process for an ACF Project

The development of a successful ACF arrangement will require attention to a large variety of issues. There are five key stages in the Alternative Capital Financing process.





1. IDENTIFICATION STAGE

The initial identification of alternative capital financing/delivery potential for a project is made in the Preliminary Business Case. Identification will usually be based on a preliminary assessment of the following types of factors:

- ❖ A market exists for partners with the expertise required to successfully deliver project objectives or it can be reasonably expected to develop;
- ❖ The project will present significant opportunities for private sector innovation in design, construction, service delivery and/or asset use;
- ❖ The private sector has an ability, under legislation, to provide health care services (e.g., nursing home services);
- ❖ Clearly definable and measurable service output specifications can be established, suitable for payment to be made on a services-delivered basis;
- ❖ There is potential to transfer risk to the private sector;
- ❖ The private-sector partner has an opportunity to generate non-health care delivery streams of revenue; and/or
- ❖ Projects of a similar nature have been successfully procured using a similar method.

2. ASSESSMENT STAGE

If the Preliminary Business Case indicates that a project may have potential for an alternative capital financing/delivery approach, the Health Authority is next asked to prepare an ACF Opportunity Paper (the first high level assessment) to establish that the project meets the fundamental criteria for alternative capital financing or delivery.

- ❖ The Health Authority prepares an ACF Opportunity Paper in the format outlined in Appendix 3, submits it to Alberta Infrastructure and Transportation and provides a copy to Alberta Health & Wellness.
- ❖ An assessment of the ACF Opportunity Paper is completed and recommendations made to the ACF Review Committee.
- ❖ Where the ACF Review Committee does not support the Opportunity Paper, Alberta Infrastructure and Transportation will advise the Health Authority of the decision and the reasons why the proposed ACF was not supported.
- ❖ If the ACF Opportunity Paper is endorsed by the ACF Review Committee, recommendations are forwarded to the Deputy Minister's Capital Planning Committee (DMCPC).
- ❖ The DMCPC will review the ACF Opportunity Paper and the ACF Review Committee's assessment and determine if the ACF Opportunity Paper will be endorsed.



- ❖ If the DMCPD does not endorse the ACF Opportunity Paper, Alberta Infrastructure and Transportation will advise the Health Authority of the decision and the reasons why the proposal was not supported.
- ❖ Further action by Alberta Infrastructure and Transportation and the Health Authority will be contingent on the relative provincial priority of the proposed project as determined using the criteria and rating tools described in Section 7.
- ❖ If the project is a high provincial priority, the Health Authority will be granted approval and funding to complete a full ACF Business Case.

3. ANALYSIS, REVIEW & APPROVAL STAGE

This stage establishes, based on more detailed analyses, whether an ACF approach is preferable to traditional procurement.

If, based on a review of the Opportunity Paper, it is determined that there is sufficient potential to warrant examining an alternative financing or delivery approach in more detail, a Detailed ACF Business Case will be developed to demonstrate the relative merits of ACF relative to conventional financing.

The process proceeds as follows:

- ❖ The Health Authority is notified, in writing, by the Ministers of Infrastructure and Transportation and Health & Wellness that approval has been granted to proceed with the preparation of a Detailed ACF Business Case. Costs will normally be funded by Alberta Infrastructure and Transportation.
- ❖ The Health Authority prepares a Detailed ACF Business Case in the format outlined in Appendix 4.
- ❖ To complete a Detailed ACF Business Case, the Health Authority may need to undertake a preliminary market sounding exercise. This market sounding process needs to be structured so that it does not harm the future competitive positions of potential respondents to any Requests for Proposals. Market sounding should only be initiated following consultation with Alberta Infrastructure and Transportation.
- ❖ The Health Authority submits the completed Detailed ACF Business Case to Alberta Infrastructure and Transportation and provides a copy to Alberta Health & Wellness.
- ❖ Alberta Infrastructure and Transportation completes an assessment of the Detailed ACF Business Case and makes recommendations to the ACF Review Committee.
- ❖ Where the ACF Review Committee does not support the proposal, Alberta Infrastructure and Transportation will advise the Health Authority of the decision and the reasons why the proposal was rejected.



- ❖ If the Detailed ACF Business Case is endorsed by the ACF Review Committee, recommendations are forwarded to the Deputy Minister's Capital Planning Committee (DMCPC).
- ❖ The DMCPC will review the Detailed ACF Business Case and Alberta Infrastructure and Transportation's assessment, and determine if the ACF project is to be endorsed. If the DMCPC supports the project, a recommendation is sent to the Ministers and, subsequently to the Advisory Committee on Alternative Capital Financing (ACACF).
- ❖ The ACACF reviews the Detailed ACF Analysis and provides recommendations to Treasury Board. The ACACF may employ internal or external resources and/or call upon Alberta Infrastructure and Transportation, Alberta Health and Wellness or the Health Authority in the course of its review.

Depending on project size, complexity and the financial commitment required, the ACF Business Case may also be assessed by a number of areas within the government.

If an ACF project is rated as a high provincial priority in the provincial capital plan and is recommended for approval, Treasury Board, when deciding whether to approve the project, will also make a decision on the implementation method - ACF or with a different funding recommendation.

4. IMPLEMENTATION STAGE

Note: Implementation guidelines for an ACF approach based on Health Authority borrowing are not covered in this manual.

Following approval of the project by Treasury Board, proposals are requested from the private sector using a Request for Qualification (RFQ) and Request for Proposal (RFP). Proposals are assessed based on their ability to meet the detailed program and infrastructure requirements.

General implementation guidelines for P3 projects are available from Alberta Infrastructure and Transportation. The application of these guidelines will depend on the specific nature of the project, arrangements and desired outcomes. It is expected, however, that the public interest will be protected throughout the implementation phase of all projects and that the following procedures will be followed:

- ❖ P3 partners will be chosen through a fair and competitive bidding process.
- ❖ Prior to executing contracts during the implementation stage, Alberta Infrastructure and Transportation must confirm that the contracts are consistent with the Detailed ACF Business Case.
- ❖ Where there are material changes to an ACF project's expected cost or arrangements compared with those initially approved by Treasury Board, a revised ACF Business case must be submitted to the ACACF and Treasury Board for approval.



- ❖ Treasury Board may request Alberta Infrastructure and Transportation to report on project status at various points during the implementation process. When this occurs, Treasury Board may request the involvement of the ACACF before it reviews the status of any project.
- ❖ Treasury Board approval should be obtained for the final contract negotiated by the Health Authority.

The partnership agreement between the Health Authority and the successful proponent is intended to describe a relationship for the mutual benefit of each party. The contract must be performance-based and clearly establish terms, expectations and costs for each party. It must be sufficiently flexible to promote innovation and include a risk management plan. Once a contract is in place, a formal implementation team is established and a detailed project plan is developed and approved.

5. EVALUATION STAGE

For each ACF project, Alberta Infrastructure and Transportation is responsible for ensuring that there is a post implementation or post-occupancy review immediately following completion of the project. Alberta Infrastructure and Transportation will also schedule any additional reviews that may be needed throughout the contract life cycle. This could involve ongoing performance reviews of the established partnership agreement, the procedures involved and the overall success of the project. The results will be shared with relevant stakeholders. Post implementation reviews are intended to share lessons learned and provide information to ensure future project successes.

The following table summarizes Health Authority responsibilities at each of the key decision points, the outputs stated in terms of decisions, and the tools/templates that are currently available to assist Health Authorities.

Alternative Capital Finance Process Overview

Key Step	Health Authority Inputs	Outputs (Responsibility)	Tools
Identify	Develop concepts and review with Alberta Infrastructure and Transportation. Preliminary business case assessment of ACF potential	Recognition of ACF potential (Alberta Infrastructure and Transportation)	Preliminary Business Case
Assess	Assessment of potential financing alternatives for all major capital projects	Recognition of ACF potential (Deputy Minister’s Committee)	ACF Opportunity Paper Template
Analyze, Review & Approve	Evaluation of the relative merits of alternative capital financing relative to current year revenue funding. Issue EOI (market sounding).	Approval to proceed with ACF project (ACACF, Treasury Board)	Detailed ACF Business Case Template



Alternative Capital Finance Process Overview

Key Step	Health Authority Inputs	Outputs (Responsibility)	Tools
Implement	<ul style="list-style-type: none"> Implementation plan for project. Issue RFQ/RFP. Obtain approvals at local level. Respond to public on issues. Obtain and manage other funding as appropriate. Implement project. Report progress to Alberta Infrastructure and Transportation. 	Signed contracts (Alberta Infrastructure and Transportation/Treasury Board)	
Evaluate	Assessment of project costs and performance	Determination of value and lessons learned (Alberta Infrastructure, Health Authority)	Post Implementation Review Template

Unsolicited Proposals

While the government wishes to encourage innovation and the introduction of creative solutions, public sector procurement policy and arrangements such as the Internal Agreement on Trade, demand fair and open competition. Unsolicited proposals can, therefore, present a dilemma.

The usual justification for unsolicited proposals - that they present a unique concept or technology or address a need not recognized by government – may be somewhat problematic when applied to health facility infrastructure. It is not evident what novel technologies in health facility construction could not survive a competitive process and it would be rare where health authorities did not recognize an infrastructure need.

The fundamental requirement in dealing with an unsolicited proposal is a clear indication that it is meeting a service need and that the project is a priority for the Health Authority and for the government. Building unneeded or low priority health infrastructure because there is an immediate opportunity while higher priority health projects must await funding is not acceptable public policy.

Assuming it meets the test of a needed facility, there may be circumstances where accepting an unsolicited proposal is appropriate. In deciding whether to accept an unsolicited proposal, the Health Authority should ensure that:

- a) The unsolicited proposal does not relate to a project for which a selection process has been initiated or announced.
- b) The Health authority has determined, based on an assessment of the appropriateness of the arrangement, the proponent's qualifications, feasibility of the project and value



- for money, that the project is in the public interest and meets a real and high-priority need.
- c) The unsolicited proposal can be evaluated without violating the proponent's intellectual property rights.
 - d) That it is truly an unsolicited proposal providing a facility or service that is innovative or unique and is not merely a marketing initiative.

An Opportunity Paper must be prepared for any unsolicited proposal. The assessment and approval process will be the same as that outlined for other ACF projects.

ACF Tools and Templates

The following tools and templates are available from Alberta Infrastructure and Transportation to support the ACF process:

- **ACF Opportunity Paper Template:** (Appendix 3) This is the first formal documentation of an ACF proposal. It is completed by the Health Authority originating the ACF proposal and then submitted to Alberta Infrastructure and Transportation for review. Alberta Infrastructure and Transportation will present the ACF Opportunity Paper to the ACF Review Committee and the Deputy Minister's Capital Planning Committee for endorsement. If supported, the next step in the process would be completion of a Detailed ACF Business Case.
- **Detailed ACF Business Case Template:** (Appendix 4) This is where an in-depth analysis of the ACF proposal is completed. It expands on the Opportunity Paper and uses a business case format for most of the input.
- **ACF Assessment Criteria:** The generic guidelines used by Alberta Infrastructure and Transportation to assess an ACF Opportunity Paper and Detailed ACF Business Case. Alberta Infrastructure and Transportation may modify this template to incorporate other criteria applicable to health sector projects.
- **ACF Implementation Guidelines:** This set of general implementation guidelines provides a high-level approach to follow when implementing an ACF project.
- **ACF Post Implementation Review Template:** This template provides a format for documenting post implementation reviews of ACF projects.

The ACF Business Case

While there is no universal model for an ACF Business Case, the template provided in Appendix 4 requires documentation in terms of the following key elements:



- a) Project objectives and alignment with government policy and the Health Authority Health Plan.
- b) Scope of the project defined in terms of outputs.
- c) Risk analysis and risk allocation identifying material risks, who assumes them and why.
- d) Cost estimates and evaluation against the public sector comparator.
- e) Description of the public sector commitment and obligations.
- f) Cost benefit analysis to demonstrate value for money in comparison to other options, including doing nothing.
- g) Analysis of the private sector's capability to deliver the project, its interest in doing so and the level of competition.
- h) Description of the proposed performance measurement and how it relates to payments from the government.
- i) Identification of key stakeholders within and outside the Health Authority and the consultation plan.
- j) Demonstration of how the project serves the public interest.
- k) Indication of how significant site issues, legal concerns, labour relations, environmental and planning issues will be addressed.
- l) Project timetable and evidence that the Health Authority has the personnel and other resources to proceed with a successful ACF.



All sections of the ACF business case template will normally be completed. However, the information provided in each section is scalable to the nature, size and impact of the project.

Health authorities are responsible for determining the depth of analysis required for each element of an ACF business case - based on the project's size, complexity and risk. However, it is recommended that the Health Authority discuss requirements with their primary contact person at Alberta

Infrastructure and Transportation prior to issuing a Request for Proposals for consultant services.

Funds to Complete an ACF Business Case

Preparation of an ACF Business Case requires the prior joint approval of the Ministers of Infrastructure and Transportation and Health & Wellness. Alberta Infrastructure and Transportation will provide a grant to cover the consultant costs that will be incurred by the Health Authority to prepare the ACF Business Case.



When approval to proceed is received, a Request for Proposals is prepared by the Health Authority and sent to at least three qualified consulting firms. Proposals are reviewed, a final consultant selection made and an agreement drawn up and awarded to the consultant of choice.

Alberta Infrastructure and Transportation staff must be consulted when preparing the Request for Proposals and negotiating the resultant consultant agreement or contract. Both Alberta Infrastructure and Transportation and Alberta Health and Wellness staff should be kept involved and informed as preparation of the ACF Business Case progresses.

Long-Term Care Facility Partnerships

The Government of Alberta has approved the principle of Health Authorities entering into partnerships with private, voluntary, or public sector partners to develop and operate approved long-term care facilities.

A “long-term care facility infrastructure partnership” is defined as a contractual relationship between a Health Authority and a private, voluntary, or public sector partner to develop and operate long-term care infrastructure. Under this arrangement the partner will contract with the Health Authority to perform all of the following functions - design, build, finance, own, operate and maintain the long-term care facilities.

These special forms of partnership models developed for the long-term care sector are not required to follow the ACF planning and approval process outlined in this section. For long-term care infrastructure partnership projects, the government will provide a one-time, up-front capital grant to a Health Authority. The Health Authority uses this grant to make payments to the partner organization.

Government approval of this type of infrastructure partnership project is subject to availability of funding and the provincial priority of the proposed project. Government is **not** a partner in these arrangements.

Capital funds provided by Alberta Infrastructure and Transportation for a long-term care facility partnership project are restricted to that portion of the project that will operate under the Nursing Home Act or the Hospitals Act. Under current health legislation, long-term care facilities in Alberta are classified as either nursing homes or auxiliary hospitals. Auxiliary hospitals are owned by Health Authorities or voluntary, non-profit organizations and are operated under the Hospitals Act. Nursing homes are owned by Health Authorities, voluntary organizations or private corporations and are operated under the Nursing Homes Act.

Two partnership funding models are being used at this time:



1. Supplementary Payments Model

Government supports the partnership by providing a one-time, up-front capital grant to enable the Health Authority to make annual supplementary payments to the partner over the term of the partnership contract (usually equivalent to the estimated useful life of the infrastructure).

2. Modified Mortgage Model

Government supports the partnership by providing a one-time, up-front capital grant to the Health Authority. The Health Authority in turn provides a demand loan to the partner. The partner uses these funds towards the construction of the facility. The loan is forgiven over the useful life of the infrastructure.

Principles

Long-term care facility partnership projects must adhere to the following principles:

1. Provincial support will only be given for projects that have been identified in the Health Authority's multi-year capital plan and that have been assessed as a high provincial priority based on the application of capital rating criteria.
2. The proposed infrastructure partnership project must be clearly defined and supported by a Preliminary Business Case.
3. The proposed infrastructure partnership project must offer the best solution based on a careful evaluation of alternative methods of delivering the infrastructure, and clearly demonstrate a benefit to Albertans.
4. Risk factors must be clearly identified in the Preliminary Business Case including which partner will assume, manage and/or mitigate that risk.
5. The process used by the Health Authority to select a partner must be an open competitive process that establishes, in advance, a planned schedule of events and processes to be followed, activities to be carried out and specific evaluation criteria.
6. The Health Authority must have contracting guidelines in place for the infrastructure partnership project process that comply with sound business practices, ensure transparency of process, and include provisions to avoid conflicts of interest.
7. The contractual arrangements must protect the public interest and public investment in the infrastructure. They must clearly delineate accountabilities, responsibilities, performance standards, target dates, outputs and deliverables, financial terms and options for termination.
8. The Health Authority must clearly identify the partnership arrangement in its financial statements in accordance with the most recent financial directives



issued by the Minister(s). Financial aspects of the contractual arrangement may be subject to special reviews requested by the Minister(s).

9. If a partnership involves the complete or partial replacement of an existing facility owned and operated by a Health Authority, the Health Authority is expected to develop and implement strategies to manage the human resource component of the existing operation. The following specific requirements must be met:
 - ❑ The Health Authority must assess the impact of the proposed partnership on staff of the existing operation and implement an effective transition process that respects the employment rights and benefits of existing employees.
 - ❑ The transition management process must incorporate the principles and provisions provided for in the Alberta Labour Relations Code, relevant collective agreements and other contractual arrangements. A reference to the management of human resources should form an integral component of the Request for Proposals for the infrastructure partnership.
 - ❑ The Health Authority must engage in early and on-going consultation with unions and other affected work groups in order to execute an effective transfer and resolve related employment issues.
10. The Health Authority must develop and implement an effective communication strategy for all parties, including residents and their families, staff, and external stakeholders.

Financial Arrangements

The following financial arrangements apply to all approved long-term care infrastructure partnership projects:

1. The Health Authority must request proposals from potential partners that address:
 - ❑ The overall costs of developing, financing and operating the facilities (including all maintenance and upgrading) over a specified period, normally 30 years. These costs should be provided in sufficient detail to allow the Health Authority to fully understand the cost structure of the proposal.
 - ❑ The amount of capital funding needed to make the infrastructure partnership project financially viable.
2. If the government should implement changes in the accommodation charges paid by long-term care residents such that a portion of the accommodation charge is designated for capital construction, then the operating per-diem payments from the Health Authority to the operator will be adjusted by the portion of the accommodation charge designated for capital construction.



3. For projects that have been approved by the government, Alberta Infrastructure and Transportation will assist the partnership arrangement by providing up-front capital grant funds to the Health Authority. These funds will be provided according to a schedule established by Alberta Infrastructure and Transportation. Alberta Infrastructure and Transportation will deposit provincial funds into the Health Authority's Consolidated Cash Investment Trust Fund (CCITF) account.
4. The Government will not provide additional capital funding to address project cost overruns or funding shortfalls.
5. The project scope, description, cost, financing arrangements and partnership contracts must be approved by the Minister of Infrastructure and Transportation and the Minister of Health & Wellness prior to withdrawing funds from the CCITF account.
6. For partnerships developed under the Supplementary Payments Model:
 - Health Authority Investment Bylaws, approved by the Minister of Health and Wellness, must be in place before any provincial capital funds will be provided to the Health Authority to support an infrastructure partnership.
 - Alberta Health and Wellness and Infrastructure and Transportation will review the proposed investment portfolio for reasonableness and compliance with bylaws and applicable borrowing guidelines.
 - The Health Authority is responsible for investing provincial grant funds for the approved project, in compliance with its approved Investment Bylaws. Investment revenue on these funds and the grant itself must be used to meet the financial obligations of the approved project or other approved projects with the prior approval of the government.
7. Capital funds provided by the Province to the Health Authority for specific infrastructure partnership projects cannot be pledged as security or collateral for any other purpose.
8. Where the partnership includes contracted responsibility for ongoing service delivery by the partner, the contractual arrangement must specify that the financial obligation to the partner will be conditional on the partner maintaining a Service Agreement in good standing with the Health Authority.

Reporting Requirements

The following reporting requirements will apply to all approved long-term care facility partnership projects:

1. To facilitate timely government approval to transfer funds from the CCITF account and to proceed with the project, Health Authorities must keep Alberta Health and Wellness and Alberta Infrastructure and Transportation



informed as the partner selection process and partnership arrangements are planned and negotiated.

- 2. The Health Authority is responsible for reviewing all project documents, plans, specifications, zoning and other municipal use and construction by-laws, etc. to ensure compliance and for providing copies to Alberta Infrastructure and Transportation for review and comment.
- 3. Alberta Infrastructure and Transportation and Health and Wellness officials will be given the opportunity to review or approve contractual documents as specified in the following table:

	Review and Comment	Approval
RFI document	√	
RFI short-listing decisions	√	
RFP document	√	
RFP selection decisions	√	
Conceptual design and outline specifications		√
Partnership contracts	√	√
Plans, specifications	√	

- 4. The Health Authority will require and review progress reports from the partner at specified key milestone events during the planning, design, construction and commissioning phases of the project and will provide copies of these reports to Alberta Infrastructure and Transportation within 30 days of the specified event.
- 5. For partnerships developed under the Supplementary Payments Model:
 - Before April 1st of each fiscal year, the Health Authority will provide Alberta Health and Wellness and Alberta Infrastructure and Transportation with details of the proposed asset mix of its investment portfolio. The investment portfolio must demonstrate that projected future investment revenues and principal will be adequate to meet future financial obligations to the partner.
 - Within 60 days following the end of a fiscal year, the Health Authority will provide Alberta Health and Wellness and Alberta Infrastructure and Transportation with a comparison of the actual performance of the investment portfolio to that proposed at the beginning of the year. Where the investment stream has been less than that proposed, the Health Authority must identify and address the shortfall without further Government funding assistance. The Health Authority will identify how the shortfall will be addressed over the remaining term of the partnership arrangement.
 - At the conclusion of the term of the partnership arrangement, any residual funds remaining in the investment portfolio must be transferred to the CCITF account. These funds may be retained by the Health



Authority to address other capital needs in the health region. Expenditure of these residual funds will require the prior approval of the Ministers of Health and Wellness and Infrastructure and Transportation.

**Part 1
Section 7****Consolidated Provincial Capital Plan**

Consolidated capital planning refers to the process whereby health authority capital plans are rolled up into a single provincial health capital plan, which is then incorporated into the provincial Capital Plan as part of the government's annual budgeting process.

This approach allows the Province to:

- ✓ Establish fiscal controls such as capital expenditure limits, debt targets or debt-service limits commensurate with the government's overall fiscal priorities;
- ✓ Assess whether ministry capital plans are consistent with provincial strategies, initiatives and priorities;
- ✓ Identify and assess critical capital funding pressures and develop provincial strategies to address them; and
- ✓ Allocate capital resources to meet competing needs and make informed trade-offs (e.g. investment in health care vs. transportation or education infrastructure).



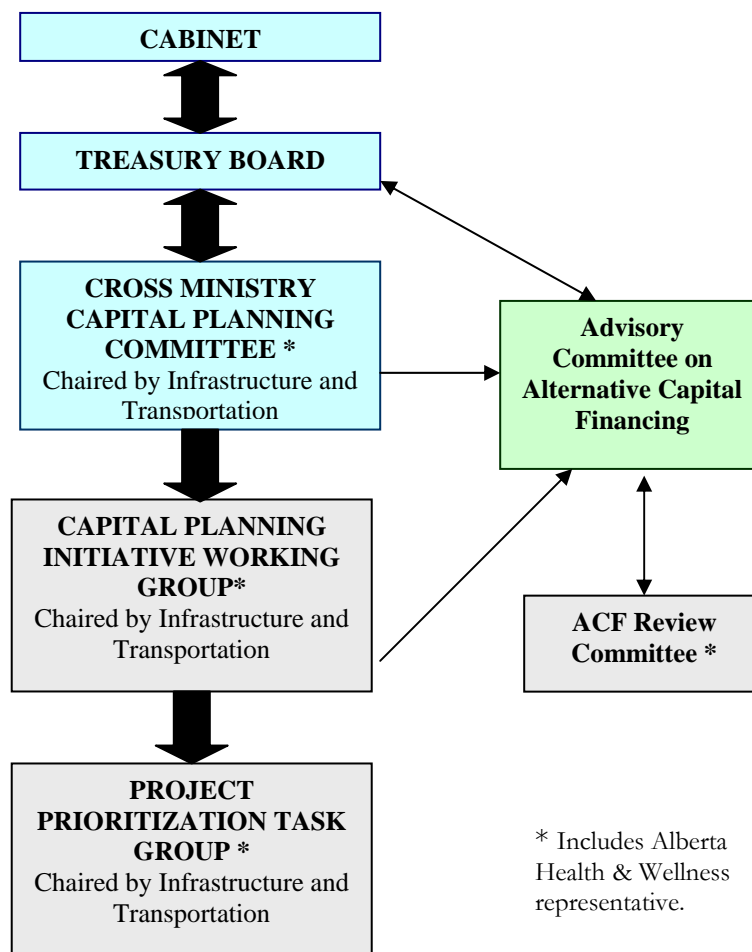
Treasury Board and Cabinet are the decision and approval authorities for government expenditures. With respect to capital expenditures, Treasury Board relies on recommendations from a Ministerial Capital Planning Committee and an Advisory Committee on Alternative Capital Financing but is ultimately responsible for approving the consolidated provincial Capital Plan.



Each year, a cross-ministry Deputy Minister’s Capital Planning Committee, with support from the Capital Planning Working Group and its various Task Groups, prepares an updated consolidated provincial capital plan for review by the Ministerial Capital Planning Committee. This updated provincial plan includes all previously approved capital projects that have not yet been completed as well as high priority new capital projects recommended for approval.

Consolidated Capital Planning (CCP) Process

The organizational structure for consolidated capital planning is illustrated as follows



The annual CCP process generally follows the following steps:

1. On an annual basis, health authorities update their multi-year capital plans, identifying and prioritizing their major capital project needs.



2. Health authorities submit their capital plans to Alberta Infrastructure and Transportation and Alberta Health and Wellness by June 30th each year.
3. The Cross Ministry Capital Planning Committee seeks direction from Treasury Board and issues preliminary budget instructions to the Capital Planning Initiative Working Group, outlining the annual budget schedule and priorities and specific direction regarding ministry capital plans. These instructions usually address, at a minimum:
 - ✓ Any strategic government priorities for the budget cycle;
 - ✓ Schedules for developing and submitting a consolidated provincial capital plan, with guidance regarding its form or content; and
 - ✓ If possible, notional or actual capital expenditure targets for publicly-supported infrastructure.
4. The Cross Ministry Capital Planning Committee issues budget instructions to individual ministries through its Working Group and Task Group structure. These instructions address, at a minimum, a ministry-level version of the same factors noted above for preparation of the provincial capital plan.
5. Consistent with these instructions, Alberta Infrastructure and Transportation and Health and Wellness consolidate health authority multi-year capital plans and prepare a ministry-level capital plan.
6. Alberta Health and Wellness presents eligible proposals for new capital projects to the Capital Prioritization Task Group (CPTG) for prioritization as part of a cross-ministry prioritization process. The number of health projects presented each year is determined based on instructions provided by the Cross Ministry Capital Planning Committee.
7. Health authorities are advised when a project proposed in their capital plan will be submitted to the CPTG. The Health Authority may be asked to provide additional information or analyses to assist ministry staff in the preparation of documentation required for CPTG review of projects.
8. The Capital Prioritization Task Group prepares a consolidated provincial capital plan, consolidating the highest priority projects and other capital spending requirements of all participating ministries for consideration by the Cross Ministry Capital Planning Committee. Projects are assigned a priority ranking using a corporate capital rating scale. This process is normally concluded by October 31st each year.
9. The Cross Ministry Capital Planning Committee assesses the plan's implications in the context of the overall government fiscal and debt strategy, strategic provincial capital management issues and provincial program priorities. Based on these and other factors, the Committee recommends an overall capital budget to Treasury Board.
10. Budget resources are allocated to the highest-priority projects and ministries are advised which new projects may proceed. This process normally begins in November and is concluded by March 31st.



11. Alberta Infrastructure and Transportation and Health and Wellness prepare and issue joint ministerial funding approval letters for specific health projects approved by Treasury Board. Notification of health authorities generally occurs immediately following announcement of the provincial budget (i.e., after April 1st).
12. When a new project is approved, the scope of work, cost and any conditions for implementation of the project are communicated to the Health Authority in a Letter of Approval from the Ministers of Health and Wellness and Infrastructure and Transportation.

Mid-year Project Approvals

The approval of new major capital projects is not normally considered by the government outside the annual budget process.

Corporate Capital Project Rating Scale

The Cross Ministry Capital Planning Committee has corporate responsibility for making recommendations on capital funding priorities for all government-owned infrastructure as well as infrastructure that is supported by government, but may be owned by agencies, school boards, municipalities and health authorities.



The corporate Capital Plan developed each year outlines spending requirements for each infrastructure program, identifies associated facility and program operating costs for any proposed new capital spending and prioritizes all proposed new major capital projects.

A rating system is used to establish provincial project priorities across the various infrastructure types (highways, schools, health facilities, etc.). Cross-government capital project priorities are determined using specific criteria and a scoring system for applying those criteria. Proposed new projects submitted by each government ministry are rated on these criteria and the total score is used to establish relative provincial priority. The rating criteria are reviewed annually to ensure that they remain current and consistent with government Business Plan objectives.

The rating system has been developed to respond to a wide variety of types of capital projects and programs. Many proposed health projects will not score on all, or even most, of these criteria. It is not the total score that matters as much as the score relative to other projects being considered that determines priority.

The current rating system (2004-2005) is comprised of several “non-economic factors” such as Program Delivery and Infrastructure Performance and “economic factors” such as Economic Benefits, Cost Avoidance and Savings and Alternate Funding Opportunities.

The current set of criteria and their relative weighting are summarized as follows:



CRITERION	PURPOSE	SCORING
1. Program Delivery	Assesses the importance of the project to achieving ministry strategic priorities or key initiatives by addressing constraints imposed by existing infrastructure (or lack of infrastructure).	up to 15 points
2. Access to Services	Assesses whether the project improves access to programs and services in a community, geographical area or sector that does not have adequate and/or reasonably convenient access in relation to ministry standards.	up to 5 points
3. Project Impact/Benefit	Assesses the magnitude of impact of the project in terms of the number of Albertans who will benefit from it.	up to 10 points
4. Joint Public Sector Venture	Recognizes projects that involve accommodation sharing between ministries or public sector agencies that result in economic or non-economic benefits.	up to 5 points
5. Procedural Requirements	Reinforces procedural requirements by awarding 2 points for projects that have completed a detailed planning study or business case and an additional 3 points to <u>one</u> project or program identified as the ministry's highest priority.	up to 5 points
6. Functionality	Assesses whether the project reduces problems caused by the functional condition of, or supports a significant change in the functional use of existing infrastructure.	up to 10 points
7. Physical Condition	Assesses whether the project reduces problems caused by the physical condition of existing infrastructure. Additional points may be awarded if the condition of the infrastructure presents serious health or safety concerns.	up to 10 points
8. Utilization/Capacity	Assesses whether the project will respond to utilization issues that result in the need to adjust program delivery capacity. Scoring is based on the relative proportion of capital invested in adjusting program service capacity relative to the total investment.	up to 15 points
9. Strategic Alignment	Assesses whether the project will support four key government strategies - Innovation, Learning, Competitiveness and Quality of Life.	up to 6 points
10. Cost Avoidance and Savings	Assesses operational savings from the project stated in terms of the time it will take to payback the capital investment.	up to 5 points
11. Alternate Funding Opportunities	Recognizes capital contributions from other parties that reduce the requirement for provincial capital funding. Scoring is based on the magnitude of the savings to the province.	up to 4 points
12. Economic Benefit	Assesses economic benefits resulting from the project - economic efficiency, job creation and economic diversification.	up to 10 points
Total:		up to 100 points

**Part 2
Section 1****Infrastructure Maintenance Program**

The Infrastructure Maintenance Program (IMP) budget provides funds to Health Authorities each year to cover the cost of repairs, upgrades, maintenance and replacement of building systems and building service equipment. The IMP budget also covers the cost of minor functional renovations and upgrading projects required to meet health delivery needs. Finally, the IMP budget is the

sources of funds for the preparation of various studies and investigative analyses required to support planning requirements for major capital projects and IMP projects.

IMP funds are flowed to health authorities each year as block-funding based on an allocation formula that takes into account:

- The replacement value and age of supported infrastructure in the health region, with two-thirds of the allocation weighting based on this factor; and
- The health authority's volume of services as reflected by their annual operating budget, with one-third of the allocation weighting based on this factor.

The IMP funding allocation formula is reviewed on a regular basis to ensure its ongoing appropriateness.

Each year, before applying the allocation formula, Alberta Infrastructure and Transportation reserves a portion of the annual IMP budget for:

- Projects required to meet the infrastructure needs of province-wide health programs and initiatives such as the northern and southern Alberta renal dialysis programs; and
- The costs of approved programming studies and ACF Business Cases.

Health authorities may apply for a grant from the reserve for province-wide programs by submitting a written request to the attention of the appropriate Regional Director at Alberta Infrastructure and Transportation. Approval of funds to initiate programming studies and business cases will be recommended to the Ministers of Infrastructure and Transportation and Health and Wellness each year following the review of Health Authority multi-year capital plans.



Procedure for Submitting IMP Plans

Multi-Year Infrastructure Maintenance Plan

Each Health Authority is expected to have a multi-year (5 year) Infrastructure Maintenance Program plan that is updated each year and submitted to Alberta Infrastructure and Transportation by June 30th.



The Integrated Health Facility Information System (IHFIS) has been developed to maintain and update basic infrastructure inventory and performance information, document specific project needs and to assist health authorities in maintaining their multi-year IMP plans. IHFIS is used to submit multi-year IMP plans electronically to Alberta Infrastructure and Transportation.

In summary, IHFIS enables the Health Authority to:

- Update facility profiles, utilization and evaluation data for all health infrastructure in the health region;
- Create projects based on specific deficiencies identified in facility evaluations;
- Prepare longer-term IMP plans; and
- Electronically prioritize projects and submit IMP plans to Alberta Infrastructure and Transportation.

The information provided in Health Authority multi-year IMP plans is the basis for Alberta Infrastructure and Transportation's annual budget submission to Treasury Board requesting adjustments to the amount of provincial budget funds allocated for the Infrastructure Maintenance Program.

For each project identified in the multi-year IMP plan, the following information must be entered in IHFIS:

- Project title
- Project costs (including non-construction or soft costs, if applicable)
- Project description (scope of work)
- The operating cost implication (if any) of the project.
- Reasons for the project (consequence if project does not proceed)
- Related current evaluation (electronically linked)

Annual (Current Year) Infrastructure Maintenance Expenditure Plan

Each year, following announcement of the provincial budget, the Ministers of Infrastructure and Transportation and Health and Wellness will advise the health authorities of the total amount of IMP funds budgeted for the current fiscal year and the amount allocated to each health region. Health Authorities may then request the release



of their annual IMP funding allocation by submitting a current-year IMP expenditure plan to Alberta Infrastructure and Transportation.

A signed hard copy of the current year plan should be submitted to the attention of the Assistant Deputy Minister, Capital Projects, Alberta Infrastructure and Transportation, as early in the fiscal year as possible.

The current-year plan must include:

1. A schedule of proposed new projects and expenditures that will be implemented in the current fiscal year

The type of information included in the IMP plan to support each planned current-year project or expenditure should include:

- A clear statement of the problem(s) that will be resolved by the project.
- The scope of the work and cost of the project.
- The operating cost implication (if any) of the project.
- Reference to any supporting documentation available, such as consultant reports, inspection reports, drawings or any other relevant information.

The plan may include expenditures required for the completion of feasibility studies, master plans or other types of investigative analyses. However, the plan should not include expenditures for the completion of programming studies or ACF Business Cases related to proposed major capital projects unless prior ministerial approval has been granted to do so.

2. A schedule of projects implemented in prior years that will continue in the current fiscal year.

The type of information included in the IMP plan to support ongoing projects or expenditures initiated in prior years should include the project identification number and title, total cost, scope of work, current phase, operational cost implication and expenditures required in the current fiscal year.

3. The amount of emergency reserve funds. The amount of funds to be reserved for emergencies that may arise during the current year.

4. A forecast of the impact of the plan on infrastructure performance.

Finally, the plan should report on the impact of the plan on the physical condition, functionality and utilization of the infrastructure asset base, stated in terms of provincial infrastructure performance measures.

Ministry Review of Infrastructure Maintenance Plans

Health authorities are generally authorized to use their annual IMP funding allocation to implement their highest priority infrastructure maintenance projects. However, the release of IMP funds is subject to a review of the current year expenditure plan by ministry officials and a written notification of support for implementation of the plan from the Assistant Deputy Minister, Capital Projects, Alberta Infrastructure and Transportation.



Alberta Infrastructure and Transportation and Alberta Health and Wellness staff are available, at the request of the Health Authority, to provide technical advice, to assist with problem evaluation or the assessment of alternative solutions and to respond to questions regarding eligibility prior to the inclusion of a project or expenditure in the IMP plan.

Health and Wellness and Infrastructure and Transportation staff review the current year IMP plan following its submission and may be required to make recommendations on specific project-related issues at the request of the Assistant Deputy Minister.

Endorsement of the current year IMP expenditure plan by Alberta Infrastructure and Transportation is not intended to preclude a Health Authority from revising its plan during the year should expenditure priorities or project needs change. Health Authorities also have the flexibility to transfer funds between projects in the plan, as required, during the fiscal year and may use surplus funds from completed projects in the annual plan to initiate new projects.

General Program Eligibility Criteria



Most types of health infrastructure owned, contracted or leased by a Health Authority are eligible for IMP funding. The specific types of eligible infrastructure, stated in terms of legislative designation and ownership, are described in the Introduction section of the manual.

Some long-term care facilities that were built under a partnership arrangement between a Health Authority and a private, voluntary or public sector organization may not be eligible for IMP grants (refer to Part 1, Section 6).

Within these general eligibility requirements, projects may be funded from the IMP allocation provided that:

- The total cost of the project or a self-sufficient phase (i.e., ongoing infrastructure and program operations are not dependent on completion of subsequent phases) of the project does not exceed \$2.5 million.
- The project does not involve routine maintenance, repair or preventive maintenance. Health Authorities are expected to allocate sufficient funds within their operating budget for routine maintenance and repairs and preventive maintenance.
- The primary objective of the project is not the repair, upgrade or replacement of existing program delivery equipment or furniture.
- The scope of work for the project was not included as part of an approved major capital project that is in progress. IMP funds may not be used to cover cost overages on approved major capital projects.



- The work does not provide or modify facilities to accommodate programs or activities that will not be operated by the Health Authority or operationally funded by Alberta Health and Wellness or another government ministry.

Eligible IMP Project Costs

An IMP-funded project may include the following types of costs:

- The construction work to rectify the problem(s);
- The cost of acquiring land required to implement an approved major capital project or reasonably needed to implement a major capital project identified in the health authority's multi-year capital plan;
- Fees for consultants and inspection agencies;
- The installation, replacement, upgrading or repair of building systems equipment;
- The purchase of program delivery equipment required, as the direct result of the project, for new programs or needed, as the direct result of the project, to expand an existing program;
- The repair, upgrade or replacement of existing program delivery equipment and furniture that cannot practically or cost-effectively be reused as the direct result of the project; and
- The cost of transferring or moving any existing program delivery equipment and furniture that can be reused.

Emergency IMP Grants

Health Authorities are expected to reserve funds within their annual IMP funding allocation for emergency situations that may arise during the year.



However, Alberta Infrastructure and Transportation may consider providing supplementary financial assistance in the event that a catastrophic situation has affected ongoing building or program operations and immediate repair or replacement of building components is needed to keep the facility safely in operation. Such emergency grants will only be considered when the cost of corrective action is not covered by property insurance and is of such a large financial magnitude that it could not be reasonably

accommodated within the current year IMP funding allocation

The Health Authority must immediately inform the Health Facility Projects Branch Regional Director at Alberta Infrastructure and Transportation, by telephone, of the nature of the emergency and provide a preliminary estimate of the cost of remedial work needed. Written confirmation of the verbal information must be forwarded to Alberta Infrastructure and Transportation as soon as possible.



IMP Reporting and Audit Requirements

The *Health Care Facility Construction Projects Funding and Accounting Procedures Manual*, available from Alberta Infrastructure and Transportation, describes program administration and reporting requirements that Health Authorities must follow. These requirements include quarterly progress reports, a final annual statement of funding and expenditures and annual audit requirements.

The following additional Alberta Infrastructure and Transportation reference documents are also available to Health Authorities:

- Technical Design Guidelines for Health Care Facilities (Blue Book)
- Framework for the Procurement of Architectural and Engineering Services
- Health Facilities Master Specifications
- Site Requirements Checklist
- Construction Management – An Owner’s Guide to Using the Construction Management Project Delivery System on Alberta Infrastructure Funded Projects
- Inter Provincial Agreement on Internal Trade
- Contracting Directives for Funded Building Infrastructure Projects
- Requirements for External Auditors





PART 3 Section 1

Equipment Funding Guidelines



Health authorities and other health care operators are responsible for funding the cost of the ongoing repair, upgrading and replacement of equipment and furniture from their regional or facility operating budgets. Alberta Health and Wellness Financial Directive FD-10 recommends that health

authorities develop asset management plans and establish operating reserves for the ongoing maintenance and replacement of equipment and furniture.

Funding for equipment and furniture may also be provided to health authorities from the Alberta Infrastructure and Transportation budget as a component of approved major capital projects and infrastructure maintenance projects. The following guidelines clarify the financial responsibilities of health authorities and Alberta Infrastructure and Transportation for equipment and furniture costs associated with approved projects.

Categories of Equipment

For purposes of determining funding eligibility as a component of a capital project or infrastructure maintenance project, health facility equipment is classified into two general categories – building systems equipment or program delivery equipment and furniture.

- **Building systems equipment** is defined as equipment needed to provide adequate environmental conditions and/or services in the building. Examples of building systems equipment are provided on Schedule 1 at the end of this section.
- **Program delivery equipment** is defined as equipment or furniture installed in the building to enable the occupant to deliver health programs. Examples of program delivery equipment are provided on Schedule 2 at the end of this section.



Alberta Infrastructure and Transportation Funding Responsibilities

Capital projects or infrastructure maintenance projects can be approved for, or include funding for, the installation, replacement, upgrading or repair of building systems equipment.

Capital projects or infrastructure maintenance projects will not be approved solely for the purchase, repair, upgrading or replacement of program delivery equipment and furniture. However, approved projects may include funds for program delivery equipment in the following circumstances:

- When a new health facility is constructed, for the initial purchase of program delivery equipment and furniture.
- When an existing health facility is redeveloped (i.e., replacement, expansion, upgrade or renovation) and the redeveloped facility includes accommodation for new or expanded programs, for the initial purchase of program delivery equipment required for new programs or needed to expand an existing program.
- Alberta Infrastructure and Transportation is not responsible for the repair, upgrade or replacement of existing program delivery equipment and furniture. However, if existing program delivery equipment and furniture cannot practically or cost-effectively be reused as the direct result of an approved construction project, the project budget may include funds for replacement costs.
- The project budget may include the costs of transferring or moving any existing program delivery equipment and furniture that can be practically or cost-effectively reused.

Alberta Infrastructure and Transportation funding responsibilities for equipment and furniture costs associated with approved projects are summarized as follows:

PROGRAM DELIVERY EQUIPMENT AND FURNITURE

Initial purchase of program delivery equipment and furniture when new facilities are built.

Replacement of program delivery equipment and furniture that cannot be practically reused as the direct result of approved capital redevelopment.

Initial purchase of program delivery equipment and furniture required for new programs or needed to expand an existing program.

Costs of moving program delivery equipment and furniture for reuse.

BUILDING SYSTEMS EQUIPMENT

Initial installation of all building systems equipment when facilities are built.

Repair, upgrade and replacement cost of all building system equipment, except for routine and preventive maintenance.



Health Authority Funding Responsibilities

- Health authorities are responsible for the cost of ongoing repair, upgrading and replacement of program delivery equipment and furniture.
- Health authorities are responsible for the cost of all equipment and furniture items that are not essential for the delivery of health programs. Examples include staff lounge appliances, patient/resident room televisions, entertainment units, musical instruments, gift shop fittings and fixtures, wall hangings, plants and other decorative accessories.
- Health authorities are responsible for the cost of all minor equipment and operational commissioning items such as forceps, retractors, instruments, hand tools, linens, china, cutlery, calculators, stationery and all consumable and disposable supplies.
- Health authorities are responsible for the cost of all equipment and furniture related to commercial activities such as retail or food service operations, vending machines or in-house coin-operated laundry processing.
- Health authorities are responsible for the cost of all vehicles, including automobiles, vans, trucks and buses.
- Health authorities are responsible for the cost of routine and preventive maintenance of the building and the building systems equipment.

Schedule 1 Examples of Building Systems Equipment

Capital grants may be provided for, or include funding for, the installation, replacement or repair of building systems and building systems equipment. Building systems equipment refers to equipment needed to provide adequate environmental conditions and/or services in the building.

The following examples of building systems equipment are provided to clarify funding eligibility for Alberta Infrastructure and Transportation capital grants. This is not intended to be an all-inclusive list of building systems equipment.

Fire Protection and Building Security

- Building security systems such as CCTV cameras, card access readers, video loop recorders, motion detectors and wandering control devices.
- Automated building control and monitoring systems.
- Fire alarm systems including pull stations, enunciators, locator panels, protection systems for food preparation equipment and fire fighting devices (not including hand-held extinguishers).
- Lightning protection system.
- Radiation protection partitions and shielding for magnetic and RF interference.



Communications

- Paging systems including antennas, transmitters, amplifiers and hand-held paging receivers.
- Intercom systems including dedicated handsets.
- Telephone systems including exchanges, switches, switchboards, computerized control and monitoring, hardware and software and handsets.
- Nurse call systems including bedside devices, central stations, presence stations, enunciators, computer hardware and software.
- Central dictation systems including hand/head sets, data storage, system control hardware and software, but not including word processing hardware and software
- Electronic Data Communication (EDP) systems including conduit, raceways, cabling, conductors, wall connectors, access flooring and foot grills but not including software, workstations (PCs) and peripherals (i.e., printers, scanners)
- Cable television distribution system including antennae, control cabinets, switches distribution devices, amplifiers and mounting brackets, but not including TV receivers, TV projection systems or satellite dishes.

Internal Conveyance

- Elevators, pneumatic tube systems, dumbwaiters, car rails and similar materiel transport systems.

Mechanical

- Basic building support systems such as heating, ventilation, refrigeration and plumbing (including toilets, sinks, tubs, shower stalls, water fountains, eyewash stations and related fixtures and fittings).
- Built-in, custom metal fabrications such as exhaust hoods/cabinets, chemical fume hoods, and range hoods.
- Central wet/dry mop systems.
- Medical gas systems including compressors, cylinder manifolds and distribution piping, but not including medical gas flow meters at patient care sites.
- Water treatment systems including chemical softeners, de-ionizers, stills, RO systems and distribution piping, but not including local-use devices for pure water production.
- Built-in therapy pools and related mechanical/electrical services, but not including mobile extremity tanks.

Architectural Specialties

- Service columns and modular service units providing medical gases, electrical power and communications.



Electrical

- Electrical switchgear, distribution panels, breakers, motors, starters and motor control centres.
- Specialty lighting systems, fixtures and fittings in operating room theatres, trauma rooms, minor procedure, examination and LDRP rooms.
- Transformers providing special voltages to diagnostic imaging equipment, but not including transformers and other electrical devices normally supplied as part of an imaging system.
- Central clock systems.
- Essential exterior electrical systems and devices including lighting, security and parking control.

Schedule 2
Examples of Program Delivery Equipment

Capital projects or infrastructure maintenance projects will not be approved for the sole purpose of purchasing, repairing, upgrading or replacing program delivery equipment and furniture. Program delivery equipment is equipment that is installed in a health facility to allow the occupant to deliver health programs. Health authority operating budgets should be the source of funds for the ongoing repair, upgrading and replacement cost of program delivery equipment and furniture.

Major capital projects and infrastructure maintenance projects may include funding for equipment and furniture in the following circumstances:

- for the initial purchase of program delivery equipment and furniture when new facilities are constructed.
- for the initial purchase of program delivery equipment and furniture when facilities are constructed for new programs or to expand the service capacity of existing programs.
- for the replacement of program delivery equipment and furniture that cannot practically be reused as the direct result of approved capital redevelopment.

The following examples of program delivery equipment and furniture for several program areas are provided to clarify funding eligibility for Alberta Infrastructure and Transportation capital grants. This is not intended to be an all-inclusive list.

Diagnostic Imaging	Radiography suites/units Imaging units, mobile Camera systems Sensitometers Immobilizers ID systems Densitometers Injection chairs/tables Dispensers, film	Processors Multi-loaders Racks/holders, apron Illuminators/viewers File systems Screens Carts, file/film Seating, task Shelving, mobile/high density systems
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Central Sterile Supply	Sterilizers Washers/disinfectors Decontaminators	Sealers Work tables Shelving units/carts
Patient Rooms	Beds/cribs/bassinets Bedside tables/dressers Overbed tables Seating Desks Monitors, bedside Shower curtains Privacy curtains and track	Wheelchairs Walkers Patient lifts Commodes Wardrobes Regulators Drapes and track
Food Services	Stoves/ovens/ranges Fryers Steam kettles/cookers/tables Toasters, mixers Refrigeration units, reach-in Lowerators Dishwasher systems Disposal units	Food/tray carts Peelers/slicers Conveyors Microwaves Pot wash counters/sinks Beverage dispensers Racks, pot Tables, preparation/ cook/work
Emergency	Physiologic monitoring system Defibrillator/Monitors Simulators, ECG Monitors, ECG Cast cutters Ophthalmoscopes Stethoscopes, ultrasonic Infusion pumps/stands Seating, task/reception Stretchers, trauma/exam/bed/ transport	Vacuums, cast cutter Eye equipment Lights, examination Warmers Pressure infusers Oximeters Instrument stands Cabinets, instrument Mayo stands Carts, resuscitation/crash/plaster/traction/supply Examination tables
Administration	Computers, PC/servers Printers Photocopiers Fax machines Shredders Postage metres Tables, conference/end round	Desks/workstations Shelving units/bookcases Audio visual equipment Furniture panel systems File cabinets Pagers Credenzas Seating, desk/waiting/steno/conference



PART 3
Section 2 Property Transactions

From time to time, Health Authorities may determine that property is no longer required for



health care delivery or that new property must be acquired for health care delivery. These types of transactions are regulated under the *Regional Health Authorities Regulation, 15/95* and are subject to provincial policy.

The policy outlined in this section, sets out the requirements and conditions that apply to the acquisition or disposal of land and/or buildings owned by a Health Authority.

Legislative Context

The policy outlined in this Section is issued pursuant to the *Regional Health Authorities Regulation (AR 15/95)*. Relevant sections are as follows:

Acquisition and Disposal of Land

Under section 2.6 of the *Regional Health Authorities Regulation (AR 15/95)*, health authorities require ministerial approval to purchase, lease or dispose of an interest in land.

*“No regional health authority shall
(a) enter into an agreement for the purchase or lease of an interest in land, or
(b) dispose of an interest in land
without the prior written consent of the Minister”*

Demolition of Buildings

Under section 2.61 of the *Regional Health Authorities Regulation (AR 15/95)*, health authorities require ministerial approval to demolish a health care facility or a structure used for health care purposes.

*“No regional health authority shall without the written consent of the Minister demolish
(a) a health care facility, or
(b) another structure used for health care purposes
that has a value in excess of an amount specified by the Minister in a directive.”*



Adherence to Policy

Under section 2.62 of the *Regional Health Authorities Regulation* (AR 15/95), health authorities must dispose of a capitalized asset in accordance with written policies and rules issued by the Minister.

*“Where a regional health authority acquires or disposes of
(a) a capitalized asset, other than an interest in land, or
(b) equipment,
it shall do so in accordance with written policies and rules issued by the Minister for the purpose and given to the regional health authority.”*

Fair Value

Under section 2.71(1) of the *Regional Health Authorities Regulation* (AR 15/95), no health authority shall transfer property to any person unless the health authority receives fair value in exchange for the transfer.

“Subject to this section, no regional health authority shall confer a benefit on or transfer property, including money, to any person unless the regional health authority receives fair value in exchange for the benefit or transfer.”

Approval Requirements

Health Authorities must obtain prior written approval from the Minister of Health and Wellness and/or Cabinet for the following types of property transactions.

SUMMARY OF PROPERTY TRANSACTION APPROVAL REQUIREMENTS		
Transaction	Ministerial	Cabinet
Purchase of property	X	
Sale of property		X
Donation of property		X
Lease of property (Health Authority as lessor)		X
Lease of property (Health Authority as lessee)	X	



For guidance on approval requirements for other types of property transactions such as options, easements and right of ways, Health Authorities should contact the Health Facilities Planning Branch at Alberta Health and Wellness.

Property acquisition and disposition strategies should be referenced in the Health Authority’s multi-year capital plan.

In addition to the regulatory requirements for the Minister’s or Cabinet involvement in property transactions, health authorities should seek legal



advice when acquiring and disposing of real property at an appropriate stage of the transaction.

Other Types of Property Transactions

The policy outlined in this section applies only to the acquisition and sale of land and buildings owned by a Health Authority. Other types of transactions involving the acquisition and disposal of capital assets are generally handled as follows:

- ✓ Alberta Infrastructure and Transportation is responsible for the disposal of land and buildings owned by the Province. Proceeds are returned to the Province.
- ✓ The sale of property by a voluntary hospital board is regulated by the *Hospitals Act*. Ministerial approval is required and the process to be followed is usually specified in an Equity Agreement.
- ✓ The *Regional Health Authorities Regulation, 15/95*, provides health authorities with the ability to acquire and dispose of equipment in accordance with written policies issued by the Minister of Health and Wellness.
- ✓ The lease of health facilities or space in buildings owned by Health Authorities is treated as an ancillary operation as defined in the *Regional Health Authorities Regulation, 15/95*. Ministerial approval is required prior to a Health Authority engaging in an ancillary operation.

Policy on the Acquisition of Property

To obtain Ministerial approval to acquire property, the Health Authority Board Chair should write to the Minister of Health and Wellness providing, at a minimum, the following information:

- a) A legal description of the property being acquired. If the property being acquired by the Health Authority is part of a larger property that must first be subdivided, the subdivision should be finalized and a new legal description of the property registered prior to writing to the Minister.
- b) The purchase price of the property.
- c) A copy of an independent appraisal of the property indicating its fair market value (FMV).
- d) The source of funds to acquire the property.
- e) An explanation of the reason for acquiring the property.

The Minister may make an approval conditional on the Health Authority providing further information regarding the offer, the proposed use of the property or other matters related to the transaction.

Health authorities proposing to acquire real property that is subject to reservations, encumbrances, or encroachments must determine that these restrictions will not affect the anticipated use of the property.



When a capital project is approved by the Ministers of Infrastructure and Transportation and Health and Wellness that will require the acquisition of property, the approval granted for the project does not normally constitute approval for the acquisition of a specific property. The Health Authority must seek separate approval of the Minister of Health and Wellness to acquire the specific property.

Policy on the Disposition of Property

Health Authorities are responsible for determining how they will use the land, buildings or facilities that they own. When a health authority decides to dispose of an interest in land, a health care facility or a structure used for health care purposes, Cabinet approval is required. Government policy outlined in this section, sets out the requirements and conditions that apply to these transactions as well as to the use of proceeds from approved sale transactions.

Health authorities do not require prior approval to list a property for sale or lease. However,



before the sale agreement is executed, Cabinet approval must be obtained.

Before recommending the sale of any property to Cabinet, the Ministers of Health and Wellness and Infrastructure and Transportation will determine whether the Province would have any use for the property

to support Government programs or services. If a use is identified, the Ministers will recommend transfer of ownership of the property to the Province. Where the land was originally acquired through a local requisitioning process, the Province may consider making a payment to the municipalities equivalent to the amount originally requisitioned.

The following requirements and conditions apply when a health authority proposes to dispose of an interest in land, a health care facility or a structure used for health care purposes:

1. Health Authorities require ministerial approval to dispose of an interest in land, a health care facility or a structure used for health purposes that they own. Disposal encompasses the sale, capital lease or donation of property.
2. Health Authorities must receive “fair value” when disposing of land and/or facilities. When selling property, “fair value” is normally interpreted as “fair market value” as determined by an independent appraisal of the land and/or facilities undertaken by the Health Authority.



3. When deciding whether a Health Authority is receiving fair value for the sale of its property, the Minister may consider other factors and benefits. For example, the Minister may approve the sale or donation of a property for less than fair market value if the property will be used for the ongoing benefit of residents of the health region.
4. When a property is needed to accommodate government programs or services, the Province may assume ownership of the property. Where the property includes land, originally acquired through the local requisitioning process, the Province may consider a payment to the municipalities equivalent to the amount originally requisitioned.
5. When submitting a proposal to sell property, a Health Authority writes to the Minister of Health and Wellness providing the following information for consideration by the Minister:
 - a) The legal description of the property. Property requiring subdivision must be subdivided and a new legal description registered prior to writing to the Minister.
 - b) Information on any liens and/or encumbrances.
 - c) Information on any local requisitioning obligations for the property.
 - d) An independent appraisal of the fair market value (FMV) of the property.
 - e) An explanation of why the Health Authority proposes to sell the property.
 - f) Confirmation that the local M.L.A.(s) has been informed of the proposed disposition.
 - g) The selling price of the property.
 - h) An explanation of how the proceeds of the disposition would be used.

The Minister may make an approval conditional on the Health Authority providing further information regarding the buyer, the offer and/or the proposed use of the property.

6. The Minister of Health and Wellness, in consultation with the Minister of Infrastructure and Transportation, may specify whether the sale transaction is to be handled by the Health Authority or Alberta Infrastructure and Transportation, on behalf of the Health Authority.
7. In certain cases, the Minister may have set conditions on the disposal of land when that land was originally acquired. These conditions must be met when disposing of the land. For example, the Minister may have specified that the proceeds from the future sale of land would be returned to the municipalities that contributed to the purchase of the land. Where land originally acquired through the local requisitioning process is sold, the net proceeds from the sale of the land must be returned to the municipalities that were requisitioned. If the land will be sold for less than fair market value, prior consent of the requisitioned municipalities is required.



Policy on Leases

Leases are considered to be an interest in land and, therefore, require prior Ministerial approval. Health Authorities may contact the Health Facilities Planning Branch at Alberta Health and Wellness with any questions regarding the approval of lease transactions.

Policy on Disposition of Equipment



Health authorities have the authority to transfer, sell, donate or otherwise dispose of surplus equipment, including items originally purchased with provincial grants. The health authority may retain the net proceeds from any such transactions subject to following restrictions:

1. Removal of integral building systems equipment should be done in consultation with Alberta Infrastructure and transportation to ensure that the integrity of the building and its systems is not compromised.
2. Equipment and furnishings items which are considered surplus to the needs of a Health Authority should first be offered for sale, at fair value, to other health authorities before being sold or donated outside the provincial health system.
3. Donations of equipment should be restricted to not-for-profit organizations or to individuals who will not gain from use or subsequent sale.



PART 3
Section 3

Infrastructure Performance Measures

Health authorities are responsible for monitoring the physical condition, utilization and functional adequacy of their infrastructure to ensure that the condition of the facilities does not deteriorate, that the facilities are effectively utilized and that they are capable of providing adequate services to Albertans.



Three performance criteria and measures are used by all provincial ministries with responsibility for owned or supported physical infrastructure:

Performance Criterion	Measure
Physical Condition	Percentage of physical infrastructure rated as being in good, fair and poor condition, with good and fair ratings considered acceptable.
Utilization	Percentage of physical infrastructure for which utilization level is within targeted capacity.
Functional Adequacy	Percentage of physical infrastructure that provides acceptable functional service.

Government ministries are required to report, annually, in their Business Plans on infrastructure performance targets. Health authorities are required to report annually, in their multi-year capital plans, on infrastructure performance for the health region.

Physical Condition

Definition:

The physical condition criterion measures the adequacy of infrastructure for its intended use in terms of the degree of deterioration of its physical components. It is stated in terms of a Facility Health Index (FHI).

Infrastructure rated in good physical condition is considered to be adequate for its intended use and expected to provide continued service with average levels of ongoing maintenance. Fair physical condition means that the building components are aging and nearing the end of their life cycle, requiring additional expenditures for renewal or refurbishing. Poor physical condition means the facilities require upgrading to comply with minimum codes or standards and that building components have deteriorated to the point where major repairs or replacement are necessary.



Methodology:

- The Facility Health Index is the ratio of the total estimated cost of correcting identified physical deficiencies (PD\$) over a 5-year period to the current estimated replacement cost (CR\$) of the building.
- The total cost of correcting identified physical deficiencies over a 5-year period is determined using data reported in the most recent IHFIS evaluation of the building.
- The replacement cost of the building is calculated by Alberta Infrastructure and Transportation by applying current cost indices for the type of infrastructure to the existing building area.
- The Facility Health Index is then calculated using the following formula:

$$\text{FHI} = [\text{PD\$} / \text{CR\$}] \times 100$$

EXAMPLE 1: The current estimated replacement cost (CR\$) of a building is \$25 million; the total cost of correcting identified physical deficiencies over a 5-year period (PD\$) is \$500,000. The Facility Health Index would be $[\$500,000 / \$25,000,000] \times 100 = 2$.

EXAMPLE 2: The current estimated replacement cost (CR\$) of a building is \$25 million; the total cost of correcting identified physical deficiencies over a 5-year period (PD\$) is \$1,250,000. The Facility Health Index would be $[\$1,250,000 / \$25,000,000] \times 100 = 5$.

Interpretation of Ratings

- Both the International Facility Management Association (IFMA) and the Building Owners & Managers Association (BOMA) recommend that annual building maintenance expenditures approximate 1% of the replacement value of a building. For a building with an estimated \$25 million replacement cost, the investment in building maintenance should be \$250,000 per year or \$1.25 million over a 5 year period. This would be equivalent to a FHI of 5.
- Infrastructure with a Facility Health Index of less than 5 is considered to be in good physical condition. Annual building maintenance requirements over the next five-year period are within recommended industry standards and indicate that there are probably no deferred maintenance requirements. Infrastructure with a Facility Health Index greater than 5 indicates a degree of deferred maintenance.
- Based on the above guideline, the physical condition of health facilities is rated as being either poor, fair or good, based on its HFI, as follows:



Facility Health Index Physical Condition Rating

Less than 5	Good
5 to 10	Fair
Higher than 10	Poor

- A physical condition rating of good or fair is considered to be acceptable.

Utilization



Definition:

The utilization criterion measures the percentage of the infrastructure that is currently being used for the delivery of health care services or for approved alternative purposes. Utilization is considered acceptable if it is within the range of 85% to 100%.

Methodology:

- Utilization is stated as being either adequate or inadequate.
- The utilization rate is the ratio of space in use to total available space. The target utilization rate for health infrastructure is 85-100%.

Utilization Level	Rating
85% - 100%	Adequate
<85% or >100%	Inadequate

Functional Adequacy

Definition:

The functional adequacy criterion measures the adequacy of the infrastructure for its intended use based on its chronological age and investments that have been made for functional improvements. It is stated in terms of an Operational Deterioration Rate.



General Assumptions:

- As infrastructure ages, a progressive deterioration of its functional performance is inevitable. It, therefore, seems reasonable to assume that functional deterioration of infrastructure bears a relationship to chronological age.



- However, functional deterioration can be addressed by means of periodic investments to correct functional deficiencies. Chronological age needs to be adjusted to reflect any such significant historical investment that has extended the functional life of the infrastructure.

- Adjustments to the chronological age of a building to reflect the impact of a major capital investment on its functional condition are made using the following formula:

$$\text{Chronological Age} = \text{Current Year} - \text{Year of Original Construction}$$

$$\text{Adjusted Age} = [\text{Current Year} - \text{Year of Major Upgrade}] + [\text{Year of Major Upgrade} - \text{Year of Original Construction}] * \text{Upgrade Factor}$$

- Four upgrade factors are used to reflect the magnitude of the investment made in the infrastructure:

- 1/3 - a relatively minor investment having the effect of reducing age by 33%.
- 1/2 - a relatively minor investment having the effect of reducing age by 50%.
- 2/3 - a relatively major investment having the effect of reducing age by 66%.
- 1 - a relatively major investment having the effect of reducing age by 100%.

- On average, the expected life of health infrastructure in Alberta is 40 years. Functional deterioration occurs at an average annual rate of 2.5% over the entire 40 years (the ANNUAL DETERIORATION RATE).

Methodology:

- The OPERATIONAL DETERIORATION RATE of infrastructure is calculated by multiplying its ADJUSTED AGE by the ANNUAL DETERIORATION RATE.
- The functional condition of health infrastructure is rated as being either poor, fair or good, based on its OPERATIONAL DETERIORATION RATE, as follows:



Operational Deterioration Rate	Functional Condition Rating
Less than 50% (or 20 years)	Good
50% to 80% (or 20 to 32 years)	Fair
Higher than 80% (or 32 years+)	Poor

- A functional condition rating of good or fair is considered to be acceptable.



Appendix 1

Preliminary Business Case

Health Major Capital Project

[Project Name]



Section 1

Executive Summary

[Project Name]

The Executive Summary Section should contain the following information:

- ✓ **Background.** An overview of the key reasons for initiating a business case and the current situation that leads to proposing this project.
- ✓ **Project Description Summary.** A summary of the following information taken from the business case:
 - The opportunity or challenge that the project is addressing.
 - Strategic alignment between the projects goals and objectives and those of the health authority.
 - The impact the project will have on current operations.
 - The financial requirements of the project (capital and operating).
- ✓ **Options Considered.** Without providing extensive detail, describe all viable options considered and highlight the main reasons why some of these options were not selected (cost factors, risk factors, timeliness, resources available).
- ✓ **Options Analysis Results.** An outline of the information gathered from this process.
- ✓ **Recommendations.** A summary of key recommendations and next steps.

Checklist for the Executive Summary Section

1. Will the reader get a clear understanding of the reasons for the project and its outcome by outlining the "Why, What, When, Who, and How" of the project?
2. Does it contain any information that is not contained in the body of the business case? (should not)
3. Is the Executive Summary 3 pages or less?
4. Can the Executive Summary be treated as a stand-alone document?



Section 2

Background

[Project Name]

The Background Section should contain the following information:

Current Situation

An overview of programs and services, activity and workload and relevant infrastructure condition and performance measures that directly relate to the proposed capital investment.

Description of Service Context

- Describe the facility's current and future role in the community and health region, including service relationships or dependencies between the facility and others.
- Describe programs currently delivered at the facility, indicating why and how these programs need to be modified.
- Describe any new programs that need to be introduced indicating the specific improvements expected upon completion of the project.

Activity Analysis

- Current and projected activity for each service or program affected by the project.

Assessment of Existing Infrastructure

- Describe the key physical and functional deficiencies to be addressed by the project.

Analysis of Alternative Service Delivery Strategies

- Describe alternative service delivery strategies that were considered as means to avoid or reduce the need for capital spending.

Summary of Work to-Date

Describe any planning work completed so far on the project.

Problems/Opportunities

Provide a brief description of the problems or opportunities that the project will address.

Checklist for Background Section

1. Are the relevant facts and statistical information outlined so that the reader has a clear understanding of the relevant current situation and the resulting operational problems or opportunities?
2. Is the "gap" in service provision between the current situation and the projected activity levels identified?



Section 3

Project Description

[Project Name]

The Project Description Section should contain the following information:

Scope of Work

Describe the preliminary physical parameters of the project including the preferred timeframes and estimated space requirements.

Anticipated Outcomes

Describe the specific and measurable deliverables or outcomes of the project.

Stakeholders

Identify the parties that may be impacted by the project and provide an overview of any consultation that has taken place.

Checklist for Project Description Section

1. Is it clear what is included in the project and what the project will accomplish? Are the project outcomes clear, focused and reflected throughout the rest of the business case?
2. Will the reader know all parties that will be impacted by the project?
3. Are the general requirements of each stakeholder clearly laid out?
4. Are the timelines of the project clearly outlined?
5. Does the business case mention what consultation has taken place with stakeholders?



Section 4

Strategic & Environmental Alignment

[Project Name]

The Strategic and Environmental Alignment Section should contain the following information:

Factors Driving Capital Needs

Provide an analysis of the most significant factors driving capital needs.

Strategic Alignment

- Identify the impact the project will have on achieving Health Plan objectives or strategic actions.
- Clearly define the objectives for the project.
- Where applicable, provide policy, regulation, or legislation impact statements.

Environmental Analysis

- Provide an analysis of what other health regions or other jurisdictions have done or are doing to address similar types of problems or to meet similar objectives.
- Summarize findings from research studies that identify relevant industry trends and best practices.

Checklist for Strategic & Environmental Alignment Section

1. Are project objectives directly linked to the health authority's Health Plan? Are the objectives for the project valid?
2. For objectives that have been assigned a high level of impact, is the project truly critical to achieving these objectives?
3. Does the explanation support the evaluation of how the project impacts the objectives?
4. Has the experience of other jurisdictions been incorporated or considered in the business case?



Section 5

Strategic Options Analysis

[Project Name]

The Strategic Options Analysis Section should contain the following information:

Identification of Options

Describe the full spectrum of options, based on a traditional procurement approach, including an appropriate reference or base-case scenario.

Preliminary Risk Assessment

Document a high-level analysis of potential risks to estimate their likelihood and consequences and establish risk mitigation strategies.

Preliminary Cost Analysis

Provide a preliminary estimate of the capital and operating costs associated with each option.

Short-List Options

Identify the quantitative and qualitative criteria used to screen options and provide, at a minimum, a qualitative assessment of the various options, relative to each screening criteria.

Develop a short-list of the most promising option(s).

Identify Potential for Alternative Procurement

State criteria and assess options against the criteria.

Checklist for Strategic Options Analysis Section

1. Has consideration been given to a sufficiently wide range of options (including a do-nothing or do-minimum option) for meeting the project objectives?
2. Are options described in output and functional terms and clearly distinguishable?
3. Are the criteria used for short-listing options clear?
4. Are sound reasons provided for including or excluding each option, considered against the criteria?
5. Have the viable options been described sufficiently well to enable assessment of costs, operational benefits and risks?
6. Have all viable options been determined? Is there sufficient reason for the exclusion of possible solutions?
7. Have all constraints for each option been identified?
8. Is the analysis of options as objective as possible and not biased towards a preference for a particular option?



Section 6

Conclusions & Recommendations

[Project Name]

The Conclusion & Recommendation Section provides specific recommendations for moving the project forward.

Conclusions

Recap each of the options based on factors such as operational impact, risk and cost and choose a recommended option(s), selecting the one(s) that maximizes effectiveness and efficiency while minimizing risk and cost.

Recommendations

Make specific recommendations on proceeding with the project.

Checklist for Conclusions & Recommendations Section

1. Is there a clear recommendation of a preferred option(s), and does it provide value for money? Are the reasons for selecting this option clearly stated?
2. Is there any evidence to suggest that the preferred option was not selected on the basis of a sound appraisal process?



Appendix 2

Alternative Capital Financing (ACF) Opportunity Paper Template

NOTE TO READER:

This template is to be used to prepare ACF Opportunity Papers. It is to be completed for projects where a Preliminary Business Case has identified the potential for an ACF procurement approach. This is the second step required to assess an ACF approach.



Section

1

Business Need & Project Description

[Project Name]

Provide a summary of the following information taken from the Preliminary Business Case for the project and updated as required:

- a) A brief description of the problems or opportunities the project will address;
- b) A brief description of the project and how it will address the problems/opportunities;
- c) An outline of the program and infrastructure objectives of the project;
- d) A brief description of what is in the scope of the project;
- e) A brief description of what is not in the scope of the project; and
- f) An identification of stakeholders involved in, or impacted by the project.



Section

2

ACF Alternatives

Provide a brief description of the ACF approaches that are available to address the problems or opportunities. Where an ACF approach has been identified and eliminated from further consideration, provide the rationale.



Section

3

Business & Operational Impact Assessment

Assess the ACF potential of the project in terms of business and operational impacts using the following criteria:

- **Technical** - Does the project have any inherent technical constraints that cannot be resolved by a private/not for profit sector partner? Can the Health Authority develop appropriate technical output specifications for the project? Can appropriate mechanisms be established to monitor the private/not for profit sector partner's performance?
- **Operational** – Can the Health Authority develop appropriate operating standards for the project? Are there any operational issues that cannot be realistically addressed by a private/not for profit sector partner? Can the private/not for profit sector partner be held accountable for appropriate performance?
- **Acceptability** – Is an ACF approach and the involvement of a private/not for profit sector partner in the project acceptable to the public? Elected officials? Other stakeholders? Health Authority staff?
- **Implementation** – Is it possible to generate meaningful competition for an ACF procurement? Is the project free of jurisdictional and liability issues that could prevent a Health Authority from using an ACF approach? Can an internal project champion be found? Can the project champion access the resources necessary to be a competent partner? Can a successful transition plan be developed?
- **Timing** – Are the timelines adequate to develop operating specifications, contract documents, and to undertake an ACF solicitation and evaluation? Can the issues raised in this assessment be addressed in the project timelines?



Section

4

Preliminary Project Risk Assessment

Identify all risks that may relate to the project and how the ACF approach may mitigate them or lead to more effective risk management.

Also, identify all risks that may relate to undertaking the project under an ACF approach. Where possible, indicate potential mitigation strategies.



Section

5

Preliminary Value Analysis**Benchmark Cost Estimate and Assessment of ACF Value Potential**

Prepare a cost estimate based on the assumption that the project is implemented using traditional methods of providing the proposed facilities and program delivery.

Identify opportunities where the ACF approach may result in achieving:

- a) Cost savings
- b) Improved efficiency
- c) Improved quality of service
- d) Impact on the timeline for implementation
- e) Innovations

Early assumptions around preliminary schematic architectural planning work and financial projections may be required to complete this cost estimate. These assumptions will be further refined in the full ACF business case.



Section

6

Preliminary Project Schedule

Provide an overview of the project schedule, including key milestones.



Section

7

Conclusion & Recommendation

Provide a conclusion as to why undertaking the project, as an ACF, will result in the most effective and efficient approach to achieving the objectives of the project from both a program delivery and infrastructure viewpoint.

Identify specific recommendations that are required to move the project forward.



Health Authority Name

Address

Appendix 3

Detailed Alternative Capital Financing (ACF) Business Case Template

NOTE TO READER:

This document is to be used to propose an Alternative Capital Financing (ACF) approach for a project. Ministerial approval is required to proceed with the preparation of a Full ACF Business Case. It is an extension of the analysis and ideas submitted in the Preliminary Business Case and ACF Opportunity Paper.



Section

1

Executive Summary

[Project Name]

The Executive Summary is a stand-alone section highlighting the key findings and recommendations of the ACF Business Case. It captures and reports the information and recommendations that decision-makers need in a minimum number of pages. The reader should be able to understand what the project is about and how the project improves the overall efficiency and/or effectiveness of the Health Authority if delivered using an ACF procurement method.

The information should be presented without detailed justification (which can be found in the body of the ACF Business Case document itself), focusing on the information needs and concerns of an executive-level audience.

The Executive Summary Section should contain the following information:

- ✓ **Background.** An overview of the key reasons for initiating a Business Case and the current situation that leads to proposing this project.
- ✓ **Project Description Summary.** A summary of the following information taken from the Business Case:
 - The opportunity or challenge that the project is addressing.
 - Strategic alignment between the projects goals and objectives and those of the Health Authority.
 - The impact the project will have on current operations.
 - The significant features of the project such as the scope of work and physical requirements.
- ✓ **Options Analysis Results.** Without providing extensive detail, describe the viable options considered and highlight the main reasons why the preferred ACF procurement option was selected (costs factors, risk factors, timeliness, resources available).
- ✓ **Recommendations.** A summary of key recommendations and financial impact (capital and operating).



Section

2

Business Need and Project Description

The Preliminary Business Case should be used as the primary source of information for Section 2 and updated where necessary.

The Business Need and Project Description Section will contain much the same information that was provided in the Background and the Strategic & Environmental Alignment sections of the Preliminary Business Case. However, it will be necessary, if considerable time has passed since the Preliminary Business Case was prepared, to update this information.

The section should contain the following information:

- ✓ **Service Context.** A clear and concise description of the facility's current and future role in the community and the region. Describe the health programs currently delivered at the facility, indicate why and how these programs will be modified by the project, describe any new programs being introduced and indicate the specific improvements expected upon completion of the project. Service relationships or dependencies between the facility and others should be described to convey the larger, regional or provincial health system context. It is important to demonstrate the relationship between the role of the facility and the health authority's Health Plan.
- ✓ **Project Objectives.** A brief descriptive summary of the problems or opportunities that the project is intended to address as well as the most significant factors driving the need for the project. These may originate from either a program or infrastructure perspective. Describe the specific and measurable deliverables or outcomes of the project.
- ✓ **Project Description.** A brief description of the project. Include how the project will address the business problems/opportunity. Indicate items that are specifically excluded from the project from both a program and building perspective.
- ✓ **Stakeholders.** Identify any stakeholders that may only be involved in certain procurement alternatives. Include any information that may indicate the level of interest from the private sector to participate in an ACF approach.
- ✓ **Project Team.** Identify the proposed project team that will be responsible for the project. Identify any prior ACF procurement experience.



Section

3

Functional Program

The Functional Program Section of the ACF Business Case will describe the functional requirements of the project in terms of groupings of activities and assigned spaces that are physically related by their common purpose to satisfy a specific group of functions or operations. For each functional component, performance specifications will be defined.

The Functional Program Section should contain the following information for each functional component of the project:

- ✓ **Functional Description**, providing information on the future general services of the component and its basic features or characteristics.
- ✓ **Operational Description**, providing information on the proposed operation of the component internally, as well as in relation to other components.
- ✓ **Workload**, summarizing the projected future workload in appropriate work units. Workload projections should be based on historical data for each service or program affected by the project and should be expressed in as much detail as possible.
- ✓ **Staffing**, providing estimates of future fulltime equivalent staff (FTEs), unique work patterns and peak day shift staffing presented for the same years used for workload projections.
- ✓ **Design Criteria**, outlining external (or inter-component) physical and operational relationship requirements and internal relationship/concepts to be incorporated into the design of the component.
- ✓ **Capacity Requirements**, outlining the capacity requirements for the functional component. (i.e., the number of beds, rooms or support spaces required to accommodate the future workload taking into account factors such as staffing, room utilization or occupancy rates, average case time, and routine hours of operation).
- ✓ **Space Requirements**, outlining the net and gross component space requirements for the functional component based on its capacity requirements.
- ✓ **Performance Specifications**, describing the required results or outputs for the functional component over the period of an ACF contract and the criteria that would be used to verify compliance with the specifications.

In addition, the Business Case must indicate whether Health Authority intends to specify a general site location for the project (i.e., where the project is intended to serve a particular catchment area of a health region) identify the specific site or leave the question of location open to bidders.



Section

3

Functional Program

If land must be acquired for the project, the ACF Business Case must identify the specific requirements, costs and the location criteria.

Specific requirements would include the amount of land needed to accommodate the project as well as access, servicing, traffic circulation and parking requirements. Among the key issues that may need to be specified in the Business Case are:

- ✓ Requirement for direct or indirect access to a highway.
- ✓ Adequacy of road access.
- ✓ Requirement for a Traffic Impact Assessment (T.I.A.).
- ✓ Availability and adequacy of public transportation.
- ✓ Compliance with planning/zoning requirements.
- ✓ Requirement for an environmental site assessment.
- ✓ Suitability of the site topography for the project.
- ✓ Location of site in relationship to 1:100 year floodplain (1:1000 for hospitals).
- ✓ Storm water management requirements.
- ✓ Availability of offsite services such as power, gas, water, sanitary and storm sewers.
- ✓ Consideration of geotechnical/foundation concerns.



Section

4

ACF Alternatives

The ACF Alternatives Section provides the reader with an outline of the specific ACF approaches that are available to address the problem or opportunity. It provides the reader with the rationale for eliminating any as viable alternatives. Finally, it provides a detailed description of viable options that will address the business problem or opportunity.

List all possible ACF solutions that may meet the business problem or opportunity. Based on a practical and common sense analysis, narrow the list down to include only viable alternatives, stating the reasons for excluding an alternative. Only the viable alternatives will be further detailed and carried forward into following sections of the business case analysis.

For each viable alternative, explain the key features including people, processes and systems. Discuss how each viable option addresses the business problems and meets the objectives of the project within the outlined scope. Specifically, for each alternative identify:

- Advantages;
- Disadvantages;
- Critical success factors; and
- Constraints.

Each viable alternative must be defined in sufficient detail to enable the identification of specific impacts (Section 5 – Business & Operational Impacts), project risks (Section 6 – Project Risk Assessment), and quantifiable and non-quantifiable benefits and costs (Section 7 – Value Analysis).



Section

5

Business & Operational Impacts

The Business & Operational Impacts Section provides the reader with an analysis of all business and operational impacts of the project for each stakeholder. Each impact is described and analyzed for each viable alternative.

For each stakeholder (identified in Section 2), identify all impacts from the project. For a capital project, these will include technical, operational, acceptability, implementation and timing impacts.

For each impact, identify the magnitude of impact (high, medium, low, or none) for each alternative using the following guidelines:

High indicates that the magnitude of impact is significant and stakeholder support and preparation is critical to the alternative’s success

Medium indicates that there is a manageable impact to the stakeholder

Low indicates the alternative will have a minor impact to the stakeholder

None indicates that the stakeholder will not be impacted by the alternative

If necessary, document the rationale for the evaluation.

Impact & Description	Alternative 1	Alternative 2	Alternative 3
Stakeholder 1:			
Impact 1 - Describe impact 1	High	Medium	High
Impact 2 - Describe impact 2	Medium	Medium	Medium
Stakeholder 2:			



Section

6

Project Risk Assessment

The Project Risk Assessment Section provides the reader with an understanding of the risks associated with the ACF alternative and how these risks may vary by viable alternative. This section also includes a risk mitigation strategy for each identified risk.

Risk is inherent in all projects. The key to success in ACF projects is not to ignore or be intimidated by risk, but to analyze and manage it effectively. That way, health authorities can exploit opportunities that might otherwise be judged too uncertain. They can also take positive action to minimize the risk of adverse events as far as practicable.

Risk profiles for individual projects may vary by Health Authority and project type. For example, a multi-million dollar project may be considered routine in one health region while the same project may be considered high risk in another health region when the Health Authority's experience and the project characteristics are taken into consideration.

Identify all risks that may relate to each ACF alternative. A risk is any factor or event that may jeopardize the project from achieving the anticipated benefits or increase the cost of the project.

The following table provides a checklist to help identify the risks a project can present.

Risk Category	Description of Risk
Commissioning risk	The risk that the infrastructure will not receive all approvals to satisfy an output specification, such as expected changes in legislation which allow for a specific output specification not materializing
Construction risk	The risk that the construction of the assets required for the project will not be completed on time, budget or to specification
Demand (usage) risk	The risk that actual demand for a service is lower than planned
Design risk	The risk that the proposed design will be unable to meet the performance and service requirements in the output specification
Environmental risk	The risks that the project could have an adverse environmental impact, which affects project costs not foreseen in the environmental impact assessment
Financial risk	The risk that the private sector overstresses a project by inappropriate financial structuring
Force majeure risk	An act occasioned by an unanticipated, unnatural or natural disaster such as war, earthquake or flood of such magnitude that it delays or destroys the project and cannot be mitigated
Industrial relations risk	The risk that industrial relations issues will adversely affect construction costs, timetable and service delivery
Latent defect risk	The risk that an inherent defect exists in the structure being built or equipment used, which is not identified upfront and which will inhibit provision of the required service
Operating risk (service under-performance)	The risks associated with the daily operation of the project, including an unexpected change in operation costs over budget



Section

6

Project Risk Assessment

Risk Category	Description of Risk
Performance risk	The risk that the operator will not perform to the specified service level, such as a power generator supplying less power than demanded
Change in law risk	The risk that the current regulatory regime will change materially over the project or produce unexpected results
Residual value risk	The risk that the expected realizable value of the underlying assets at the end of the project will be less than expected
Technology obsolescence risk	The risk that the technology used will be unexpectedly superseded during the term of the project and will not be able to satisfy the requirements in the output specification
Upgrade risk	The risks associated with the need for upgrade of the assets over the term of the project to meet performance requirements

Having identified the risks engendered by a project, the next task is to establish the expected value of those risks. A possible approach to estimating the value of the risks could include assessing the costs and probability of the risks. These costs should be reflected in the Value Analysis Section.

For each risk, identify the probability of the risk occurring and the financial impact it may have on each viable alternative, using the following guidelines:

Impact of Risk (\$)

High indicates that the event has a significant impact to the project

Medium indicates that the event will impact the project

Low indicates that the impact is relatively minor to the project

Probability of Risk (%)

High indicates that the event is high likely to occur

Medium indicates that the event is likely to occur

Low indicates that the event is not likely to occur

Expected Value (\$)

Is the weighted average of dollar value impacts

(i.e. [High Impact (\$) x High Probability (%)] + [Med Impact (\$) x Med Probability (%)] + [Low Impact (\$) x Low Probability (%)] = Expected Value (\$))

Allocation

Health Authority – The Health Authority retains responsibility for managing the risk.

Private Sector – Risk is transferred to the Private Sector.

Shares – The Health Authority and Private Sector share responsibility for managing the risk



Section

6

Project Risk Assessment

If necessary, document the rationale for the evaluation.

Risk	Impact (\$)			Probability (%)			Expected Value (\$)	Allocation
	High	Med	Low	High	Med	Low		
ACF Alternative 1								
Risk 1 / Risk 1 Mitigation								
ACF Alternative 2								



Section

7

Value Analysis

The Value Analysis Section provides the reader with an evaluation of the costs and benefits associated with each viable ACF alternative. The reader can easily understand and compare the initial capital cost and ongoing operating costs to the expected financial and non-financial benefits, for each viable alternative over a concession period. The length of the concession period should reflect industry experience and allow for risk transfer over a long period, while simultaneously keeping the tariff at a reasonable level.

Two quantitative models are normally used to analyze and evaluate the quantifiable financial aspects of ACF delivery - the Public Sector Comparator (PSC) and the Private Sector Shadow Bid Model.

Public Sector Comparator

By definition, the PSC estimates the hypothetical risk-adjusted costs (using net present value) if a project were to be constructed, owned and implemented by the public sector. The PSC is meant to be developed in accordance with the required output specifications and is based on the most efficient form and means of public sector delivery. The PSC also provides a reliable means of demonstrating value for money by creating a base cost for a project with which to compare the financial attractiveness of an ACF proposal.

The PSC has the following components:

Base Costs – represents the base cost to the public sector of delivering the project including the costs of design, construction, operation and the periodic costs associated with the delivery of services.

Transferable Risk – those risks that are likely to be transferred to the private sector because they are best able to manage the risk at least cost.

Retained Risk – those risks that the public sector proposes to bear itself.

Shared Risk – those risks that are jointly shared between the public and private sectors.

The PSC is the Net Present Value (NPV) of the total of these components. Further information on NPV analysis may be obtained by contacting Alberta Finance.

Private Sector Shadow Bid

The Private Sector Shadow Bid is a model of the project as if it were constructed and owned by the private sector. In addition, some defined range of services is usually assumed to be provided by the private sector over a period of years, known as the concession period. The model calculates the public sector's annual payment (tariff) to the private sector provider for the services. The private sector provider uses the tariff to pay operating costs, repay debt and obtain a return on its investment.



Section

7

Value Analysis

The private sector shadow bid can be used as part of the value for money assessment of the ACF through a comparison of the PSC against the private sector shadow bid. It can also serve as a benchmark to assess the RFP submissions of private/not for profit partners in the implementation phase of the project.

Quantitative Analysis – Financial Costs & Benefits**Full Life Cycle Cost Analysis**

A typical ACF analysis will include a full life cycle cost analysis. All costs and expected benefits resulting from each viable alternative should be analyzed and compared to the costs and benefits of a PSC. This methodology provides the reader with a total cost picture that includes both capital and operating expenditures.

Timeframe. An appropriate timeframe for the analysis should be used, based on the type of capital project being considered (i.e. 30 years for roads, etc)

Costs. All relevant costs should be identified over the chosen project timeframe. These may include:

- Capital Costs:
 - Construction
 - Property, plant, and/or buildings
 - Land/facility assets
 - Specialized machinery/equipment
 - Information technology/specialized software
 - Fixtures and furnishings
 - Change orders/scope changes
 - Demolition/site preparation
 - Decanting/occupant placement costs

- Annual Operating Costs:
 - Program salary and benefits
 - Program supplies and services
 - Lease payments
 - Facility operating and maintenance
 - Administration costs



Section

7

Value Analysis

- Cyclical Costs:
 - Repairs and maintenance
 - Information technology / software upgrades
 - Fixtures and furnishings

- Receipts:
 - 3rd party lease revenue
 - Parking or other revenue
 - Gain on sale of land and/or buildings
 - Grants/donations

- Residual Value:
 - Buildings
 - Land
 - Machinery and Equipment
 - Loss on sale of land or buildings

Consideration should be given to when the costs will be incurred, who will incur the costs and certainty of costs.

Sample Costing Template for Each Viable Alternative

Quantitative Analysis – ACF Alternative 1	Year 0	Year 1	Year 2	...	Year X
Capital Costs:					
Construction					
Property, plant, and/or buildings					
Land/facility assets					
Specialized machinery/equipment					
Information technology/specialized software					
Fixtures and furnishings					
Change Orders/scope changes					
Demolition/site preparation					
Decanting/occupant placement cost					
Annual Operating Costs:					
Program salary and benefits					
Program supplies and services					
Lease payments					
Facility operating and maintenance					
Administration costs					



Section

7

Value Analysis

Sample Costing Template for Each Viable Alternative

Quantitative Analysis – Alternative 1	Year 0	Year 1	Year 2	...	Year X
Cyclical Costs:					
Repairs and maintenance					
Information technology/software upgrades					
Furnishings and equipment					
Receipts:					
Third party lease revenue					
Parking or other revenue					
Gain on sale of land and/or buildings					
Grants/donations					
Residual Value:					
Buildings					
Land					
Furniture and Equipment					
Loss on sale of land or buildings					
Net Cost (Revenue):					
Net Present Value (X%):					

Benefits Analysis

Identify all quantifiable benefits to stakeholders over the chosen project timeframe.

Consideration should be given to:

- When the benefits will be achieved
- Who will be the recipient of the benefits
- The certainty of the benefits

Sample of a Summary Cost Benefit Template

Summary of Quantitative Cost/Benefit	Public Sector Comparator	ACF Alternative 1	ACF Alternative 2
Capital Costs			
Annual Operating Costs			
Cyclical Costs			
Receipts			
Residual Value			
Total NPV over X years			



Section

7

Value Analysis

Qualitative Analysis – Non-Financial Benefits

Some of the costs and benefits of the project may not be quantifiable (difficult to attach a dollar value). Examples of non-quantifiable benefits could include increased patient satisfaction, increased staff morale, reduced health authority image or adverse public perception. Wherever reasonable, costs and benefits should be translated into quantifiable benefits. For example, increased staff morale may lead to higher productivity which may lead to less over-time costs.

However, where this is not practical, the non-quantifiable costs and benefits can be summarized in the following manner:

Alternative 1

Qualitative Summary	Description	Stakeholder(s) Impacted
Benefits:		
Benefit 1	Description of Benefit 1	
Benefit 2	Description of Benefit 2	
Costs:		
Cost 1	Description of Cost 1	
Cost 2	Description of Cost 2	

Examples of non-financial benefits typically associated with an ACF alternative are:

- Improved service quality
- Increased innovation resulting in more effective and/or efficient delivery of service
- Additional social and economic benefits
- Risk transfer as a benefit

Examples of non-financial costs typically associated with an ACF alternative are:

- Loss of control or accountability
- The change and upheaval associated with partnering
- Loss of in-house expertise
- Risk transfer as a liability

All non-financial benefits and costs should be outlined for each ACF alternative. The public sector comparator should be used as a reference point.



Section

7

Value Analysis**Assumptions**

All assumptions used to determine both the quantitative and qualitative costs and benefits should be clearly documented. This would include general assumptions as well as assumptions specific to each alternative. Any assumptions used to forecast the status quo, develop the public sector comparator, and establish the ACF alternative should be well documented. These assumptions will be re-visited as the project moves through the various stages of implementation and may be changed or removed.



Section

8

Conclusions & Recommendations

The Conclusion & Recommendation Section provides the reader with a selected alternative based on an overall evaluation of the alternatives in terms of impact, risk, and cost/benefit. Specific recommendations for moving the project forward are also presented.

Conclusions

This section will recap each of the alternatives based on their Business & Operational Impact, Project Risk Assessment, and Value Analysis. Based on these results, a conclusion on which alternative should be chosen is made.

	Alternative 1	Alternative 2	Alternative 3
Business & Operational Impact	Describe overall assessment	Describe overall assessment	Describe overall assessment
Risk Assessment	Describe overall assessment	Describe overall assessment	Describe overall assessment
Quantifiable Value Analysis	Describe overall assessment	Describe overall assessment	Describe overall assessment
Non-quantifiable Value Analysis	Describe overall assessment	Describe overall assessment	Describe overall assessment

Choose the recommended alternative based on the above recap, selecting the alternative that maximizes the effectiveness and efficiency, minimizes the government’s exposure to risk, and clearly shows value for money.

Recommendations

This section will make specific recommendations on proceeding with the project using ACF.

The extent of the recommendations may range from recommending approval for full project implementation to recommending a more detailed requirements analysis be done to validate some key ACF Business Case components.

The preferred solution should be described in terms of:

- ✓ its major features;
- ✓ its technical scope (defining technical features and an explanation of how they differ technically from other options); and
- ✓ financial information such as costs, revenues and funding sources.



Section

9

Implementation Strategy

The Implementation Strategy Section ensures that those approving the ACF Business Case understand the resources they must allocate (people, dollars, time) to complete the recommended next steps of the project, and ensure successful implementation of the project.

Outline the proposed implementation plan for the recommended next steps at a high level.

This section should include:

- Major project phases
- High-level work plan, deliverables and target dates for completion
- Costs (\$) required to carry out the implementation plan
- Personnel (departments, roles, competencies) required
- Outside resources required (consultants, etc)
- Proposed project structure
- Assign responsibility for implementing and monitoring the risk mitigation strategies (Section 6)
- Post Implementation Review (Evaluation) approach