ACADEMIC HEALTH CENTER
STRATEGIC COMMUNICATIONS PLANNING PROCESS

PROCESS GOAL: To complete a two-year strategic plan to position and promote the University of Minnesota through its Academic Health Center, its schools and colleges, and its people and programs

GUIDING PRINCIPLES: The planning process will

1. be highly participatory and inclusive.
2. assume a team approach to delivering the objectives.
3. respect the past, but focus on the future.
4. respect the process, but focus on the action.
5. result in a draft plan by August 1, 1997.

PARTICIPANTS:

AHC Strategic Planning Team:

- AHC Communications Staff
- AHC Provost's Office
  - Vic Vikmanis, Asst. VP for External Affairs
  - Jeanette Louden, Director of Human Resources
- Representatives of AHC Colleges, Schools, Centers, Institutes, Programs
  - Colleen Southwell, Cancer Center
  - Ann Benrud, Medical School Department of Pediatrics
  - Susan Hayes, School of Public Health
  - Phil Oswald, College of Veterinary Medicine
  - Gail Shea, School of Dentistry
  - Cheri Perlmutter, Medical School Dean's Office
  - Dina Flaherty, School of Medicine-Duluth
  - Henry Mann, College of Pharmacy
  - Karen Meyers, College of Pharmacy
  - Laurel Mallon, College of Pharmacy
  - Nursing (?)
- Other Volunteers

Leadership Team :

- AHC Strategic Planning Team (see above)
- Provostal Faculty Consultative Committee Representative (s)
- Provostal Student Consultative Committee Representative (s)
- Council for Health Interdisciplinary Participation (C.H.I.P.)
  - Jenny Meslow, Coordinator
- AHC Staff Representative (s) from P & A, Civil Service, AFSCME
- AHC Provost's Office
  - Terry Bock, Associate Provost and Chief of Staff
  - John Fetrow, Vice Provost for Organizational Design
  - Dean (s) of AHC Colleges and Schools
- University of Minnesota Institutional Relations
  - Marcia Fluer, Director of University Relations
  - Donna Peterson, Director of State Relations
  - Tom DeRanitz, Manager of Marketing

University of Minnesota Alumni Association
Tom Garrison, Director of Communications
University of Minnesota Foundation
Linda Berg, Director of Communications
Minnesota Medical Foundation
Dan Saftig, Director of Communications and Marketing
Fairview Health System
Barbara Nye, Vice President for Marketing and Communications
University of Minnesota Physicians
Lisa Jetland, Executive Director
Other Volunteers

Work Groups:
Work groups will be composed of volunteers who have an interest or expertise in the issue area. Each group will be led by co-chairs and supported by staff from the AHC Office of Communications. Work groups include

Internal Communications
Communications Technology
Strategic Partnerships/Fairview
Media Relations
Legislative Relations

PLANNING PROCESS:

1. Organize and agree on plan to plan no later than June 12, 1997.
   --Discuss proposal with AHC Communications Staff
   --Discuss proposal with Terry Bock, AHC Associate Provost
   --Discuss proposal with Deans Council
   --Discuss proposal with Provostal Faculty Consultative Committee
   --Discuss proposal with University Relations Staff

2. Meet with AHC Communicators on June 12, 1997.

3. Organize work groups to address specific issue areas. By July 18, 1997, each work group will
   --complete a review and analysis of current needs
   --assess current initiatives
   --identify issues and opportunities
   --make recommendations for enhancement or additional tactics

4. Convene Strategic Planning Team to finalize process and timeline, complete an environmental analysis (SWOT?), review prior studies, recommend work group topics and chairs, and prepare materials for the Leadership Team meeting. (Tuesday, June 24, 1997, 1:00-4:00 p.m.)

5. Hold meeting of the planning Leadership Team to review and discuss other AHC strategic communications plans, to define strategic questions and finalize work group topics. (Tuesday, July 1, 1997, 9:00 a.m.-noon)

6. Conduct a full-day facilitated creative session with stakeholders, partners, customers, and team members to define key audiences and messages, to brainstorm tactical ideas, and to consider potential goals and objectives. (Thursday, July 17, 1997, 9:00 a.m.-3:00 p.m.)

Activity Report for Katherine M. Johnston

Chief Financial Officer, Academic Health Center

May 31, 1997

FY 1997 Goals and Objectives

I modeled objectives for the 1997 fiscal year to achieve the overall goal included in the AHC Strategic Plan: Strengthen financial management to promote flexibility, investment, and healthy reserve resources.

FY 1997 Objectives:

On October 3, 1996, I outlined the following objectives for my first year as Chief Financial Officer of the Academic Health Center. The status of each objective is shown in italics.

1. Business Systems Design

    a) The establishment of a task force to develop a set of computer applications and operating principles to assist Deans, Department Heads, and other administrators in the acquisition and analysis of data needed to manage resources

    b) The design of a plan to implement the recommendations of the Task Force

    c) The development of a training program to 'roll out' the new applications and guidelines

    Status: Committee completed work in January and issued a report. The next step was forming an action plan for implementing the recommendations. But, the committee chairman left the University in February before this work was completed. I have formed committees to implement two of the recommendations: Consistent Application of the Chart of Accounts, which will be chaired by Nick Molitor, and CUFS training. The other recommendations have been put on hold until the new Director of Information Systems arrives.

2. Transitional Financial Model

    a) Form a set of alternatives to produce strategies for achieving financial

equilibrium in the Academic Health Center within a three-year period

Status: Completed

b) Modify and enhance the model so that instantaneous output can be produced so that Deans and other decision makers can use the model as a management tool

Status: In progress

3. Interim Financial Performance Reporting System

   a) Design and implement a system of reporting financial performance

   Status: Completed

4. Development of a comprehensive reporting system for all fund balances

   Status: In Progress

5. Restructure the allocation process in the AHC

   Status: In progress. We have made some advancement in this area by reorganizing the budget structure of the Provost's Office and organizing the commitment process. I expect further progress as we release allocations for FY 1998 through the establishment of requirements for budget execution.

6. Streamline financial processes in the AHC

   a) Emphasize "systems thinking" (understanding the cause/effect relationships between activities that are part of a process chain and institute systemic remedies when operational inefficiencies are apparent)

   b) Develop measures of organizational productivity, cost-effectiveness, customer service and use them to identify opportunities for improvement

   Status: This objective will be achieved through the efforts of the AHC Change process.

7. Develop a tracking system for the follow-up and implementation of audit comments

Status: I have had several discussions with Gail Klatt and Betty Win. I have formed a proposed process which I need to document for presentation to the provost.

8. Organize 1997-98 operating budgets

   a) Articulate biennial budget requests

      Status: Complete

   b) Develop a framework and monitoring system for the Strategic Investment Pool

      Status: My proposal for the framework is completed. After the process is determined for selecting programs to be funded from this pool, I will develop a proposal for the monitoring system.

   c) Develop a continuous process for collecting, reviewing, distributing, and executing operating budget allocations

      Status: We followed the university timeline this year -- which I believe is unsatisfactory. The MAD group identified the budget process as an area of major dissatisfaction. We need to develop our own schedule -- and connect it with university timelines -- that allows ample time for units to do a good job of preparing resource requests.

9. Organize capital budget process

   a) Develop 1998-2003 proposal

      Status: Completed

   b) In collaboration with Terry Bock, form an on-going, inclusive, comprehensive capital budget process to identify and quantify the capital needs of the AHC

      Status: The project was delayed until the new Facilities Director was hired. I will be working with Terry Bock and Laurie Wederstrom over the summer to coordinate facilities and budgeting activities.

   c) Identify and quantify the deferred maintenance needs of the AHC

      Status: Deferred until summer 1997

10. Develop an equipment replacement model

Status: This initiative is underway. I have outlined the general concept, and collected the raw data, i.e., inventory values, equipment age, expected life, etc. The next step is to construct a model that can be used to estimate the extent of equipment obsolescence in the AHC, and a reasonable cycle of replacement and renewal for scientific, computer and office equipment.

11. Initiate a comprehensive training program for AHC employees in Financial Responsibilities and compliance

    Status: Gail Klatt and Kathy Bush presented their training program on Rolea and Responsibilities for Financial Officers and Internal Controls to the Deans and to the Fiscal Officers. I arranged for them to roll out the program to all employees of the AHC who have responsibilities for fiscal operations. My intent was to conduct several sessions that would mix staff from different schools rather than set up seven sessions for the individual schools. In this way, we could provide the training AND promote relationships across the AHC. Kathy Bush left the University in April, so the program is temporarily on hold. I have confirmed with Gail that she will continue to offer the training, but the schedule has not yet been determined.

12. Develop a benchmarking and peer comparison process

    Status: Deferred until FY 1998

FY 1997 Accomplishments

I have reflected my accomplishments by outlining the status of each of my FY 1997 objectives in the preceding section. In addition to the work related to my stated objectives, I was involved in the following activities.

1. Development of the Attrition Management Program
2. Representative to the Executive Negotiating Committee
3. Search Committees (Information Officer and Vice Provost for Clinical Affairs)
4. Enterprise Integration Committee
5. Human Resources Information System Steering Committee
6. University Financial Officers Committee

7. State Appropriations Cost Alignment Committee

8. Exit Strategies Committee

Draft FY 1998 Objectives

Continuing Work on FY 1997 Objectives

1. Business Systems Design

   a) Continue implementation the recommendations of the Task Force

2. Transitional Financial Model

   a) Continue the enhancement of the model so that instantaneous output can be produced so that Deans and other decision makers can use the model as a management tool

   b) Locate the model on the AHC Financial homepage for easy acquisition and modification by users in the AHC

3. Financial Performance Reporting System

   a) Modify the current system to include budget construction that reflects anticipated expenditures so that more definite analysis of actual versus budget variances can be completed

4. Development of a comprehensive reporting system for all fund balances

   a) Design and construct a database that will connect with MMF, UMF, and the University's Treasurer's office to provide information on endowments and other funds

   b) Locate access to the database on the AHC's Financial homepage

5. Streamline financial processes in the AHC

   a) Emphasize "systems thinking" (understanding the cause/effect relationships between activities that are part of a process chain and institute systemic remedies when operational inefficiencies are apparent)

   b) Develop measures of organizational productivity, cost-effectiveness, customer service and use them to identify opportunities for improvement

6. Develop a tracking system for the follow-up and implementation of audit comments

7. Monitor 1997-98 operating budgets

   a) Implement the framework and monitoring system for the Strategic Investment Pool

   b) Develop a continuous process for collecting, reviewing, distributing, and executing operating budget allocations

8. Organize capital budget process

   a) In collaboration with Terry Bock, form an on-going, inclusive, comprehensive capital budget process to identify and quantify the capital needs of the AHC

   b) Identify and quantify the deferred maintenance needs of the AHC

9. Complete the development of an equipment replacement model

10. Continue the 'roll-out' of the comprehensive training program for AHC employees in Financial Responsibilities and compliance

11. Develop a benchmarking and peer comparison process

Proposed New Objectives for FY 1998

1. Improve communications on financial issues between the AHC Provost's Office, Central Administration, the AHC schools, Fairview, UMP, and other groups

2. Identify opportunities to increase the reputation of the AHC financial group as a customer-oriented service provider

3. Staff the financial organization at the appropriate level to accomplish the stated objectives

4. Introduce an Internship Program to develop future financial leaders in the AHC

5. Develop a procedure for linking concurrent budget processes for the schools of the AHC, the Fairview system, the University of Minnesota Physicians, and other funding partners

6. Develop standard funding formulas for the distribution of the state allocation to the AHC

7. Develop additional Decision Support Systems for financial management

8. Research productivity models currently in use at other institutions of higher education, particularly at Academic Health Centers

9. Continue professional development opportunities for the staff of the financial organization

UNIVERSITY OF MINNESOTA

University Senate

427 Morrill Hall
100 Church Street S.E.
Minneapolis, MN 55455-0110

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Fax: 612-626-1609
E-mail: senate@mailbox.mail.umn.edu

May 28, 1997

Ms. Lorelee Wederstrom
Director of Facilities Management
Academic Health Center
Box 501 Mayo
East Bank

Dear Ms. Wederstrom:

On behalf of the Academic Health Center Faculty Consultative Committee (AHC FCC), I am writing to invite you to attend one of our upcoming meetings. Members of the committee look forward to meeting you and are interested in hearing about your short and long-term workscope for the 1997-98 academic year. Vickie Courtney, University Senate Office, will be contacting you in the next week to schedule a time for you to meet with us.

Thank you.

Sincerely,

Judy Garrard

Judith Garrard, Chair
ACH FCC

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Minneapolis, MN 55455-0110

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E-mail: senate@mailbox.mail.umn.edu

May 28, 1997

Ms. Kathryn Johnston
Chief Financial Officer
Academic Health Center
Box 501 Mayo
East Bank

Dear Ms. Johnston:

On behalf of the Academic Health Center Faculty Consultative Committee (AHC FCC), I am writing to invite you to attend one of our upcoming meetings. Members of the committee look forward to meeting you and are interested in hearing about your short and long-term workscope for the 1997-98 academic year. Vickie Courtney, University Senate Office, will be contacting you in the next week to schedule a time for you to meet with us.

Thank you.

Sincerely,

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May 28, 1997

Ms. Jeanette Louden
Director of Human Resources
Academic Health Center
Box 23 Mayo
East Bank

Dear Ms. Louden:

On behalf of the Academic Health Center Faculty Consultative Committee (AHC FCC), I am writing to invite you to attend one of our upcoming meetings. Members of the committee look forward to meeting you and are interested in hearing about your short and long-term workscope for the 1997-98 academic year. Vickie Courtney, University Senate Office, will be contacting you in the next week to schedule a time for you to meet with us.

Thank you.

Sincerely,

Judy Garrard

Judith Garrard, Chair
ACH FCC

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May 28, 1997

Ms. Christine Roberts
Director of Communications
Academic Health Center
Box 735 Mayo
East Bank

Dear Ms. Roberts:

On behalf of the Academic Health Center Faculty Consultative Committee (AHC FCC), I am writing to invite you to attend one of our upcoming meetings. Members of the committee look forward to meeting you and are interested in hearing about your short and long-term workscope for the 1997-98 academic year. Vickie Courtney, University Senate Office, will be contacting you in the next week to schedule a time for you to meet with us.

Thank you.

Sincerely,

Judith Garrard, Chair
ACH FCC

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From: "Peggy Rinard" <rinard@mailbox.mail.umn.edu>
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AHC-FCC members,

Next (and last) issues of "this thursday" will be published Sept. 11 and 25. I hope to get a column from your group for one or both. Deadlines are Sept. 3 and Sept. 17. Please let me know.

The Sept. 25 issue will be called "The Last Thursday." Might be a good time to reflect on faculty issues over the past couple of years and look toward the future.

Just a suggestion...

A monthly community newsletter will be launched in October to replace TT. You will be welcome to continue your column in the new format. The new pub will be guided by a faculty-staff advisory board. Let me know if you would like to serve on this.

Thanks,

Peggy Rinard

AHC Office of Communications
624-9912
625-2129 (fax)

UNIVERSITY OF MINNESOTA

Twin Cities Campus

Institute for Health Services Research
School of Public Health

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President Designate Mark Yudof
c/o Steve Bosacker, Executive Director
Board of Regents
220 Morrill Hall
FAX: 624-3318

Dear President Designate Yudof:

The Provostial Faculty Consultative Committee (PFCC) of the Academic Health Center (AHC) hereby invite you to meet with the faculty of the AHC at your earliest convenience. We understand that you may be setting aside a block of time for the AHC during your visit to the U of M the week of February 25, 1997. The opportunity to meet with you at noon (in order to avoid well-established clinic and classroom hours) on the Tuesday of that week would be ideal. We have discussed this invitation with our provost, Dr. Frank Cerra, and he is supportive of both our invitation and the request for time. The PFCC believes that a faculty-sponsored session for the AHC faculty to meet the President-Designate is a very important part of building morale in the AHC.

We envision a threefold purpose for this meeting:

- to give you and the AHC faculty a chance to meet and exchange ideas,
- to provide an opportunity for the faculty to hear what your general plans are for the AHC in the coming year, and
- to have an opportunity to hear your thoughts on some specific questions raised by the faculty

All AHC faculty would be invited to the meeting which would be held in one of the large auditoria in the AHC. We propose that following a brief statement about your vision for the AHC, you address some questions that have been raised previously by the faculty. As the faculty governance committee of the AHC, we will solicit questions from the faculty, in writing, and send these to you in advance of your visit to the Twin Cities. In coordination with Provost Cerra, you will also be sent background materials about the AHC in advance.

Although this may be the first general meeting with U of M faculty in a provostial unit, the PFCC feel that the timing is very important. The AHC has undergone a great deal of transition over the past two years, and we are now in the process of building and re-building our center as a world-class teaching and research institution. The opportunity to hear about your expectations for the future are very important. Our provost will also be at the meeting, and the PFCC feel that this will be a good demonstration of faculty and administration working together to bring important people and issues to the attention of the faculty.

On a personal note, I would also like to add that only a few of us from the AHC had the opportunity to meet you as part of the University level FCC interview in December. I felt a great deal of hope as a result of that meeting, and I would like to give my colleagues the opportunity to share in that hope. I am looking forward to hearing from you. I can be reached at my office, (612) 625-9169, and via e-mail: jgarrard@maroon.tc.umn.edu.

Sincerely,

Judy Garrard

Judith Garrard, Ph.D.
Professor and Chair, AHC PFCC

cc: Members of the AHC PFCC (see next page)
Provost Frank Cerra (FAX: 6-2111)

AHC Provostial Faculty Consultative Committee

Sheila Corcoran-Perry, Ph.D.
Professor
School of Nursing

Muriel Bebeau, Ph.D.
Professor, Preventive Sciences
Dental School

Peter Bitterman, M.D.
Professor, Department of Medicine
Medical School

Daniel Feeney, DVM
Professor
College of Veterinary Medicine

Judith Garrard, Ph.D., Chair
Professor, Institute for Health Services Research
School of Public Health

Cynthia Gross, Ph.D.
Professor
College of Pharmacy

Frederic Hafferty, Ph.D.
School of Medicine, Duluth

David Hamilton, Ph.D.
Professor, Department of Laboratory Medicine
Medical School

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Mime-Version: 1.0
Content-Type: text/plain; charset="us-ascii"
Date: Thu, 22 May 1997 11:38:03 -0500
To: Michael Armstrong <armstron@lenti.med.umn.edu>
From: Judy Garrard <jgarrard@maroon.tc.umn.edu>
Subject: Re: Future joint meeting
Cc: courtney@mailbox.mail.umn.edu

Thursday, May 22

Thursday June 26 3:30 at 4:30 they meet w/ Mark

Dear Michael,
Thanks for your note. I have asked Vickie Courtney to set up a meeting time for our two committees to meet. We meet once a month from 12-1:30, and I know that our next two meetings are booked. We're meeting with the new administrative directors (HR, Communications, Facilities, and Finance). (You all might think about doing the same thing too.) Now that the Information person has just been appointed, I imagine that we'll need to meet with him too.

I also agree that we need to discuss an agenda. If you have some topics in mind, please e-mail me. I'll discuss with the committee what they, too, would like to have covered. I expect that we'll need about an hour. (THe meetings with the adminsitrative people are going to be 30 minutes each; so we're processing them two/meeting.) Vickie will contact you and work with your staff person to get this arranged. Thanks,
Judy

Dr. Garrard,

As was discussed in our committees' meeting together on March 20, we need to set up a joint meeting for Spring quarter. Since the quarter is rpaidly coming to a close, setting this meeting for the relative near future would be most beneficial. Please let me know when the best time for our groups to meet would be. Later in the day is best for us in that it minimizes class conflicts. Also, we should get together briefly prior to this meeting to set an agenda. Thank you for your attention to this matter.

Looking forward to hearing from you,

Michael B. Armstrong, Chair
AHC PSCC

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Judith Garrard, Ph.D.
Professor, Institute for Health Services Research
School of Public Health
Box 729 UMHC
420 Delaware Street, S.E.

DRAFT - 2/11/97

University of Minnesota
Academic Health Center
Instructional Technology Grant Program

Purpose:

The instructional technology grant program is designed to improve the quality, efficiency and the student orientation of instruction by encouraging the development and use of modern information technology in the seven schools of the Academic Health Center. These technologies include computer-assisted instruction, distance education, web-based courses, computer-based course support and other computer-based instructional methods such as simulations and modeling. It encompasses both innovative explorations of new instructional methods as well as evolution of existing courses within the current information technology environment.

Program Details:

The Learning Resources Center will provide funds in the amount of $50,000 and accompanying instructional development support services that will be competitively awarded to faculty members of the Academic Health Center. Proposals that incorporate faculty teams, focus on professional education and that are part of the required curriculum will be particularly encouraged. Requests for support of specific activities related to existing projects will also be considered. Proposals will be evaluated by a faculty committee consisting of representatives from each of the schools in the Academic Health Center. Budgets will be negotiated to optimize the number of awards.

Award Process:

1. Two page letters of intent describing the focus course, the intended technology approach and the persons to be involved will be due by March 1.
2. The faculty evaluation committee will review the letters of intent and select up to ten projects for further development by March 15.
3. The selected letters of intent will be developed into full proposals of not more than 15 pages that will fully describe the project and its required resources by April 15.
4. The evaluation committee will rank the final set and recommend awards for each proposal by May 1.

ACADEMIC HEALTH CENTER

Attrition Management Program

A statement outlining the guidelines, policies and procedures for the AHC Attrition Management Program was sent to Deans on February 5. Since the announcement of the program, many questions and concerns have been raised. The following question and answer sequence has been prepared to clarify the principles and policies of the AHC Attrition Management Program.

Q: Why is an Attrition Management Program necessary?

A: The Attrition Management Program is necessary for three reasons: we must reduce the number of positions in the AHC, we must create funding sources for new investments in programs, ***and*** we must correct structural imbalances in school budgets.

The Central University Administration has mandated a reduction in the number of positions funded in non-sponsored programs throughout the institution. Reduction targets are being established; 5 percent for faculty and 8 percent for staff have been proposed. The Attrition Management Program was designed to achieve those targets in an orderly manner.

In order to thrive in the future, we must make strategic investments in programs now, and ensure that these programmatic investments occur in accord with the strategic plan at Central, AHC, and the school level. The resources of the Academic Health Center are 'locked' in current commitments. In fact, current expense commitments substantially exceed expected future revenues. A forecast of forward year revenues and expenses completed last summer revealed a gap of $40 million annually in each of the next three years.

Q: Why was attrition chosen to be the primary method for reducing staffing and costs?

A: It is clear that we must reduce the number of positions in the Academic Health Center. First, we must comply with the University's mandate to reduce faculty and staff positions. Second, 70 percent of the expenditures in the Academic Health Center are for salary and benefit costs. Therefore, personnel cost is the most logical place to trim in the alignment of revenues with expenses. An alternative to attrition is involuntary separations. But, layoffs are expensive in two ways. The dollar cost of involuntary separation can equal a full half year of salary and benefit expense. And, the damage to morale and the interruption in programs has a cost that is difficult to quantify.

Q: Is the Attrition Management Program just a fancy name for a position freeze?

A: No. The program is designed to encourage careful planning for replacements of staff who leave employment in the AHC. Refilling vacant positions should not be automatic. Alternatives for covering the tasks assigned to the vacant position should be investigated before the position is refilled.

Q: Do departments have to get permission before they can refill positions?

A: The Provost has delegated the authority for making decisions on replacements to the Deans. It is expected that the Dean will further delegate this authority to department chairs, especially for larger departments.

Q: My department never has any attrition. How can we achieve the targets if there is no attrition in the 1997 calendar year?

A: In setting the targets, historical attrition rates were studied. Over the last five years, the attrition rate of ranked faculty positions has averaged 5.6 percent for the AHC. By school, the average has ranged from a low of 2.7

percent to a high of 6.4 percent. Attrition for P&A and civil service/bargaining unit staff has been in the same range.

Q: Is the reallocation target an across-the-board reduction?

A: No. Targets for the schools of the AHC are selective and differential. The targets are based on the size of the staff and the extent of budget imbalance. It is expected that the same criteria will be used by the Dean's to establish targets for departments.

Q: How can the school reduce the amount of the target?

A: The total target -- which ranges from 5 percent to 15 percent -- is divided into three pools:

- AHC Strategic Investment Pool 25%
- School-specific Investment Pool 25%
- Correction of structural imbalance 50%

All schools must return the 50 percent portion that will build the two investment pools. Assessment of the 50 percent that is intended to offset deficit fund balances is dependent on the current financial condition of the schools, or the projection of forward year balances. Schools that demonstrate that there is a realistic plan for correcting any existing or projected deficit in the total non-sponsored budget **WILL NOT BE ASSESSED THE PORTION OF THE TARGET THAT IS INTENDED TO CORRECT THE STRUCTURAL IMBALANCE.** The analysis of the financial condition of each school, and whether the 50 percent corrective strategy is applied, will occur during the review of school strategic plans in May.

Q: How can we be sure that the funds returned to the AHC Strategic Investment Pool are used for academic programs, and not for expanding administration?

A: The allocation of the Strategic Investment Pool funds will be an open, competitive process. An accounting of

the funds will be accessible on the Financial Page of the Academic Health Center Home Page. The accounting will include the names of programs funded, the participants in the programs, the amount and purposes of the dollars allocated, period-to-date financial performance of each program, and other relevant information.

Q: Will balances of solvent departments be used to 'bail out' departments who run deficit operations?

A: Using fund balances of solvent departments to 'bail out' departments who have accumulated deficit balances is not the intent of this program. We expect the program to create positive incentives for better financial management. Rewarding good financial management and discouraging poor financial management are the principles of the Attrition Management Program.

Q: Are there other ways to accomplish the objectives of the Attrition Management Program?

A: Absolutely. Several are currently being explored. We have proposed an early retirement and/or buyout program for faculty and staff. We are working with Central Administration to develop a proposal that will be attractive to faculty and staff, but affordable to the AHC and schools. We are also examining the possibility of alternate working schedules for faculty and staff.

Faculty and staff are encouraged to forward other ideas for creative strategies to build the two investment pools and to ensure the future financial stability of the AHC. Please send suggestions to Katherine Johnston, CFO, Academic Health Center at kmjohnst@mailbox.mail.umn.edu. Also, if there are questions or concerns that were not addressed in the preceding narrative, please send them to the same e-mail address.

DRAFT

TASK FORCE ON THE ALLIED HEALTH PROFESSIONS

Scope: Develop a three to five year strategic plan for the AHC's Allied Health Programs. The task force shall:

- Review and analyze projected work force needs for allied health professionals over the next five to ten years in Minnesota and nationally.
- Analyze what role the AHC should have in meeting these needs. Should the AHC's focus be state, regional or national? Within Minnesota, should the AHC be the sole or primary provider?
- Assess what changes are required in AHC educational programs and enrollments to meet projected work force needs.
- Examine potential partnerships with other educational institutions to meet projected work force needs.
- Assess what changes are required to enhance AHC research and outreach programs.
- Examine alternative organizational structures for the AHC's Allied Health Programs to enhance their effectiveness.
- Develop a three to five year financial plan with projected revenues and expenses.
- Prepare a report with specific, prioritized recommendations by July 1, 1997 or sooner.

Allied Health Professions Covered:

- Medical Technology
- Mortuary Science
- Occupational Therapy
- Physical Therapy
- Health Informatics
- Dental Hygiene

Are one or more of these programs needed to maintain the viability of the other programs?

Task Force Members:

Kathleen Newell, Director, Dental Hygiene
Karen Karni, Director, Medical Technology
John Kroshus, Director, Mortuary Science
James Carey, Director, Physical Therapy
Judith Reisman, Director, Occupational Therapy
Stanley Finkelstein, Director, Health Informatics Graduate Program
Edith Leyasmeyer, Dean, School of Public Health
Michael Till, Dean, School of Dentistry
Robert Howe, Medical School
John Fetrow, Provost's Office
Official from the state Department of Health

Resource People:

Institute for Health Services Research
Office of Academic Affairs
AHC Fiscal Staff

files. Files of those not admitted and incomplete files are retained by this office on an agreed upon retention schedule.

Access to Computerized Databases

Any School of Nursing employee with access to computerized student record databases will be required to sign the University of Minnesota Compliance Statement For Access To Student Records. The statement will be renewed annually.

Release of Information

Except as outlined below, private data from a student's record will be released to a faculty member only after the student has signed a release of information form. The form permits the student to outline which parts of the record are released, for what purpose and for what period of time. If the student does not designate a period of time for the release, the Minnesota Government Data Practices Act allows the release to be in effect for one year. The release of information form is available from the Office of Student Services.

Faculty Access to School of Nursing Student Records

Faculty, in their roles of teacher, reference, advisor, and decision maker with respect to admission and progression, have legitimate needs for access to information about their students. Advisors and those involved in admission and progression decisions need access to all parts of the student record bearing on the decisions for which they are responsible. Faculty members whose only relationship is that of teacher of a course or reference are normally not given access to the official record without a signed release from the student.

Student Services Staff Access to School of Nursing Student Records

Staff members of the Office of Student Services have access to all parts of the student record for purposes of providing student services to the prospective and enrolled student. Staff members are required to sign the Compliance Statement for Access to Students Records and obtain a secure ID access to the Student Access system. They are expected to attend classes sponsored by the Office of the Registrar (OTR) and have an individual orientation from the OTR staff and other systems experts.

III. School of Nursing Procedures

A. Procedure for Access To Official Student Records

To obtain access to the official student record, faculty currently serving on the Admissions and Progressions Committee should contact the responsible staff member of the Office of Student Services to make arrangements to view the admissions files assigned for review. After completing the work, the files should be returned to a staff person to refile.

Faculty who require access to a student file for reference letters or graduate school applications should secure a release of information form or a comparable statement from the student and submit this form/statement to the Enrollment Management Specialist in the

Office of Student Services, School of Nursing, prior to seeking access to the file. The Enrollment Management Specialist will provide only the private data described in the release.

Requests for aggregate data on student records should be made in writing to the Director of Student Services for processing.

B. Procedure for Return of Student Papers

The following language has been suggested for inclusion in the course syllabus: "In order to assure compliance with U.S. Department of Education guidelines related to confidentiality of student records, the following method will be used for returning your [exams/course assignments/other materials]."

Courses offered on the Twin Cities campus

Unless the faculty member selects one of the following methods as an exclusive method or has made other arrangement for the return of student work, materials should be returned according to the following schedule.

1. Papers will be returned on the first regularly scheduled class following the completion of grading. No papers should be picked up by a fellow student without a signed release from the student being graded.

2. For final course grades and for courses that are not a part of a continuing sequence, materials should be returned by the faculty member during office hours scheduled for this purpose during the exam period or during the first week of the following term.

3. Students are encouraged to submit a stamped, self-addressed enveloper for return of papers that cannot be returned in class.

4. Faculty members should not be expected to retain materials indefinitely. Unless other arrangements are appropriate, students should be informed that materials will be destroyed after four weeks.

Courses offered away from the Twin Cities campus or by faculty at a distant site

The School of Nursing will cover the cost of sending the entire packet of materials to be returned to the on-site coordinator. From that point on, the procedure for returning papers on the Twin Cities campus will be in effect.

December 23, 1996

Academic Health Center
Work Plans for the AHC: July through December 1997

Broad Strategies	Activities	Progress through November 1	November/December Priorities
Improve the learning/working environment for students, faculty, and staff	• Improve the learning facilities and student environment across the AHC: classroom improvement, student common space, access to learning technologies • Develop plans for an AHC-wide Education Support Services unit to assist faculty to use technology in teaching and support their development as educators	• Planning underway for improving AHC classrooms. Vet Med classroom upgrade completed.	• AHC classroom improvement plan completed; implementation underway • Deans Council review of plans for AHC-wide Education Support Services Organization
Re-shape our educational programs to adapt to new professional roles	• Develop and allocate funds for interdisciplinary/interscholastic health education initiatives, creating national models of interdisciplinary health education • Study and decide the best approach for allied health professional education in the AHC • Expand the Rural Health School to increase the number of students and communities served • Complete planning for restructuring of the biological sciences • Develop better programs for identifying and recruiting graduate students • Collaborate with other University units in improving graduate education programs	• Five interdisciplinary/interscholastic education initiatives have been developed and funds approved • Task force on allied health professional programs has completed its work and forwarded its recommendations to the council • Rural Health School has expanded community sites from three to five • Plans for restructuring of the biological sciences are being forwarded to the faculty and senior administrators for review	• Work by education initiative teams underway • Deans Council review of allied health professionals task force report • Planning for biological sciences reorganization completed and implementation begun

Broad Strategies	Activities	Progress through November 1	November/December Priorities
Direct our resources to focused programs of excellence in research and strengthen our partnerships with private industry	• Allocate AHC strategic research investment funds • Develop plans to strengthen the University's molecular and cellular biology programs • Implement an AHC private sector research services organization (PSRSO) to enhance access and interaction with the private biomedical sector • Assess opportunities for initiatives with other private industry sectors • Establish an enhanced technology transfer organization	• Proposals for legislative research initiatives have been developed and forwarded to the council for review • Plans for a molecular and cellular biology initiative have been developed; request for supplemental program funds from the legislature has been completed • Small grant and strategic investment process designed; applications are due October 31 • Plans for private sector research services organization completed; selection of director underway	• Deans Council approval of legislative research initiatives; work begun • Small grant and strategic investment applications reviewed and selected • PSRSO Director appointed and operations begun • New conflict of interest process implemented
Strengthen financial support for health education	• Lay the groundwork for an expanded "public utility model" for financing health education • Develop improved options for funding professional, graduate, and graduate professional education	• Active participation by AHC in designing the process and procedures for allocating MERC funds • Discussions with federal and state officials on future of graduate medical education underway	• Complete and submit applications for MERC funds.

Broad Strategies	Activities	Progress through November 1	November/December Priorities
Increase the scope and impact of our clinical programs	• Continue implementation of the Fairview/AHC affiliation agreement; strengthen linkages and working relationships at the senior administrative and operational levels. • Complete the integration of all Medical School faculty practices into University of Minnesota Physicians, including the transfer of personnel • Enhance utilization of the University's Dental Clinics and Veterinary Teaching Hospital • Address the issues of non-physician practice plans and multiple site practice by University health care providers • Support the development of new interprofessional health care delivery models, integrated with health education • Develop projections of the market needs for faculty clinical services • Explore methods for recognizing clinical practice in promotion and tenure decisions	• Joint Fairview/University committee of senior administrators established to coordinate and lead implementation • Integration of Medical School faculty practices into University of Minnesota Physicians is on schedule for January 1	• Report on Fairview affiliation prepared for Regents; work plan developed and implemented • Integration of Medical School faculty practices into University of Minnesota Physicians completed • Task force established to develop strategic plan for clinical services, beginning with medical services and expanding to include other AHC services • Strategic planning for CUHCC begun
Strengthen our ties to the community, creating responsive and relevant relationships	• Develop external advisory groups • Develop a strong network of individuals in the community in support of the AHC and its schools and colleges	• Community open house during Yudof Inaugural Week	• External advisory groups appointed • Planning for major community outreach effort in 1998 underway

Broad Strategies	Activities	Progress through November 1	November/December Priorities
Expand the diversity of our student, faculty, and staff populations	• Establish an AHC task force to examine ways to enhance recruitment and retention of underrepresentated students, faculty and staff • Clarify the University's position on affirmative action • Unify the diversity programs of the AHC • Create opportunities for greater interaction across colleges for under-represented students, faculty, and staff • Develop funds for scholarships and recruitment	• Task force charge is being developed for council review	• Task force appointed
Expand the reach of our communications programs: develop an identify for the University of Minnesota's Academic Health Center and each college or school	• Complete a communications strategic plan and begin implementation • Expand people's sense of identify of the AHC and its schools and colleges, both externally and internally	• Communications strategic plan completed. Implementation begun. Three new internal publications begun. AHC event held during Yudof Inaugural Week. • Expanded media program underway	• Continued implementation of communications strategic plan

Broad Strategies	Activities	Progress through November 1	November/December Priorities
Improve the quality and efficiency of our infrastructure in support of our education, research, and outreach missions	• Implement the PIDP model • Establish planning systems within each school/college and the AHC that accurately project and monitor fiscal performance • Develop training and development programs to assure competency of all AHC staff who perform financial services • Develop a strategic plan for AHC facilities and facilities management • Develop a plan for replacing the JOML complex • Improve the effectiveness of the recruitment and hiring process for faculty and staff • Develop a strategic information technology plan • Integrate all colleges/schools into a common information sharing and server format • Establish a team of technical contacts within each college/school • Establish plans to separate AHC and Fairview networks • Create an AHC technical support service and site licensing for common software	• PIDP procedures are being drafted • Financial planning systems are being developed and implemented • Task force has been established to draft training and development programs for AHC staff who perform financial services • Strategic facilities planning is underway. Interim AHC space management and capital project procedures/systems put in place. • Work underway on a predesign study for a JOML replacement facility. Study is on schedule for January 1 completion • Work underway to redesign recruitment and hiring processes. Central has delegated recruitment and hiring authority to AHC HR Office. AHC and Medical School human resources staffs have been integrated. • Development of common budgeting system and human resources information system underway • Fairview/AHC network separation underway	• Lead dean concept implemented • PIDP procedures drafted • Administrative services redesign underway • Drafting of strategic facilities plan underway • JOML predesign study completed • Continuing development of common budgeting system and human resources information systems • Information technology strategic planning underway
Enhance the skills of our leaders in guiding change in the AHC	• Develop a plan for leadership development: communications, roles and responsibilities, skills development, support systems	• Leadership development plan being drafted for council review • Staff training/development program being developed and piloted	• Council review of leadership development plan; implementation begun • Staff training/development program begun

Broad Strategies	Activities	Progress through November 1	November/December Priorities
Work for closer cooperation with the University at large, in both academic and administrative arenas		• Cerra is member of Executive and Vice President Councils • Joint development and planning of biological sciences reorganization and the molecular and cellular biology initiative with other University colleges and units • Joint planning and work efforts between central and AHC HR, communications, financial, facilities, and information technology staffs	• Continued joint development and planning of biological sciences reorganization and the molecular and cellular biology initiative • Continued joint planning and work efforts between central and AHC HR, communications, financial, facilities, and information technology staffs

November 11, 1997

Answering the Defining Questions for the AHC Strategic Planning Process

Response from the School of Nursing

April 5, 2000

(Final Draft)

EXECUTIVE SUMMARY

ANSWERING THE DEFINING QUESTIONS FOR THE AHC STRATEGIC PLANNING PROCESS
RESPONSE FROM THE SCHOOL OF NURSING
APRIL 5, 2000

The School of Nursing faculty provided their input to the AHC strategic plan by addressing the six strategic planning questions. Through a series of sessions, faculty were asked to propose options and recommendations for each of the questions. Information was synthesized from six sessions with faculty and one session with the School of Nursing Alumni Society Board. Four consistent themes emerged from the questions:

- The research mission is clearly the unique contribution that the AHC makes to the state, nation and world.
- The AHC should be the leader in demonstrating and testing new ways of delivering health care services.
- Developing partnerships with organizations and agencies outside the University is essential to fulfill the three missions of the AHC.
- All the schools/colleges/units make up the collective strength of the AHC and its unique ability to address the **health** of Minnesotans. Specifically, the AHC is more than the medical school.

Within the context of these themes and the six questions, a series of recommendations were outlined:

1. To be a leader and in the forefront for health care in the state, nation, and world, the AHC needs to draw on the collective strengths of all the schools/colleges as well as promote the visibility of all the schools/colleges.
2. The competencies for health care professionals outlined by the *Pew Health Professions Commission* should be used as benchmarks for the AHC schools/colleges with special emphasis on four competencies: providing leadership in making changes in the health care delivery system; functioning effectively as a member of an interdisciplinary team; proficiency in the use of technology as a prerequisite for using evidence-based practice; and knowledge, sensitivity and skill in providing health care to persons who are from other cultures and ethnic backgrounds.

3. The AHC should take a leadership role in addressing health care professional work force needs.
4. The AHC should be a leader in shaping the health care delivery system through designing, testing, and evaluating interdisciplinary team care models by drawing on the collective strengths of the schools/colleges.
5. Develop new "clinical laboratories" for educating health professional students that are community-based and emerge from new partnerships with organizations, agencies, and communities.
6. Invest in junior faculty researchers and recruitment and retention of senior faculty researchers.
7. Collaboratively seek new partners to support the three missions of the AHC.
8. Invest in an infrastructure to support the use of technology for the three missions of the AHC.
9. Develop and implement strategies, incentives and rewards to foster a collaborative culture of accountability among the schools/colleges in the AHC and to minimize some of the real or perceived perceptions held by the schools/colleges regarding valuing one school/college over another.
10. Promote the language of **health** care rather than **medical** care to emphasize the collective strength of the AHC made up by the schools/colleges.

Each of the schools/colleges has strengths to contribute to the overall success of the AHC. These strengths need to be leveraged through collaborative strategies. One of the unique strengths of the School of Nursing in promoting a successful future for the AHC is its experience in community-based and interdisciplinary education.

ANSWERING THE DEFINING QUESTIONS FOR THE AHC STRATEGIC PLANNING PROCESS
RESPONSE FROM THE SCHOOL OF NURSING
APRIL 5, 2000

The Academic Health Center (AHC) strategic planning process involves deliberate efforts to obtain the best thinking of the faculty to address questions designed to define the strategic plan for the AHC. Faculty are responsible and accountable for the vision and strategic plan for the AHC which will subsequently serve as the basis for AHC biannual requests to the legislature and for resource allocation within the AHC.

Coordinated by the School of Nursing Faculty Consultative Committee (FCC), the School of Nursing faculty provided their input to the AHC strategic plan by addressing the six strategic planning questions. In Phase I of the AHC strategic planning process, School of Nursing faculty input was obtained during the School's Faculty General Assembly meeting on February 14, 2000 followed by a series of sessions held the week of March 6 (5 sessions). During those sessions, faculty confirmed the six strategic planning questions and proposed options and recommendations for each of the AHC strategic planning questions. In addition, a meeting was held with the School of Nursing Alumni Society Board to obtain their perspectives on the six strategic planning questions.

A summary of the faculty's input for each of the questions is provided. Four consistent themes emerged from the questions:

- The research mission is clearly the unique contribution that the AHC makes to the state, nation and world.
- The AHC should be <u>the</u> leader in demonstrating and testing new ways of delivering health care services.

- Developing partnerships with organizations and agencies outside the University is essential to fulfill the three missions of the AHC.
- All the schools/colleges/units make up the collective strength of the AHC and its unique ability to address the **health** of Minnesotans. Specifically, the AHC is more than the medical school.

What is our role in the health of Minnesotans—our land grant mandate?

This question provided the broadest array of options and approaches as recommendations for the AHC strategic plan. An overriding theme was that the focus of the AHC should be **health** care rather than **medical** care. A focus on **health** is important in communicating the purpose and mission of the AHC to policy makers, the public, employers, funders, and payors. To be a leader and in the forefront for **health** care in the state, nation and world, the AHC needs to draw on the strengths of all the schools as well as promote the visibility of all the schools. For example, the Mini Medical School is clearly a successful and innovative strategy for promoting the visibility of the Academic Health Center and providing a service to Minnesotans, however the visibility and contributions of the non-medical school colleges/schools is very limited in this endeavor.

The AHC must to be responsive to the needs of the community at large (local, state, regional, nation and world). Such responsiveness includes ensuring that the graduates from the AHC schools/colleges have the competencies enabling them to function effectively as health care providers and researchers. The *Pew Health Professions Commission* identified twenty-one competencies for successful health professional practice in the future[1] (Appendix A). These

[1] The Fourth Report of the Pew Health Professions Commission. *Recreating Health Professional Practice for a New Century.* December, 1998.

competencies, which are aimed at a broad array of health professional education programs, should be used as benchmarks for the AHC schools/colleges.

In addition to providing qualified and relevant health care providers, the AHC provides a unique and crucial contribution through the development and dissemination of knowledge. The needs of the community are great and pervasive, thus the AHC needs to make thoughtful, wise decisions about where it can invest its resources to be responsive to the needs of the community.

Health profession work force issues are crucial. The profession of nursing, in particular, is on the brink of experiencing a long-term shortage of nurses. Work force issues go beyond the number of health care professionals that are needed. These issues include preparing health care professionals that can address the growing aging population as well as the increasingly diverse population of persons from other cultures and ethnic backgrounds. The AHC needs to take a leadership role in addressing these work force needs, but remain attentive to the quality of the education program and the graduate.

The School of Nursing is unique in that it has the only doctoral nursing program in the State and addresses the current and future shortage of nurses for faculty positions in schools of nursing and leadership and research positions in service, education and policy settings. Further, its large graduate program prepares nurses for advanced practice and leadership positions.

The AHC needs to create a state-of-the-art infrastructure to achieve the three missions. To be a significant leader in the state, nation and world, we need facilities, buildings, classrooms, technology and staff to support the missions. The vision about that infrastructure should be determined and shared by all schools/colleges.

How will we become a leader in the health care delivery system?

The AHC has a unique opportunity to serve as the leader in shaping the health care delivery system through designing, testing and evaluating interdisciplinary team care models. The shrinking health professional work force, as well as demographic changes, demand that we figure out models of health care for the future that will most effectively use the existing and future health care professional work force and ensure that is responsive to the needs of the community. This challenge is best met by the AHC because it draws on the three missions: research, education and service/practice and requires integration of these three missions. Further, the AHC has a rich array of health care disciplines and professions in its schools/colleges/units—unlike any other university or school in the State.

Historically, the nursing profession has implemented numerous innovative community and institutional-based care delivery models which have been based on the specific needs of the community. Nurses are skilled in team care and working collaboratively with other health care professionals. The School of Nursing is prepared to provide leadership and collaborate with other AHC schools/colleges in developing innovative care delivery models that foster interdisciplinary team care. The School's Densford Center for Nursing Leadership is a valuable resource for such efforts.

The culture of the AHC has to change in order for the AHC to have the leadership role in shaping health care delivery through interdisciplinary team care models. The new culture must reflect collaboration to facilitate interdisciplinary education, research and practice. Individual competition for intramural and extramural resources has to be minimized and incentives to secure resources through collaboration has to be promoted.

A key factor in becoming a leader in the health care delivery system is through partnerships with organizations, agencies and communities. These partnerships can be developed most successfully when there is a collaborative approach among the schools/colleges. Faculty need support for their "outreach role" to facilitate partnerships and collaborative efforts with community partners.

What is our vision for the health professionals we educate?

Health care professionals need to meet the *Pew Commission's Health Professional* competencies referred to earlier. However, four competencies were emphasized through deliberations with School of Nursing faculty. The first competency was the ability of health care professionals to anticipate and adapt to change and to be leaders who are able to make changes in the health care delivery system. The second competency was functioning as an effective member of an interdisciplinary team. To that end, all health care professional students in the AHC need to have at least one substantial interdisciplinary education experience. The third competency underscored by faculty was having proficiency in the use of technology as a prerequisite for using evidenced-based practice. The fourth competency emphasized was demonstrating knowledge, sensitivity, and skill in providing health care to persons who are from other cultures and ethnic backgrounds.

The majority of the clinical education of health care professional students has been in hospital settings. That "clinical laboratory" is no longer viable for a variety of reasons, the foremost is that health care services are increasingly provided in non-institutional settings. We need to reconceptualize the "clinical laboratory" for educating health professional students. Again, schools of nursing have had a long history in successfully developing and using community-based settings enabling students to learn how to provide health care for individuals,

families, populations and communities. The School of Nursing brings that expertise and experience to the AHC as the AHC schools/ colleges consider new and relevant ways to provide clinical education opportunities for student learning. These opportunities will be achieved through the development and sustainment of partners with community-based organizations and communities that can provide learning experiences for students and are willing to collaborate on the education process.

How will we support research and how will we become top ranked in research performance?

There was no question that a unique and essential contribution of the AHC is the creation and dissemination of new knowledge. To that end, the School of Nursing has recently initiated two Centers of Excellence for Nursing Research—one with a focus on research related to the care and services to elders and the other with a focus on health promotion for families and children. These Centers are intended to be a viable resource for obtaining external funding to support faculty research and graduate and post-doctoral student research. Investment and support of these Centers, as well as others initiated by other schools/colleges, are necessary in their early development so that they can be successful in becoming national centers for excellence in research and subsequently become self-sustaining.

Resources to support the research mission are essential and need to be attended to on a regular basis. In addition to using resources to attract and retain senior faculty researchers with national and international reputations, the AHC needs to significantly invest in the new faculty. Such investment would include substantial seed money and "protected" time in the first several years for new faculty to initiate a research program.

The realization that the University "lost" a natural research partner with the University Hospital requires that the AHC seek out new partners. Seeking new partners should be a collaborative effort among the AHC schools/colleges. The collective strengths of all the colleges/schools will attract viable and sustaining research partnerships.

There needs to be improved communication among AHC faculty regarding their research such that interdisciplinary research efforts can be spawned. System changes need to be made to reward interdisciplinary research.

How will we meet the challenge of the electronic age?

The electronic age represents more to the AHC than distance learning. It includes a means to:

- conduct research with partners across the globe;
- provide health care;
- seek and find information;
- efficiently store, access and retrieve information (databases);
- communicate with colleagues, graduates, students and patients;
- promote the mission and services of the AHC to Minnesotans.

Technology is a tool to enhance all three missions of the AHC. It should not be a driver, but should serve as an essential resource to meet our missions. For that reason, it is essential that the AHC have a strong, effective infrastructure to support the use of technology for all three missions. That infrastructure needs to start with technology improvements in the classroom. We need adequate numbers and quality of personnel to support an infrastructure for technology. What we have today is simply inadequate.

Specific to technology enhanced learning (TEL), we need to take a watchful, but proactive approach. Quality of education for students should not be compromised, regardless of the methodology to deliver that education. We need to pay attention to our competition of other degree granting institutions using TEL, but we should be proactive rather than reactive in regards to such competition.

How do we develop a culture of accountability, in both internal and external relations, with an environment of good communication and consultative decision making?

To develop a culture of accountability and an environment of good communication and consultative decision making, all schools/colleges/units in the AHC need to be acknowledged and valued for the contributions made to the AHC. There is a perception that the loyalty and interest of the AHC is the medical school. The AHC is more than the medical school and that needs to be talked about, demonstrated and illustrated in public arenas. There are questions about whether the interests of **all** the AHC schools/colleges are being represented and whether the AHC administration is able to represent and give voice to all schools in the AHC. Real or perceived perspectives that the non-medical school colleges/schools are not equal players in the AHC is damaging and gets in the way of things such as strategic planning for the AHC. Added to this is that all the AHC schools bear the burden of negative publicity. This has resulted in a fair amount of resentment toward the medical school and creates barriers to accomplishing the collective mission of the AHC.

The "language" used in public arenas when referring to the AHC can have a significant impact on how the public understands the purpose and mission of the AHC. Nursing, in particular, does not view **medical** care and **health** care as synonymous. Yet, there are innumerable times in which the term **medical** care is used interchangeably with **health** care in

public arenas, subsequently highlighting the medical school as the focus of the AHC. Medical care focuses on the diagnosis and treatment of diseases—usually of individuals. Health care has a much broader perspective and includes medical care, but also the prevention of diseases, promotion of healthy behaviors, and assisting individuals and families in the management and coping with chronic disease. The focus is on the health of individuals, families, communities and populations. Using the language of **health** care rather than **medical** care also leaves room for complementary approaches to health care including an emphasis on spiritual health and the link between mind and body. All the AHC schools/colleges contribute to health care. For those representing the AHC in public arenas, there needs to be a higher consciousness about the language used and the resulting implications of this lack of consciousness.

The issues regarding language and perceived valuing of one school over others can be minimized if we are able to create a **collaborative** culture of accountability. Collaboration means sharing the risks, responsibilities, resources and rewards. We have a system and culture that includes favoring rugged individuals who do what they need to do to get things (e.g. tenure, funding, awards). We have created structures of power and inequities that lead to this. We need a system and culture to favor collaboration. Demonstrating the value and contributions of all schools/colleges, internally and publically, is a first place to start. Creating incentives and rewards at the AHC level for interdisciplinary and collaborative efforts among the colleges/schools will go a long way to changing the culture of the AHC and eliminating the perceptions of who or what is valued the most in the AHC.

The often quoted statement from Dickens is fitting for the AHC: "These are the best of times and the worst of times." The "worst of times" too often captures and drains our energy as the AHC struggles with shrinking resources. However, crisis creates opportunities and the AHC

is in unique position to take advantage of those opportunities. Thus, these are the "best of times" to take advantage of opportunities to develop new partnerships for research, education and service. The collective strength of the schools/colleges that make up the AHC place it in the unique situation to design, test, and evaluate innovative interdisciplinary health care delivery models and concurrently provide interdisciplinary education opportunities for students. The key to the success of the AHC is developing and building on the collective strengths of the colleges/schools to promote their individual contributions as well as the contributions they can make to the health of people through collaborative research, education and service. The School of Nursing is fully prepared to work as a collaborative partner to promote the three missions of the AHC.

Appendix A

Fourth Report of the Pew Health Professions Commission. *Recreating Health Professional Practice for a New Century.* December, 1998. Pp. 29-43.

The competencies, as presented here, are abbreviated. Each competency has suggested strategies which can be used by health profession education programs to achieve the competency. The full document can be viewed on the world wide web at http://www.futurehealth.ucsf.edu/home.html.

Twenty-One Competencies for the Twenty-First Century

- **Embrace a personal ethic of social responsibility and service.** The definition of professionalism for health care clinicians ought to be expanded to include service to society. For example, health profession education programs should institute a community volunteer or service-learning requirement for all students.
- **Exhibit ethical behavior in all professional activities**. Health professionals need to demonstrate respect for the privacy and dignity of patients, being accountable to the community for their clinical judgements and foster equity in the delivery of health care.
- **Provide evidence-based, clinically competent care.** Health professionals must be able to evaluate a variety of sources on care-related evidence, including current research findings and clinical practice guidelines and apply them appropriately to the management and treatment of disease.
- **Incorporate the multiple determinants of health in clinical care.** In addition to physiological determinants of human health, the emotional, pyschosocial, cultural, economic, environmental, geographic and political factors have a profound effect on the health of individuals and communities. An understanding of these multiple determinants is necessary to enable providers to focus their care appropriately and link with other providers and community resources.
- **Apply knowledge of the new sciences.** Today's practitioners must at least understand the basics of the new sciences (e.g. pharmacoeconomics, pschoneuroimmunology) and their vast human and social implications and advocate for their cautious and ethical application to health care.
- **Demonstrate critical thinking, reflection and problem-solving skills.** Health professionals must be able to apply analytical reasoning, reflection, and rational problem-solving skills, using verifiable information and clinical judgement, in order to choose among or create alternative solutions to clinical problems. They must recognize the contextual nature of health care and be able to use their analytical skills to adapt evidence-based guidelines to unique and novel situations.
- **Understand the role of primary care.** All health practitioners should understand the value and role of primary care and for those choosing not to work in primary care, they must be able to work effectively with primary care providers in the delivery of comprehensive care.
- **Rigorously practice preventive health care.** Such practice should be evident in the health care professional's own life as well as in how they help their clients and communities learn self-management skills that promote and protect their health.

- **Integrate population-based care and services into practice.** Health professionals must adopt a population-wide perspective of health care that encompasses the knowledge and methods of clinical epidemiology, biostatistics, behavioral and political sciences, and their application to the communities or defined populations with whom health professionals share responsibility for health outcomes.
- **Improve access to health care for those with unmet health needs.** Health professionals have a responsibility to improve access to basic health care services by distributing health resources as widely and efficiently as they can, and by acting as public and private advocates for individuals and communities with unmet health needs.
- **Practice relationship-centered care with individuals and families.** Fundamental to professional practice is the ability to communicate and interact with these parties clearly, effectively and appropriately. Health professionals must have the skills to convey ideas clearly and concisely both orally and in writing, listen openly and empathetically, and resolve conflicts. Health professionals must also have a desire and ability to convey compassion for people's experience of health and illness, including the meaning it holds for them in the context of their lives.
- **Provide culturally sensitive care to a diverse society.** To provide appropriate and effective care, health professionals must understand how culturally learned values and customs affect people's health beliefs and practices. Health professionals must use this knowledge to collaborate with individuals and communities to provide health care that is sensitive to and consistent with cultural values, beliefs and customs.
- **Partner with communities in health care decisions.** Health professionals must work to reconnect health care resources with the communities they serve. Health care professionals must embrace individuals, families and communities as full and equal partners in health care decisions and provide them with information they need to consider available alternatives and make informed choices for themselves.
- **Use communication and information technology effectively and appropriately.** Health professionals must be willing to work cooperatively with information systems officials in an ongoing effort to build and refine information technologies. A general awareness of the capabilities of computers and networks, as they apply in both the professional and personal environments, will be invaluable help in making clinical and administrative systems work to the benefit of patients and clinicians alike.
- **Work in interdisciplinary teams.** The coordinated efforts of practitioners from many disciplines provide the best outcomes for the sickest patients. To assure effective and efficient coordination of care, health professionals must work interdependently in carrying out their roles and responsibilities, conveying mutual respect, trust, support and appreciation of each discipline's unique contributions to health care.
- **Ensure care that balances individual, professional, system and societal needs.** As newer life-saving and life-sustaining technologies evolve, including gene therapies, individual patients and practitioners as well as society will be faced with increasingly difficulty choices about the distribution of health care resources. Health professionals must be prepared to assist individuals and families consume these resources in a competent, rational and cost-effective manner.

- **Practice leadership.** The complexity and integration of health care services in the emerging systems of care require health professionals to be able to work effectively within and across complex integrated organizational and institutional boundaries. This will require health professionals that can think and act from the perspective of the system.
- **Take responsibility for quality of care and health outcomes at all levels.** Practitioners must accept accountability for their individual competence and performance and be fully aware of the standards and practices of their profession. They must acknowledge their part in documenting the accountability of their health care team and institution.
- **Contribute to continuous improvement in the health care system.** The principle of continuous improvement should become a routine part of clinical care. The ability to apply systems thinking, measure variation, and organize and use information is essential if health professionals are to continuously improve the processes, outcomes and cost-effectiveness of health care for both individuals and populations.
- **Advocate for public policy that promotes and protects the health of the public.** Health professionals must at least be aware of and ideally politically active in the advancement of public policy affecting the health care system. Given their expert knowledge and direct involvement in providing or administering health care, they have a special obligation to act on behalf of and in concert with the public as advocates for healthy public policy.
- **Continue to learn and help others learn.** Health professionals must embrace a career-long commitment to continuous learning and to continuously improve their knowledge and skills to ensure their relevance and competence throughout their professional careers.

AHC STRATEGIC PLANNING INITIATIVE 2000

Dental Subcommittee

To the Dental Faculty in Draft Form and for Discussion

(Draft 3/29/00)

Introduction:

This report is the Phase I response of the School of Dentistry to the charge given by Dr. Frank Cerra, Senior Vice President, to the executive committee for AHC Strategic Planning Initiative 2000. This charge takes the form of six defining questions raised in Dr. Cerra's speech of October 25th 1999, and reiterated in his email memo "AHC Strategic Planning Update" to the AHC Community on January 24th 2000.

Since Phase I is a college response, this report is organized at two levels:

1. In the first level, the Academic Health Center is considered as an integrated whole. It is our understanding that the principal driving force behind the strategic planning effort is to identify ways in which the component units can more effectively function together as an integrated AHC. It is believed that this will lead to new, innovative ways of working together and that collaborations will be identified resulting in a synergistic outcome with the whole AHC greater than the sum of its individual parts. This should also result in more effective use of limited resources.

2. There is a second level, which is an important and necessary part of the process. Our deliberations have uncovered key problems facing our individual unit. These are not always clearly linked to the first level. The School of Dentistry is uniquely charged with providing quality clinical dental care, producing quality dentists and dental hygienists, and investigating the many questions affecting oral health and disease. A culture, parts of which are unique, is not peculiar to our School, but is common to all of the units within the AHC to some degree. Each of us is charged with a well-known tripartite mission, which is linked to our own discipline. This results in unique cultures in terms of service, education and research.

It is our hope that future phases of the strategic vision process will give appropriate weighting to the first and second levels of this and other reports. Our ability to work together as an innovative AHC system is predicated entirely on each individual unit's strength in meeting its core mission. In summary, we need to foster a close relationship for those activities which should be shared and we need to foster opportunity for the unique things each of us do.

Process:

The Dental Team consisted of a core committee of six members and thirteen dental advisors. The committee was comprised of Chair, William Douglas and members, Gary Anderson, Kathy Newell, Bob Ophaug, Don Simone, and Dan Skaar. Following an invitation to the dental faculty for nominations, the following advisors were selected: Bruce Pihlstrom, Noah Sandler, Steve Shuman, Darryl Hamamoto, Mark Herzberg, Jorge Perdigao, Joy Lua, Joel Rudney, Mike Speidel, Gary Hill, Nelson Rhodus, Burt Shapiro, and Jill Stoltenberg.

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The committee invited advisors for a series of noon plenary meetings, with three to four advisors per meeting. In this context the defining questions were debated. In an equal number of other meetings, the committee alone reduced the minutes from the plenary meetings to the form presented here.

Each of the following defining questions carries an implicit problem or difficulty to be dealt with. Our responses to these questions take the form of bulleted items of various lengths. The responses are either in the form of a suggested solution, an approach, an observation, or a concern. It will be clear from the context, which of the kind of response is being made.

Some of the responses cut across more than one question, and it is the committee's belief that these may offer more viable and credible opportunities for integration and participation within the AHC.

Six Defining Questions:

1. What is our role in the health of Minnesotans - our land grant mandate?

A) AHC Level

- Our role is to provide access to Health Care for all citizens and Minnesota residents. This must now become a primary focus of effort and the standard by which we measure our success.
- AHC must recognize the importance of quality of life Healthcare services for our patients. As life span increases, there is a need to place an increasing emphasis on services, which improve quality of life, in contrast to more traditionally supported acute medical services. Dentistry, physical therapy, occupational therapy, nursing, pharmacy, public health and varied medical disciplines all have important contributions to make.
- Training of HealthCare professionals who can serve effectively in all demographic sectors and locations within our State.

B) Dental School Level

- Address the disparity of "access to dental care" issues within the state. Access to dental care is a state and national problem recognized at all levels. An approach should be developed to the following opportunities: 1) Dental outreach programs for under-served populations, which integrate with comprehensive health care initiatives. 2) Delivery of dental care at the School for Medical Assistance and Medicare Patients as long as operationally feasible.
- Train dentists who are able to diagnose and treat a broad range of dental conditions needed by an aging Minnesota population. Address on an interdisciplinary basis the medical implications of dental diseases and associated therapies.

2. How will we be a real player in the health-care delivery process?

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- Much of what has been said under Question 1 could be repeated here. We must become the provider of choice, by ensuring patient satisfaction, and meeting all of the health care needs.
- The AHC must function as a seamless integrated health care system, offering comprehensive health care coverage.

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- Dentistry should contribute more to the creation of a seamless, integrated health care system within the AHC. This can be achieved through activities of the Hospital Dental Clinic/ General Practice Residency in caring for medically complex, transplant and cancer patients. Other services should be provided by the divisions or programs in Oral and Maxillofacial Surgery; the Maxillofacial Prosthodontics; Pediatric Dentistry; TMJ and Orofacial Pain. The consulting and diagnostic services provided by the Divisions of Oral Medicine & Oral and Maxillofacial Radiology and Oral and Maxillofacial Pathology should also be included. These clinical services must address issues of referral, service, and contracting for all AHC patients. The AHC must gain fuller awareness and appreciation for the skills of all players within the AHC.
- Build on the existing models within the AHC outreach, such as the Wilder Center, which started as dental outreach and has grown into AHC outreach.
- Remove the physical and other impediments to care and patient-centeredness. Improve parking, Signage, and provide information staff and coordinators, to improve interaction and patient flow between the varied clinics of the School of Dentistry.

3. What is our vision for the health-care professionals that we train?

A) AHC Level

- Improve School of Dentistry Contribution to AHC Curriculum: There is a strong belief that Dentistry can contribute to the education of other health-care professional students regarding oral health and disease. An organized educational process regarding dentistry for the rest of the AHC should be considered. Such interactions among the AHC units will train health care professionals skilled and comfortable with providing care within a team setting.

- Improve Basic Science Curriculum: The basic science curriculum can be shared across the AHC, but up to a point. Once the common background is delivered, there is a strong sense that discipline specific material within dentistry is of importance. This is likely to be true in the other units.
- Develop Multiple Degree Opportunities: Promote flexibility for unique academic programs leading to degrees in multiple disciplines, e.g. DDS, MD, PharmD, PhD. This should be considered in the broadest sense across the entire University, e.g. JD and MBA. The human resources/appointment system for the University should support these options. This flexibility may produce our future leaders.

B) Dental School Level

- Institute Curriculum Review: There is need to set up a process for continual curriculum review and revision based on evidence. If outdated techniques are dropped from the curriculum it will allow inclusion of new development/technology, e.g. complete dentures dropped and dental implants added.
- Develop Graduate Evidence-based Practitioners: The practice of general dentistry continues as a technical, surgical field and graduates must be ready to practice immediately upon graduation (unlike our medical colleagues with mandatory residency programs). Careful thought and consideration needs to be given to the development of graduating dentists with critical evaluation skills, who are still competent surgical technicians. Consideration should be given to expanded technical duties for support staff, e.g. dental hygienists, analogous to the nurse practitioner of medicine (there is already some evidence for this in orthodontics). Current and future graduates must be trained in disease management, as well as surgical intervention. The role of science in the clinical curriculum, beyond the basic science courses, is of great value in the teaching of critical thinking skills. This will require a new role and new incentives for clinical faculty. In some cases it may require different faculty. The present and future roles of the Patient Care Groups (PCGs) need to be carefully assessed.
- Implement Riverwood Model: There is interest in a faculty-driven model for clinical education with improved translation to the current practice of dentistry as compared to our current clinical organization. It will require data management support, faculty commitment and manpower, and possibly increased staff and materials. This model would facilitate the training of evidence-based practitioners in dentistry and dental hygiene. A plan for this model has been outlined in detail by Dr. Ralph Delong, Dr. Gary Hill and others, but has not been implemented due to lack of resources. (This is referred to elsewhere in this report).
- Extend Clinical Outreach: This activity could compensate for educational experiences and exposures unavailable on site. Downsides are loss of clinical income and difficulties in standardizing faculty instruction and assessment.

4. How will we achieve top-ranking in research performance?

A) AHC Level

- Hire faculty willing to interact across the AHC. "The opportunities are huge for those who reach out," and there are many successful examples within the School.
- Create "incubators" built around a research question, e.g. pain, where dental faculty have realized considerable success through interaction. Incentives for these interactions must be real, as at times our most effective cross-disciplinary collaborators within Dentistry are penalized by our P&T system.
- It is important not to discount the individual investigator's ability to identify future questions of importance and forge the relationships necessary for effective investigation. Good research is not usually "top down," but "bottom up." The AHC environment needs to be flexible enough to provide opportunity for this, at times unpredictable process, and not tie up all resources in the large-scale efforts driven from above.
- Large, expensive technologies can be shared but we need to ensure equitable access.
- Strengthen existing NIH competitiveness, but seek out new partnerships in the research enterprise. These may include industry, foundations and institutes. This may require a cultural change and seeking of new mechanisms of research administration that mesh with strategic plans of new partners.

B) Dental School Level

- Research should be expanded in relation to service. Examples would be increased emphasis on health services research, and prevention of dentally-related diseases.
- There needs to be renewed emphasis on clinical research, with a view to developing better evidence-based treatments.
- The School has a responsibility to find ways to support oral health research, which may not show direct connections to the rest of the AHC. This case must be effectively made at the highest levels of the AHC.

5. How do we exploit the technology of the electronic age?

A) AHC Level

- Electronic patient records are required to enable more effective delivery of integrated care across the AHC.
- It is suggested that there be the development of high-speed lines to transfer large images and large files and enable true electronic data conferencing.
- Develop Digital Medicine, which consists of intelligent 3D renditions of the patient on the screen to encourage new methodologies in education, diagnosis, cooperation and long distance consultation.

B) Dental School Level

- There is a need for an information system, which can provide data for patient management, outcome assessment, student evaluation, faculty evaluation, billing, etc. This is also required for the so-called Riverwood Model in dentistry where the faculty take primary responsibility for patient care and distribute the cases to the students under

their supervision. Such an information system would facilitate certain aspects of Health Service research.

- Development of the Virtual Dental Patient, which is a subset of Digital Medicine, as described above, and for the same reasons.

6. How do we develop a culture of service and accountability, in both internal and external relations, with an environment of good communication and consultative decision making?

A) AHC Level

The faculty in the varied AHC units would benefit from better understanding and respect each other's skills and abilities.

B) Dental School Level

- There is need to improve internal communication and to build a sense of trust within the School of Dentistry. An appreciation for the importance of all of the players within the School needs to be fostered.
- Clinical Track Faculty: There is need to develop clear job descriptions for the Clinical Track faculty, which includes some level of scholarly activity. This could be linked to merit incentives such as longer contracts. The Clinical Track faculty should be made voting members of the School. Increased scholarly activity throughout the clinical faculty would foster an appreciation for the scientific method and clinical thinking on the clinical floors. This is vital to the training of evidence-based practitioners.

AHC Vision & Planning
COLLEGE OF VETERINARY MEDICINE (CVM)
Executive Summary
4/7/00

Introduction:

The CVM Vision & Planning Committee was formed from a mixture of the elected faculty on the CVM Strategic Planning Committee and other faculty appointed through a consensus process among Dean Jeffrey Klausner, Faculty Council Chair, Alan Lipowitz, and Dan Feeney (the Academic Health Center (AHC) Strategic Vision Executive Committee member serving as CVM Strategic Planning Committee Chair). Input from faculty, staff, students and non-CVM constituents was solicited and was incorporated into 6 "brainstorming" sessions held to address the questions posed by AHC Administration. Internal Subcommittees were defined to prepare specific responses to each of the 5 "Defining Questions". Those reports are attached. Once near final draft reports were prepared, they were made available for CVM faculty, staff & student comment before final reports were prepared for submission.

The underlying theme in this report is one of connectedness and functional linkage both within the CVM and by the CVM to its clients, constituents and the rest of the AHC. The CVM must be recognized in its role as a major player in endeavors affecting the entire AHC including genomics, food safety and zoonoses. This exercise was a combination of defining the CVM's current status (Where is the CVM now?), visioning for the CVM's future (Where do we want to be in the next 3 - 5 years?), and assessing the political/fiscal realities for the CVM (What will it take to get where we want to be?). This Executive Summary provides an overview using this approach, where applicable, to each of the Defining Questions.

Defining Questions:

1. What is our role in the health of Minnesotans, our land grant mandate?

. The CVM role in Minnesotans' health is far reaching. From an education perspective, it includes training the next generation of veterinary practitioners, and offering continuing education/update/retool programs for the State's veterinary professionals. From a community service perspective, it includes providing referral, diagnostic and consultation services to veterinary practitioners and livestock producers, protecting and improving the safety of the State's food supply, and serving as a sentinel for diseases and agricultural-related environmental circumstances that may affect Minnesota's animal and/or human populations. From a research perspective, it includes the continuous quest to identify, treat and eliminate diseases or circumstances affecting animal health, the identification and humane utilization of animal models for human disease, the understanding of and promotion of the human-animal bond and its importance to human physical and mental health, the development and utilization of advanced technologies (e.g. molecular and genetic processes) to facilitate animal production and human/animal well-being, and to serve as a source of "cutting-edge" bioinformation and economic analyses for Minnesota's agricultural production and companion animal consumers, practitioners and consultants. To fulfill this "big picture", the CVM must expand its collaborative liaisons across the AHC, it must foster its relationships with producers and practitioners, and it must increase its visibility and role in animal research related to human health. The future must include incorporation of user-friendly, internet-based access ports to CVM databases and CVM experts which can be a combination of fee for service and extension/land grant missions.

2. How are we going to be a real player in the health care delivery process?

The CVM has 3 major portals for its health care delivery endeavors. These include the Veterinary Teaching Hospital (VTH), the Veterinary Diagnostic Laboratory (VDL), and the CVM's heard health management programs. All of these missions should be nurtured and expanded to serve the needs of the State. The VTH is currently the only full-service referral veterinary hospital in Minnesota and, although growing, it must expand both its markets and its capabilities to maintain its market share. The VTH has become a massive referral practice in which teaching of veterinary students, interns, residents and graduate students occurs. It relies primarily on income generation for its survival because less than 15% of its operating budget comes from State/University of Minnesota revenues. The rest is income from services rendered to clients. The VTH has suffered from its initial and continued underfunded status, but has prospered despite its heavy commitment to education. The VTH needs to expand its operation beyond the St. Paul Campus for all of its teaching, service and research endeavors. It needs an infusion of capital

(approximately $3.5M on a one-time basis) and restoration/expansion of teaching and research faculty (approximately $1.2M/year recurring) to jump-start its quest to be both full-service and "state of the art". Details and financial needs are outlined in the attachments. Capital requests for VDM "state of the art" and faculty improvements are $ 1.12M, one full faculty FTE and four half faculty FTE's (the other half to be funded through VDM) for the next biennium." Included in these VTH & VDM needs are those related to electronic communication, database management, and accountability.

The VDL like the VTH is experiencing volume growth from fee for service and research users and an expansion of offerings due to technological developments. Because of its multifaceted mission of monitoring production and companion animal disease, developing more sensitive and specific diagnostic techniques, and providing current and applicable information to the practitioners, producers, and private consumers of Minnesota, internal updates related to infomatics, molecular and genetic techniques, as well as faculty positions to support these expansions will be necessary. Details and financial needs are outlined in the attachments.

The CVM must maintain and expand its connectedness to the livestock producers of Minnesota through its heard health economics and management programs. These programs are research-based and some are unique to the University of Minnesota. Their relevance to the economic health of Minnesota livestock producers, the economic impact of livestock production on Minnesota consumers, and food safety cannot be overstated. These programs need to have broader recognition across the State for their contribution as well as within the AHC as a source of research collaboration.

3. What is our vision for the health professionals that we education and train?

The CVM has the dual strength and potential of producing both graduate veterinarians as well as specialty and/or advanced degree trained veterinarians and researchers. The vision for the Doctor of Veterinary Medicine (DVM) students is one of having "practice-ready" skills (including business and ethics), possessing the basic skills to pursue employment paths other than classical practice (e.g. industrial medicine and research, public/government practice, environmental/zoonotic monitoring, etc.), and promoting lifelong learning (including skills related to electronic communication and continuing education). These endeavors require continued awareness of the advantages of this profession through public information campaigns, a pool of talented and dedicated applicants (which is currently very strong and must be maintained), sources of financial aid to allow opportunities for those of all socioeconomic and ethnic backgrounds, a diverse and talented faculty (which has suffered due to recurrent retrenchments), an efficient and user-friendly curriculum with course offerings applicable to professional (DVM) and graduate students as well as post graduates wishing to update or retool. These endeavors require conscious evolution which has been occurring and will continue to occur. The vision for the clinical specialty and graduate degree training programs is to provide the best possible training to ensure these individuals are highly competitive in both the referral practice and academic arenas. However, increased faculty and technical support positions and well as infrastructure development will be needed to realize these visions.

4. How will we achieve being top ranked in research performance?

The CVM currently has a largely untapped research potential. While the College has strong, individualized research programs in companion and production animal medicine/management, pathologic mechanisms/origins of disease, molecular biology, genomics and food animal biotechnology, integration of these programs across applicable disciplines has never been achieved. The concept of multidisciplinary research teams from within the College and other AHC or Agricultural Institute experts has been advanced by the CVM Strategic Vision Committee. The impetus here is to capitalize on the combined clinical and basic expertise available in the College. This would foster research relevant to the conditions recognized in the clinical/applied CVM endeavors which can be investigated in collaboration with the CVM management and molecular experts. These research teams may be constructed around species or body systems. This collaborative approach would make optimum use of the CVM's collective academic potential and effectively utilize those with proven grant-writing expertise. This team approach would enable the CVM to develop relationships with private industry, other AHC units and the College of Agriculture to foster research funding as well as having prepared groups to pursue grant opportunities promptly as they come available. Coordination would occur at the level of the CVM Associate Dean for Research.

5. How will we develop a culture of service and accountability (internal and external) with an environment of good communication and consultative decision making?

The University of Minnesota has regularly used the dubious process of incremental budget modification (usually retrenchment) without regard to its differential effect on core teaching, research or service programs, evolving programs in any of these areas, or the effects on the faculty or staff. Faculty cannot be held accountable for situations beyond their responsibility. Being asked to responsibly shepherd resources is one aspect. However, being financially crippled but told to "do good things" without the necessary resources is quite another. The CVM suffers from economic strangulation. The institution is afflicted by analytic paralysis (based in part on protectionism) rendering it unable to define what it takes (e.g. academic positions, space, support staff, infrastructure) to do a specific job (e.g. train professional or graduate students, provide public service, perform research, maintain professional accreditation). The AHC needs to develop metrics related to effort needed for and effort expended on teaching, research, and service. The AHC also needs to identify what it actually needs in the way of faculty and staff positions (full-time equivalents [FTE's]), space, etc. to do the things it must do. A long-term plan should be in place to permit the institution, the AHC and the DVM to make thoughtful position and fund allocations based on the needs in and expectations for any specific area (e.g. college, department, service portal, etc.).

This need for "right-sizing" goes beyond having defined and adequately funded core programs. It must also encompass accountability within those programs through analysis of defined metrics. In addition, it places appropriate perspective and priority on programs that are not core, but which are complementary to (but not essential for) core programs. Retrenchments tend to weaken core programs and new initiatives rarely rebuild these core programs. In those noncore programs, funding alternatives must be explored, but there should be no expectation that such programs will continue unless they become self-supporting. This accountability must be based on a combination quality assessment, income generation, relationship to program accreditation, costs, operation efficiency and quantifiable products/output/effort. Formula-based fund/FTE allocation coupled with appropriate incentive plans developed in an environment of broad faculty, staff, student, and constituent consultation may be the key to defensible legislative requests, justifiable program decisions (e.g. phase-out, maintain, enhance, initiate), realistic faculty expectations, and appropriate faculty recognition and rewards. Details related to CVM teaching, research service, professional development and web challenge are included in the attachments.

There is also a need for administrative accountability. This is particularly notable for the faculty and staff working in the units managed by specific administrators. Decisions should be based on broad input and the outcome justified to the faculty and staff affected. This is how "buy-in" for change can be achieved without resorting to "top-down" authoritarian measures which rarely result in willing participation by those doing the work. This is particularly important for AHC and CVM units involved with revenue generation.

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- Improve School of Dentistry Contribution to AHC Curriculum: There is a strong belief that Dentistry can contribute to the education of other health-care professional students regarding oral health and disease. An organized educational process regarding dentistry for the rest of the AHC should be considered. Such interactions among the AHC units will train health care professionals skilled and comfortable with providing care within a team setting.

- Improve Basic Science Curriculum: The basic science curriculum can be shared across the AHC, but up to a point. Once the common background is delivered, there is a strong sense that discipline specific material within dentistry is of importance. This is likely to be true in the other units.
- Develop Multiple Degree Opportunities: Promote flexibility for unique academic programs leading to degrees in multiple disciplines, e.g. DDS, MD, PharmD, PhD. This should be considered in the broadest sense across the entire University, e.g. JD and MBA. The human resources/appointment system for the University should support these options. This flexibility may produce our future leaders.

B) Dental School Level

- Institute Curriculum Review: There is need to set up a process for continual curriculum review and revision based on evidence. If outdated techniques are dropped from the curriculum it will allow inclusion of new development/technology, e.g. complete dentures dropped and dental implants added.
- Develop Graduate Evidence-based Practitioners: The practice of general dentistry continues as a technical, surgical field and graduates must be ready to practice immediately upon graduation (unlike our medical colleagues with mandatory residency programs). Careful thought and consideration needs to be given to the development of graduating dentists with critical evaluation skills, who are still competent surgical technicians. Consideration should be given to expanded technical duties for support staff, e.g. dental hygienists, analogous to the nurse practitioner of medicine (there is already some evidence for this in orthodontics). Current and future graduates must be trained in disease management, as well as surgical intervention. The role of science in the clinical curriculum, beyond the basic science courses, is of great value in the teaching of critical thinking skills. This will require a new role and new incentives for clinical faculty. In some cases it may require different faculty. The present and future roles of the Patient Care Groups (PCGs) need to be carefully assessed.
- Implement Riverwood Model: There is interest in a faculty-driven model for clinical education with improved translation to the current practice of dentistry as compared to our current clinical organization. It will require data management support, faculty commitment and manpower, and possibly increased staff and materials. This model would facilitate the training of evidence-based practitioners in dentistry and dental hygiene. A plan for this model has been outlined in detail by Dr. Ralph Delong, Dr. Gary Hill and others, but has not been implemented due to lack of resources. (This is referred to elsewhere in this report).
- Extend Clinical Outreach: This activity could compensate for educational experiences and exposures unavailable on site. Downsides are loss of clinical income and difficulties in standardizing faculty instruction and assessment.

4. How will we achieve top-ranking in research performance?

A) AHC Level

- Hire faculty willing to interact across the AHC. "The opportunities are huge for those who reach out," and there are many successful examples within the School.
- Create "incubators" built around a research question, e.g. pain, where dental faculty have realized considerable success through interaction. Incentives for these interactions must be real, as at times our most effective cross-disciplinary collaborators within Dentistry are penalized by our P&T system.
- It is important not to discount the individual investigator's ability to identify future questions of importance and forge the relationships necessary for effective investigation. Good research is not usually "top down," but "bottom up." The AHC environment needs to be flexible enough to provide opportunity for this, at times unpredictable process, and not tie up all resources in the large-scale efforts driven from above.
- Large, expensive technologies can be shared but we need to ensure equitable access.
- Strengthen existing NIH competitiveness, but seek out new partnerships in the research enterprise. These may include industry, foundations and institutes. This may require a cultural change and seeking of new mechanisms of research administration that mesh with strategic plans of new partners.

B) Dental School Level

- Research should be expanded in relation to service. Examples would be increased emphasis on health services research, and prevention of dentally-related diseases.
- There needs to be renewed emphasis on clinical research, with a view to developing better evidence-based treatments.
- The School has a responsibility to find ways to support oral health research, which may not show direct connections to the rest of the AHC. This case must be effectively made at the highest levels of the AHC.

5. How do we exploit the technology of the electronic age?

A) AHC Level

- Electronic patient records are required to enable more effective delivery of integrated care across the AHC.
- It is suggested that there be the development of high-speed lines to transfer large images and large files and enable true electronic data conferencing.
- Develop Digital Medicine, which consists of intelligent 3D renditions of the patient on the screen to encourage new methodologies in education, diagnosis, cooperation and long distance consultation.

B) Dental School Level

- There is a need for an information system, which can provide data for patient management, outcome assessment, student evaluation, faculty evaluation, billing, etc. This is also required for the so-called Riverwood Model in dentistry where the faculty take primary responsibility for patient care and distribute the cases to the students under

their supervision. Such an information system would facilitate certain aspects of Health Service research.

- Development of the Virtual Dental Patient, which is a subset of Digital Medicine, as described above, and for the same reasons.

6. How do we develop a culture of service and accountability, in both internal and external relations, with an environment of good communication and consultative decision making?

A) AHC Level

The faculty in the varied AHC units would benefit from better understanding and respect each other's skills and abilities.

B) Dental School Level

- There is need to improve internal communication and to build a sense of trust within the School of Dentistry. An appreciation for the importance of all of the players within the School needs to be fostered.
- Clinical Track Faculty: There is need to develop clear job descriptions for the Clinical Track faculty, which includes some level of scholarly activity. This could be linked to merit incentives such as longer contracts. The Clinical Track faculty should be made voting members of the School. Increased scholarly activity throughout the clinical faculty would foster an appreciation for the scientific method and clinical thinking on the clinical floors. This is vital to the training of evidence-based practitioners.

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MEMORANDUM

April 11, 2000

TO: Board of Regents, University of Minnesota
FR: J. Finnegan, Associate Dean for Academic Affairs
School of Public Health
RE: Executive Summary, School of Public Health Input
Academic Health Center Strategic Plan, Phase I

Executive Summary

To assist Phase I AHC Strategic Planning, the School of Public Health (SPH) conducted two focus groups of faculty, students, and staff on February 15 and 21, 2000. The School's Policy Council served as the basis for this input. Since 1994, it has been the designated representative governing body of the SPH to assist and advise the Dean on policy issues and decisions. It is also representative of the School's constituencies including faculty, students and staff. In addition to the Dean, it is composed of 20 members of whom 9 are elected faculty representatives, 4 are division heads (and faculty), 3 are elected staff representatives, and 1 is the student senate co-president. The remaining 3 members are non-voting ex-officio members including two associate deans, and the chair of the AHC Faculty Consultative Committee.

In summary, the following key themes emerged:

The Central Role of Research

1) Research must be at the center of any AHC-wide vision. The AHC is the ONLY organization in the state with the full capacity to conduct cutting edge biomedical and public health research.

2) While faculty believe that the tripartite mission of research, education, and service is synergistic, they also acknowledge that what makes the AHC unique in the state is its research culture. Research drives improvements in patient care, public prevention and education, and the education of health professionals. To try to change the driving force of the AHC would necessitate creating a fundamentally different culture than currently exists. If research were NOT to form the center of the AHC vision, most faculty who COULD leave, would do so unhesitatingly. Under such conditions, Minnesota would have squandered a jewel in its scientific (and economic) crown.

3) Many faculty felt that basic research should be afforded a role in the AHC strategic plan. Government and corporate interests, it seems, are more interested in funding applied research rather than basic research. Yet without basic research, and some means to fund it, the intellectual platform for applied research starts to crumble and collapse sooner or later. There are many examples in the AHC's history of basic research providing later applications not dreamt of at the time. For example, an interest in basic research in human physiology led Ancel Keys and others to understand the role of dietary and blood lipids in human health.

4) The AHC vision with research at the center must include mechanisms to support the entrepreneurial scientific spirit and cross disciplinary team building activity that have built successful research enterprises in the AHC.

Ideas to Drive the AHC Vision

5) Chronic Disease Prevention and Management as an AHC-wide research, education, and outreach initiative emerged as a "20,000 foot" idea that may interest many of the AHC's diverse stakeholders and interest groups.

6) Developing the "Team Approach" to health care and prevention was a second idea suggested as an AHC-wide emphasis. The idea here was that the AHC should engage in a radical re-thinking of health professional education and practice based in a "team" concept that focuses on the patient AND the community and could include establishing clinical and community "laboratories" in key regions of the state.

7) Development of more and better public outreach and dissemination efforts. Participants were extremely impressed with the Mini Med School as a method of public dissemination and also building public support. Efforts like this should be institutionalized AHC wide, and other efforts using the Web (e.g., Cancer Center). There must be recurring support for these efforts.

The Problems of Finance and Management

8) Participants averred that any AHC strategic vision must include a fix of the Medical School's financial problems. Many participants expressed reservations about the AHC's capacity to pursue strategic directions absent some fundamental reordering of the Medical School's situation. Many view the decline of the Medical School (e.g., measured in national reputation) as "pulling us all down." Despite misgivings about the Medical School's financial management and concern that it has yet to make hard financial decisions, participants were unanimous in wanting the School to succeed but not at the expense of the rest of the AHC.

9) Some participants believe that financial changes are also needed at Central Administration before the AHC will have a stronger resource base to realize its strategic directions. For example, currently Central Administration taxes revenue

streams differentially. ICR, the primary revenue stream of the AHC, is taxed at the rate of 49 percent and garners some $30 million. Tuition, the primary revenue stream of the CLA, is taxed at 1% and garners some $1.7 million. Thus the perception exists on this side of Washington Avenue that the AHC is heavily subsidizing the rest of the University. In this light, Central is engaged in an income redistribution scheme which itself is partially causal of the AHC's (Medical School's) financial problems.

The Political Environment of the AHC and the University

10) Participants raised concerns about the style and quality of legislative lobbying and public communication surrounding the AHC's agenda. Participants were cognizant of the political environment surrounding legislative decision-making about funding the University of Minnesota and the AHC. The general perception was that the legislature today is much less interested in investing in the University and the AHC, but that the public do not understand the consequences of this on Minnesota's scientific, educational, and economic standing, nor on the availability of a high quality health professional workforce. Participants urged a more aggressive, sharp-edged approach to communicating with the public and legislature. Quiet, reasonable persuasion and cooperation apparently has not worked. The University and the AHC are easy to ignore; there are no political consequences for doing so.

11) Participants noted that many legislators complain that federal and corporate interests increasingly influence the health research agenda, and that the state has decreasing influence. This is largely a function of who provides resources. Federal and corporate research funding have been increasing. Over time, state funding has been decreasing. If the state wishes to reclaim its influence on biomedical and public health research directions, it could do so by creating a self-sustaining research endowment.

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Date: October 31, 1997

To: Academic Health Center Deans Council

From: Terry L. Bock
Chief of Staff

Re: Draft Work Plan

Enclosed is a draft copy of the AHC six month work plan for July through December 1997, our progress through November 1, and possible November and December priorities. Please review. We will discuss and finalize the plan at the Council's November 4 meeting.

enclosure

DRAFT

Academic Health Center
Work Plans for the AHC: July through December 1997

Broad Strategies	Activities	Progress through November 1	November/December Priorities
Improve the learning/working environment for students, faculty, and staff	• Improve the learning facilities and student environment across the AHC: classroom improvement, student common space, access to learning technologies • Develop plans for an AHC-wide Education Support Services unit to assist faculty to use technology in teaching and support their development as educators	• Planning underway for improving AHC classrooms. Vet Med classroom upgrade completed.	• AHC classroom improvement plan completed; implementation underway • Deans Council review of plans for AHC-wide Education Support Services Organization
Re-shape our educational programs to adapt to new professional roles	• Develop and allocate funds for interdisciplinary/interscholastic health education initiatives, creating national models of interdisciplinary health education • Study and decide the best approach for allied health professional education in the AHC • Expand the Rural Health School to increase the number of students and communities served • Complete planning for restructuring of the biological sciences • Develop better programs for identifying and recruiting graduate students • Collaborate with other University units in improving graduate education programs	• Five interdisciplinary/interscholastic education initiatives have been developed and funds approved • Task force on allied health professional programs has completed its work and forwarded its recommendations to the council • Rural Health School has expanded community sites from three to five • Plans for restructuring of the biological sciences are being forwarded to the faculty and senior administrators for review	• Work by education initiative teams underway • Deans Council review of allied health professionals task force report. • Planning for biological sciences reorganization completed and implementation begun

Broad Strategies	Activities	Progress through November 1	November/December Priorities
Direct our resources to focused programs of excellence in research and strengthen our partnerships with private industry	• Allocate AHC strategic research investment funds • Develop plans to strengthen the University's molecular and cellular biology programs • Implement an AHC private sector research services organization to enhance access and interaction with the private biomedical sector • Establish an enhanced technology transfer organization	• Proposals for legislative research initiatives have been developed and forwarded to the council for review • Plans for a molecular and cellular biology initiative have been developed; request for supplemental program funds from the legislature has been completed • Small grant and strategic investment process designed; applications are due October 31 • Plans for private sector research services organization completed; selection of director underway	• Deans Council approval of legislative research initiatives; work begun • Small grant and strategic investment applications reviewed and selected • RSO Director appointed and operations begun • New conflict of interest process implemented
Strengthen financial support for health education	• Lay the groundwork for an expanded "public utility model" for financing health education • Develop improved options for funding professional, graduate, and graduate professional education	• Active participation by AHC in designing the process and procedures for allocating MERC funds • Discussions with federal and state officials on future of graduate medical education underway	

Broad Strategies	Activities	Progress through November 1	November/December Priorities
Increase the scope and impact of our clinical programs	• Continue implementation of the Fairview/AHC affiliation agreement; strengthen linkages and working relationships at the senior administrative and operational levels. • Complete the integration of all Medical School faculty practices into University of Minnesota Physicians, including the transfer of personnel • Enhance utilization of the University's Dental Clinics and Veterinary Teaching Hospital • Address the issues of non-physician practice plans and multiple site practice by University health care providers • Support the development of new interprofessional health care delivery models, integrated with health education • Develop projections of the market needs for faculty clinical services • Explore methods for recognizing clinical practice in promotion and tenure decisions	• Joint Fairview/University committee of senior administrators established to coordinate and lead implementation • Integration of Medical School faculty practices into University of Minnesota Physicians is on schedule for January 1	• Report on Fairview affiliation prepared for Regents; work plan developed and implemented • Integration of Medical School faculty practices into University of Minnesota Physicians completed • Task force established to develop strategic plan for medical clinical services • Strategic planning for CUHCC begun
Strengthen our ties to the community, creating responsive and relevant relationships	• Develop external advisory groups • Develop a strong network of individuals in the community in support of the AHC and its schools and colleges	• Community open house during Yudof Inaugural Week	• External advisory groups appointed • Planning for major community outreach effort in 1998 underway

Broad Strategies	Activities	Progress through November 1	November/December Priorities
Expand the diversity of our student, faculty, and staff populations	• Establish an AHC task force to examine ways to enhance recruitment and retention of underrepresentated students, faculty and staff • Clarify the University's position on affirmative action • Unify the diversity programs of the AHC • Create opportunities for greater interaction across colleges for under-represented students, faculty, and staff • Develop funds for scholarships and recruitment	• Task force charge is being developed for council review	• Task force appointed
Expand the reach of our communications programs: develop an identify for the University of Minnesota's Academic Health Center and each college or school	• Complete a communications strategic plan and begin implementation • Expand people's sense of identify of the AHC and its schools and colleges, both externally and internally	• Communications strategic plan completed. Implementation begun. Three new internal publications begun. AHC event held during Yudof Inaugural Week. • Expanded media program underway	• Continued implementation of communications strategic plan

Broad Strategies	Activities	Progress through November 1	November/December Priorities
Improve the quality and efficiency of our infrastructure in support of our education, research, and outreach missions	• Implement the PIDP model • Establish planning systems within each school/college and the AHC that accurately project and monitor fiscal performance • Develop training and development programs to assure competency of all AHC staff who perform financial services • Develop a strategic plan for AHC facilities and facilities management • Develop a plan for replacing the JOML complex • Improve the effectiveness of the recruitment and hiring process for faculty and staff • Develop a strategic information technology plan • Integrate all colleges/schools into a common information sharing and server format • Establish a team of technical contacts within each college/school • Establish plans to separate AHC and Fairview networks • Create an AHC technical support service and site licensing for common software	• PIDP procedures are being drafted • Financial planning systems are being developed and implemented • Task force has been established to draft training and development programs for AHC staff who perform financial services • Strategic facilities planning is underway. Interim AHC space management and capital project procedures/systems put in place. • Work underway on a predesign study for a JOML replacement facility. Study is on schedule for January 1 completion • Work underway to redesign recruitment and hiring processes. Central has delegated recruitment and hiring authority to AHC HR Office. AHC and Medical School human resources staffs have been integrated. • Development of common budgeting system and human resources information system underway • Fairview/AHC network separation underway	• Lead dean concept implemented • PIDP procedures drafted • Administrative services redesign underway • Drafting of strategic facilities plan underway • JOML predesign study completed • Continuing development of common budgeting system and human resources information systems • Information technology strategic planning underway
Enhance the skills of our leaders in guiding change in the AHC	• Develop a plan for leadership development: communications, roles and responsibilities, skills development, support systems	• Leadership development plan being drafted for council review • Staff training/development program being developed and piloted	• Council review of leadership development plan; implementation begun • Staff training/development program begun

Broad Strategies	Activities	Progress through November 1	November/December Priorities
Work for closer cooperation with the University at large, in both academic and administrative arenas		• Cerra is member of Executive and Vice President Councils • Joint development and planning of biological sciences reorganization and the molecular and cellular biology initiative with other University colleges and units • Joint planning and work efforts between central and AHC HR, communications, financial, facilities, and information technology staffs	• Continued joint development and planning of biological sciences reorganization and the molecular and cellular biology initiative • Continued joint planning and work efforts between central and AHC HR, communications, financial, facilities, and information technology staffs

DRAFT

Work Plan: Senior Vice President for Health Sciences
for 1997-98

Initiative	Desired Outcomes	Service Improvements	Savings or Investment	Timeline
interscholastic health professional curriculum	• design and begin to implement new curriculum addressing informatics competency, business skills, preventive health and wellness, continuous quality improvement, outcomes assessment, performance systems, and epidemiology • shift paradigm from hospital and encounter-based to community, nonhospital and population based • increased use of information technology in education	• interdisciplinary and interscholastic educational curriculum • increased community and healthsystem involvement in education process • market evaluation of scope and skills necessary for health professionals • improved medical informatics skills for faculty, students, and graduates • implementation of educational computer systems for students	• investment of $4 million of special legislative funding for curriculum and educational technology • established faculty and student requested educational service organization (ESO)	• ESO operational in 1998 • interscholastic educational process defined in 1998 • prototype interscholastic community-based education ready to implement in 1998 • market evaluation process operational in 1998

Work Plan: Senior Vice President for Health Sciences
for 1997-98

Initiative	Desired Outcomes	Service Improvements	Savings or Investment	Timeline
advance the AHC's position as a national leader in health research	• increased external funding for research ~ federal ~ private corporations • increased national prominence in targeted programs of excellence • increased recognition of faculty and program excellence	• streamlined and user friendly access to AHC faculty by private enterprise • strategic investments in areas of research excellence • enhanced technology transfer and capture of value of AHC intellectual property • establish National Health Policy Institute with St. Thomas • improved communication about achievements of faculty, staff and programs	• development of the AHC Research Service Organization • prudent application of $2 million legislative appropriation for improved technology transfer • $3.75 million in targeted research investments to stimulate top programs • increased technology transfer • 3% increase in publicly sponsored research (NIH)	• RSO start-up in Fall 1997 • investments in the hands of faculty by February 1, 1998 • technology prospecting process in place in 1998 (with ORTTA)

Work Plan: Senior Vice President for Health Sciences
for 1997-98

Initiative	Desired Outcomes	Service Improvements	Savings or Investment	Timeline
public/private partnerships to promote health professional education and research	• public/private/University partnership that funds health care professional education ~ State ~ Federal ~ health care organizations • closer integration of marketplace needs and AHC program offerings • community, population based education and training in urban and rural settings • development of models of team care in communities	• increased stability of funding for health education, particularly for graduate medical education of physicians • closer match between the needs of the market and the skills of our graduates • AHC leadership in shaping the health care delivery systems and the roles of health care professionals for the future • community involvement in educational content and process	• increased and more stable funding of health professional education • increased access to patients for education and research • broader support base for expenses of medical education • reduced cost of medical education at FUMC • expansion of rural healthcare initiatives through UMD Rural Health Training Program	• development of the partnership model in collaboration with health care providers by summer 1998 • 2 new education sites in rural communities by June 1998 • advisory group functioning by June 1998 • education "bucket" operational end of 1997 in FUMC

Work Plan: Senior Vice President for Health Sciences
for 1997-98

Initiative	Desired Outcomes	Service Improvements	Savings or Investment	Timeline
expanded clinical services by AHC faculty	• increased offerings, demand and revenues for clinical services by AHC faculty • expanded opportunity for clinical education • expanded patient base for clinical research • strategic goals for clinical enterprise established and coordinated with Fairview • effective influence on strategic investments and developments at FUMC and Fairview system	• continued integration with the Fairview System in Fairview/University Medical Center • strategic alliances with other health care providers in Minnesota • increased integration between colleges to enhance competitive position and model new types of team care • coordinated urban and greater Minnesota development for patient care with Fairview	• 10% increase in clinical revenue generation • 10% reduction in practice plan expenses • increased market share in MN • coordinated clinical enterprise strategic plan - with Fairview and with other constituents	• increased clinical revenues, and reduced expenses by June 1998 • strategic plan for clinical enterprise completed January 1998 • coordination with FUMC strategic goals by June 1998
implementation of contractural obligations in AHC-Fairview agreements	• education and research funding "bucket" operating • Philanthropy integration completed • base program definitions completed • new program development process completed	• cost of medical education documented • philanthropy resources fully utilized • efficient decision-making for program investments • communication pathways functional	• reduced costs related to education and research at FUMC • investments in new programs with market potential	• tasks completed by June 1998

Work Plan: Senior Vice President for Health Sciences
for 1997-98

Initiative	Desired Outcomes	Service Improvements	Savings or Investment	Timeline
administrative services improvements	• improved quality of service - facilities, HR, information systems, finance and communication in AHC • decreased cost of service • delivery model defined with central and users for each administrative service • understand deficits in AHC schools and develop corrective action plan	• continued process redesign in finance, facilities management, information technology, human resources, and communications. • determine baseline for current expenditures. • clarify roles of central administration, AHC, colleges, departments. • eliminate redundancy	• reduce service cost 10% enterprise wide in 1998 while maintaining quality • increase philanthropy revenue 10% in 1998 • reduce net aggregate deficit of AHC schools by 50%	• baseline costs by December 1997 • process re-design ongoing through year • dollars redirected for 1998-1999 budget • deficit reduction in fiscal 97-98
strategic communications plan for AHC	• better understanding of the many roles of the AHC by our constituencies and the general public • integration and coordination with University goals and plans	• improved use of AHC publications and public media • improved identification and targeting of AHC audiences • proactive efforts to tell the positive about the AHC • increased role of external constituencies in the AHC • external leadership group for strategic directions • coordinate with central University efforts	• reduced waste and ineffective efforts • enhanced quality and specificity of targeting • enhanced coordination and "brand recognition" • increased external support for AHC funding	• strategic communications plan by Fall 1997, implementation by Spring 1998 • external strategic leadership group operational December 1997

Work Plan: Senior Vice President for Health Sciences
for 1997-98

Initiative	Desired Outcomes	Service Improvements	Savings or Investment	Timeline
increase our efforts to support and develop leadership in the AHC	• increase the skills of leaders at all levels to better respond to the need for change and greater accountability • clear definition of program and departmental roles and responsibilities	• clarified roles and responsibilities • improved and targeted channels of communication and decision-making • specific skills training • enhanced support systems for leaders	• investment in leadership development • savings in program efficiency, program development, administrative problems	• on-going program designed and under way by January 1998
positioning of Allied Health Professions	• defined function and structure in AHC • integration with community, University and MnSCU based programs • financial stability of each program	• contribution to health professional education defined • each program needs to be more effectively considered, evaluated, and coordinated across AHC • task force on future of allied health professions • coordination with Mayo, MnSCU and other training programs	• reduce program infrastructure redundancy • match program with resources that are available	• taskforce report in 1997 • plan developed in 1998 • begin in repositioning in 1998