

James Pease: Reflection on the 2019 Health Care Project Delivery Conference, San Diego, CA

I spent the weekend catching up after a successful conference in San Diego on Jan 24th and 25th. Yes, it took a full week to get my email down to a reasonable level. In reality, it took about two uninterrupted hours, but it seems like that is nearly impossible these days, I'm sure you can relate.

The conference in San Diego was called the [Health Care Project Delivery Conference](#). It was the first annual (yes they have confirmed it will take place next year) and it was definitely worth attending.

There were about 500 people there this year. What I found most interesting was the mix of people. This conference had a higher than usual attendance of owners in the health care space as well as a large number of finance and P3 (Public Private Partnership) attendees. This was new to me and completely fascinating. I shared my experiences with project delivery as I've learned over the years, going from lump sum public work, to negotiated GMPs and now onto [Integrated Project Delivery](#) (IPD) with design/build trade partners. The feedback was positive and I will send a copy of the recording as soon as I receive it. Here are my two big takeaways.

Progressive Design/Build: Currently, public agencies in the United States do not use IPD as a model due to the current understanding of procurement laws. Interestingly enough, almost all IPD projects in Canada are conducted by public agencies. I also just learned that a public agency in the United States is working on their first IPD project - I'll share when this becomes official. While owners today can't use IPD, they still want the benefits of early collaboration from build partners and the ability to participate in the generative design process. Progressive Design/Build is becoming a tool for both the University of California and the California State University System. Originally called "Design-build with progressive Guaranteed Maximum Price (GMP) packaging", the name has since been shortened and I can understand why. Essentially this system allows the owner to select a team based on a big design idea but not a complete design. They then can participate in the iterations of a typical design process with full cost and constructability input from a design/build team. The pricing for the project cannot exceed the original proposed amount, yet the design is able to flux significantly during this process in alignment with the original big idea. More to come in the future on this method, this is just a quick intro.

Public Private Partnerships (P3): The two brothers who run this conference come from financial backgrounds. They started with P3 conferences and are now moving into the health care delivery space. With this transition, two types of attendees which I haven't seen before were in attendance. One - P3 sponsors such as [Plenary Group](#) and Two - Equity funds looking to finance health care. I was fortunate to sit down with some leaders at KPMG to learn more about the structure and design of P3 projects (forgive any misrepresentations here as this is far from my area of study). If you want to learn more, look at the UC Merced campus going on in California right now. Basically, a private group funds the construction of the campus (health care, college, etc.) and is paid over a 30-year period when the rooms are "available". If the rooms are NOT available within specified tolerances (i.e. temperature, lighting, elevators working, etc.) then the payments for the "unavailable" space is deducted from the amount owner to the developer. These P3 projects are managed through a "special purpose entity", an LLC or other corporate structure set up for the project. The limited partner equity comes from pension funds like CalPERS or CalStirs. The fact that the government entity (university of hospital) is paying for the space makes the debt for these projects Investment Grade. After completion, they can be sold to a life insurance company who wants to purchase guaranteed payments over 30 years subject to "availability" of the space. This type of delivery has been used successfully to build a number of complete hospital campuses in Canada and the model is making its way down to California in light of the 2030 seismic compliance deadline set by SB1953. I believe we'll see more of this with public health systems looking to transfer build risk as well as finance their hospital replacement projects. Within the special purpose entity, Design-Build seems to be the delivery model of choice although I expect to see IPD pilots based on my conversations at the conference. I also found it interesting that the private equity folks are interested in a similar investment deal for deferred maintenance in our hospitals. They will finance and run the renovation of our central plant, then "rent" it back to us based on it operating within agreed conditions for 30 years. This might not be a bad idea due to the cost and challenge of keeping these systems running over this long duration.

Conclusion: There is lots to learn related to health care project delivery. Reliability of delivery is important to those who are putting their own money on the line. All attendees agreed that greater collaboration and transparency are part of the solution to making projects more reliable. Will 2019 be the first year we see a US public institution go with IPD either directly or through a P3? My guess is yes...