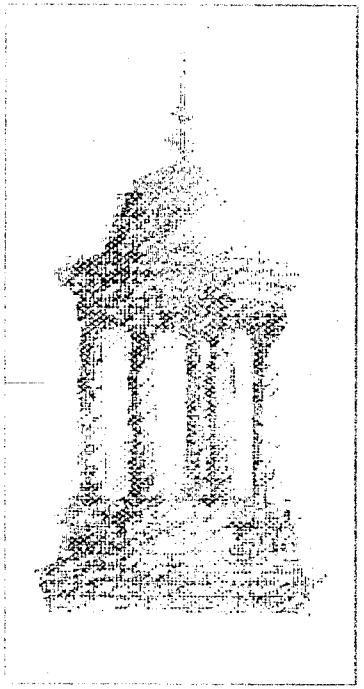
copy to: Exec staff
Fairview – David Page
Bill Mansell
Judy Alexander

AHC-FCC
AHC Deans

University of Minnesota
Board of Regents
Facilities Committee
March 11, 1999

Presentation of the
AHC Strategic Facility Plan
& Precinct Plan



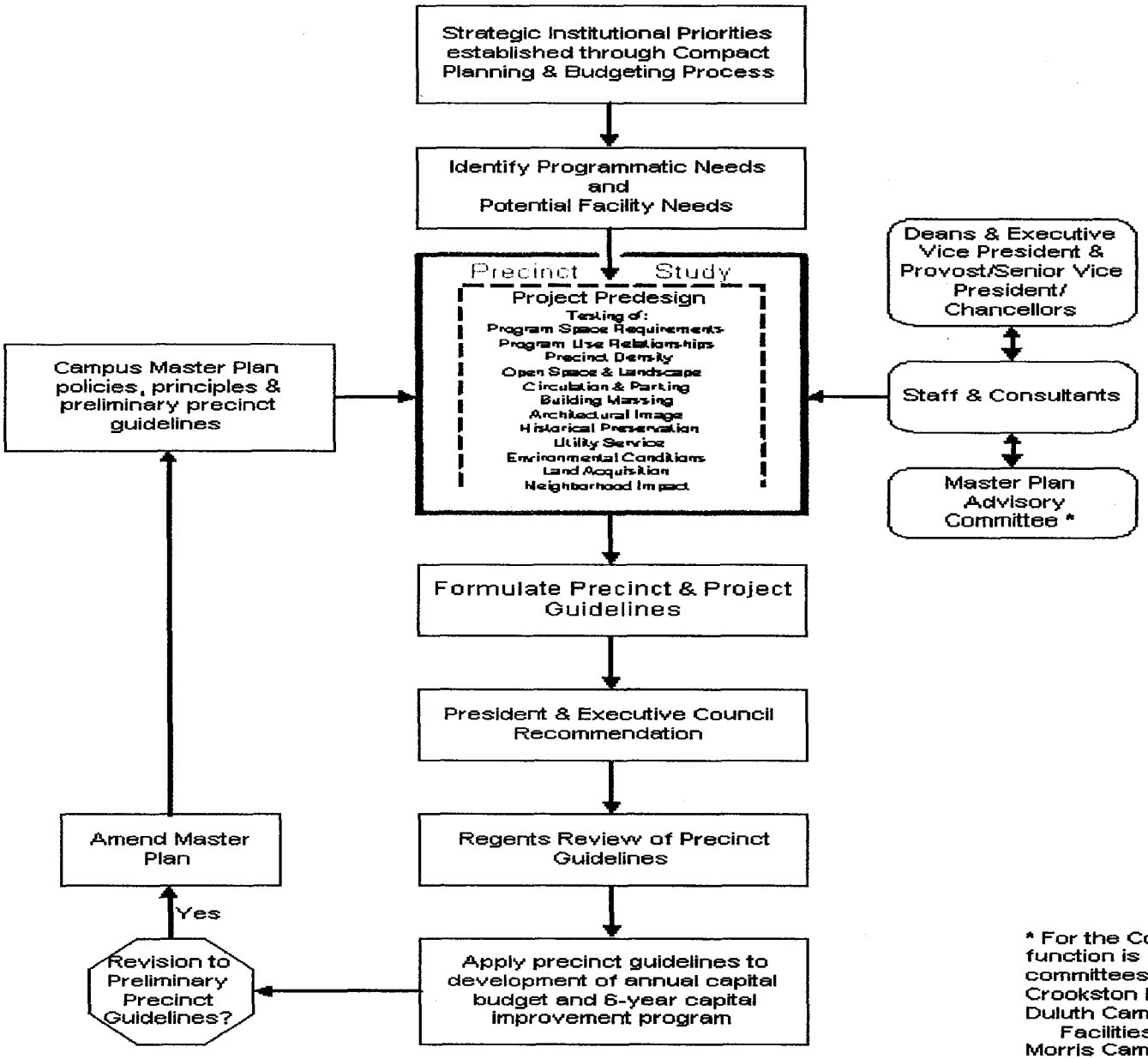
AcademicHealthCenter
UNIVERSITY OF MINNESOTA

Purpose of Today's Presentation

- To brief you on the AHC's strategic facility planning process - a process that:
  - Demonstrates the University's new precinct planning model
  - Closely ties academic program needs to space planning and use
  - Illustrates the development by the faculty of performance criteria for space assignment and use
  - Identifies AHC facilities issues that have major policy implications

PRECINCT PLANNING PROCESS

University of Minnesota



* For the Coordinate campuses, this function is served by the following committees:
Crookston Master Planning Committee
Duluth Campus Assembly Physical Facilities Committee
Morris Campus Resource & Planning Committee

AHC Strategic Facility Planning began in April, 1997 to address the dissatisfaction, challenges and opportunities in the academic component of facilities management.

These opportunities and challenges are:

▼Academic priorities need to guide space assignment and use and facilities management.

▼A rational, understandable process for developing and prioritizing projects is needed.

▼Interscholastic cooperation is required to solve the AHC's facilities challenges
Examples include:

- ⇨Cellular and molecular biology
- ⇨Use of Fairview release space
- ⇨Geographic consolidation of School of Public Health
- ⇨ A large number of other space initiatives.

Goals of the AHC's Strategic Facility Planning

■To develop a "working vision" that serves to guide academic planning and programmatic management of facilities

■To further develop consistency and continuity with the U of M Master Plan

■To recognize and utilize internal resources and information at the University

■To better integrate AHC academic program management with University FM's physical facilities management.

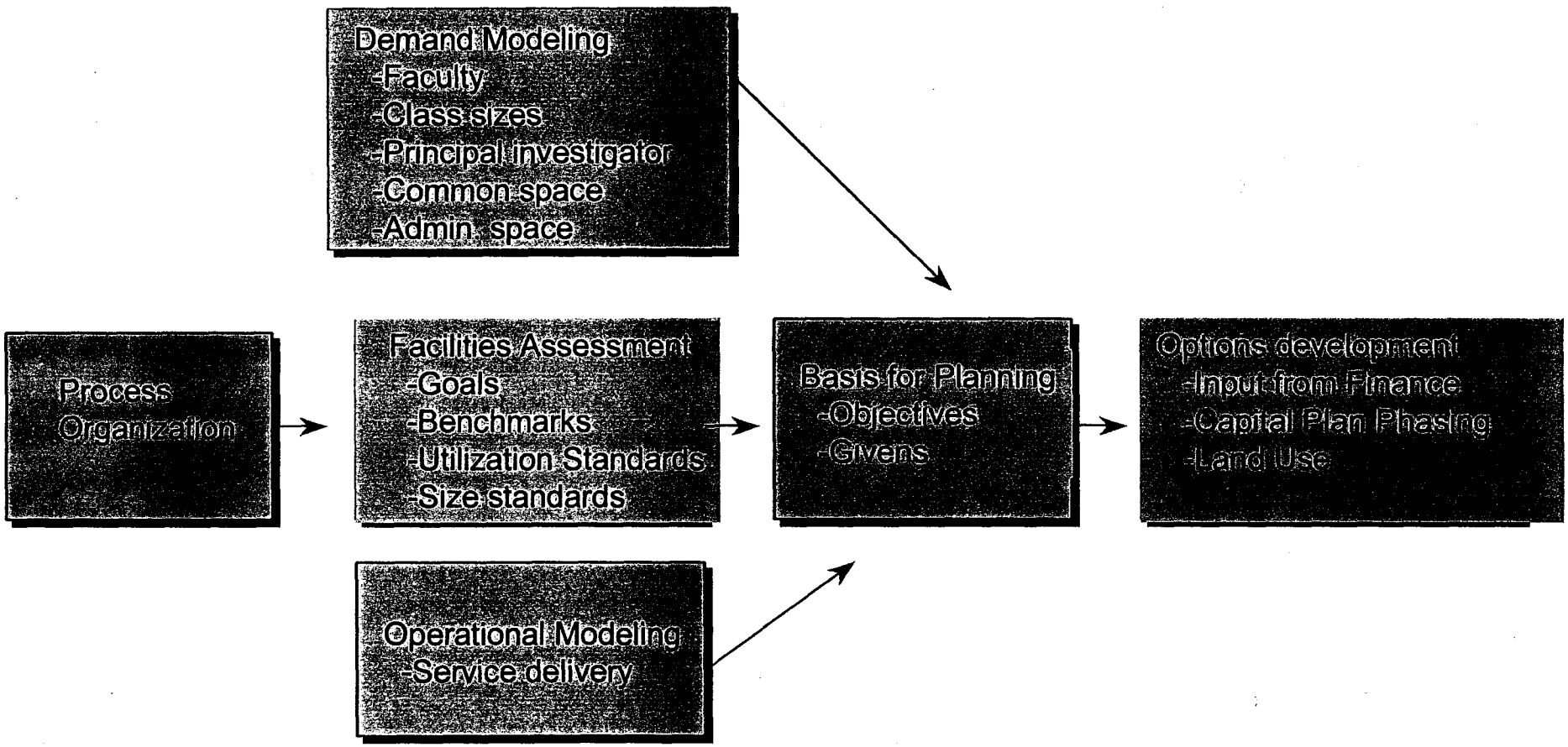
Process

Inclusive

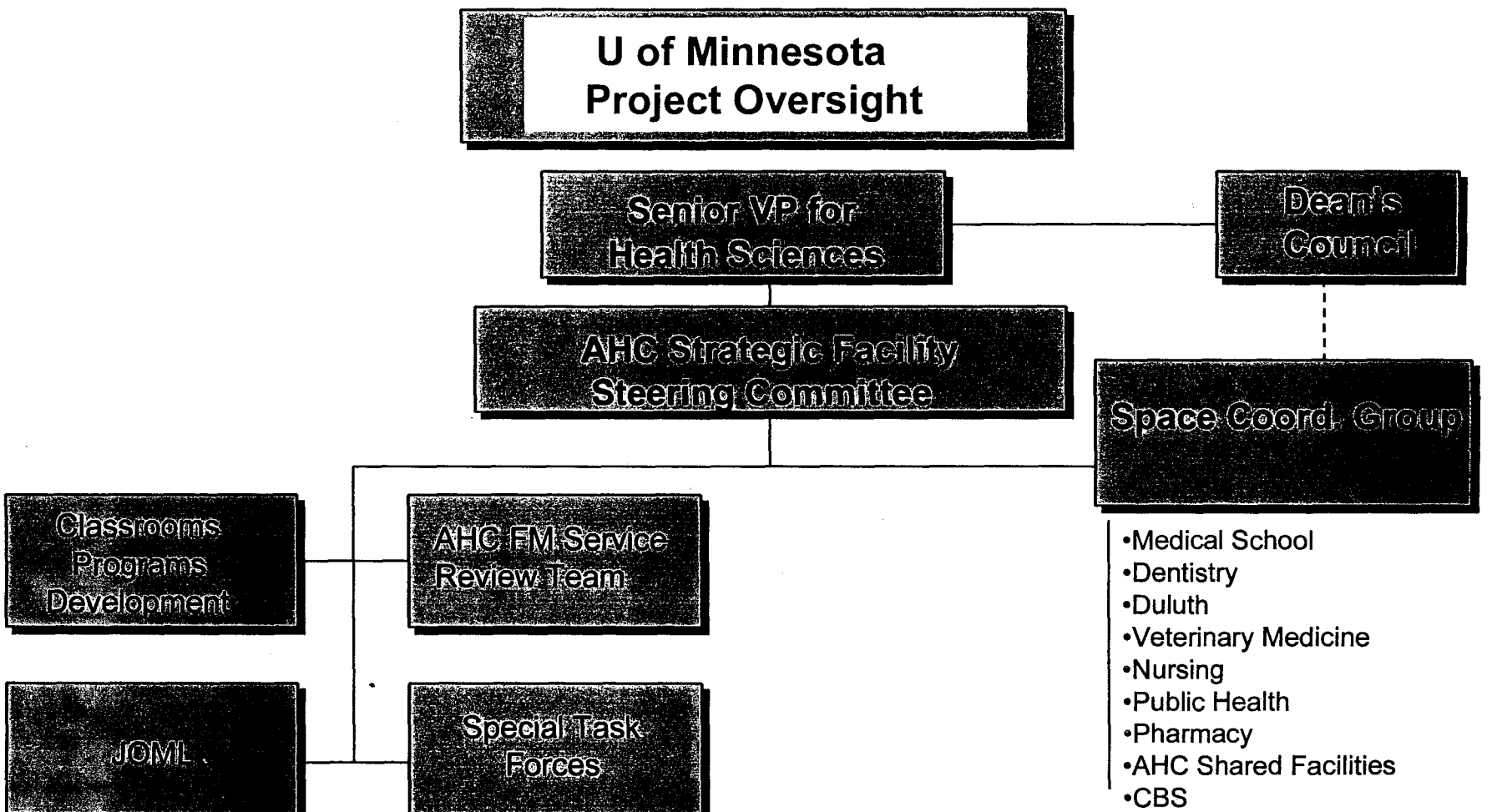
Bottom-up

Inside-out

Academic Health Center
Strategic Facility Plan
Project Organization

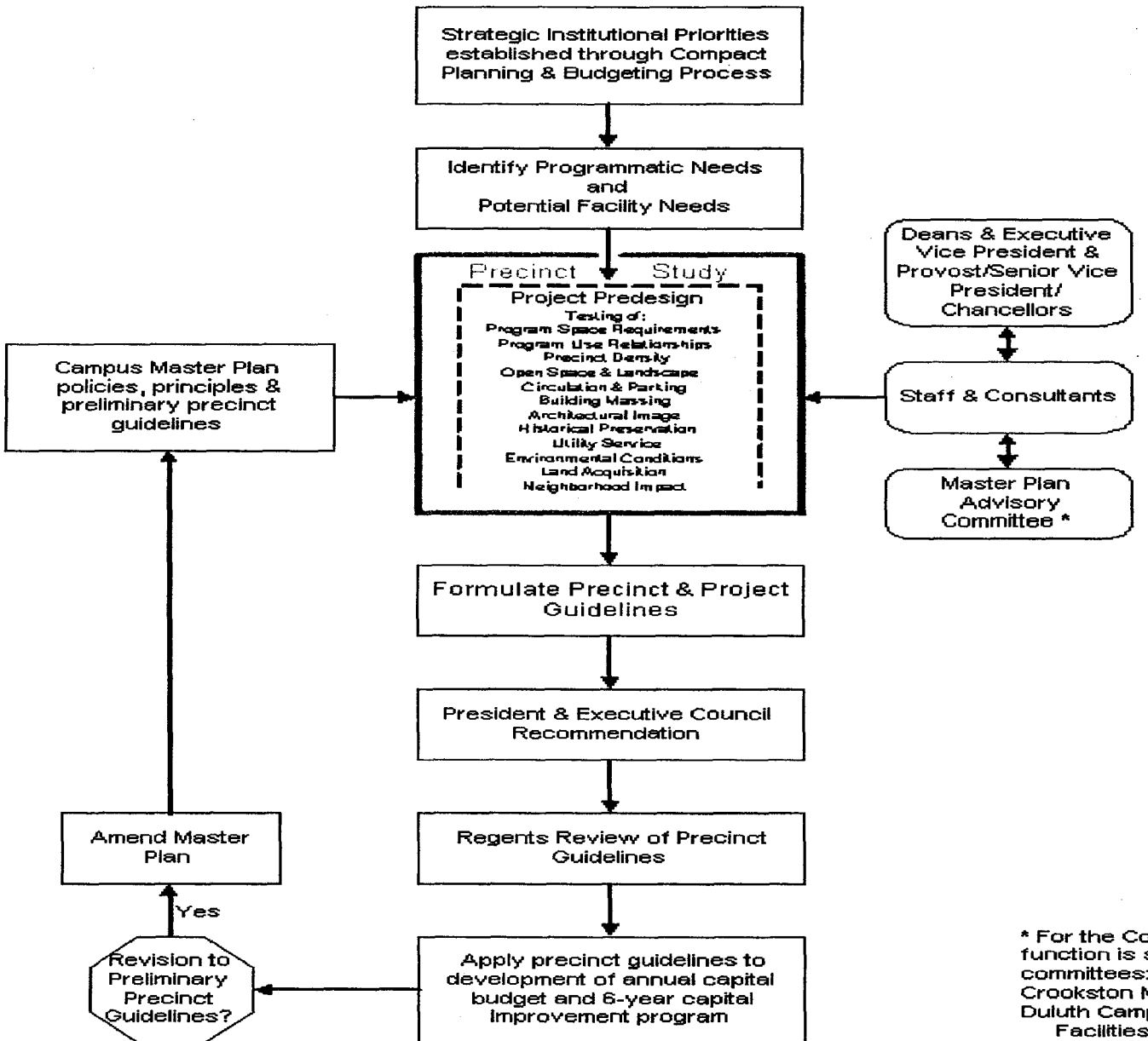


Academic Health Center
Strategic Facility Plan
Project Organization



PRECINCT PLANNING PROCESS

University of Minnesota



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Duluth Campus Assembly Physical Facilities Committee
Morris Campus Resource & Planning Committee

Deliverables

- **Options for development that tie academic goals and objectives to space utilization**
  - Education
  - Research
  - Clinical and Outreach
  - Office Environments
  - Consolidation
  - Infrastructure and support services
- **Faculty based process for academic assignment and utilization of space**
- **Clear definition of facility needs and capital projects for AHC academic programs**

Academic Health Center
Strategic Facility Plan
"Options for Development"

MISSION

The mission of the Academic Health Center is to be a leader in the ethical, innovative, and efficient discovery and dissemination of knowledge to enhance the health and well being of Minnesota, the nation, and the world.

GOALS	DIRECT FACILITY OBJECTIVES
♦ To enhance the competitive relevance and position of AHC research	▪ Have the ability to respond quickly with facilities for grant requests ▪ Create adaptability in facility design and use for future requests ▪ Optimize existing space ▪ AHC needs vital spaces which are responsive to program needs ▪ AHC is an institution that care's about it's people -- this should be reflected in the research facilities we design and build ▪ Create "short streets" between clinical and basic science researchers. ▪ Facilities should aesthetically foster learning, collegiality and discovery

Implementation Strategies

Projects	Cost	Source	Immediate	Short Term	Long Term	Operations
➢ New facility requests—Molecular Biology, Biologic Containment, Equine Research, and Goat Barn.	$30.3 million			✓		❑ Make maximum use of what we have ❑ Provide incentives for shared space
➢ Renovate existing labs for Vet Medicine, Molecular Medicine, Genetics, Developmental Biology, Pharmacy, Public Health, Endowed Chair in Rural Dentistry and Endowed Chair in Pharmacy to support NIH and other sponsored funding.	$7.5 million		✓	✓		❑ Develop space allocation program for use across the AHC that optimizes current occupancy.
➢ Create a pool of standard/generic research labs for recruitment and retention commitments and interscholastic opportunities.	$3 million/ annually		✓	✓	✓	
➢ Improve space and utilization for Research Animal Resources	TBD		✓	✓		
➢ Increase square footage available for AHC research programs.	TBD			✓	✓	

AHC Strategic Facility Planning Comprehensive Worksheet--1999

RESEARCH

Sort Criteria: E = Education services; R = Research; CO=Conslidation O = Offices; C = Clinical; S = Support Services; UA = Unassigned

Renovation	Space Request	New Building	Renning/Pre-Design	Department Code:AC = Academic Health Center; M = Molecular & Cellular Biology; MS = Medical School; COP = College of Pharmacy; SS = Swing Space; College of Veterinary Medicine; SPH = School of Pub Health; N = Nursing; Critical Life Safety Emergency Yes=1 N	Criteria Score	Item Number	Item Description	Amount	Fund Source	Yr. Funded	Link to Master Plan	EDUCATION	RESEARCH	OFFICES	CONSOLIDATION	CLINICAL	SUPPORT	UNASSIGNED
x	x		x	MS	1010	1	Stone Labs	3,500 SF					R					
x			x	MS	715	2	Genetics Institute Programs PWB7	1,800 SF					R	O				
	x		x	MS	655	3	Molecular Medicine Program	11,000 SF					R					
x	x		x	AHC	655	4	Research Animal Resources						R					
	x		x	MS	635	5	Center for Neurobehavioral Development	2,500 SF					R					
x	x	x	x	AHC	600	6	Completion of MCBB						R					
x	x		x	MS	575	7	HSIAO Research	2,500 SF					R					
	x		x	MS	560	8	Initiative in Molecular Biology in Medicine	60,000SF					R					
	x			COP	545	9	Pharmacy Endowed Chair-Weaver Chair	3,000 SF					R	O				
	x		x	MS	510	10	Bone Marrow Transplant(McGlave Retention)	3,000 SF					R		CO			
x	x			N	505	11	Faculty Research Space - Non-Lab	635 SF					R					
	x			D	485	13	Endowed Chair in Rural Dentistry					E	R	O				
	x		x	AHC	485	14	Interscholastic Research Spaces						R					
x			x	D	475	15	Research Labs	5,900 SF					R					
	x			SPH	455	16	Faculty Research Space - Non-Lab	8,000 SF					R	O				
	x		x	MS	455	17	Health Outcomes Research (CORC)	1,475 SF					R					
x			x	SPH	440	18	Industrial Hygiene Laboratories						R					
		x		VM	440	19	Biologic Containment Facility						R				S	
x			x	VM	435	20	Research Lab Renovations-Molecular Diagnostic Lab	5000 SF					R					
	x			SPH	430	21	New Research Laboratories	2,000 SF					R					
			x	SPH	420	22	Long range growth	60,000 SF		2008		E	R	O		C		
x			x	COP	400	23	8th Floor P3 Facility						R					
x	x		x	MS	395	24	Orthapaedic Surgery	8,000 SF					R			C		
x			x	MS	390	25	Surgery-Mayo 1 (Rehab and Surgery Lab)	35,000 SF					R					
x			x	SPH	375	26	Microbiology Laboratories						R					
x			x	MS	375	27	Heme/Onc consolidation (Peds)	5,000 SF					R	O	CO	C		
x			x	MS	360	28	Cardiology--Offices(red) 1 2 3 - VCRC						R			C		
	x		x	MS	355	29	Recruitment Space for Lab Medicine and Pathology & Immunology	6,000 SF					R					
	x			COP	340	30	New Faculty Lab Space	5@1,000 SF					R					
	x			COP	340	31	Faculty Research Space - Non-Lab	10@150					R					
x	x		x	MS	315	32	Graduate Programs Office	3,000SF					R	O				

Academic Health Center
Strategic Facility Plan
"Options for Development"

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GOALS	DIRECT FACILITY OBJECTIVES
♦ To enhance the competitive relevance and position of AHC education	▪ Faculty offices need to be accessible to students ▪ Improve all AHC classrooms ▪ Create space allocation usage and utilization policy ▪ Rebuild AHC with JOML replacement as Step 1 ▪ Use curriculum driven design in all renovation and new building projects (functions determine structure) ▪ Enhance the quality and habitability of spaces by using natural light and fresh air ▪ Create student gathering spaces ▪ Create spaces that aesthetically foster learning

Implementation Strategies

Projects	Cost	Source	Immediate	Short Term	Long Term
➢ Design AHC Education Center and Student Commons that is located to allow for inter-disciplinary collegial gatherings of faculty, alumni, and students. Student Services to include bookstore, registration and student information services and food services. • Includes additional technologically advanced classrooms, virtual learning environments, student lounges, study spaces, continuing and interactive education activities, small group rooms, computer labs and seminar rooms.	$20 million	Private Funds		✓	✓
			✓	✓	
➢ Renovation of existing school classrooms – Vet Medicine, Nursing, Pharmacy, Public Health--centrally scheduled.	$3 million	Central		✓	
➢ Create hi tech virtual teaching labs including dental patient labs	TBD	Schools/ Central		✓	✓
➢ Renovation of Biomedical Library	$10 million	TBD	✓		✓

Operations

- ❑ Establish maintenance standards for all classroom facilities and enforcement by Zone FM.
- ❑ Establish resources for Technology upgrade reviews and User training.

AHC Strategic Facility Planning Comprehensive Worksheet--1999

Renovation	Space Request	New Building	Planning/Pre-Design	Department Code: AC = Academic Health Center; MCB = Molecular & Cellular Biology; MS = Medical School; COP = College of Pharmacyl; SS = Swing Space; VM = College of Veterinary Medicine; SPH = School of Public Health; N = Nursing; Critical Life Safety Emergency Yes=1 No=0	Critical Criteria Score	Item Number	EDUCATION Item Description	Amount	Fund Source	Yr. Funded	Link to Master Plan	Sort Criteria: E = Education services; R = Research; C = Clinical; O = Offices; CO=Consolidation; S = Support Services; UA = Unassigned						
												EDUCATION	RESEARCH	OFFICES	CONSOLIDATION	CLINICAL	SUPPORT	UNASSIGNED
	x			AHC	870	1	Classroom and Student Spaces					E						
	x	x		MS	685	2	AHC Education Center	160,000 SF				E						
x			x	D	585	3	Virtual Dental Patient Labs					E				C		
			x	D	570	4	Planning for Facility redesign	2,300 SF				E	R	O				
x			x	COP	550	5	Classroom Renovation 7-193/195 & 2-110-140 Weaver Densford	3,500SF				E						
x	x		x	D	550	6	Continuing Education classrooms					E						
	x			VM	540	7	Education Commons area/Alumni Student Research	24,000SF				E		O			S	
x			x	MS	515	8	Occupational Therapy--PM & R	2,500 SF				E				C		
	x			SPH	505	9	New classrooms	5,000 SF				E						
	x			SPH	505	10	Continuing Education Offices, etc.	5,000 SF				E		O				
x				AHC	500	12	Biomedical Library					E	R					
			x	N	480	11	Planning for Facility Redesign					E	R	O				
			x	COP	480	11	Planning for facility Redesign of Weaver Densford:					E	R	O	CO			
x			x	VM	470	12	Classrooms: Room 135	1,200 SF				E						
	x			AHC	440	13	Continuing Education Facilities					E						
x			x	COP	400	14	Renovation of 3-120	3,000				E						
x			x	VM	353	15	Rewire Existing Classrooms					E					S	
				VM	290	16	Small Group Classrooms					E						
x			x	COP	0	17	Decommissioned Space					E	R	O		C		

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						❑ Make maximum use of what we have
➢ New facility requests—Molecular Biology, Biologic Containment, Equine Research, and Goat Barn.	$30.3 million			✓		❑ Provide incentives for shared space
➢ Renovate existing labs for Vet Medicine, Molecular Medicine, Genetics, Developmental Biology, Pharmacy, Public Health, Endowed Chair in Rural Dentistry and Endowed Chair in Pharmacy to support NIH and other sponsored funding.	$7.5 million		✓	✓		❑ Develop space allocation program for use across the AHC that optimizes current occupancy.
➢ Create a pool of standard/generic research labs for recruitment and retention commitments and interscholastic opportunities.	$3 million/ annually		✓	✓	✓	
➢ Improve space and utilization for Research Animal Resources	TBD		✓	✓		
➢ Increase square footage available for AHC research programs.	TBD			✓	✓	

AHC Strategic Facility Planning Comprehensive Worksheet--1999

RESEARCH

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x	x		x	MS	1010	1	Stone Labs	3,500 SF					R					
x			x	MS	715	2	Genetics Institute Programs PWB7	1,800 SF					R	O				
	x		x	MS	655	3	Molecular Medicine Program	11,000 SF					R					
x	x		x	AHC	655	4	Research Animal Resources						R					
	x		x	MS	635	5	Center for Neurobehavioral Development	2,500 SF					R					
x	x	x	x	AHC	600	6	Completion of MCBB						R					
x	x		x	MS	575	7	HSIAO Research	2,500 SF					R					
	x		x	MS	560	8	Initiative in Molecular Biology in Medicine	60,000SF					R					
	x			COP	545	9	Pharmacy Endowed Chair-Weaver Chair	3,000 SF					R	O				
	x		x	MS	510	10	Bone Marrow Transplant(McGlave Retention)	3,000 SF					R		CO			
x	x			N	505	11	Faculty Research Space - Non-Lab	635 SF					R					
	x			D	485	13	Endowed Chair in Rural Dentistry					E	R	O				
	x		x	AHC	485	14	Interscholastic Research Spaces						R					
x			x	D	475	15	Research Labs	5,900 SF					R					
	x			SPH	455	16	Faculty Research Space - Non-Lab	8,000 SF					R	O				
	x		x	MS	455	17	Health Outcomes Research (CORC)	1,475 SF					R					
x			x	SPH	440	18	Industrial Hygiene Laboratories						R					
		x		VM	440	19	Biologic Containment Facility						R				S	
x			x	VM	435	20	Research Lab Renovations-Molecular Diagnostic Lab	5000 SF					R					
	x			SPH	430	21	New Research Laboratories	2,000 SF					R					
			x	SPH	420	22	Long range growth	80,000 SF		2008		E	R	O		C		
x			x	COP	400	23	8th Floor P3 Facility						R					
x	x		x	MS	395	24	Orthapaedic Surgery	8,000 SF					R			C		
x			x	MS	390	25	Surgery-Mayo 1 (Rehab and Surgery Lab)	35,000 SF					R					
x			x	SPH	375	26	Microbiology Laboratories						R					
x			x	MS	375	27	Heme/Onc consolidation (Peds)	5,000 SF					R	O	CO	C		
x			x	MS	360	28	Cardiology--Offices(red) 1 2 3 - VCRC						R			C		

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								Recruitment Space for Lab											
	x		x	MS		355	29	Medicine and Pathology & Immunology	6,000 SF					R					
	x			COP		340	30	New Faculty Lab Space	5@1,000 SF					R					
	x			COP		340	31	Faculty Research Space - Non-Lab	10@150					R					
x	x		x	MS		315	32	**Graduate Programs Office**	3,000SF					R	O				
x	x		x	D		290	33	Dental Radiography Facility					E	R					
		x		VM		239	34	Equine Research Center						R					
x			x	COP		230	35	8th Floor NMR Room						R					
x			x	COP		230	36	9-157 Weaver Densford						R					
x	x		x	MS		200	37	Cardiology Expansion	20,000 SF					R			C		
		x		VM		133	38	Second Goat Barn						R					
	x			VM		100	39	MFM Research	22,800 SF					R					
x			x	VM		100	40	Decommissioned Space					E	R	O		C	S	
x			x	MS		50	41	Consolidation of Lab Medicine and Pathology Space	30,000 SF					R	O		C		
				MS		0	42	Decommissioned Space-Remodel						R	O				
x				AHC		0	43	Sub-category of MCBB--- Technology-AHC						R					
x				AHC		0	44	Sub-category of MCBB--- Infrastructure						R					
x				AHC		0	45	Sub-category of MCBB--- FFE(Furniture, Fixtures, & Equipment)						R					
	x			SPH			46	Relocation of Park Avenue Space						R			C		

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Academic Health Center
Strategic Facility Plan
"Options for Development"

MISSION

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GOALS	DIRECT FACILITY OBJECTIVES
♦ To improve competitive position of clinical and outreach services for all health professionals in the AHC.	▪ Develop ways for facilities to respond quickly to market opportunities ▪ Create "short streets" between clinical/basic science research ▪ Create off-campus property development that pays attention to on-campus access (i.e. off-campus clinics) ▪ Clinical Service improvements to be funded by clinical revenues when feasible

Implementation Strategies

Projects	Cost	Source	Immediate	Short Term	Long Term	Operations
➢ Renovation of clinical areas include the CUUCH Clinic, Dental Patient Care Clinics, &Vet Teaching Hospital.	$1.5 million	College & private funds	✓	✓		
➢ Provide service and outreach opportunities for Center for Spirituality and Healing, AHC Transplant Institute, Pharmaceutical Care, Family Practice expansion, and Center for Molecular and Cellular Therapy.	$33.3 million	Private Funds	✓	✓		
➢ Develop relocation plan for UMP Clinic	TBD			✓		

AHC Strategic Facility Planning Comprehensive Worksheet--1999

CLINICAL

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Renovation	Space Request	New Building	Planning/Pre-Design	Department Code: AC = Academic Health Center; MCB = Molecular & Cellular Biology; MS = Medical School; COP = College of Pharmacy; SS = Swing Space; VM = College of Veterinary Medicine; SPH = School of Public Health; N = Nursing; Critical Life Safety Emergency Yes=1 No=0	Critical	Criteria Score	Item Number	Item Description	Amount	Fund Source	Yr. Funded	Link to Master Plan	EDUCATION	RESEARCH	OFFICES	CONSOLIDATION	CLINICAL	SUPPORT	UNASSIGNED
x	x		x	AHC		605	1	Center for Spirituality and Healing	10,000 SF				E	R	O		C		
x		x	x	AHC		600	2	CUHCC Clinic									C		
x			x	D		580	3	Patient Care Clinic renovations									C		
	x			AHC		575	4	AHC Transplant Institute						R			C		
x	x			N		540	5	New Faculty clinical areas	1,235 SF								C		
	x			COP		445	7	Pharmaceutical Care Clinic Space	5,000								C		
	x			D		421	8	Faculty Practice Clinic expansion									C		
	x		x	MS		340	9	Center for Molecular & Cellular Therapy	2,500 SF								C		
x			x	VM		250	11	VTH Renovations for Clinical care, lobby and safety.							O		C	S	
	x			COP		210	12	Drug Design Institute									C		

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GOALS	DIRECT FACILITY OBJECTIVES
♦ To enhance the competitive relevance of programs that are geographically dispersed or in facilities that no longer support them by creating opportunities for physical consolidation and/or plans for renovation that will allow for more effective use of the space we have.	▪ Rebuild AHC with JOML replacement as Step 1 ▪ Create adaptability in facility design and use for future requests ▪ Use curriculum driven design in all renovation and new building projects ▪ Enhance and simplify circulation patterns within the AHC ▪ Create a common denominator place for all AHC schools and programs ▪ Optimize existing space ▪ Create connectedness

Implementation Strategies

Projects	Cost	Source	Immediate	Short Term	Long Term	Operations
➢ Public Health Consolidation	$60.6 million		✓	✓	✓	❑ Increase efficiency of all school operations. ❑ Reduce overall lease costs
➢ Facility Redesigns – ❖ Dentistry ❖ Nursing ❖ Pharmacy	TBD		✓	✓		
➢ Consolidation of Lab Medicine and Pathology, Hematology/Oncology, Bone Marrow Transplant	$7.2 million		✓	✓		
➢ Relocation of Center for American Indian and Minority Health	TBD				✓	

AHC Strategic Facility Planning Comprehensive Worksheet--1999

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					Critical														
		x		SPH		605	1	Consolidated Public Health Facility	300,000 SF							N			

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GOALS	DIRECT FACILITY OBJECTIVES
♦ Enhance the office environment to promote faculty and staff creativity, excellence and productivity.	▪ Improve the quality and habitability of office spaces ▪ Optimize existing space ▪ Faculty and staff need clean and properly working facilities ▪ Use program driven design in all renovations ▪ Faculty offices should be accessible to students ▪ Create relationships between labs/offices/classrooms

Implementation Strategies

Projects	Cost	Source	Immediate	Short Term	Long Term
➢ Renovation of existing offices—include wiring standard for electronic equipment capability.	TBD	Schools/ AHC	✓	✓	✓
➢ New faculty offices including a managed inventory of additional offices for recruitment and retention.	TBD	Schools	✓		✓
➢ New faculty and administrative support offices.	TBD	Schools	✓		
➢ Develop opportunities to improve departmental efficiency by reassigning space that allows for consolidated programming.	TBD	Schools/ AHC	✓		

Operations

- ❑ Establish maintenance standards for all offices and enforcement by Zone FM.
- ❑ Develop space allocation program for use across the AHC that optimizes current occupancy and assigns new space fairly.

AHC Strategic Facility Planning Comprehensive Worksheet--1999

OFFICES

Sort Criteria: E = Education services; R = Research; CO=Conslidation O = Offices; C = Clinical; S = Support Services; UA = Unassigned

Renovation	Space Request	New Building	Planning/Pre-Design	Department Code: AC = Academic Health Center; MCB = Molecular & Cellular Biology; MS = Medical School; COP = College of Pharmacyl; SS = Swing Space; VM = College of Veterinary Medicine; SPH = School of Public Health; N = Nursing;	Critical Life Safety Emergency Yes=1 No=0	Criteria Score	Item Number	Item Description	Amount	Fund Source	Yr. Funded	Link to Master Plan	EDUCATION	RESEARCH	OFFICES	CONSLIDATION	CLINICAL	SUPPORT	UNASSIGNED
x			x	COP		590	1	Computer Server Room renovation on 1st Floor Weaver Densford							O				
x	x			N		555	2	New Faculty Offices/support	7,520 SF						O				
x			x	D		530	3	Admissions area renovations							O				
x				AHC		530	4	Fairview Release)	36,856 SF				E	R	O		C		
	x			COP		525	5	New Faculty Offices--Non-Tenure Track/Residents	6@120 SF						O				
x	x		x	COP		515	6	Office of Student Affairs	2,300 SF						O				
x				N		515	6	Redesign current offices							O				
	x			AHC		505	7	Pool of Labs & Offices for Recruitment & Retention							O				
	x			SPH		455	8	New Faculty Offices	15,000 SF						O				
x				N		405	9	Faculty/staff meeting areas							O				
	x			COP		340	10	New Faculty Tenure Track-Offices	10@150 SF						O				
	x			AHC		325	11	Ctr. Amer.Indian & Minority Health	990 SF						O	CO			
x	x		x	COP		290	12	Staff offices	3@120 SF						O				
				VM		280	13	Office Space							O				
x			x	COP		215	14	7-145 Conference Room							O				
x	x		x	MS		210	15	Family Practice Consolidation	10,000 SF						O		C		
x				AHC		120	16	Decommissioned Space					E		O		C	S	
	x		x	MS		90	17	Emeritus Offices	2,000 SF						O				

Academic Health Center
Strategic Facility Plan
"Options for Development"

MISSION

The mission of the Academic Health Center is to be a leader in the ethical, innovative, and efficient discovery and dissemination of knowledge to enhance the health and well being of Minnesota, the nation, and the world.

GOALS	DIRECT FACILITY OBJECTIVES
♦ Establish efficient and effective support services <u>infrastructure</u> across the AHC	▪ Create space allocation usage and utilization policy ▪ Enhance and simplify circulation patterns within the AHC ▪ Create a common denominator place for all AHC schools and programs ▪ Create a welcoming image for AHC students, faculty, patients and visitors ▪ Enhance the quality and habitability of AHC spaces ▪ Optimize use of existing space ▪ Faculty and staff need clean and properly working facilities ▪ Develop and implement improved way- finding ▪ Improve patient/visitor access and orientation ▪ Improve parking and traffic around the AHC

Implementation Strategies

Projects	Cost	Source	Immediate	Short Term	Long Term	Operations
➢ Develop signage and corridor upgrades throughout AHC thoroughfare (interior and exterior).	TBD		✓	✓		❑ FM Zone ❑ Parking and Transportation
➢ Develop Information Technology plan for AHC including research computing	TBD		✓	✓		❑ Environmental Health and Safety
➢ Replace Mayo garage.	TBD				✓	❑ Develop space allocation program for use across the AHC
➢ Develop improved access and entry programs.	TBD			✓		
➢ Develop security program for AHC, including security lighting, monitors, emergency telephones, and protection for research programs.	TBD			✓		

AHC Strategic Facility Planning Comprehensive Worksheet--1999

SUPPORT

Sort Criteria: E = Education services; R = Research; CO=Consolidation; O = Offices; C = Clinical; S = Support Services; UA = Unassigned

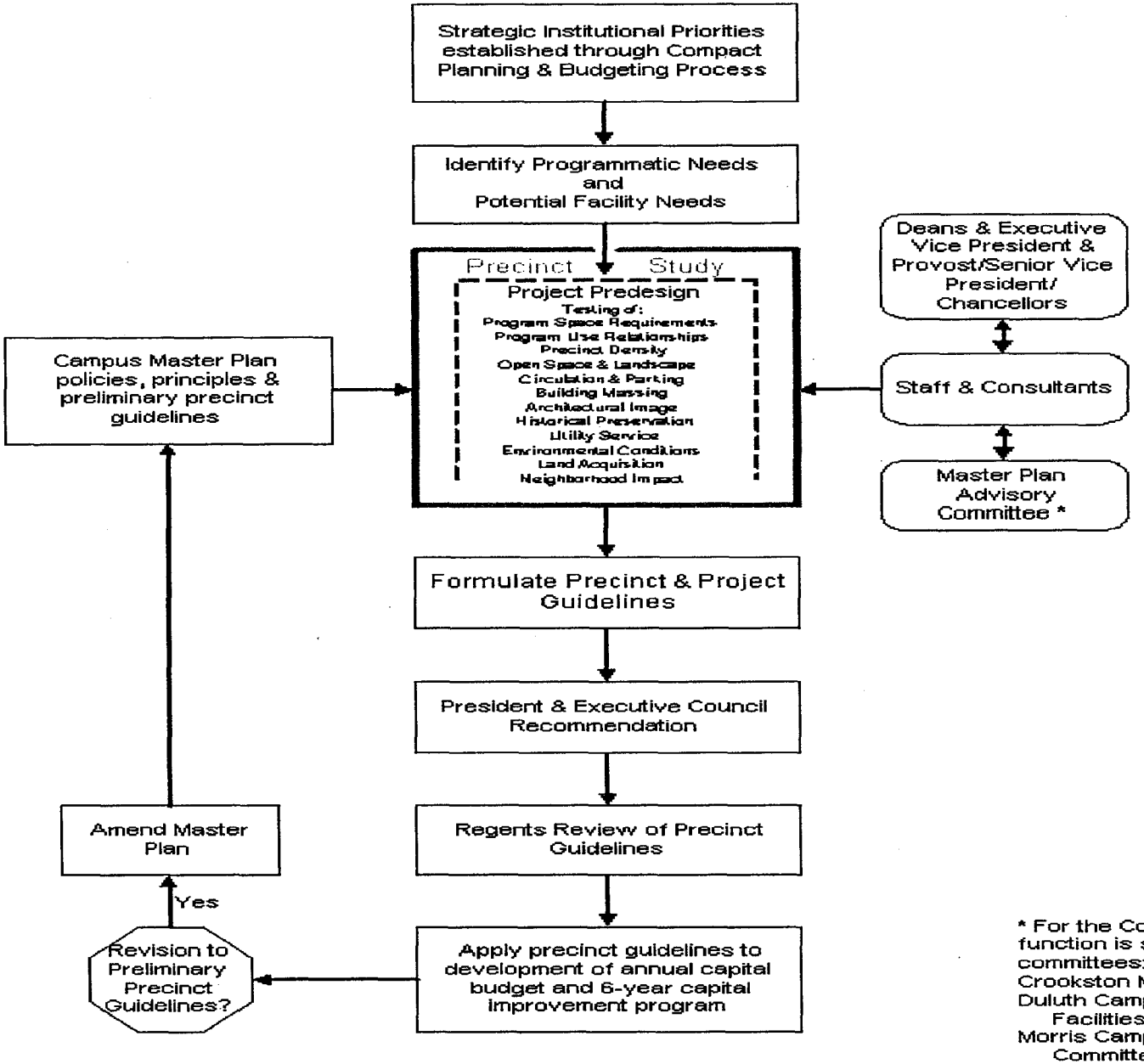
Renovation	Space Request	New Building	Planning/Pre-Design	Department Code: AC = Academic Health Center; MCB = Molecular & Cellular Biology; MS = Medical School; COP = College of Pharmacy; SS = Swing Space; VM = College of Veterinary Medicine; SPH = School of Public Health; N = Nursing; Critical Life Safety Emergency Yes=1 No=0	Critical Criteria Score	Item Number	Item Description	Amount	Fund Source	Yr. Funded	Link to Master Plan	EDUCATION	RESEARCH	OFFICES	CONSOLIDATION	CLINICAL	SUPPORT	UNASSIGNED
x			x	D	555	1	Accessibility Issues					E	R	O		C	S	
x			x	AHC	#REF!	3	Security Systems: AHC wide	5 yr allow.									S	
		x		AHC	230	4	Bridge to Amundson Hall	120 LF						O			S	
			x	AHC	230	5	Site Access / Signage	district									S	
			x	AHC	230	6	Site Access / Entries	5 entries									S	
			x	AHC	200	7	Site: Corridor Connections										S	
x			x	AHC	435	8	Technology: other AHC	5 yr allow.									S	

Facilities Issues with Major Policy Implications

- The AHC needs an additional 300,000 square feet of space to meet current academic program needs-even after the remodeling of Jackson, construction of the Molecular & Cellular Biology Building and renovation of Fairview release space.
- Changing program needs require extensive remodeling and reassignment of space.
- The AHC is land-locked, but interdisciplinary education and research require faculty to be located near each other to be effective.

PRECINCT PLANNING PROCESS

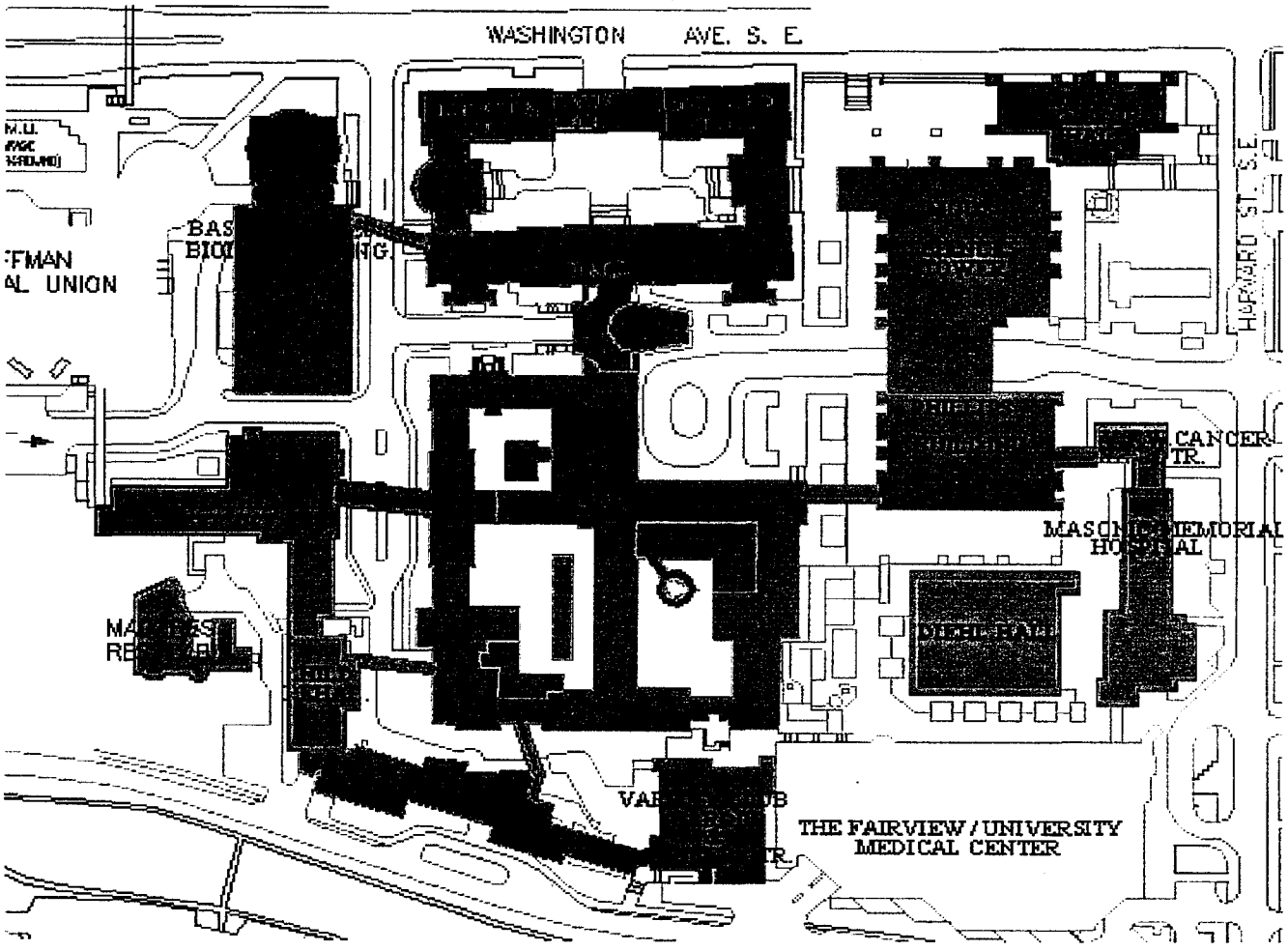
University of Minnesota



* For the Coordinate campuses, this function is served by the following committees:
Crookston Master Planning Committee
Duluth Campus Assembly Physical Facilities Committee
Morris Campus Resource & Planning Committee

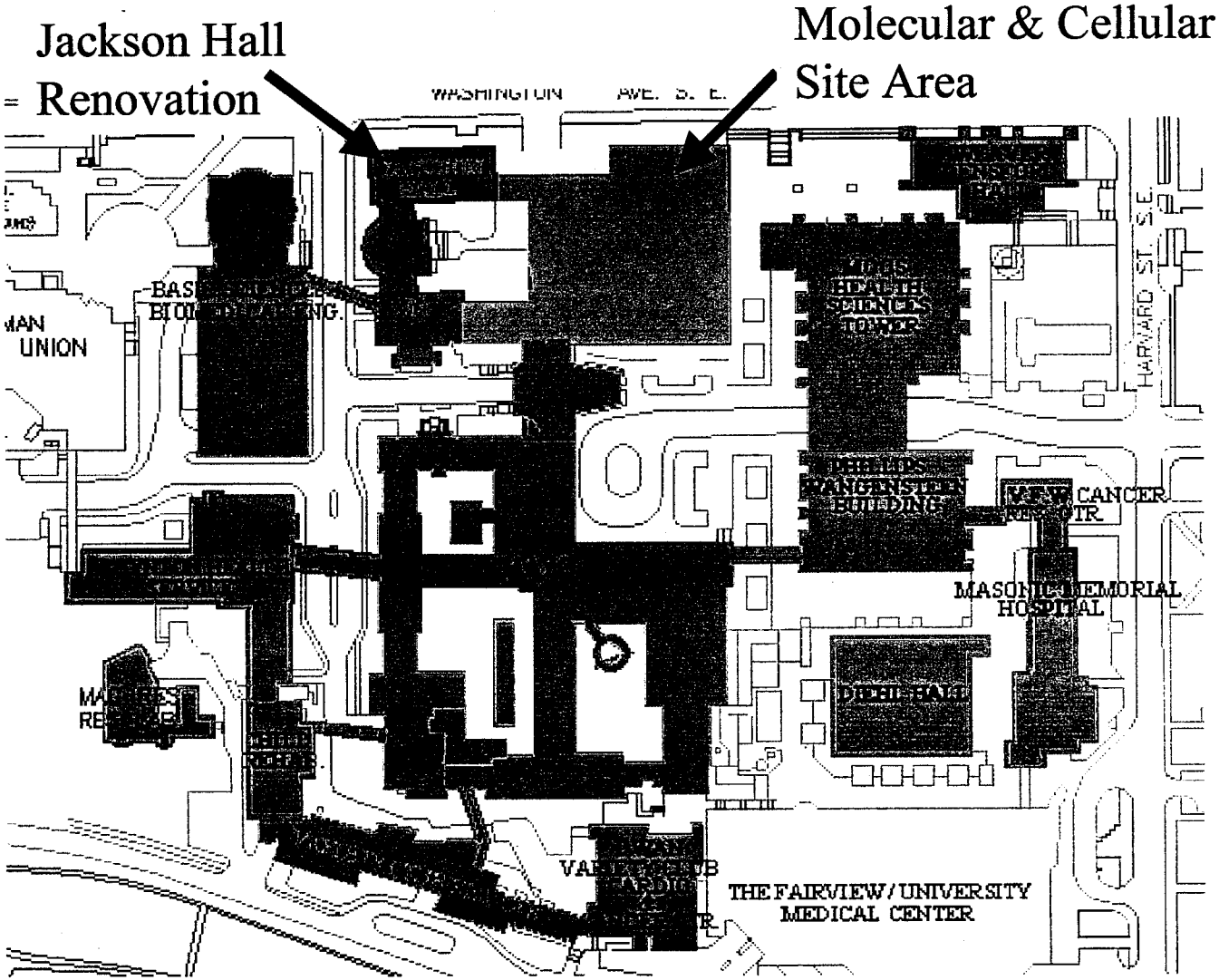
Academic Health Center Precinct

Existing Conditions



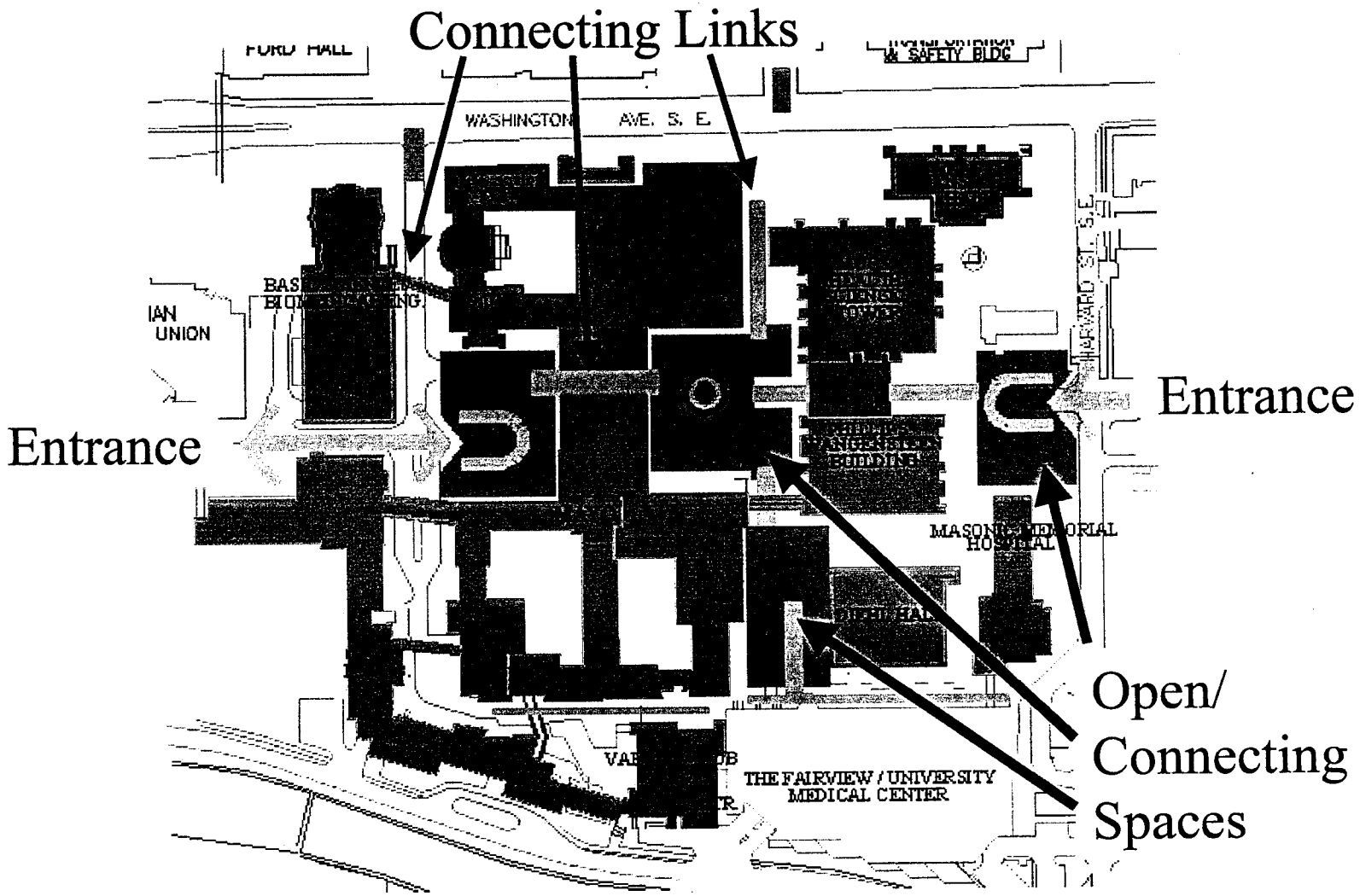
Academic Health Center Precinct Concepts

Current Development



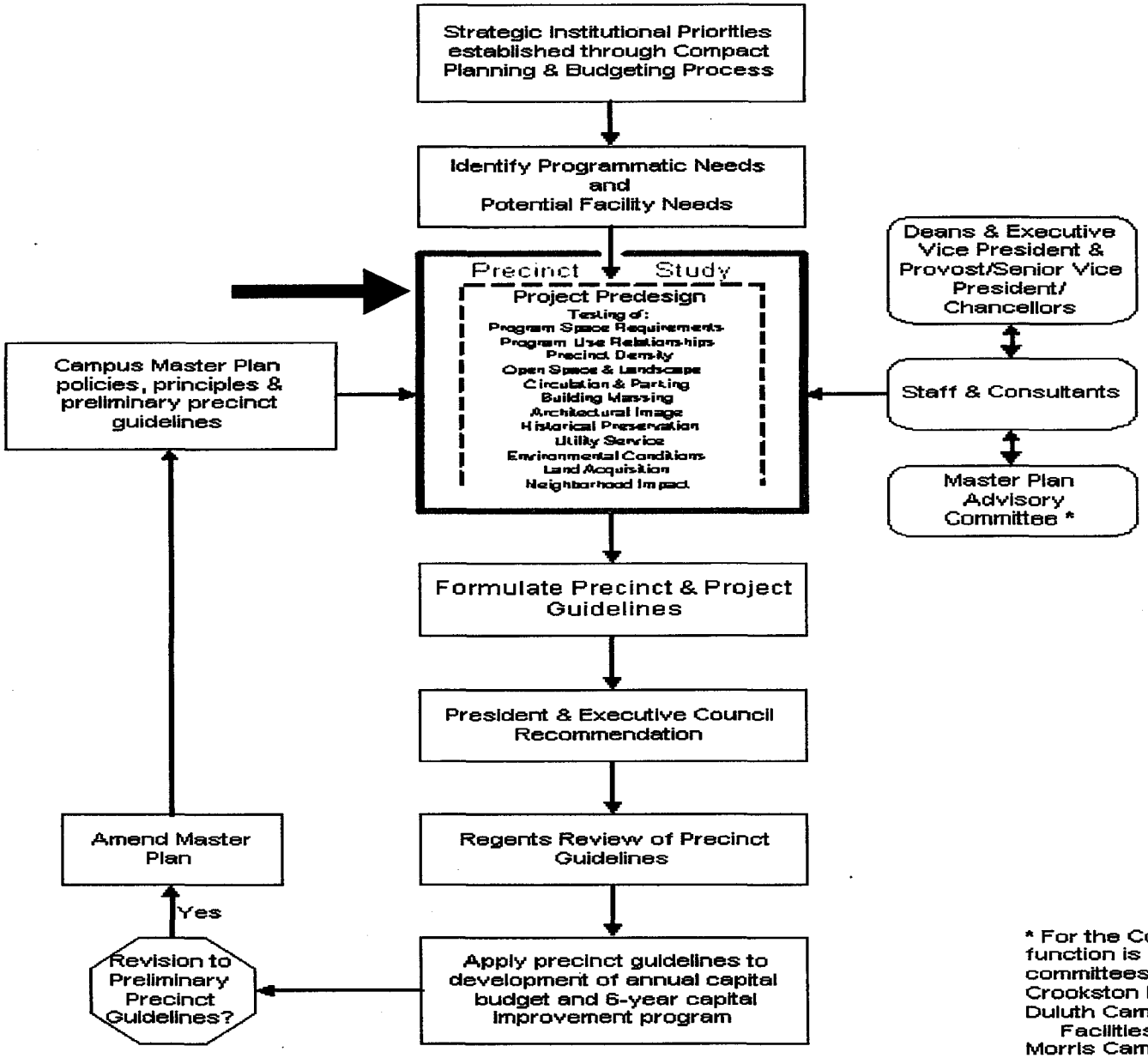
Academic Health Center Precinct Concepts

Linkages and Open/Connecting Spaces



PRECINCT PLANNING PROCESS

University of Minnesota



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Improving Administration in the Academic Health Center

Project Status -- March 1999

A Report from:

Frank B. Cerra, MD
Senior Vice President for Health Sciences
University of Minnesota

AcademicHealthCenter
UNIVERSITY OF MINNESOTA

Vision for AHC Administrative Services

The Academic Health Center will create and sustain administrative services that support faculty and staff in carrying out our education, research, and service missions --

- services that are user friendly;
- simple to use by faculty and staff;
- meet the needs of academic units;
- are responsive, of high quality, and efficient.

Impetus for Improving Administrative Services: Why and Why Now?

- Assessment of administrative services by State of Minnesota's Management Analysis Division:
  an objective outside assessment of administrative services that identified areas of weaknesses and strength.

- Changes occurring from other University initiatives:

  - Grants Management:
    Changes that reduce administrative paperwork; provide more accurate and timely information and support to faculty in managing their grants; improve oversight and internal controls

  - Enterprise Student Systems and Human Resources Project:
    Changes that eliminate cumbersome and inflexible policies and processes; provide more accurate and timely information to faculty, staff, and students; automate much of the routine paperwork and enable faculty, staff, and students to serve themselves; decentralize decision-making to collegiate units; reduce administrative costs; and replace systems that are not Y2K compliant

Goals Established for Administrative Process Improvement in the AHC

- Improve the effectiveness of administrative services to better support our education, research, and service missions
  - ⇒ Transition to more self-service
  - ⇒ Simplify administrative processes
  - ⇒ Increase responsiveness
- Reduce costs of administration and increase investment in core activities

  Administrative costs ↓ Academic investment ↑
- Improve the quality of the work environment and expand development opportunities for employees
  - ⇒ Support the distribution of responsibility and authority to departments
  - ⇒ Develop humane implementation strategies that consider the impact on people
  - ⇒ Communicate the wins and recognize the early innovators and adopters
  - ⇒ As jobs change, retrain staff for new opportunities
- Create incentives to encourage staff involvement in process improvement projects

Highlights: Plan for Improving Administrative Processes in the AHC

Objectives

- Seamless integration of:
  - ⇒ Work done by university organizations
  - ⇒ Work done by AHC
  - ⇒ Work done by AHC Schools
- Clear definition of:
  - ⇒ Roles and responsibilities
  - ⇒ Required competencies
- Redefinition of:
  - ⇒ Work and who does it

Resources and Tools

- State of Minnesota's Management Analysis Division
- Current and future computer applications
  - ⇒ FormsNirvana
  - ⇒ Grants management software
  - ⇒ Warehouse reports
  - ⇒ Enterprise/PeopleSoft Human Resources and Student Systems
- Process improvement techniques (e.g., mapping)
- Activity-based evaluation techniques

Action Items in the Plan for Improving Administrative Processes in the AHC

- Identify administrative functions to target
  - ⇒ Criterion 1: AHC programmatic and administrative priorities
  - ⇒ Criterion 2: Potential savings
- Evaluate current processes in AHC schools and departments
- Establish benchmark measures for the processes: time, resources, quality, and cost
- Revise or redesign processes
- Connect new or revised processes with University redesign/improvement efforts
- Pilot and test the redesigned processes in selected AHC units
- Train AHC staff in the redesigned processes and implement AHC-wide
- Collect data for measuring against established benchmarks
- Conduct routine evaluations

Expected Outcomes from the AHC Administrative Process Improvement Program

- Improved service to faculty, staff, students, and administrators
- Increased efficiency and reduced costs
  - ⇒ Overall reduction expected to equal 15 percent of administrative costs
  - ⇒ Early success: reduced number of payroll staff in Veterinary Medicine from 7 FTE to 4 FTE

  Important: a significant percentage of savings will be realized by Central university units

  Example: direct entry of invoices through FormsNirvana eliminates work in Disbursement Services
- Increased competency of staff
  - ⇒ Reduction in required rework of transactions
- Expanded opportunities for staff development
  - ⇒ Increased mobility of staff across AHC schools and departments
- Improved access to timely, accurate information
  - ⇒ More informed decision making
- Improved internal controls
  - ⇒ Reduced risk
- New distributed management models
  - ⇒ Authority, responsibility and accountability distributed to achieve optimal effectiveness and efficiency

Update on Initiatives in Financial Management

- Financial Transactions Training Programs

Project 1: Training and certification in financial transaction processing

⇒ Designed curriculum of courses for financial staff

- ⊃ Completed inventory of currently available classes offered by Central organizations, University foundations, etc.
- ⊃ Defined currently unmet training needs; working with appropriate offices to develop new classes

⇒ Identified standards for competency in 17 financial processes

⇒ Training encounters for AHC staff: Calendar Year 1997 = 716
Calendar Year 1998 = 1,708

Project 2: Personalized training courses for faculty in the use of Financial Reports on the Web

⇒ First step in eliminating paper reports from university's accounting system in College of Pharmacy

⇒ Full implementation targeted for 7/1/99

Project 3: Financial Management Internship Program

⇒ Train future financial leadership for the AHC

⇒ Provide career paths for current employees

⇒ Three AHC staff currently in program

Initiatives in Financial Management *(continued)*

- Electronic transactions

Project 1: Implement FormsNirvana throughout AHC by March 1, 1999

⇒ Documents submitted via FormsNirvana
  - ⊃ 41% in December
  - ⊃ 49% in January
  - ⊃ 57% in February

⇒ Central University units savings = conservative estimate of $240,000 to $500,000 annually
AHC savings = $30,000 annually

⇒ Implemented a charge for paper documents in March 1999

Project 2: Process Improvement Readiness Program

⇒ In collaboration with Grants Management Project group

⇒ Access readiness of units to implement FormsNirvana and EGMS
  - ⊃ Evaluate computers, software, and network connections
  - ⊃ Evaluate staff readiness (appropriate training)
  - ⊃ Provide on-site assistance in implementing new applications for first 90 days

Project 3: Expand available applications in FormsNirvana

⇒ Travel vouchers

⇒ Payments to individuals

Initiatives in Financial Management (continued)

Activity-Based Evaluation Projects:

- Completed Projects:
  - ⇒ Billing services in UMP and CUHCC
    - ⊃ Transfer of CUHCC billing services to UMP
  - ⇒ College of Pharmacy
    - ⊃ Savings identified: one of five staff positions in business office
  - ⇒ Payroll across the AHC
    - ⊃ Improvements in reconciling payrolls
    - ⊃ Automated identification of changes in employees on payroll/saved on average 2 hours per department per payday
    - ⊃ Improved internal controls

- New Project: Standard Staffing Model
  - ⇒ Collaboration between AHC Finance Staff and Grants Management Project staff
  - ⇒ Development of a mathematical model to compute staffing requirements for financial services and grants management
  - ⇒ First pilot: Division of Epidemiology
  - ⇒ Second pilot: Administrative centers in Medical School
  - ⇒ Expected outcomes:
    - ⊃ Identification of best practices
    - ⊃ Effective benchmark for evaluating adequacy of staffing
    - ⊃ Better match of staff skills and workload

Initiatives in Financial Management (continued)

- Financial Information Applications
  - ⇒ Completed design and implementation of new integrated Budget and Financial Planning System
    - ⊃ On-line preparation of annual budget and automated entry of annual budgets into University's accounting system
    - ⊃ Improvements in monthly financial performance reporting
    - ⊃ In development: Forward year financial planning application

- Distributed Management Model
  - ⇒ Decentralize financial management to departments
    - ⊃ Resource decisions
    - ⊃ Transaction processing (through FormsNirvana (source point entry)
    - ⊃ Future financial planning
  - ⇒ Changing role of administrative staff
    - ⊃ Consultants rather than controllers
    - ⊃ Authority and accountability assigned to academic leadership; information and counsel furnished by administrative staff
    - ⊃ Department heads accountable to deans; deans accountable to Senior Vice President for Health Sciences who is accountable to President and Regents
  - ⇒ New technology supports decentralization
    - ⊃ Better control assurance
    - ⊃ Reduced error rate
    - ⊃ More problem solving at point of entry

Initiatives in Administrative Services (continued)

Administrative Information Systems

- Created core of professional staff to serve all AHC schools:
  - ⇒ Transferred 5 Medical School information systems staff to the AHC
  - ⇒ Added 2 staff to work on PeopleSoft development and implementation
  - ⇒ Added 1 staff to work on Y2K
  - ⇒ Added 1 staff to handle work formally done by the Hospital and UMP
  - ⇒ Added 4 desk top support staff at request of departments
- Developing a strategic administrative information systems plan to clarify needs, reduce duplication, and better leverage critical resources that are in high demand.
- Developing common administrative systems for AHC schools and departments to provide more timely and accurate information and more comparable data across units. Tied to central systems and data warehouses -- to avoid duplicate data entry and to use common data. AIS development costs are $40/hour compared with private consultant costs of $100/hour.
  - ⇒ Eliminate expenses of maintaining stand-alone shadow systems (many of which have significant security, back-up, maintenance, data validity, and Y2K problems)
  - ⇒ First systems developed: budget, performance reporting, and human resources tracking systems. 150 current users

Initiatives in Administrative Services (continued)

- Launched major initiative to create electronic administrative reports and reduce paper reports.
- Developed hardware and software standards for all AHC administrative offices -- to reduce operating and support costs and to improve ability to share information between units. Three-year conversion plan under implementation.
- Software purchasing: through volume purchases, AIS has cut licensing costs for calendar software by 50% and anti-virus software by 60%. Savings in 1998 were $49,750
- Operate network of servers for calendering, file sharing, and web services AHC-wide: 750 users connected to AHC administrative servers; 1,000 users on AHC calendar system.
- Developed desktop support services for interested AHC schools and departments. The service is optional. 500 current users. At $900/year per machine, the service is less expensive than departments hiring their own staff or Office of Information Technology guidelines of $1,100 per year.
- Rather than creating its own help desk, University of Minnesota Physicians (UMP) is negotiating with the AHC for these services.

Initiatives in Administrative Services (continued)

- Distributed Management Model under development:

  ⇒ AHC-AIS will develop and maintain AHC-wide applications; develop and support AHC-wide desktop, network and data standards; operate an AHC-wide network of servers; and provide desktop support and help desk services to interested units. Collegiate and department units will be responsible for developing necessary local applications. They can use AHC-AIS servers, networks, and support services or operate their own as long as they meet University and AHC-side standards.

Initiatives in Administrative Services (continued)

Human Resources

- Established core of human resource professionals to serve all AHC schools
  - ⇒ Transferred 2 Medical School human resources staff
  - ⇒ Transferred 6 staff and 3 student workers from central Human Resources
  - ⇒ Added 4 staff to work on PeopleSoft

  AHC has assumed responsibility from central for employment, compensation, grievance handling, employee relations, and human resources consulting.

- Establishing a service vision for Human Resources: more flexible, innovative policies/services; trusting rather than policing line administrators; simplifying processes. Strategies: establishing new policies; redesigning processes; building new information systems; and building the human resources knowledge/expertise of administrators and administrative staff.

- Mapped and redesigned seven processes within AHC departments: recruitment, initial appointment, contract renewal, termination, salary increases, job reclassification, and the administrative aspects of the faculty promotion and tenure process. Results: reduced time to fill staff positions by 20%; reduced time to review and approve reclassification requests from 20 to 10 days; reduced number of staff salary reviews by AHC HR staff by 85%; eliminated the duplicate auditing and approval of Medical School personnel documents so that two staff can be reassigned to work on PeopleSoft implementation.

Initiatives in Administrative Services (continued)

- Improving the human resources competencies of administrators and administrative staff: developed management guides on major human resources policies; monthly information and training sessions for collegiate and department human resources staff; and monthly training sessions for supervisors, managers, and administrators.

- Established five pilot sites for PeopleSoft human resources system implementation. Working to identify changes needed in the system to better meet unit needs. Using PeopeSoft to do further process redesign. Leading implementation of PeopleSoft at the unit level in the AHC. Developing implementation tools and strategies that can be used elsewhere, for example, data verification and correction effort.

- Developing staffing models, defining staff competencies, developing training, and preparing for decentralization of human resources in the AHC.

- Distributed Management Model under development:

  ⇒ AHC-HR will have a core of human resources professionals to advise and assist schools on employment, compensation, labor-management, employee relations, and training and development matters. Handling of routine human resources work will be done by trained staff in collegiate units or administrative service centers. As much human resources paperwork as possible will be automated and become self-service.

Initiatives in Administrative Services (continued)

Facilities Management

- Completed a strategic facilities plan for the AHC that identifies needs for the next five to ten years. AHC facilities staff and faculty/staff committees prepared plan (rather than engaging outside consultants). Estimated cost of using outside consultants would have been $500,000 to $750,000. The plan includes over 100 projects with an estimated cost of at least $250 million.

- Developed a project administration process for AHC capital projects to improve the delineation of programmatic needs, cost estimates, and budget control. AHC-FM staff are currently overseeing 60 projects with a total estimated cost of $100 million; last year AHC-FM oversaw and completed 50 projects totaling $16 million.

- Implementing an initiative to better utilize existing space, including the development of new space allocation guidelines.

- Developing cost/quality benchmarks for projects using past AHC projects and comparable projects from other institutions.

- Proposing collaborative efforts with University Facilities Management staff to improve project management processes that would reduce overall costs and increase quality of service to AHC user groups.

Initiatives in Administrative Services (continued)

- Distributed Management Model under Development:

  ⇒ AHC-FM will be responsible for the programmatic planning and management of AHC facilities. They will work with AHC units in developing an AHC-wide strategic facilities plan and the six-year capital improvement plan. They will be responsible for planning, programming, and project administration of approved capital projects. The Senior Vice President's office will be responsible for allocating space to colleges and schools; collegiate units will be responsible for managing and allocating the space assigned to them.

Other Academic Health Center Initiatives

- Grants Management
  - ⇒ Four focused projects underway in Surgery, Epidemiology, Pediatrics and Biochemistry
  - ⇒ New best practice in effort reporting developed; has potential to reduce the number of salary redistributions by 50 percent
  - ⇒ Established target date of July 1, 1999 for full implementation of FormsNirvana and EGMS in the Medical School

- Research Services Organization
  - ⇒ Involved in 29 new clinical trials in 1998, at an estimated contract value of $2.1 million
  - ⇒ At year-end, 15 new projects in initiation stages at an estimated contract value of $2.6 million
  - ⇒ Process time (from the first contact to the enrollment of the first patient) reduced from171 to 57 days
  - ⇒ Assisted in the review of 103 clinical trials in 1998

- Internal Service Organization reviews

  Project 1: Scientific Apparatus

  Current Status: Completed review and closed operation in September 1998. Customers referred to other internal operations.

  Project 2: Biomedical Graphics

- Classroom Support
  - ⇒ Hired students enrolled in classes to make sure equipment works and supplies are available
  - ⇒ Result: Dramatic reduction in complaints from covered classrooms

Lessons Learned

- Redesign takes strong leadership and support from the top.
- If the goals are not clear, the process will not be successful.
- Voluntary administrative redesign does not work.
- Redesigning process more difficult than anticipated.
- Resistance to change higher than predicted.
- No single model exists for effective, efficient administration.
- Savings are often hard to "capture" and often benefit units "upstream".
- Success is invisible.
- Continuous skillful communication is critical.
- Communicate both successes and failures.
- Financial incentives (or penalties) will affect behavior in a positive way
- Even under the best conditions, someone will complain.

Basics of
Budget Development

A Presentation to the
Academic Health Center Faculty Consultative Committee
April 13, 1999

Presented by:

Katherine M. Johnston
CFO for Health Sciences

Presentation Overview

- Purpose of Budgets
- Key Components of Successful Budget Processes
- Roles and Responsibilities in the Budget Process
- Major Phases of the Budget Development Cycle
  - ⇒ Connecting to the Strategic Plan
  - ⇒ Collecting Data
  - ⇒ Composing the Elements of the Budget
  - ⇒ Making Resource Allocation Decisions
  - ⇒ Executing and Evaluating the Budget

Purpose of Budgets

- Translation of the institution's long-range goals to annual objectives or actions
- Institution's formal financial plan
- Communication of priorities
- Control structure
- Framework for negotiation
- Political statement

Key Components of Successful Budget Processes

- Distributed authority, responsibility, and accountability
- Bottom-up establishment of priorities
- Collaborative, consultative decision making
- Clear, concise performance expectations
- Continuous, effective communication

Roles and Responsibilities in the Budget Process

Governing Boards:

- Creating the climate for resource management
- Ultimate responsibility and accountability for:
  - ⇒ Viable long-range finance plan
  - ⇒ Oversight of institutional financial performance
  - ⇒ Resource maximization and financial stability

Roles and Responsibilities in the Budget Process

Presidents:

- Internal and external communication
  - ⇒ Governing board
  - ⇒ Legislative and Executive Branches of State Government
  - ⇒ Alumni and other external constituencies
- Determining institutional financial strategies
- Determining final allocation decisions
  - ⇒ Strategic investments
  - ⇒ Enrollment plans
  - ⇒ Tuition policies
  - ⇒ Performance goals

Roles and Responsibilities in the Budget Process

Business Officers:

- Changing role

  Traditional Role: ***CONTROL***ler

  New Role: ***CONSULT***ant

- Key Responsibilities:
  - ⇒ Establish the principles and facilitate the process for budget development and execution
  - ⇒ Provide timely, accurate information to deans, department chairs, and other managers
  - ⇒ Facilitate resource decisions
  - ⇒ Recommend alternatives for revenue and expenditure plans
  - ⇒ Maintain clear communication links

Roles and Responsibilities in the Budget Process

College and Departmental Administration:

- Connect institutional financial strategy to departmental activities
- Provide input to the construction of the institution's long-range financial plan
- Translate long-range financial plan to department's annual resource requirement
- Monitor department's resources throughout the year
- Initiate timely responses to deviations from annual plan
- Communicate up, down, and across the organization

Roles and Responsibilities in the Budget Process

Advisory Committees

- Consultation
  - ⇒ Counsel to president on all major budget and planning issues, including capital requests
- Communication
  - ⇒ Committee members present the views of the constituents they represent
  - ⇒ Committee members transmit the work of the committee to the constituents they represent

Roles and Responsibilities in the Budget Process

Examples of advisory committees:

- Budget and Planning committee
  - ⇒ Reviews strategic plan and annual financial plans
- Investment committee
  - ⇒ Review investment strategies (e.g., institutional spending formula)
- Capital projects committee
  - ⇒ Reviews all major projects to be included in the university's capital plan
- Capital plan committee
  - ⇒ Review capital plan and make recommendations on prioritization of projects to president (and board, if appropriate)
- Space utilization committee
  - ⇒ Advises administration on the use and/or assignment of space

Roles and Responsibilities in the Budget Process

Typical membership of advisory committees

- Chair: President or Chief Academic Officer
- Appointed or elected members:
  - ⇒ Faculty members (cross-section)
  - ⇒ Staff (cross-section)
  - ⇒ Officers of senates (or assemblies)
  - ⇒ Undergraduate student(s)
  - ⇒ Graduate student(s)
- Ex officio members
  - ⇒ Chief Academic Officer
  - ⇒ Chief Financial Officer
  - ⇒ Chief Facilities Officer (for capital related issues)

Roles and Responsibilities in the Budget Process

Typical calendars

Option 1: meet quarterly

- ⇒ To review results of prior year
- ⇒ To review planning assumptions for next 3 to 5 years
- ⇒ To review proposed budget for next year
- ⇒ To review proposed tuition and fees

Option 2: meet monthly

Option 3: meet on an ad hoc basis when the president needs advice

Major Phases of the Budget Cycle

Connecting to the Strategic Plan

- Identifying and communicating the financial challenges, opportunities, and risks
- Deriving annual objectives or actions from the Institution's Strategic Plan

Data Collection

- Collecting Internal Information
- Collecting External Information

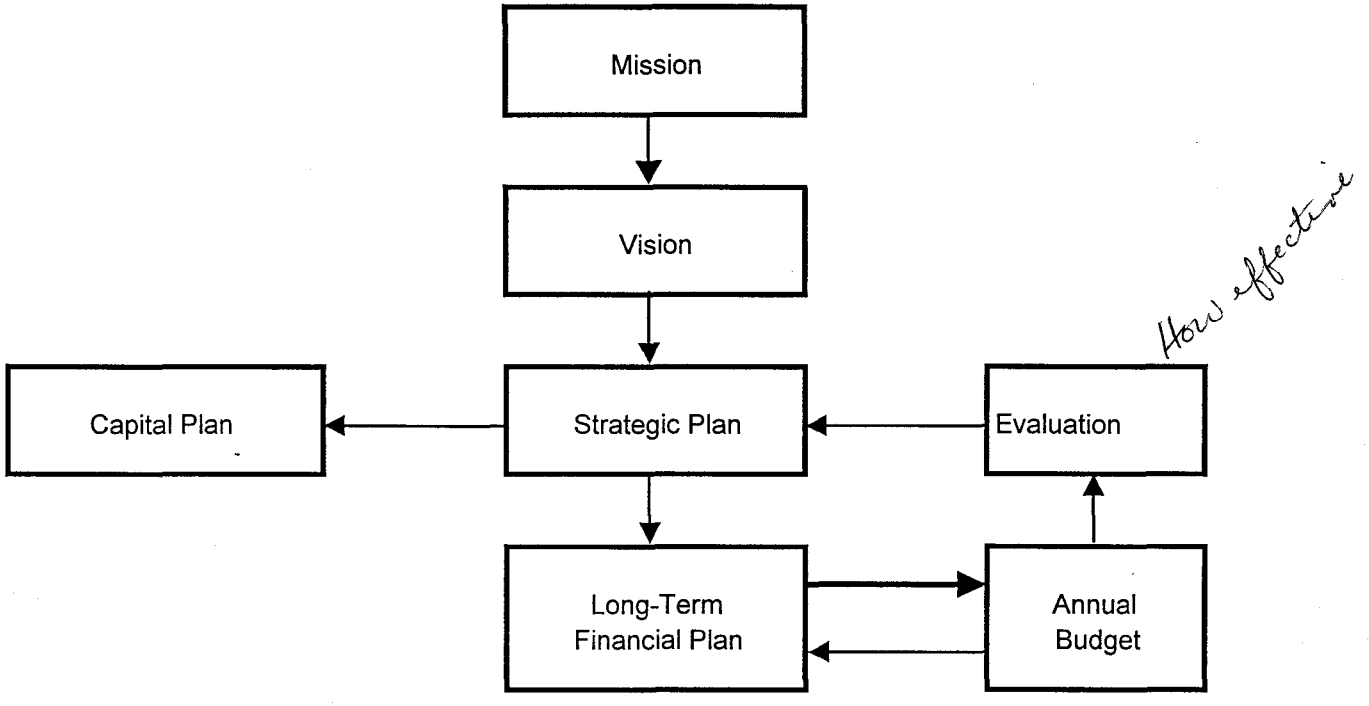
Composing the Elements of the Budget

- Forecasting available revenues
- Projecting expenses

Making Resource allocation decisions (aka: aligning revenues and expenses)

Executing and evaluating the approved budget

Connecting the budget to the strategic plan



Connecting the Budget to the Strategic Plan

- Annual objectives or actions derived from institution's strategic plan
- Guiding principles:
  - ⇒ Realign current resources to achieve university goals
  - ⇒ Allocate new resources to meet university goals
- Procedures:

  First time:
  - ⇒ Translate goals to annual actions or deliverables
  - ⇒ Prioritize actions
  - ⇒ Allocate resources to highest priorities

  Recurring:
  - ⇒ Measure progress in meeting last year's actions or deliverables
  - ⇒ Revise actions and identify new actions
  - ⇒ Allocate resources to highest priorities

Collecting Data

Internal Information Collection

- ⇒ Produce and publish a timetable of events
- ⇒ Establish principles and guidelines
- ⇒ Define format for collection of budget requests
- ⇒ Issue budget instructions
- ⇒ Collate and synthesize resource requests
- ⇒ Prepare presentations for decision makers

Collecting Data

External Information Collection

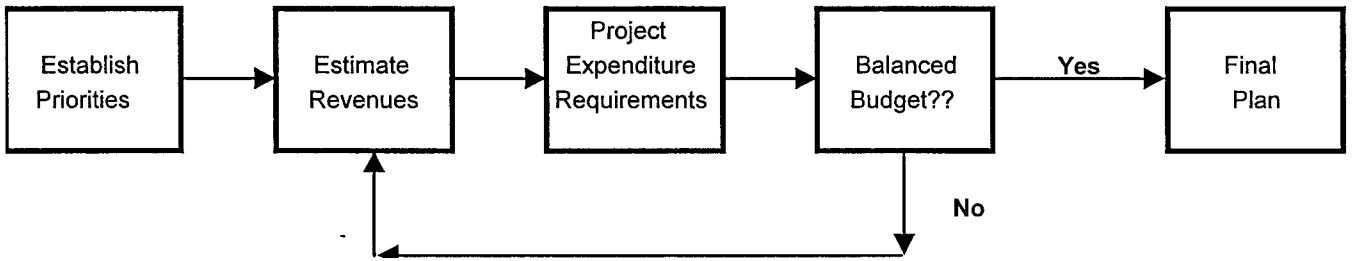
- ⇒ National and regional enrollment trends and predictions
- ⇒ Salary trends and predictions
- ⇒ Competition for state and federal tax dollars
- ⇒ Federal and state laws and regulations
- ⇒ Structural changes in higher education
  - » Growth in 'older' learners
  - » Distance learning
  - » Integration of technology in college curricula
  - » Increased competition from corporate training programs

Budget Structure for Higher Education

Operating budgets:

- Educational and General Programs
  - ⇒ Instruction
  - ⇒ Research
  - ⇒ Public Service
  - ⇒ Academic Support
  - ⇒ Institutional Support
  - ⇒ Operation and Maintenance of Physical Plant
- Auxiliary Enterprises
- Student Financial Aid
- Sponsored Programs

Composing the Elements of the Budget



Composing the Elements of the Budget

Estimating Revenues:

major categories in higher education budgets:

- Tuition
- State and Federal appropriations
- Auxiliary revenues
- Sales revenues
- Endowment earnings
- Gifts
- Grant and contract revenues (direct and indirect)

Composing the Elements of the Budget

Projecting Expenses:

a sample of techniques:

- Open-ended budgeting
- Incremental budgeting
- Alternate-level budgeting
- Zero-base budgeting
- Program budgeting
- Formula budgeting
- Performance budgeting

Making Resource Allocation Decisions

A perfect world: revenues = resource requirements

Reality: resource requirements exceed revenues

Aligning revenues and expenses:

- Consolidate operations
- Eliminate duplication
- Evaluate effect of institutional policies
- Redesign processes
- Change pricing structures
- Assign reallocation targets

Executing the Annual Budget

- Ratify revenue and expenditure plans
- Communicate the final budget
  - ⇒ Community meetings
  - ⇒ Campus newspapers
  - ⇒ Web-page
- Communicate decisions to participants
- Evaluate the budget process

Evaluating the Annual Budget

- Report financial performance on a regular basis
- Explain variances between the original budget and year-to-date financial results
- Preserve historical record of expenditures and revenues
- Document expenditure and revenue trends
- Incorporate current year's experience and trends into next year's budget
- Update the institution's strategic plan

UNIVERSITY OF MINNESOTA

The Fairview Relationship:
A Progress Report

University of Minnesota
Board of Regents

December 11, 1997

AcademicHealthCenter

UNIVERSITY OF MINNESOTA

This progress report provides:

1) A summary of the transaction

2) A one-year progress report on the relationship

3) An overview for moving forward

Summary of the Transaction:

In January 1997, University Hospital was sold to Fairview Hospital and Health System, and a unique public-private relationship was established.

The basis for this relationship remains:

A. to provide greater access to patients for education/ research and clinical practice of faculty

B. to meet a FHHS need to enhance its care delivery system by adding a flagship, world-class component

C. to improve the University Hospital financial performance

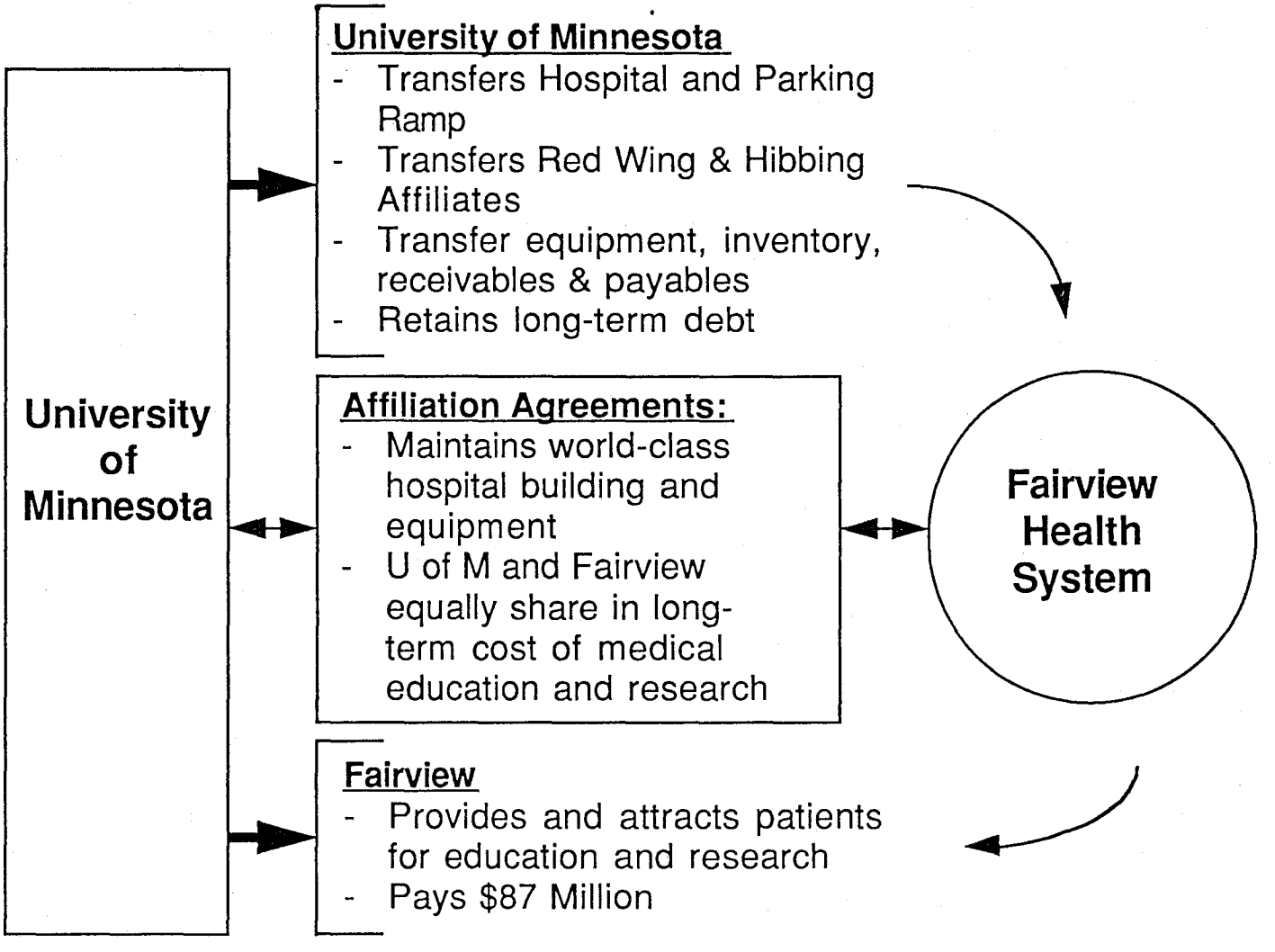
D. to stabilize one portion of the financial base of the Medical School/AHC

E. to provide enhanced opportunities for education and research development within FHHS

F. to support the public community mission of the Medical School and AHC schools

Fairview Transaction & Affiliation

Summary



New Mission Statement

Fairview's mission is to improve the health of the communities we serve. We commit our skills and resources to the benefit of the whole person by providing the finest in health care, while addressing the physical, emotional and spiritual needs of individuals and their families. We further pledge to support the research and education efforts of our partner, the University of Minnesota, and its tradition of excellence.

Progress Report on the Relationship

I. Patient Care

- Admissions per month increased 1.6% (3,247 per month in 1997)
- Average daily census decreased 0.8% (ADC 670 per month in 1997)
- Length of stay decreased 6.8 to 6.4 days
- Customer satisfaction: percentage positive responses are within 2 to 6% of previous
- Joint Commission on Accreditation of Healthcare Organizations Survey: passed and received a positive special comment on quality of care environment and care services delivered

Progress Report on the Relationship

II. Impact on Students

- Medicine, Nursing, Pharmacy, Dentistry students use FUMC
- Educational experience unaffected
- Improvements: lounge, computer access, on-call room security, new teaching rotations
- Potential for enhanced educational experience is understood, and work underway to realize the potential, e.g., pharmacy training program

Progress Report on the Relationship

III. Impact on Faculty

- Faculty are involved at all organizational levels at FUMC - 21 departments, 12 committees, 13 clinical service lines
- The number of compensated physician leaders has increased in FUMC, while total financial support decreased about 20%
- Faculty turnover rate remains unchanged from its historical 6-8% per year
- Patient care activities are strong
- Recruited 3 new senior faculty with excellent academic credentials: cardiology, orthopedic surgery, gastroenterology
- Loss of access to Regentally delegated funds to UMHS governing board for faculty recruitments and retentions, and program development
- Loss of clinical revenue to the Medical School in 1996-97 for reasons that directly related to the transaction ($9.6 M)
- Cultural integration has not been achieved

Progress Report on the Relationship

IV. FUMC Performance

- Financial performance of FUMC operations is cash positive
- Operations plan slow to implement on both campuses
- Program investments are being made by Fairview:
  - new faculty research and education (800K)
  - donation to School of Nursing Leadership Institute (500K)
  - $1.3M in clinic renovations for UMP clinics
  - Children's services: Perinatal Mental Health; genetic counseling; expanded Woman's Health; Immunlink
  - Transplant Services: Marketing program; expanded services lines
  - Oncology Services: Breast Cancer Center ($1.7M); enhanced outreach; coordinated research protocols with Cancer Center and communities
  - Neuroscience: New programs in pain, epilepsy, stroke and interventional NMR
  - Other: UMP Outreach in Fairview System; Digestive Disease Center; Upgrade FUMC to Level II Trauma

Progress Report on the Relationship

V. FUMC Employees

- About 4,000 employees transferred to Fairview
- University paid about $6 million in transition benefits; State contributed $1.8 million
- Although 200 layoffs were expected, almost none occurred; over 100 employment vacancies are present
- AFSCME represents approximately 900 service and maintenance unit employees
- Cultural integration continues

Progress Report on the Relationship

VI. Research

- The Institutional Review Board (IRB) for the use of human subjects in research serves both the University and Fairview, and incorporates Fairview members into its panels.

- The research operations interface between the AHC and FUMC is implemented.

- The number of approved clinical research protocols has risen from 1,197 in 1996 to 2,287 in 1997, with 564 new protocols approved so far in 1997.

- The AHC continues to experience an increase in sponsored research funding.

Progress Report on the Relationship

VII. Legal

- Completion of service agreements related to the transaction (e.g., CUHCC services, Medical Records, Chilled H_2O/Steam).
- Implementation agreements (e.g., IRB consolidation, trademark, marketing)
- Compliance with contract terms (e.g., lease, fund transfers)
- Monitor effective University role in FHHS division and system governance/protection of University's long-term interest
- Coordination of legal issues U/UMP/FHHS
- Interpretation of various agreements as they become operational

Progress Report on the Relationship

VIII. Financial Transactions

- Lease arrangement is working with return of space ahead of schedule; expected costs to remodel this space $24 M
- Integrity of state funds for support of education and research has been maintained; accounting mechanism for the "bucket" is in process

VIII. Financial Transactions (continued)

Summary of University Hospital/Fairview Transaction
(Excludes CUHCC Activity Retained by the University)

Dollars in Millions

Comparison of Final Amounts to July 1996 Estimates

		Dec. 1997	July 1996 Estimate
Cash Remaining with the University:			
Cash and cash equivalents:		$47.0	$39.7
Cash and equivalents	$28.4		
Endowment and gift cash	14.1		
Other current assets retained	4.5		
Cash and investments whose use is limited		159.6	157.7
Proceeds from sale to Fairview		87.5	87.5
Cash settlement on disputed items		5.7	
Total available cash and other resources		$299.8	$284.9
Obligations Remaining with the University:			
Debt and capital projects:		$131.1	$146.7
Refunded University debt	$46.4		
Debt service payments	6.3		
Restricted tax-exempt capital	71.0		
Committed to steam plant project	7.4		
Endowment and gift restrictions		14.1	
Other retained liabilities		18.8	11.9
Cost of the transaction:		66.4	56.1
Direct costs	$10.9		
Transition payments (32 mo.)	32.0		
Deficit sharing (36 mo.)	19.5		
Hibbing Hospital commitments	4.0		
Total Obligations:		$230.4	$214.7
Net Current Fund Balance Available		**$69.4**	**$70.2**

Fairview-University Relationship Report Card: First Year

Academic	Current	Expected
-improved patient access for education/research	±	+
-preserved quality of education experience	+	+
-enhanced clinical research	+	+
-maintain access to resources	–	+
-preserved integrity of state funds	+	+
Clinical		
-continued program development activity	+	+
-improved customer satisfaction	±	+
-improved status of practice plan	–	+
-improved market share	–	–
Administrative		
-develop clear, joint strategic plan	–	+
-improved financial status - hospital	+	+
-minimize layoffs	+	–
-physician attitude	±	±
-cultural integration	–	–

Moving Forward in the Fairview-University Relationship

- Make vision tangible at all levels of Fairview and AHC
- Establish effective links between Fairview and AHC planning and operations
- Continue cultural integration and development of new culture
- Maintain and/or enhance market share
- Continue development of AHC/Medical School's public mission with other health system providers and state agencies

The Broader Context: AHC/Medical School Moving Forward

- Competitive integrated practice plan
- Development of strategic plan for clinical enterprise
- Reorganization and investment in biologic sciences and digital technologies
- Increasing interdisciplinary/interscholastic education and research
- Improving fiscal performance and accountability
- Redesigning administrative infrastructure into an efficient, customer-focused service model
- Expanding technology development and transfer

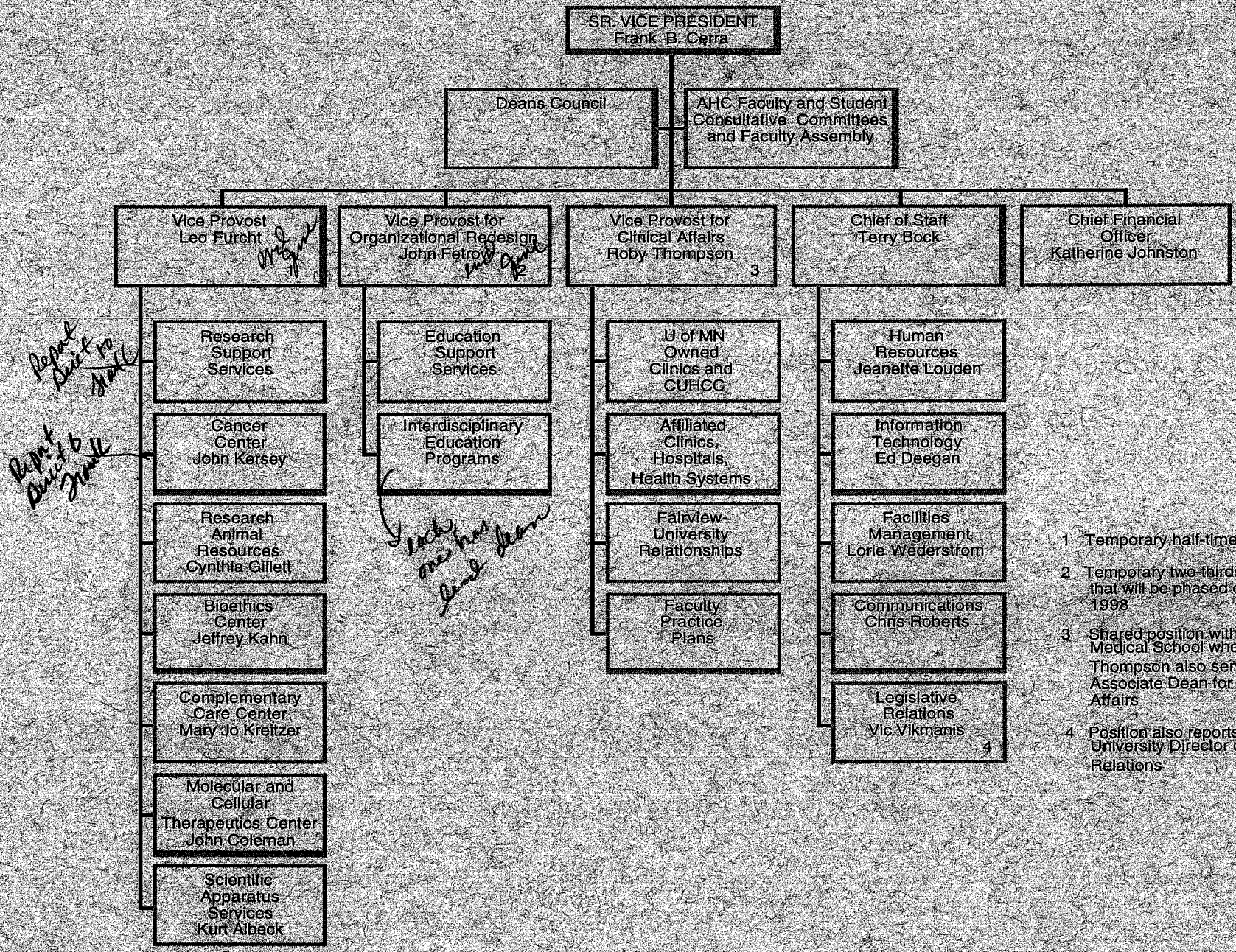
Fairview University Relationship: Conclusion

Whatever challenges are before us,

this was a good decision for

the University of Minnesota.

UNIVERSITY OF MINNESOTA
ACADEMIC HEALTH CENTER
OFFICE OF THE SENIOR VICE PRESIDENT



1 Temporary half-time position

2 Temporary two-thirds position that will be phased out in June 1998

3 Shared position with the Medical School where Dr. Thompson also serves as Associate Dean for Clinical Affairs

4 Position also reports to University Director of State Relations

Academic Health Center
Office of the Senior Vice President for Health Sciences
Year-to-Year Changes in FTE Employment

	FY97 FTE	Transfers: Med. School	Transfers: Other Univ Units	Transfers: Central	Transfers: Within AHC	Transfers: Total	Net Turnover	FY98 FTE	Correct	Adj. FY98 FTE
Regular SVPHS Operating Accounts										
SVPHS Office	7.0	1.3				1.3	1.0	9.3	0.3	9.6
Facilities Management	0.0	2.0		1.0		3.0	2.4	5.4		5.4
Human Resources	6.0	3.0		2.0		5.0	3.5	14.5		14.5
Information Technology	2.0	1.0				1.0	0.0	3.0		3.0
Communications	7.8				0.3	0.3	0.0	8.1		8.1
VP - Clinical Affairs	1.0		1.0			1.0	0.0	2.0		2.0
VP - Organizational Redesign	0.0				0.7	0.7	0.0	0.7		0.7
Chief Financial Officer	1.1	0.9	1.0		1.0	2.9	1.0	5.0		5.0
Total	24.9	8.2	2.0	3.0	2.0	15.2	7.9	48.0	0.3	48.2
Units Report to the SVPHS Office										
Learning Resources	5.3				(1.0)	(1.0)	(1.8)	2.6		2.6
CHIP	1.5					0.0	0.0	1.5		1.5
Multicultural Institute	4.5					0.0	(2.5)	2.0		2.0
Total	11.3	0.0	0.0	0.0	(1.0)	(1.0)	(4.3)	6.1	0.0	6.1
Total THSC - Health Sciences,SrVP	36.2	8.2	2.0	3.0	1.0	14.2	3.6	54.0	0.3	54.3
Shared Programs										
BSBE	0.0					0.0	0.0	0.0		0.0
ESO-New programs	0.0					0.0	0.0	0.0		0.0
Biomed Graphics	17.1					0.0	(4.7)	12.4		12.4
Research Animal Resources	0.0	62.5				62.5	0.0	62.5		62.5
Research Services Organization	0.0					0.0	2.0	2.0		2.0
Complementary Care	0.0					0.0	1.0	1.0		1.0
Research Computing	0.0					0.0	1.0	1.0		1.0
Proslavia	0.0					0.0	0.0	0.0		0.0
Scientific Apparatus	0.0	5.0				5.0	0.0	5.0		5.0
Cancer Center	24.5					0.0	3.8	28.3		28.3
Institutional Officer	0.0					0.0	0.1	0.1		0.1
Biomedical Ethics	0.0					0.0	0.0	0.0		0.0
MMCT	11.9					0.0	(2.2)	9.7		9.7
Total TAHS - AHC Shared	53.5	67.5	0.0	0.0	0.0	67.5	1.0	122.0	0.0	122.0
Grand Total	89.7	75.7	2.0	3.0	1.0	81.7	4.6	176.0	0.3	176.2

kmj--11/19/97

Tasks (1/12/98)

Area	Tasks	Responsible	Completion
1) Grants Management Group (GMG)	1.a. Reformulate	Cerra	1/27/98
	1.b. Reappoint	New Chair	
	1.c. New Chair		
	1.d. Define transition role for VPR		
	1.e. Enterprise interface		
2) GMG Budget	2.a. Finalize	Brenner/Cerra/Cawley/ and Director	2.a. 1/27/98
	2.b. Present to EOC		2.b. 1/29/98
3) Project Groups EGEMS Forms Nirvana Education/training FGMP	3.a. Define each group, leader, charge	Director/Project leader	1/23/98
	3.b. Define reporting relationships		
	3.c. Workplan/timelines		
4) FGMP	4.a. Appoint project leader	Director/Project leader	1/23/98
	4.b. IT/Chem E implement		
	4.c. Workplan/timelines		
	4.d. Enterprise interface		
5) Rollout	5.a. New GMG	Director/Cerra	1/26/98
	5.b. New structure		
	5.c. Workplan/timelines		
6) New VPR Interface	6.a. Contact/discussion	Cerra/Director	1/21/98
	6.b. Ongoing dialogue		
7) ORTTA	7.a. Develop plan	Cerra/VPR designate	2/27/98
	7.b. Implement plan		

Grants Management Project
1/20/98

A) Basis:

1) Appointment of new Vice President for Research and Dean of the Graduate School with start date of July 1, 1998
2) Need for the grants management project to continue to move forward

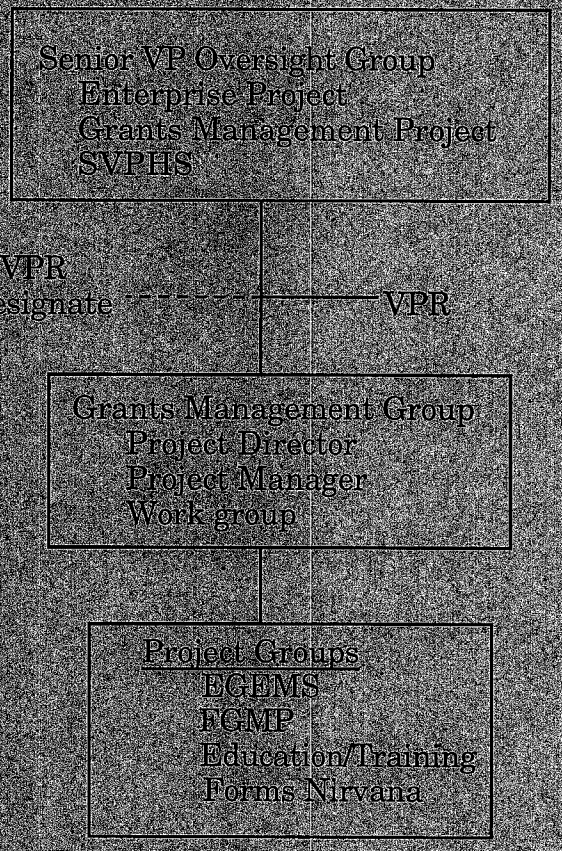
B) Goals:

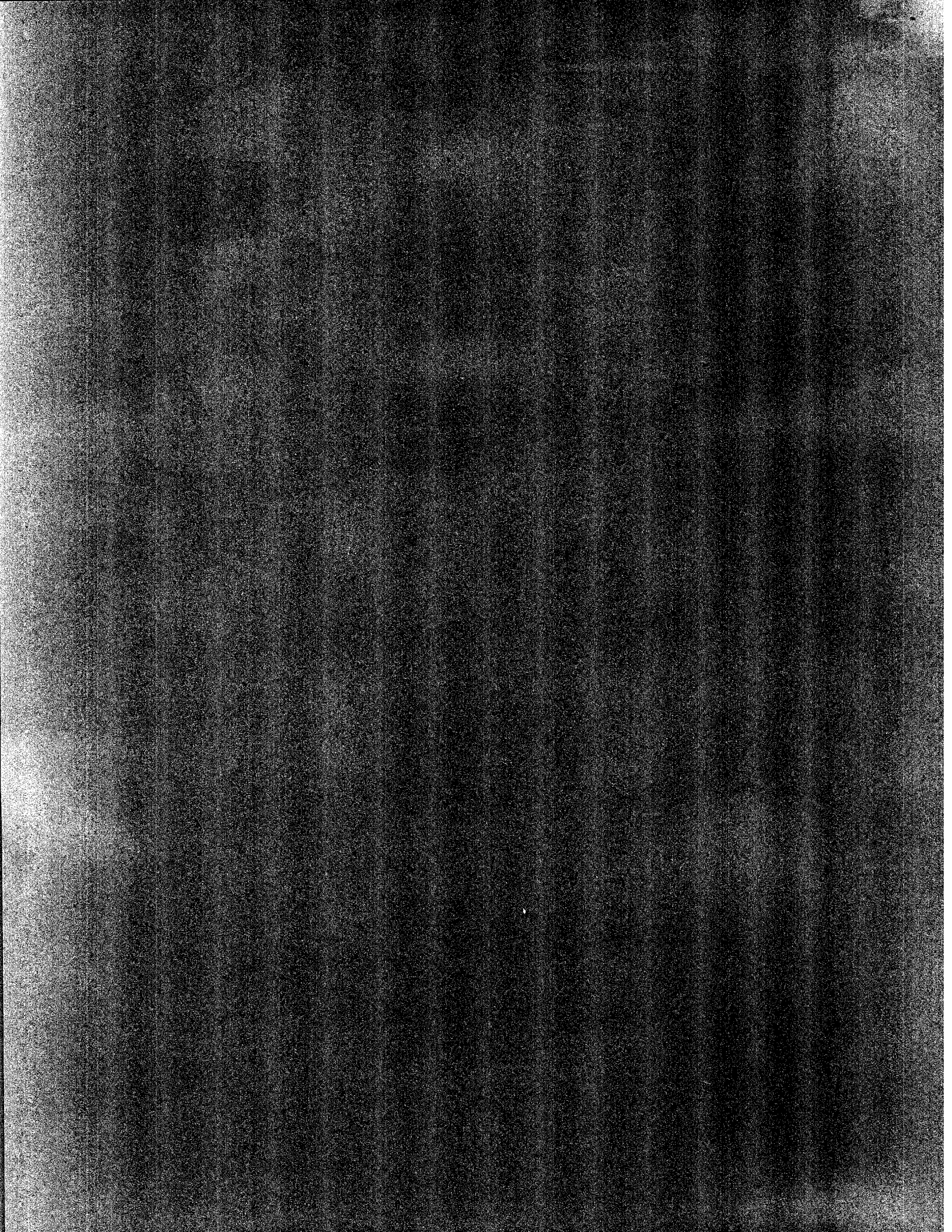
1) NIH Workplan
   - finalize agreement by February 1, 1998
   - develop/implement workplan

2) New Grants Management Model
   - complete design of operating, oversight and compliance components
   - finalize 1998-99 budget
   - develop/implement workplan - system level and Focused Grants Management Project

3) Move toward resolution of federal dispute

C) Structure:





D) Personnel

1. Project Director: 0.5 FTE, Secretarial/Space support

   Reports: Project manager, work group, project groups
   Reports to: SVPHS, Senior VP Oversight Group
   Budget: Develops; has authority and accountability
   Member: Senior VP Oversight Group
   Start: As soon as appointed

2. Project Manager: 0.75 to 1.0 FTE

   Reports: Project groups
   Reports to: Project director
   Budget: Implements
   Authority: Operational
   Member: Grants Management Group
   Start: As soon as appointed

E) Logistics

1. VPR:
   - Finish agreement with NIH: February 1, 1998
   - Continue as Grants Management Group Chairperson until February Regents meeting
   - Make research report at February 1998 Regents meeting
   - Continue VPR/DGS functions until newly appointed VPR/DGS on-site (July 1, 1998)
   - Work with SVPHS on external relationships related to grants management
   - Function as resource for Grants Management Project

2. Appoint Project Director and Project Manager as soon as possible

3. Reconstitute Grants Management Group (GMG) as soon as possible.
   Composition of GMG:

   Project Director, Chairperson
   Project Manager
   Faculty: Fennel Evans
   Scott McConnell
   Burle Gengenbach
   Associate Deans Research: Steve Crouch IT
   TBN Medical School
   Steve Cawley, Gail Klatt, VPR
   Ex Officio: Terry O'Connor
   Robert Kvavik
   Mark Bohrhorst
   Ed Wink

4 VPR/DGS Designate:

a) Transition - progressively involved in all aspects, establish communication lines

b) Member of GMC, becomes one of decision-makers

UNIVERSITY OF MINNESOTA

Twin Cities Campus

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MEMORANDUM

To: AHC Faculty Consultative Committee

From: Dr. Frank Cerra, Senior Vice President for Health Sciences

Date: February 3, 1998

Subject: Manual.

I have attached a copy of the detailed manual for Academic Health Center Intercollegiate Programs (AHC-IP). The manual provides the specifics on how new intercollegiate programs will be initiated and operated.

As you know, the question of how to define, encourage, and support intercollegiate programs has been an issue for some time. Two separate committees of faculty and staff have worked over the past two years to bring clarity and structure to the process and to try to remove some of the administrative obstacles that have made intercollegiate programs more difficult than they have needed to be for faculty. The reports of the two faculty design committees have been posted for some time on the web at: http://www.ahc.umn.edu/tf/pidp.html and http://www.ahc.umn.edu/tf/idp.html. The issue has been discussed at the Dean's Council and the manual reviewed by them.

I am pleased with the results of those efforts, now available to faculty who see opportunity in the type of new intercollegiate efforts we have already under way. I would be glad to discuss this further in our regular meetings if you would like.

Thank you.

FBC/jf

Enclosure

INTERCOLLEGIATE PROGRAMS IN THE ACADEMIC HEALTH CENTER (AHC-IP)

MANUAL FOR OPERATING AND CREATING PROGRAMS

*

DRAFT January 7, 1998

Academic Health Center
Intercollegiate Programs Manual

Table of Contents

Executive Summary: page 3

I. Purpose: page 4

II. Type of Programs: page 5

III. Operating an Intercollegiate Program: page 8

IV. Faculty Participation in an AHC Intercollegiate Program: page 12

V. Staff Participation in an AHC Intercollegiate Program: page 12

VI. Resource Management, Budgets, and Budget Administration: page 13

VII. Program Performance and Oversight: page 18

VIII. Creating an AHC Intercollegiate Program : page 19

Appendices: page 24

Appendix 1: Pre-proposal format and contents
Appendix 2: Full proposal format and contents
Appendix 3: Roles and Responsibilities of the oversight administrator
Appendix 4: Roles and Responsibilities of the AHC-IP Council
Appendix 5: Roles and Responsibilities of the Program Director
Appendix 6: Table of steps in program creation by program type
Appendix 7: Flow diagram for program creation
Appendix 8: Principles for distributing clinical income
Appendix 9: Framework for distributing tuition

Academic Health Center
Intercollegiate Programs Manual
Executive Summary

This manual details the process by which new programs within the AHC are created, administered, and brought to a close. In particular, it establishes those processes for programs which will be intercollegiate in nature and not based in one college. Each intercollegiate program will be one of five types:

Type 1: providing an **identity** to an intercollegiate effort
Type 2: providing **coordination** for an intercollegiate program
Type 3: providing **infrastructure support** for an intercollegiate program
Type 4: providing a **programmatic** base for an intercollegiate program
Type 5: serving as a **department-like academic unit**

To assure that new programs are consistent with the strategic goals of the Academic Health Center and that the proposed names are appropriate, new programs, whether intercollegiate or based in a single college, must apply for approval by the Deans Council and the Senior Vice President. This manual details the process for developing the proposal and for the review. In brief, a pre-proposal is submitted outlining the type, goals, and proposed structure for the program. The Senior Vice President, in consultation with the Deans Council, decides whether to approve the program, and if so whether the program will be a collegiate program or an AHC intercollegiate program. For intercollegiate programs of the more complex types, the Deans Council will then request a full proposal. Full proposal reviews of programs will be submitted to appropriate faculty/administrative review, depending on the program's major thrust.

Programs must have a specified purpose and mission, a director, organization, budget, governance structure, and oversight mechanism. Programs will automatically end at a specified date unless renewed. Faculty roles in programs may range from simple interest groups to formal academic units akin to departments. In the development of program plans, specific plans for resource management must be developed, including prior arrangements for responsibility and control of resources previously allocated to other programs or academic units. Program directors must account for the use of program resources and the program's actions. The program's success is monitored and supported by an oversight administrator who reports on the program to the Deans Council and the Senior Vice President.

Academic Health Center
Intercollegiate Programs Manual

I. Purpose

Numerous Centers, Institutes and Programs exist within the Academic Health Center and serve vital roles in advancing the educational, research, and service missions of the institution. The mechanisms for creating, supporting and reviewing these efforts needed to be improved. This manual is part of that effort. The goals and procedures embodied in this manual are a direct outgrowth of extensive faculty and administrative review and AHC-FCC consultation regarding program administration in the AHC. Two committees (the original Interdisciplinary Programs Committee and the follow up Programs and Interdisciplinary Programs Implementation Task Force) laid the foundation upon which this effort rests. Much of the text of this manual is taken directly form their reports.

This manual is intended as a guide to the creation and operation of intercollegiate programs in the Academic Health Center, or **AHC-IPs**. While it is recognized that most programs will remain the purview of individual colleges, there are important issues that must be resolved for the minority of intercollegiate programs which will be administered by the AHC. These include issues of strategic and annual planning, resource management and allocation, oversight, program definition, program creation and extinction, leadership and governance, and accounting.

This manual is a part of a work in progress in enhancing the AHC's ability to support its missions of education, research, and service. The manual and the procedures and processes it describes can be expected to change over time as the AHC gains experience with what works best and as operating conditions change. No process will perfectly meet all of the competing needs and priorities that play out in a complex organization. The goal is to strike a sufficiently effective combination of attributes that addresses those needs in a balanced fashion.

As you use this manual and work on AHC programs, please provide input into our efforts to make the process as easy, effective, and productive as possible.

Thank you!

II. Types of Programs

It is important that the AHC and its colleges and schools foster and support the development of interdisciplinary programs, programs that represent cutting edge efforts in education and in basic and clinical research. One important aspect is that they bring together faculty with diverse expertise. At the same time, they bring value to the faculty and the institution in fostering and supporting high quality programs that may not necessarily be broadly interdisciplinary.

This manual will not attempt to define what an 'interdisciplinary' program is. Instead, it encourages faculty and administration to seek opportunities from the synergy that can occur when faculty and administration from across administrative units join together to enhance our education, research and service missions.

Interdisciplinary programs can be operated from an administrative base within a college or as a program based with the AHC. The vast majority of programs will continue to be based in a college. For programs based in colleges, funding lines and oversight authority will be retained in the college, even if funds are provided for the program out of the AHC. Programs will be AHC based only if there are strongly compelling reasons of mission and administrative effectiveness that support that model of organization. Individual colleges are encouraged to adopt their own approach or adapt this manual's approach to collegiate administration of programs.

Existing and anticipated programs within the AHC vary greatly with respect to the number of participating faculty, the administrative responsibilities of the program, and the size and scope of the programs' missions. The names given to these such as 'program', 'laboratory', 'center', 'institute', do little to define these parameters. In order to facilitate discussion of program implementation, and how the mechanisms may vary depending on the scope of the program, the following definitions for five types of programs will be used. A description of each category is given here, along with some examples of existing programs in each category. The examples given are mostly not AHC-IP programs, but rather collegiate programs.

Programs are defined as Types 1 through 5, Type 1 being the least complex. In the descriptions below, the additional complexity of advanced level Types is described. In general the more advanced Types would also include many functions of the programs at lower levels of program complexity, but these are not repeated in the definitions. Thus, a Type 3 program might include most or all of the functions of Type 1 and 2 programs but only the additional functions of the Type 3 are described in its definition.

Type 1 AHC-IP

The function of a Type 1 AHC-IP is to provide **identity** to a single investigator or group of investigators. This may be for the purposes of fund raising (grants, foundation or private donations), program recognition by constituencies served, or attraction of other

faculty collaborators; there may be other reasons as well. No resources are committed to a Type 1 AHC-IP beyond the current salary for faculty and no particular administrative or formal governance structures are required beyond the naming of a director and submission of a plan for approval by the Senior Vice President and Deans Council. Approval to use a particular name is required at the AHC level to avoid duplication of names that would lead to confusion internally or externally. An example of a Type 1 AHC-IP might be an investigator studying a particular disease, who may have private individuals or groups interested in making donations in support of the research.

Examples:

Equine Resource Center (College of Veterinary Medicine)
Bob Allison Ataxia Research Center (Medical School)
Leukemia Task force (Medical School)
ECG Reading Center (School of Public Health)

Type 2 AHC-IP

The function of a Type 2 AHC-IP is to provide **coordination** of the efforts of a group of faculty representing a particular field. It could provide for communication among the group (e-mail lists, WWW page, newsletters, seminar series, retreats), as a voice for the group within the AHC or college (e.g., requests for shared equipment or resources, input into recruitment of faculty in the represented area, etc.), as a vehicle for enhancing recognition of the field at the AHC (both internally and externally), as an entry point for companies with interests in the field, and as a fund raising vehicle. Institutional resources committed to the AHC-IP would be small (typically less than $50,000 which might be for things such as seminar support and administrative support). Administration might consist of a director responsible for the AHC-IP and a faculty advisory group, and no formal governance structure would be required. Space would not be assigned to the AHC-IP beyond a small amount that might be needed for administrative support functions. Approval of the formation of a Type 2 AHC-IP would require approval of the Dean or Senior Vice President, depending on the faculty involved and the source of resources committed to the AHC-IP.

Examples:

Food Animal Biotechnology (College of Veterinary Medicine)
Environmental Pathology (Medical School)
Cranio-Facial Pain Group (School of Dentistry)
Center for Research in Agricultural Safety & Health (School of Public Health)
Minnesota Area Geriatric Education Center (School of Public Health)

Type 3 AHC-IP

The function of a Type 3 AHC-IP would be to provide the **infrastructure** support functions needed by a group of faculty with shared education, research or service/clinical

interests and generally (ideally) occupying contiguous space. A Type 3 AHC-IP would have space assigned to it, and a formalized administrative mechanism (including a director with administrative responsibility appointed or confirmed out of the Senior Vice President's Office). Institutional resources committed to the AHC-IP would be small to moderate (typically ranging from $100,000 and over), and might be used to provide for clerical support and shared equipment needs of the group of investigators in addition to those functions supported in Type 2 programs.

Examples:

Center for Immunology (Medical School)
MN Dental Research Center for Biomaterials and Biomechanics (School of Dentistry)
MN Oral Health Clinical Research Center (School of Dentistry)
Clinical Outcomes Research Center (School of Public Health)

Type 4 AHC-IP

Type 4 programs provide a **programmatic base** to at least some of its participating faculty. In Type 4 programs, some of the faculty will see the program as their principal academic home. In such cases, faculty may have formal joint appointments between their tenure administrative department and the program, including shared salary allocations between the program and the department. Additional administrative responsibilities might include grants administration and accounting, and assigned academic responsibilities. A Type 4 program would not be the primary tenure granting unit for any faculty member, but would have formal input into the tenure/promotions process in the home department of faculty that receive partial salary support from the AHC-IP.

Examples:

Institute of Human Genetics (Medical School)
Cancer Center (Medical School)
Biomedical Engineering Center (BMEC) (Medical School)
Veterinary Research Center (College of Veterinary Medicine)

Type 5 AHC-IP

A Type 5 AHC-IP would be essentially a department equivalent, with the exception that faculty within the AHC-IP might have appointments in different schools. It would have the ability to grant tenure and provide all the infrastructure to support faculty that a department provides.

Example:

Biomedical Engineering Institute (BMEI) (Medical School and Institute of Technology)

III. Operating an Intercollegiate Program

Every intercollegiate program will have documented the following, usually in the process of initiation and annual program planning:

1. Mission statement

A concise statement of the broad goals of the program; the context within it will develop specific plans and objectives

2. Program Director

Every program must designate one person as the program Director who will have management and administrative authority and accountability for the program. The Director will be expected to be a leader in developing the program. The director will serve as the primary contact person for the program, will submit reports to the person who has oversight responsibilities, and will be accountable for any resources allocated to the program.

The Director of the AHC-IP will report to an oversight administrator designated by the Senior Vice President. The oversight administrator will report to the Senior Vice President and the Council and act as a liaison for the Director to the AHC. In most cases, this will be the Senior Vice President's designee or a 'Lead Dean'. For collegiate programs, this will be the Dean.

The Director of the AHC-IP will be appointed by the Oversight person for the program, with the approval of the Senior Vice President and in consultation with the Council. For major programs, the appointment may involve either a search or administrative approval process consistent with University policy. The faculty of the AHC-IP should have input into the decision. A review of the Director's performance will be done annually by the oversight administrator and at the time of the cyclic review of the Program.

The Director will have at least the following responsibilities:

a. Assuring and enhancing the scholarly excellence of the program. This will include establishing an external advisory board where appropriate (Types 5, 4 and possibly 3).

b. Establishing governance processes

c. Fostering the development of faculty leadership within the program, i.e. a leadership mentoring program to create a cadre of faculty who could be program leaders or leaders in their field elsewhere.

d. Budget and resource management authority and reporting

3. Oversight Administrator

Every program must have one person designated with oversight responsibility for the program. The role of the oversight person is detailed in Appendix 3.

4. Advisory Boards

For Type 5 and 4 programs, an advisory board is strongly recommended. The role of the advisory board is to provide input from an objective external point of view that can help the program set its strategic direction, measure its performance, and test the program's impact on the University's external constituencies. Whether or not a program has a formal advisory board, programs are encouraged to seek external input and evaluation. At the time of renewal, each program of types 5 and 4 will be required to collect some form of external evaluation.

5. Program Design

As a basic principle for program design, programs will most likely succeed if:

a. program
- responsibility is held at the same point as authority (to the extent that authority is a part of the program).
- resources are controlled by the person(s) that will be held accountable for their allocation and the results achieved.
- rewards and acknowledgments are developed for those that contribute to the program's success.

b. As programs grow in size and complexity, particular efforts need to be assigned to particular individuals or groups. Often this process is not done explicitly, creating friction later on as people try to understand everyone's role. To avoid this, a program might develop a "RACI" framework for major aspects of the program. In that framework, specific aspects of the program are matched to roles for people, groups, or organizations that contribute to the program's efforts. For any single aspect of the program, different people or groups may have different roles.

	Person 1	**Person 2**	**Group 1**	**Organization 1**	**etc.**
task 1	R, A, C, or I				
task 2					
project 1					
project 2					
project 3					
etc.					

For each cell in the above hypothetical table, one of the four letter R, A, C, or I should be inserted, or the cell left blank.

R: responsibility for the task, project, etc.
A: approval authority for the plans and major decisions involved in the project or task
C: must be consulted about the project (advice given does not necessarily have to be followed)
I: must be informed about the project, task, etc.
blank: is not involved in the particular task or project or does not have a designated RACI role

These frameworks for program operation are likely to be more definition than is needed for simple programs. If a program is having operating difficulty or interpersonal friction, however, reference to these frameworks may help.

6. Governance structure

The Director of the AHC-IP will be responsible for insuring that the appropriate governance processes are established and that they function in a timely manner. The AHC-IP description will include a governance process for the AHC-IP that is appropriate for its type and activities. This will include mechanisms for faculty input into:

1. membership decisions
2. joint appointment decisions
3. promotion and tenure decisions, where appropriate
4. program planning, both strategic and annual

The governance of a program should be designed to best serve the needs of the program. It may be as simple as a group of like-minded faculty operating on a voluntary consensus basis or as formal as a Type 1 program with University dictates regarding policy and operations. Those who develop a particular program will be well served to define these issues clearly in the early stages and to be sure that everyone understands how the program is constituted. In general, the goal is to develop an appropriate system of governance that can hold the program together without undue effort or regimentation. Governance practices must be consistent with all University policies.

7. Program Plans: in addition to its mission statement, the program should develop a set of plans, both strategic and annual. Both the annual and strategic plans must include budgets that show the projected sources and uses of all funds controlled by the program.

STRATEGIC PLAN:

The program should lay out a strategic plan that sets a broad vision for at least the next three years. The strategic plan should be reviewed and modified as needed each year. The strategic plan will likely be a mixture of vision (how things will look at some point in the future) and goals (measures of practical accomplishment). Ideally, some part of the strategic plan should be measurable and should have a set timeline.

ANNUAL PLAN:

In addition to the strategic plan, a tactical annual plan should be developed that lays out specific actions and results that will be accomplished in the coming year. The annual plan will serve as the "action list" for the program and will be the primary benchmark against which program effectiveness will be compared. Annual plans should be as concrete as possible and should relate directly to budget plans. The specifics of an annual plan will obviously vary widely depending on the nature of the program. The following outline is intended only to serve as a prompter for possible areas of program activity; probably no program will have plans in all of the areas listed.

1. Education
    a. professional education
    b. undergraduate education
    c. graduate education
    d. post-graduate clinical education / GME
    e. continuing education
    f. outreach
2. Research
    a. project plans
    b. funding projections
    c. facility and equipment development
    d. new collaborations
    e. new directions in research
3. Clinical / Service
    a. program maintenance
    b. new program development
4. Organizational / administrative
5. Communications, public relations
6. Human resource development
    a. faculty
    b. staff
7. Fund raising

IV. Faculty participation in an Academic Health Center Intercollegiate Program

AHC-IPs of Category 3, 4, and 5 might have three types of faculty membership:

1. Member. Faculty not located in the AHC-IP space but having affiliation with the AHC-IP. The AHC-IP would not have formal input into promotion and tenure decisions for faculty having this status. (Types 4 and 5)

2. Member occupying AHC-IP space. This would include all faculty located within space assigned to the AHC-IP. The AHC-IP would not have formal input into promotion and tenure for faculty having this status.

3. Member with tenure home or joint appointment. For faculty whose tenure home is in the AHC-IP or faculty holding a joint appointment in the AHC-IP, the AHC-IP would have formal input into their promotion and tenure. For Type 1 programs, the AHC-IP would serve as the "department" for promotion and tenure issues for these faculty. These would in most cases be faculty located within the AHC-IP space. It would generally include, but not be limited to, faculty for whom the AHC-IP has a commitment to provide partial salary support. The specific role of the AHC-IP in reviewing faculty performance would be established as part of the position description for each individual faculty appointment.

In general, it is desirable for that a formal joint appointment status be established in program types 4 and 5 for faculty whose principal efforts are within an AHC-IPs, with faculty of the AHC-IP having formal input into the promotion and tenure decisions regarding those faculty holding a joint appointment. There should be formal written agreements between units for faculty having joint appointments, with regard to salary sources, how raises would be determined, who has responsibility for faculty support staff and infrastructure needs, etc. This includes any arrangements that would be made with Faculty Practice Organizations, departmental or school based practice groups or external parties. Appendix 8 provides one possible framework for such agreements.

Arbitration of disputes regarding faculty involvement in a program will be the responsibility of Director, the Oversight Administrator and the involved Dean or Deans. Final authority would rest with the Senior Vice President.

V. Staff participation in an Academic Health Center Intercollegiate Program

The relationship of staff to the AHC-IP should be explicitly made, including responsibilities for funding positions, hiring authority, reporting relationships, work effort evaluation, discipline, and personnel development. For each person whose job is supported by the program, a formal part of their position description and employment agreement should be what will happen to their position should the program end.

VI. Resource Management, Budgets and Budget Administration

RESOURCE ALLOCATION IN PROGRAMS

Program leaders are must develop written agreements regarding resource and financial obligations for all units involved in providing resources for operation of the AHC-IP, This would include Faculty Practice Organizations, internal service organizations, and external parties where applicable. Whenever possible, the key agreements should be for a longer term than one year, preferably for the remaining term of the program before its review/renewal date. This can provide a degree of predictability for program funding and planning. For example, for a faculty member receiving partial salary support from their home department and from the AHC-IP, this arrangement should be in the form of a written agreement between the Department Head and the Program Director. Other arrangements involving written agreements might include ICR sharing, Tuition distribution, grants administration responsibilities, space and equipment allocation and responsibility, etc.

Both the annual and strategic plans must include budgets that show the projected sources and uses of all funds controlled by the program. AHC-IP accounting should be implemented so that program funds are accounted for separately from other funds. The Director should develop projected budgets for the program that estimates expenses and revenue sources to cover those expenses for the life of the program. This will allow both program leaders, members, and the oversight administrators to understand the sources and uses of program funds. The financial staff in the Senior Vice President for Health Sciences Office can help in preparing these budgets for AHC-IP.

Educational Program Income

The Incentives for Management Growth Program (IMG), adopted by the University of Minnesota in the 1997-98 fiscal years, returns all tuition income to schools. The distribution is based on enrollments, and is calculated at the student level. The school where the student enrolls receives 25 percent of the tuition income. The school hosting the class receives 75 percent of the tuition income. The allocation of tuition is computed through a series of algorithms. The financial staff in the SVP-HS office can provide detailed information about the distribution process, and assist program leaders in forecasting potential tuition income.

The income from tuition will be credited to programs differently, depending on the source. What follows are the general guidelines for tuition income allocation. The final allocation of tuition revenues is subject to the approval of the oversight administrator in consultation with the Senior Vice President.

1. For courses taught in whole or in part through the program that are part of the existing professional or graduate curriculum and that result in no net gain in tuition

revenues, no tuition income will accrue to the program. To cover the expenses of the course(s) taught, the program must either: a) use other program funds, b) request funds or in kind support from the colleges involved or c) decline to present the course(s). When courses will be taught on an on-going basis, the Director of the program is encouraged to establish a funding relationship with the colleges so that the cost sharing does not need to be re-negotiated over and over again.

2. For courses taught in addition to the regular curriculum for students enrolled in an undergraduate, professional or graduate degree program and that bring in additional tuition dollars, 25% will accrue to the college whose student is pursuing the professional or graduate degree. The remaining 75% will be divided based on a prior agreement between the program and the academic homes of the faculty involved in the course presentation. In some cases, the program will receive all income, with the faculty "donating" their effort to the teaching. In others, the program may pay in some proportion for faculty efforts out of the course revenue by transferring money from the program budget to the faculty member's home academic unit. Appendix 9 provides one possible framework for allocating educational program income.

3. For teaching not associated with an undergraduate, professional or graduate degree program (for example for continuing education or extension / outreach programs), revenues could be retained by the program based on prior arrangement with other involved units in the university. In some of these cases, the faculty member might receive income directly from the program in addition to their regular academic salary.

Indirect Cost Recovery

The IMG program distributes Indirect Cost Recovery income from sponsored grants and contracts to schools and administrative offices. The distribution is meant to conform to the way indirect costs are actually borne by different parts of the University. Currently, schools are estimated to bear approximately 51 percent of all indirect costs and thus 51 percent of indirect cost recoveries are returned to the schools. The schools have the authority to distribute to departments, programs, and other units to meet local goals and objectives.

1. For programs Type 1, 2, and 3, all indirect cost recovery would accrue to the academic units participating in the sponsored efforts in the same way they would if the program did not exist.

2. For program Type 4, indirect cost recovery generated during the life of the program would be retained as income to the program only if, by prior arrangement, an ICR division is agreed to prior to grant funding between the academic homes of the faculty involved in the grant and the program. In general, however, ICR should be distributed to the schools and the program in proportion

to the faculty person's effort on the grant and the partitioning of their appointment between the program and the school. Thus if, for example, a faculty person serving as sole investigator were appointed 50% in the school and 50% in the program, then 25.5% of the ICR would go to the school and 25.5% of the ICR would go to the program.

3. For program Type 5, ICR would accrue to the program just as though it were an academic department.

Licensing, Patents, and Royalty income

Under University policy, income net of expenses from invention licensing, patents, and royalty is distributed generally as follows:

33.3% to University's Office of Patents and Technology Marketing
33.3% to the inventor(s) as individuals
8% to the school or collegiate home of the inventor(s)
25.3 % to the laboratory of the developers for further work. This share reverts to the department if the developer leaves the University.

1. For programs Type 1, 2, and 3, all licensing, patents, and royalty income would accrue to the academic units and faculty in the same way they would if the program did not exist.

2. For program Type 4, licensing, patents, and royalty income generated during the life of the program would be retained as income to the program only if, by prior arrangement, a division of that income is agreed to prior to grant funding between the academic homes of the faculty involved in the grant and the program. In general, however, licensing, patents, and royalty income should be distributed to the schools and the program in proportion to the faculty person's role in the invention and the partitioning of their appointment between the program and the school, consistent with Regent's Policy.

3. For program Type 5, licensing, patents, and royalty income would accrue to the program just as though it were an academic department for faculty with their tenure home in the program. For faculty whose tenure home is outside the program, item 2, above, would apply.

Fund raising

Programs may initiate fund raising efforts with the approval of the oversight administrator. Funds received must be managed under University's policies relating to donations to the University. These funds can be used at the discretion of the Director in keeping with the intent of the donor, the program's mission, and university policies, and with the approval of the Oversight Administrator. Programs should make sure that their fund raising efforts are

coordinated with and consistent with overall University and AHC development efforts.

Clinical revenue

1. For programs Type 1, 2, all clinical revenues would accrue to the academic units participating in the clinical efforts in the same way they would if the program did not exist.

2. For program Types 3 and 4, clinical revenues would be retained as income to the program only if, by prior arrangement, a division of clinical income is agreed to in advance between the academic homes of the faculty involved in the grant and the program. In general, clinical income should be distributed to the schools and the program in proportion to the faculty person's clinical role and the partitioning of their appointment between the program and the school. Usually, these divisions of clinical revenue, if any, should be part of the original design of the program and its budget. Appendix 8 provides one possible template for allocating clinical revenue.

3. For program Type 5, clinical revenue would accrue to the program just as though it were an academic department for faculty whose tenure home is in the program. Otherwise, provisions in 2, above, would apply.

SPACE AND EQUIPMENT

Allocation of space and equipment to a program should typically be done as part of the process of initiating the program. Approval of the overall plan by the Senior Vice President in consultation with the Deans Council would include approval of space and equipment allocations. Inevitably, however, new needs for space or equipment are likely to occur after the program is under operation. In those cases, new allocations would need to be discussed and agreed to by the parties desiring new resources and the parties currently responsible for those resources. If no agreeable resolution to the needs is found by the parties directly, then the program can formally apply for new resources at the next round of program applications to the AHC or refer the matter to the Senior Vice President for Health Sciences for determination.

Allocation of space or equipment to a program should include specifics such as who is responsible for costs, maintenance, repairs, renovations, and upkeep. The agreement should also be time delimited, and should designate to whom the space or equipment revert should the program end.

SUMMARY

Nothing in the above recommendations should stop responsible parties from developing different systems for resource allocation, as long as they are consistent with

University policy. Whatever system is designed, however, it must be explicit, time delimited, and approved by the Oversight Administrator. Ultimately, all resources belong to the University and, by delegation, the AHC and its units. The Senior Vice President for Health Sciences has the final authority for all resource allocation within the AHC.

Underlying each of these recommendations, there are a simple set of questions regarding resource allocation and management. If these questions have clear answers, many of the common resource problems can be avoided and when there are problems, they can be more easily resolved.

1. What is the resource under consideration?
2. What parties have to be part of the decision about how to allocate that resource?
3. For what time period is the commitment to allocate the resource made?
4. Who is responsible for managing the resource wisely in the program?
5. How should program accounting be constructed so that the program can track and understand its financial activities?
6. Who provides oversight for the program that manages the resource?

VII. Program Performance And Oversight

The period of funding approval for AHC-IPs will normally be 2 to 5 years, with the period determined by the AHC-IP Council based on the review of the proposal. During the period of active funding, a AHC-IP may submit a supplemental proposal requesting an increased level of funding or other resources such as space and/or movement to a higher level category, for example from a category 3 to a category 2 AHC-IP. Supplemental proposals will be reviewed by the same mechanism as new proposals.

YEARLY PROGRESS REPORTS/BUDGETS

The Director of the AHC-IP will submit yearly Progress Reports and Budgets, essentially equivalent to a non-competing renewal application. These will be reviewed by the oversight administrator (Lead Dean or Senior Vice President's Office). Copies of all yearly Progress Reports and Budget requests will be provided to the Senior Vice President's Office; these could be then put in a data base for the general program reviews. Also, the benefits could be weighed of having these, or edited versions of them, put on a web page for anyone in the organization to review. This might also aid outside sponsors looking to work with faculty in a given area.

COMPETITIVE RENEWAL OF AHC-IP FUNDING

At least one funding cycle before the end of the approved funding period, a full proposal for continuation of the AHC-IP may be submitted. This will be reviewed in the same way as new proposals. Outcomes of this review could include:

Continuation of the AHC-IP - maintenance of the status quo.

Movement to the next level category, where greater commitment, responsibilities, etc. occur (e.g., category 3 to 2), as a result of outstanding performance on the part of faculty, changing needs, positive review, shift in institutional strategic goals or successes in securing financial or other resources from outside of the institutions (e.g., grants, contracts, philanthropy, etc.). This would occur if requested by the AHC-IP in the renewal proposal and approved by the AHC-IP Council following review.

Movement to a lower level category (e.g. category 2 to 3) as a result of changing needs, negative review, shift in institutional strategic goals, funding limitations, constraints on other resources, etc. This could occur either at the request of the AHC-IP in the renewal proposal (although somewhat unlikely), or upon recommendation of the AHC-IP Council as a result of the review.

Elimination or the "sunset" of the AHC-IP as a result of changing needs, negative review, shift in institutional strategic goals, funding limitations, etc. This could occur either at the request of the AHC-IP (unlikely), or upon recommendation of the AHC-IP Council as a result of a negative review of the renewal proposal. When an intercollegiate program is eliminated, all of its assets and liabilities revert to the Senior Vice President for proper allocation.

VIII. Creating an AHC Intercollegiate Program

Pre-proposals and final proposals for programs are submitted and reviewed by the process described in this section. Final review of pre-proposals and full proposals will be by the Senior Vice President of the Academic Health Center and the Deans Council or their designees (referred to as the AHC-IP Council in this document). The purpose of these reviews are:

1. to assure that the program is consistent with the strategic goals and needs of the Academic Health Center and its colleges and the University and that it does not create unnecessary confusion or conflict with the existing collegiate and AHC programs
2. to assure the name chosen for the program is appropriate for its mission and that it does not create confusion with other program names in the AHC and University

PROGRAM INITIATION: THE PRE-PROPOSAL PROCESS

An AHC-IP pre-proposal will be prepared by one or more faculty, with the proposal initiating from the faculty or in response to a request for application (RFA) from heads, deans or the Senior Vice President's office. AHC Intercollegiate Programs will generally develop in the same way as new collegiate programs, driven by the vision and energy of individual faculty members or administrative leaders in response to a significant opportunity. Given that this is the case, at the beginning it may not be evident whether a program is best managed as an AHC-IP or as a collegiate program. For this reason, all new program development in the AHC will start with the same process. After review of the pre-proposal, a decision will be made by the AHC-IP Council: 1) the whether the program, if created, would be college based (most programs) or AHC based and 2) whether the program should be created at all. Only the minority of programs that will be AHC-IP will need to proceed further in the process described in this manual, although it is hoped that colleges will develop a similar process for their own collegiate programs. Approval in concept at this stage does not imply any commitment of funds from any source, nor does it imply that the program will be approved following review of the full proposal.

The initiation of a new program should begin by developing a vision for the program that includes:

1. a concise statement of the program's purpose and goals

2. a description of the relationship of the program to the broader strategic mission of the AHC or college(s), how it addresses the needs of constituencies, and how the program relates to other existing programs, if any, with similar mandates.

3. a description of the status of efforts in the general area related to the proposed program, along with a description of how those efforts would be changed or enhanced by the creation of the program

4. a list of the core faculty who are interested in initiating the development of the program, plus, if applicable, a broader concept of the kinds of faculty that might ultimately be involved

5. a preliminary description of the general sources and uses of resources to support the program (funds, space, equipment, administrative support, clinical program involvement)

6. operating organization / governance

7. advisory boards, if any

8. whether the program seems most likely to be collegiate or AHC based

9. the Type (1 - 5) of program proposed. The initiating group will identify the category level they deem appropriate for the proposed program based on the function, administration, and requested resources for the program. This identification will then provide guidance as to major items that need to be addressed in the proposal.

10. the proposed cycle time for the program, i.e. how long before the program's performance will be reviewed. This is a requirement, since all programs will be required to renew their approval for continuation one year before the end of their cycle. The shortest possible cycle is two years, the longest is five years.

Once these preliminary questions are clarified, a pre-proposal for the program can be prepared. A format for the proposal is provided in Appendix 1. One person must be identified as the key contact person for program proposal development. The deadline for twice yearly submission of pre-proposals is October 1 and April 1 each year for major submissions. For Type 1 and Type 2 programs, proposals will be reviewed quarterly (January 1, April 1, July 1, and October 1), provided that minimal new resources are requested for the program.

The pre-proposal will be reviewed by the AHC-IP Council at the AHC level. That review could have one of four outcomes:

1. the proposal could approved for the development of a full proposal for review at the AHC level. In most cases for Type 1 and 2 pre-proposals, the AHC-IP Council may give full approval of the program without further proposal development.

2. the proposal could be recommended for development of a full proposal for review at the collegiate level, pending concurrence from the Dean

The decision about whether continued review of a full proposal will be at

the AHC or collegiate level will depend upon the disciplines represented, the goals of the program, the resources used, and the "home units" of the faculty involved in the program. If all of the faculty are within a single School and only School resources are being requested, review will be within the School after approval of the name and concept at the AHC level. If there are faculty from multiple Schools involved in the proposal, its impact extends across colleges, and funds are being requested from the AHC, review will be at the AHC level. Once a full proposal at the AHC level is considered, the program might still be created as a collegiate program.

3. the proposal could be returned to the initiator(s) for further development

A request to resubmit a pre-proposal would occur when review by the AHC-IP Council identifies ways in which the proposal might be improved, for example by the group including additional faculty with similar interests.

4. the proposal could not be approved (with written reasons provided)

A pre-proposal will not be approved (not invited to continue in the process), if it is the judgment of the AHC-IP Council that even with modifications it would not result in a successful review. In this case, however, the submitting group may submit a revised pre-proposal at the next round of submissions.

When a pre-proposal is approved for the AHC, the proposing group will be invited to develop a full proposal for complete review, with any suggestions resulting from the initial review being provided in writing to the group. Type 1 and Type 2 programs may be approved at the pre-proposal stage. The format for a full proposal is included in Appendix 2. For those full proposals to be reviewed at the AHC level, the AHC-IP Council will also determine which Review Panel(s) (Education, Research or Clinical/Service) will conduct the review, depending upon the primary functions and missions of the proposed program. It is acknowledged that there will often be overlap in a program's functions across these three areas, but in general it is expected that one area would predominate. In such cases the AHC-IP Council will determine which Review Panel seems best to review the proposal, or it may refer the proposal to more than one Review Panel.

PLANNING FUNDS.

In very special cases, some funds might be made available to support planning efforts that will lead to submission of an AHC-IP proposal. These would be distributed based on a request submitted as part of the pre-proposal from a group along with a planning budget. The AHC-IP Council (see below) would determine whether funds should be allocated to support the development of a full proposal. Such funds might be used for clerical support, consultants, etc. and would normally be less than $10,000.

FULL PROPOSALS: FORMAT AND REVIEW

Full proposals will be prepared after initial approval by the AHC-IP Council. The proposal will be more expansive and detailed than the pre-proposal. In particular, budget projections for three years will be required for program types 3, 4, and 5. The format for full proposals is specified in Appendix 2. In most cases, programs slated for full proposal development can expect approval in concept. Whether funding or other resources will become available depends on the contents of the full proposal, fiscal constraints, and competing priorities.

PROGRAM APPROVAL

Full proposals, submitted for twice yearly deadlines following review and approval of pre-proposals, will be reviewed either at the AHC level. For AHC review, proposals will first be reviewed by one of three AHC-IP Review Panels, either Education, Research or Clinical/Service. For each proposal, the Review Panel will determine merit scores in three categories, (1) scholarly/scientific quality, (2) extent of interdisciplinary interactions, and (3) fit or alignment with AHC strategic goals. A second level review will then be done by the AHC-IP Council, and will include consideration of the merit scores of the Review Panels, along with considerations of funds availability, need or demand for other resources e.g. space, balance or distribution of programs among areas (Education, Research and Clinical/Service) and Schools, and fit with AHC strategic goals. As a result of this review, the Council will develop funding recommendations and submit them to the Senior Vice President for final decisions. Given the significant time demands inherent in this process, the Senior Vice President and Deans Council might consider delegating this responsibility to a differently constituted AHC-IP Council after some experience and comfort with the process has been gained .

The chairs and members of the Review Panels will be faculty members appointed by the Senior Vice President in consultation with the Deans, with the goal of achieving a broad representation of AHC expertise in each area. Review Panels should have a broad enough membership that the diverse programs of the AHC will be understood and so that reviews can proceed even if some members are unavoidably absent during the review process. Review Panels will have discretion in enlisting the aid of ad hoc reviewers in cases where additional expertise in a particular area is needed. If they do so, the program proposers must be informed. Terms of AHC-IP Panel membership will be two years, with the possibility of a member serving two terms. One half of the panel's members will be appointed each year to provide continuity in the review.

An assessment of the extent of interdisciplinary / intercollegiate interactions within a proposed program will be one of the criteria applied to its review and evaluation as an AHC level program. It may be that the AHC would determine that broadly interdisciplinary programs would receive a higher priority in this regard.

LEVEL OF REVIEW DEPENDING ON AHC-IP CATEGORY

The extent of the review process will vary depending on the category level of the proposed AHC-IP. Type 1 and 2 proposals that request no institutional funds (i.e. no funds over and above those already committed to the involved faculty through their home units) will usually only proceed through the pre-proposal process, primarily to insure that the name and mission does not overlap with existing or proposed AHC-IPs (to avoid internal and/or external confusion) and to insure entry into an AHC-wide database of AHC-IPs. These can be reviewed quickly by the AHC-IP Council, and applications for Type 1 and 2 programs will be accepted quarterly. In special cases, the Senior Vice President may accept program applications outside of the established timelines. The AHC-IP Council would retain the option of referring Type 1 and 2 proposals for Review Panel evaluation. This streamlined review will facilitate instances where a group of faculty require an institutionally recognized 'Center' or some similarly denoted entity in order to respond to an external funding opportunity. There may be cases where proposals aren't approved even when there is no request for resources. It is intended that in order for a center, program, or institute within the AHC to use the University of Minnesota name it must go through this process. If it fails to get this approval it may not portray itself as a program in the AHC.

Proposals for Category 3 through 5 AHC-IPs will generally proceed through the entire review process (see flow chart), but the extent of the review will likely differ. For Category 4 or 5 AHC-IPs which involve substantial institutional funds or other resources it may be desirable to obtain an objective external review, either in the form of solicited written reviews or a site visit by experts from other institutions. Recommendation for this would be made by the AHC-IP Council as a result of the pre-proposal review, and the outcome of the external review made available to the AHC-IP Review Panel that subsequently reviews the proposal. External review of Category 2 or 3 AHC-IPs would be rare, and probably only occur if there is little or no local expertise to assess the merit or if unusually high levels of institutional funding or other resources were being requested.

Program approval for Type 5 programs would be subject to University policy regarding the creation of new tenure granting units.

APPENDIX 1:

Academic Health Center Program Application Pre-proposal Program Format and Contents

Pre-proposals should concisely address the following topics. The pre-proposal narrative that addresses these topics should be no longer than 6 pages, single spaced. In addition, the pre-proposal should include one page biographies of the principal faculty members involved in writing the proposal and / or that will be members of the proposed program. A single person should be designated as the principal contact person for the proposal development and review process. A one page summary budget of sources and uses of funds by the program should be submitted, plus a one page description of any new resources requested from the Academic Health Center or from a college.

Topics:

1. a concise statement of the programs purpose and goals

2. a description of the relationship of the program to the broader strategic mission of the AHC or college(s), how it addresses the needs of constituencies, and how the program relates to other existing programs, if any, with similar mandates.

3. a description of the status of efforts in the general area related to the proposed program, along with a description of how those efforts would be changed or enhanced by the creation of the program

4. a list of the core faculty who are interested in initiating the development of the program, plus, if applicable, a broader concept of the kinds of faculty that might ultimately be involved

5. a preliminary description of the general sources and uses of resources to support the program (funds, space, equipment, administrative support, clinical program involvement)

6. operating organization / governance

7. advisory boards, if any

8. whether the program seems most likely to be collegiate or AHC based

9. the likely type (1 - 5) of program proposed

10. the proposed cycle time for the program, i.e. how long before the program's continuance will be reviewed. This is a requirement, since all programs will be required to renew their approval for continuation one year before the end of their cycle. The shortest possible cycle is two years, the longest is 5 years.

APPENDIX 2:

Academic Health Center Program Application Full Proposal Program Format and Contents

Cover Page- Title, Category, Period of request, Budgets for Years 1 through 3, and total funds requested, list of participating faculty

Mission statement - A brief statement of the mission of the proposed program

Executive summary

Background

1. Description of existing efforts in the Program area
2. Participants in the Program - include biosketches of faculty involved in the proposed Program

Description of proposed Program

1. Proposed category and rationale
2. Functions of program
3. Governance structure
4. Administrative structure
5. Potentials for Program revenue (e.g. Training grants, clinical/service income, private and corporate donations, etc.)
6. Requested funds and other resources and their planned uses - a narrative discussion of proposed budget and resource requests (i.e. budget/resource justification)

Proposed Budget

Proposed budgets for years one through three to five (depending on the request of the AHC-IP Council) of the proposed program (including funds available to the Program from sources other than this request (e.g. Training Grants, clinical/service income, etc.) The budgets should be comprehensive projections of sources and uses of funds by the program.

Resources Requested - space, equipment, etc.

Strategic Plan/Timeline for Program Development

Goals and benchmarks for progress

Relation to missions of the School/AHC/University

Statements of support: Letters of support from relevant department heads, Deans, Directors of other Programs

APPENDIX 3

Roles and Responsibilities for the Oversight Administrator of AHC Intercollegiate Programs

Each intercollegiate program in the Academic Health Center will have a administrator designated who will provide the oversight for the program ("Oversight Administrator"). In some cases that administrator may be a "Lead Dean", in other cases the administrator may be a member of the staff in the Senior Vice President's Office. Administrative support will be provided by the Office of the Senior Vice President of Health Sciences

I) Role:

a. The Oversight Administrator is deputized by the Senior Vice President to act on behalf of the Academic Health Center in overseeing the program. Their role cannot be further delegated to others.

b. The program's director reports to the Oversight Administrator who reports to the Senior Vice President and the Deans Council regarding the program.

c. The Oversight Administrator is responsible and accountable to the Senior Vice President for Health Sciences for the program's performance

II) Responsibilities:

a. oversight of the program: minimum responsibilities
   1) yearly review and approval of the program's strategic plan developed by the director
   2) yearly review and approval of the annual goals and work plans
   3) yearly review and approval of the annual budget prepared by the director
   4) quarterly review of budget status and monitoring of fiscal performance
   5) at least semi-annual evaluation of program performance
   6) annual performance review of the director
   7) ensure intercollegiate and external involvement as appropriate for the program
   8) periodic review and recommendation to the Senior Vice President about whether the program should continue (period set by the program's charter)

b. presentation of status reports of program performance
   1) to the Senior Vice President for Health Sciences
   2) to the Deans Council

c. leadership
   1) participate in framing the mission, goals and benchmarks for the program
   2) serve as a resource and mentor for the program director

3) serve as an advocate and spokesperson for the program

APPENDIX 4

Roles and Responsibilities of the AHC-IP Council

1. Review of pre-proposals and, for those invited for submission as full proposals, assignment of reviews to either AHC or School level.

2. Assignment of each proposal to one of the three AHC-IP Review Panels, for those proposals to be reviewed at the AHC level.

3. Determination of final recommendations for AHC-IP establishment and funding, based on the priority scores from the Review Panels, along with considerations of funds availability, need, availability of other resources, distribution of programs among areas (Education, Research and Clinical/Service) and Schools, novelty and innovation, and fit or alignment with school/college and AHC strategic goals.

4. Providing input into the assembly of the chairs and faculty membership of the AHC-IP Review Panels, following a general solicitation of interest from faculty.

MEMBERSHIP ON THE AHC-IP COUNCIL

Initially, the AHC-IP Council will be the Senior Vice President and the Deans Council. As experience is gained in the process, membership of the AHC-IP Council may evolve to include others or to be constituted entirely by people not on the Deans Council. The initial AHC-IP task force recommended that this group include approximately seven Associate Deans and eight faculty members. Faculty members would be appointed by the Senior Vice President and Deans Council in consultation with the faculty. If this approach is adopted, members would serve for a period of three to five years. If the size of such a group proves unwieldy a more abridged version could be constructed.

Review and Approval of AHC-IPs at the Collegiate Level is recommended to proceed in a manner similar to the one laid out for AHC level programs.

APPENDIX 5

Roles and Responsibilities of the Program Director

The Director of the AHC-IP will be appointed by the Oversight person for the program, with the approval of the Senior Vice President and the Deans Council. For major programs, the appointment may involve either a search or administrative approval process consistent with University policy. The faculty of the AHC-IP should have input into the decision. A review of the Director's performance will be done annually by the oversight administrator and at the time of the cyclic review of the Program.

The Director will have at least the following responsibilities:

a. Assuring and enhancing the scholarly excellence of the program. This will include establishing an external advisory board where appropriate (Types 5, 4 and possibly 3).

b. Establishing governance processes

c. Fostering the development of faculty leadership within the program, i.e. a leadership mentoring program to create a cadre of faculty who could be program leaders or leaders in their field elsewhere.

d. Budget and resource management authority and reporting

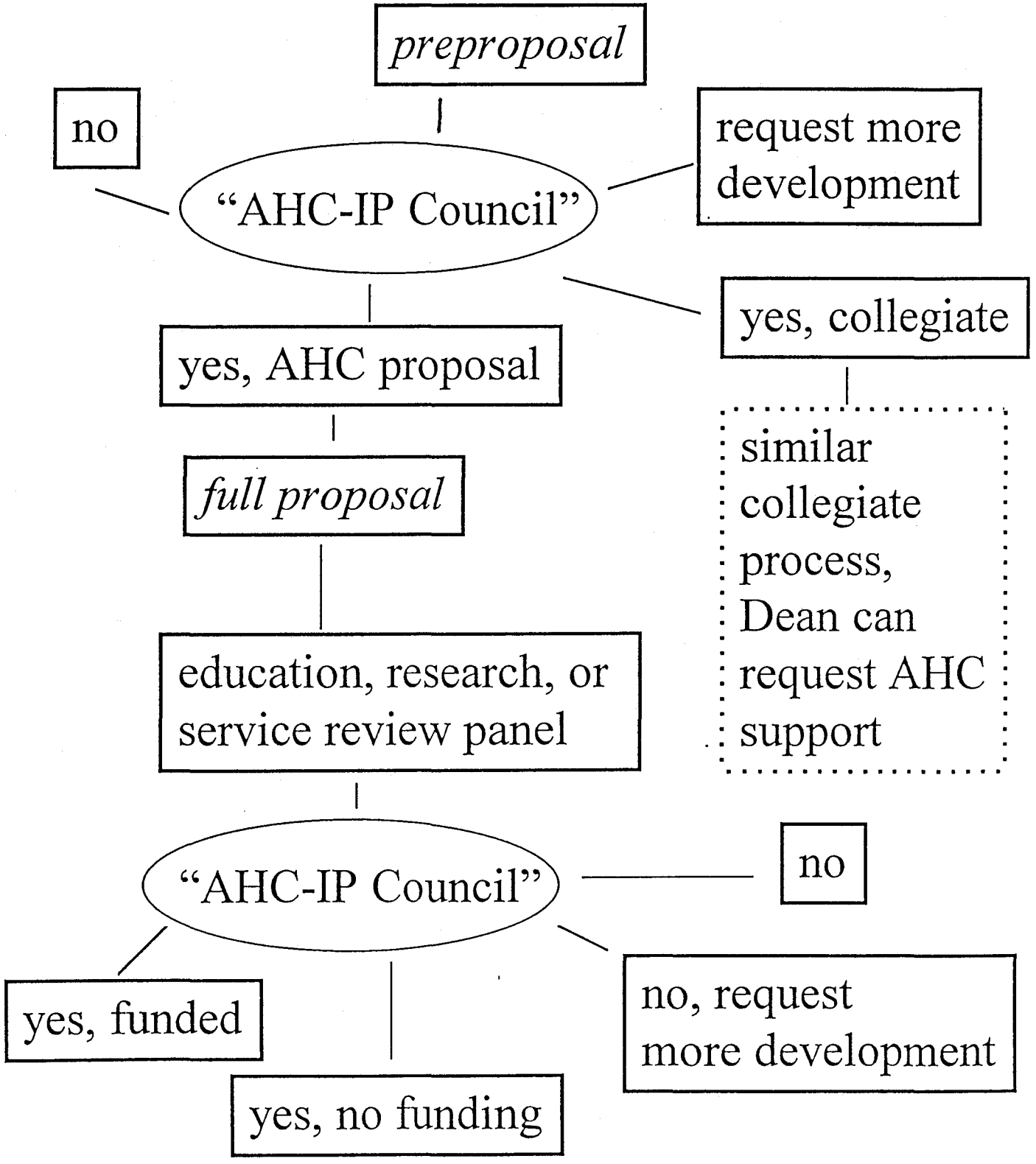
APPENDIX 6

Creating an AHC Intercollegiate Program

	Type 1	Type 2	Type 3	Type 4	Type 5
preliminary mission statement	yes	yes	yes	yes	yes
initiating faculty group members identified	yes	yes	yes	yes	yes
proposal leader specified	yes	yes	yes	yes	yes
pre-proposal submitted to AHC	yes	yes	yes	yes	yes
AHC-IP Council review	yes	yes	yes	yes	yes
can be approved based on pre-proposal	yes	yes	generally not	no	no
full proposal	unlikely	possibly	probably	yes	yes
Review Panel evaluation	unlikely	possibly	probably yes	yes	yes
AHC-IP Council final review of full proposal	probably not needed	probably not needed	probably	yes	yes
final decision by Senior Vice President	yes	yes	yes	yes	yes

Appendix 7

Developing New Programs in the AHC



APPENDIX 8

Proposed Principles for the Distribution of Clinical Income to Programs

1. Transfers of current clinical revenue sources from an academic unit to a program should strive to "do no harm" to the fiscal position of the academic unit at the time of the transfer. Thus, no program should "capture" clinical revenue that was previously allocated to an academic unit without the agreement of the unit in advance. If revenue is to be redirected to the program, then the expenses relevant to the program should also be taken up by the program.

2. Clinical revenue for the program should come from incremental clinical revenue after incremental expenses have been deducted. The proportional split between the program and the academic unit should be decided upon in advance.

3. When a faculty member is joint appointed between a program and an academic unit, the two must agree in advance how clinical income from the faculty member's efforts will be apportioned between the two.

4. Faculty involvement in clinical activities in a program must not create competitive conflicts with existing AHC clinical service units or faculty practice plans. When such potential exists, agreement in advance about the nature and scope of the new activity must be agreed to by the appropriate clinical program and academic program directors. If need be, the Senior Vice President, in consultation with the Deans Council, will determine the resolution.

5. The Director of the program will have the authority to determine the distribution of the program's portion of income from clinical activities. These decisions are subject to oversight by the program's oversight administrator and ultimately by the Senior Vice President.

6. Recruitment of clinical practitioners by the program would be at the discretion of the program if all funds will come from the program. Where a recruitment includes funds or an employment or tenure commitment from an academic unit, the academic unit will have the right of final approval on the hiring decision.

APPENDIX 9

One Framework for Distributing Tuition Income from Program-based Education

1. Based on IMG rules, 25% of the tuition income would be distributed to the school in which the student is enrolled.

2. Of the remaining 75% of tuition, a fraction that covers at least the direct operating expenses of the program for the course would remain with the program.

3. For faculty tenured in the program (Type 5 programs), tuition revenue for those faculty would go to the program in rough proportion to their proportion of effort in the course. For faculty with either joint appointments (possible in Type 4 programs) or tenure outside of the program, in general the tuition should be distributed proportionate to their effort in the course and their distribution of appointment between the program and their other academic home.

ACADEMIC HEALTH CENTER

UNIVERSITY OF MINNESOTA

FACILITIES STRATEGIC PLANNING COMMITTEE

CLASSROOM DEVELOPMENT SUBCOMMITTEE

FINAL REPORT

April 1998

TABLE OF CONTENTS

1. Executive Summary p. 1-2

2. Charge p. 3

3. Members p. 3

4. Process p. 4

5. Categories for Discussion p. 6

   - Available Classroom Space p. 6
   - Access to Classroom Space p. 10
   - Classroom Equipment p. 14
   - Classroom Support p. 16

6. Appendices p. 19

   Appendix 1 - Existing Room Survey p. 19

   Appendix 2 - Room Distribution by Size/Building p. 25

EXECUTIVE SUMMARY

The Classroom Development Subcommittee of the Academic Health Center (AHC) Facilities Strategic Management Committee was charged in Fall, 1997, with 4 tasks: 1) Determine current status of AHC Classrooms; 2) Determine future needs for AHC classrooms; 3) Recommend a plan for obtaining what we need; and 4) Recommend a plan to manage AHC classrooms.

The Subcommittee focussed its efforts on classrooms in AHC buildings on the East Bank Campus, with limited input on St. Paul Campus facilities. Information was obtained from a variety of resources including survey of AHC schools, the Central Scheduling Office, the Health Sciences Learning Resources Office, University Facilities Management, and all of the Subcommittee members. Information was sought on all space used for scheduled instructional purposes, including space not traditionally considered to qualify as a classroom. However, information on the latter was limited.

After consideration of the information obtained on AHC classrooms, it became apparent that issues fell into 4 major categories: 1) Existing classroom space available; 2) Methods of access; 3) Instructional equipment; and 4) Support of room function. The report which follows addresses the Subcommittee charges in relation to these 4 categories. This executive summary will provide an overview of the perceived deficiencies and recommendations for future management as they apply to all 4 categories.

Current Status and Future Needs

Existing classroom space does not match current or future AHC instructional needs. This reflects changing programmatic needs, limited inclusion of classroom considerations in construction planning, lack of upkeep of some of the larger classrooms, and competition for AHC space between AHC and non-AHC programs. Attempts to meet emerging needs on a patchwork basis through recruitment of departmental space have only partially addressed deficiencies.

Effective access for all AHC programs to existing AHC classroom space is hindered by multiple contact points, outmoded scheduling and prioritization systems, competition for space with non-AHC programs, and lack of knowledge of all available classrooms.

Equipment and means of access vary by source of classroom control (Central, AHC or departmental) and building. Most rooms lack on-site basic presentation equipment and distribution of higher technology is limited to a few rooms. Equipment use is limited by lack of timely support services.

Room support, including cleanliness, short-term maintainance (replacement of light bulbs, repair of broken chairs, restocking, etc.), regular facility and furnishing upkeep (painting, carpet repair, etc.), and equipment support and maintainance, was considered to be largely inadequate.

In general, there is a perceived disconnect between responsibility for classroom development/management, accountability for effective classroom function in the delivery of instructional programs, and authority to achieve effective classroom function.

Recommendations for Management

The Subcommittee charges of recommending a plan to achieve future needs (#3) and developing a management program (#4) were found to overlap and have been combined for the purposes of this summary and final report. The following recommendations address all categories assessed.

1) **Establish a single office and director responsible for AHC Classrooms.** This office/officer should have the responsibility for function of all classrooms in AHC facilities, including regular monitoring of function, strategic planning, scheduling, equipment and support. This office/officer should be held accountable to AHC classroom users and administration for effective classroom function. This office/officer should have the authority and budget to either move functions into the AHC or use existing University services (examples: janitorial services, Media Resources, etc.).
2) **Establish a Web/Server based scheduling calendar displaying all AHC Classrooms.** This calendar should display all available classrooms with relevant selection information including location, seating capacity, structure, on-site and accessible equipment, and any standing restrictions in scheduling (departmental classrooms). As classes or activities are scheduled, they should also be displayed on the calendar. This will allow more effective scheduling and assessment of equipment and capacity needs.
3) **Reconsider the qualifications of a classroom for access to Central Classroom support funds.** The limitation of centrally allocated funds to centrally scheduled classrooms results in a lack of University support for many classrooms that are meeting all of the qualifications for support with the exception of scheduling site. This problem will increase if scheduling of current central classrooms are moved under the auspices of the AHC.
4) **Reevaluate the methods by which classroom needs are met.** As classroom needs have changed and grown, departments have assumed a growing responsibility for providing space, equipment and support without any specific incentives or access to central classroom funds. This has relieved the University of building large amounts of new classroom space.
5) **Reevaluate the prioritization system used for room scheduling.** AHC (and partner department) classes should have the opportunity to identify appropriate AHC classrooms and class times before the rooms are opened to non-teaching purposes or to non-AHC classes. Access should be based on educational needs and should not result in continued disadvantage for any specific AHC program.
6) **Establish a set of expectations for basic instructional equipment in each of the AHC classrooms.** Ensure that all rooms have a minimal level of presentation equipment and that higher technology resources are sufficiently accessible in enough rooms in different locations, of different seating capacities, and of different instructional set-ups that classes that need this technology can find an appropriate room.
7) **Establish a set of expectations for short- and long-term room maintainance that is enforced for all AHC Classrooms.** Responsibility/accountability and authority for monitoring and enforcing adequate maintainance should reside with the AHC Classroom Office/Officer, identified in recommendation #1 above.

SUBCOMMITTEE CHARGE

The subcommittee received 4 charges:

1) Determine the **current status** of AHC Classrooms (What do we have?).
2) Determine the **future needs** for classrooms in the AHC (Where do we need to go?).
3) **Recommend a plan** for moving from what we have in classrooms to what we need (How do we needs with resources?).
4) Recommend a **management plan** to optimize utilization of classrooms (How do we manage what we have?).

SUBCOMMITTEE COMPOSITION

John Anderson	College of Biological Sciences
Florence Brown	School of Medicine
Peg Dimatteo	School of Public Health
Lael Gatewood	Medical School (Lab Animal Medicine)
Kathryn Hanna	College of Biological Sciences
Helene Horwitz	Medical School
Kathy Lange/Steve Pearthree	School of Pharmacy
Tom Larson	School of Dentistry
Terry Margo	Facilities Management
Marilee Miller	School of Nursing
Lori Olsen	Medical School (Surgery)
Nancy Peterson	Office of the Registrar
Meegan Schaeffer	School of Pharmacy (Student)
Janet Shapiro	School of Public Health
Stuart Speedie	Health Sciences Learning Resources
Wendy St. Peter	School of Pharmacy
Micky Trent (Chair)	College of Veterinary Medicine

PROCESS

The subcommittee used a variety of approaches to meet its charges. The methods used for data collection and plan development are described below. Potential strengths and limitations of the subcommittee's process are also provided.

Definition of "Classrooms"
The subcommittee initially defined a "classroom" as any space used on a regular basis for instruction. This substantially expands the space under consideration beyond the traditional lecture and seminar rooms to include small group breakout rooms, distance education facilities, teaching laboratories, clinical teaching spaces (both functional and simulated), virtual classrooms, and self-instructional space. The need to consider educational support space (control rooms, multimedia space) and connectivity as integral parts of classroom instruction was also recognized.

Despite acknowledgment of the growing diversity in space used as "classrooms" or in support of classrooms, the information obtained by the subcommittee was still most consistent and reliable regarding the more traditional lecture, discussion, and seminar spaces, as well as on the available distance education facilities. Evaluation of the survey information obtained by the subcommittee indicates inconsistent reporting of small group breakout rooms, teaching laboratories, and clinical teaching space. Little information was obtained on virtual classrooms and self-instructional space, or on educational support space. Information on Internet and server connectivity was provided on surveys of classroom space, but the information was often contradictory between sources.

Definition of "Academic Health Center"
The Academic Health Center (AHC) consists of 5 schools (Dentistry, Medicine, Nursing, Pharmacy, Public Health) centered on the East Bank Campus, one college on the St. Paul Campus (Veterinary Medicine), and partner departments in the College of Biological Sciences.

Charge #1 - Current Status
The subcommittee obtained information about current room availability, condition, equipment, utilization and support using 5 approaches: 1) All subcommittee members were requested to complete a table survey detailing the rooms used by their school, their capacity, the equipment available, and the room desirability; 2) A subset of the committee directly evaluated all accessible rooms used for AHC instructional purposes; 3) A listing of room assignments for large classrooms in Moos for one quarter was obtained from Central Scheduling; 4) University facilities management provided data on room capacity, and 5) Subcommittee members provided information on effectiveness and sources of support. A master list of rooms identified by the survey with facilities management data was prepared and modified as indicated by the direct evaluation (Appendix 1).

Information on the prioritization systems related to classroom access was obtained from 4 sources: 1) The survey conducted by subcommittee members; 2) University facilities management data; 3) Phone communications with the Central Room Registration Office; and 4) Discussions with room schedulers from AHC schools. Information about room support was obtained through discussion with committee members, representatives of facilities management, and the Director of Health Sciences Learning Resources.

The data collection process had several limitations which should be considered in interpretation and future planning. While the subcommittee requested information on all rooms used for teaching, we received limited information on teaching laboratories, clinical teaching space, and other applied instructional situations. The survey of classroom space was limited to use of the AHC complex on the East Bank (Moos, Phillips-Wangenstein, Weaver-Densford, Diehl, Mayo, and the JOML Complex). Survey information on the JOML Complex was limited and, due to the expectations for demolition and replacement of the Complex, the subcommittee did not directly evaluate these rooms. The Basic Sciences Bioengineering Building built in 1996, was not included in the survey and evaluation components of this study. The space in this building is on a charge/use plan and is not practically accessible for classroom use. Information on St. Paul campus AHC space is limited to the veterinary complex (Veterinary Teaching Hospital, Animal Science/Veterinary Medicine Building, Veterinary Diagnostic Medicine and the Veterinary Sciences Building) and was provided by a single source (M. Trent). We did not receive information on room use or future needs from the College of Biological Sciences. We did not request or receive information on classroom space being used by AHC programs outside of the East Bank and veterinary complex, although some use of other space is known to occur. Information on non-AHC program use of AHC classroom space was limited to information available from Central Room Scheduling on large classrooms in Moos for 1 quarter.

Charge #2 - Future Needs

Future needs were based on identified deficiencies and limitations in current classrooms, consideration of ongoing trends in curricula and teaching methodology, and consideration on planned programmatic changes including semester conversion and incentive managed growth. Initial plans to quantify future AHC-wide classroom needs were hampered by the timing of this process in relation to semester conversion. Several programs do not yet have the information on the anticipated size and scheduling for semester courses that would be needed to provide a more accurate prediction of future room needs. Specific classroom needs for the quarter system are being compiled and will be submitted at a future date. This information can be used to predict future needs under a semester system. Information on future needs of partner departments in the College of Biological Sciences was not provided for this study; however, the ongoing process of biology reorganization is expected to significantly impact future needs.

Charge #3 - Recommend a Plan

Recommendations for progression from what we have to what we need were developed by discussion in committee and limited review of previous (1992 Classroom Study) and ongoing (Senate Finance Subcommittee) studies. Many of the identified future needs involved improvements in management of the existing space; therefore, charges #4 and #3 are combined to produce a set of classroom recommendations.

Charge #4 - Management Recommendations

Management recommendations were developed by discussion in committee and review of previous and ongoing studies and combined with recommendations for charge #3 to produce a set of classroom recommendations.

CATEGORIES FOR DISCUSSION

In our evaluation of the status and future needs for Classrooms in the AHC, we found that issues fell into 4 categories related to available classroom space, space access, equipment in classrooms, and classroom support. The 4 charges given to this subcommittee will be addressed with respect to each of these 4 categories.

I) AVAILABLE CLASSROOM SPACE

Background

The Classroom Space in the AHC on the Twin Cities Campus must support 5 schools (Dentistry, Medicine, Nursing, Pharmacy, Public Health) centered on the East Bank Minneapolis Campus and one college on the St. Paul Campus (Veterinary Medicine). AHC partner departments in the College of Biological Sciences also need access to AHC classroom space on the East Bank. The last major construction of new AHC classroom space (excluding the Basic Science/Bioengineering Building) occurred with the construction of Weaver Densford Hall in 1982 and was planned to suit the program structures and preferred teaching methodology of that time. Since 1982, programs have commonly increased in size resulting in demand for larger classrooms, while changes in preferred teaching methodology have increased the use of small group sessions and of intermittent intense courses. Changes in classroom space needed to meet changes in program structure and preferred teaching methodologies, as well as the inevitable yearly changes in classroom demands, have largely been met by expanding the length of the teaching day, splitting classes into multiples sections, and using space not intended or designed as classroom space. New potential classroom space was included in the Basic Science/Bioengineering Building (1996), including one large ITV room and several small-medium seminars rooms, has not been practically accessible to regular AHC classes due to the fee charged for their use.

Anticipated future changes which will impact the availability of classroom space in the AHC include conversion to a semester system in Fall, 1999, and new construction in the Jackson-Owre-Millard-Lyons complex with temporary loss of space followed, after completion of construction, by available new classrooms.

Current Status

The complete information from the survey, direct evaluation, and central room assignments is provided in Appendices 1-2. A summary of information is provided below.

- No single source of information of classroom availability was found to be accurate.
- An total of 148 rooms were submitted as classrooms on the survey of the East Bank Buildings, of which 104 were confirmed as classrooms on direct evaluation by subcommittee visit in December, 1997. A total of 27 classrooms (including teaching laboratories and clinical rounds rooms) were identified on the St. Paul Campus. (Appendices 1 and 2)
- There were some discrepancies between the results obtained by different assessment tools, preventing determination of an absolute total. Fifteen of the 148 rooms reported to be in use by collegiate surveys were found at the time of the committee evaluation to be in use

for non-teaching purposes (8 offices, 2 departmental work space, 2 storage space, 1 clinical care space). Fifty-four rooms were not observed directly by the committee, primarily because of lack of access at the time of evaluation.

- The distribution of rooms by capacity is shown in Appendix 2 with a summary provided below. Rooms included in the "Confirmed" category are rooms in frequent use for teaching by multiple departments and confirmed on direct evaluation by subcommittee members. Rooms identified as "Restricted" are limited in use for teaching, either due to poor quality (example: 100 and 125 in Mayo) or due to intentional limitation of use for teaching (example: a number of departmental conference rooms). Rooms in the unconfirmed column were identified as classrooms on survey, but could not be confirmed to be in used as classrooms by the subcommittee. Rooms listed as classrooms on survey but found on direct subcommittee evaluation to be in use for non-teaching purposes (offices, storage, other) are not included in Appendix 2 or its summary below.

Summary of Appendix #2

East Bank Campus (7 AHC Buildings)

Capacity	Confirmed	Restricted	Unconfirmed
Very Large(≥200)	**5**	**2**	**0**
Large (100-199)	**0**	**6**	**2**
Medium (50-99)	**7**	**3**	**7**
Small-Medium (20-49)	**19**	**6**	**20**
Small (<20)	**28**	**10**	**15**
Unidentified (?)			**14**
Totals	**59**	**27**	**58**

St. Paul Campus (4 Buildings in the Veterinary Complex

Capacity	Confirmed	Restricted	Unconfirmed
Very Large(≥200)	**0**	**0**	**0**
Large (100-199)	**1**	**0**	**0**
Medium (50-99)	**5**	**2**	**0**
Small-Medium (20-49)	**2**	**4**	**0**
Small (<20)	**9**	**4**	**0**
Totals	**17**	**10**	**0**

- 22.8% of the rooms confirmed to be in use for teaching were considered central classrooms and 26.2% were AHC scheduled rooms. The remaining 51% were provided by colleges or departments.
- Approximately 20% of the classes scheduled in large centrally scheduled classrooms in Moos in Fall quarter were from non-AHC programs.
- The majority of the confirmed large (80%) and medium (66.6%) East Bank classrooms were centrally or AHC scheduled classrooms designed and designated for teaching. However, the majority of confirmed small-medium and small classes (64.6%) were conducted in departmental classrooms.

The following conclusions about existing classroom space (East Bank) were made:

- Shortages in appropriately sized and equipped rooms are resulting in a variety of detrimental effects on curriculum delivery and student experience, including:
  - extension of the length of the academic days for students and faculty to 12 hours in 3 programs
  - inadequate space for an entire classes, necessitating splitting a class and delivering the same lecture 2 or more times
  - use of classrooms that have been taken out of service due to poor condition
  - inability or difficulty in offering intermittently, vertically (half or whole day classes), partial term, or block (week long or longer) scheduled courses.
- The greatest shortages exist for small (≤ 30) and middle (30-100) sized lecture and seminar rooms.
- Shortages exist in large sized rooms due to overflow from middle sized classrooms and overflow from non-AHC classes, as well as the poor quality of 50% of the large rooms.
- Current programmatic needs for small and medium sized classrooms could not currently be met without use of departmental and collegiate space. The current use of departmental and collegiate space for small and some medium classroom needs is relieving the AHC and the University from building or otherwise providing space to meet these teaching needs.
- Departments and colleges vary in their willingness or ability to provide access to their space for AHC-wide teaching needs.

Future Needs

The following items address current and future needs.

- AHC personnel need access to accurate information on the number, location and type of all available classroom space in the AHC for the purposes of scheduling and planning.
- Available classroom space must better match current and future AHC programmatic needs, including:
  - Increase the number of available small and medium sized classrooms.
  - Increased access to large classrooms of acceptable quality. This need will be exacerbated by: 1) the loss of two large, albeit low quality, classrooms in Owre; 2) semester conversion which may increase the size of classes University-wide with a decrease in offerings (2 terms vs 3); 3) semester conversion transition which will result in a 3-4 year period when some courses may be offered to 2 classes at the same time.
  - Increased access to multipurpose (flexible space) classrooms to accommodate a variety of teaching methods within one space (i.e., adjustable to suit lecture, seminar, collaborative/ cooperative learning, break-out sessions).
- Classroom space should be flexible enough to adapt to ongoing changes in curricula of AHC programs. Effective instruction should not be limited by access to classrooms.
- Semester conversion is expected to create an increased need for access to all sized rooms based on initial schedule planning. This need is expected to be highest during the first 3-4 years of conversion when some courses will be taught to several classes at the same time.

Plan Recommendations

- A single accurate list of space available for use as a classrooms by AHC Programs should be maintained and updated on an annual basis by a central AHC individual or unit. This list should be available on a computer accessible site (Web/Server).
- Existing AHC classroom space should be reviewed on an annual basis by a central AHC individual or unit (with input from the programs that use the rooms), and plans made to adjust for the anticipated space needs in subsequent years.
- The possibility of limiting some classroom space to intermittent, vertical, partial term and block scheduled classes should be considered.
- A central AHC individual or unit should be responsible for scheduling and support of all classrooms in AHC buildings to better coordinate the existing classroom space for AHC use and provide effective input for short- and long-range planning.
- Construction of one or more large classrooms should be considered a priority for future construction efforts. An increase in access to large classrooms of acceptable quality may be difficult to achieve with existing space and would require major remodeling of existing large classrooms in Mayo. Loss of the very large classroom in Owre without planned replacement will exacerbate this need. Alternatively, construction or remodeling of medium-large rooms (90-150) would relieve the overflow pressure on very large (>150) classrooms.
- Increasing the number of available small and medium sized classrooms may be possible through more effective recruitment and management of departmental and collegiate space for teaching. This approach will require provision of incentives to departments for use of their space and a central listing of available rooms. If the amount of space can not be increased to adequate levels by this method, new construction must be considered.
- The contribution of Departmental and College space as an essential part of the AHC teaching programs should be acknowledged and rewarded. An effective program to maintain access to adequate departmental and college classroom space should include:
  - Incentives should be provided for Departments and Colleges that make their space available for use as classrooms. Possible incentives include AHC support for teaching technology in appropriate rooms and access to other departmental/collegiate space.
  - Some minimum threshold for use as a teaching space should exist to qualify for access to incentives (average of 15 hours/week?).
  - Departmental/collegiate space that is used for teaching beyond a second threshold (25 hours/week?) should qualify for central classroom support funds.
  - All available departmental/collegiate classroom space should be included on an AHC-wide list of teaching space.
  - Departments and Colleges should maintain some control of their own space
- All new construction should include consideration of existing and future classroom needs and should be required to meet at least one of the high priority classroom needs. Potential classroom space should not be limited by charges (e.g., BSBE).
- Plans for development and management of classrooms in the AHC should be coordinated with ongoing classroom assessment and development studies in the University.

II) ACCESS TO CLASSROOM SPACE

Background

Classes are scheduled at least one quarter in advance from any of 4 sources: Central scheduling, AHC scheduling, individual colleges, or individual departments. Large classrooms (>100) are typically controlled by Central scheduling or the AHC, while the majority of small classrooms are controlled by departments. Each AHC program typically has one or two individuals who relay faculty or program requests for classrooms to the appropriate sources. These individuals have typically developed a set of contacts to obtain space when the central and AHC sources are not fruitful. A prioritization system exists for each of the 4 sources. The prioritization system is typically not public knowledge and, in some cases, is intentionally concealed. The prioritization system for central scheduling of AHC Classes was established at least 20 years ago. There is no identifiable system for review of central priorities.

Current Status

The information in this section relates primarily to scheduling of the East Bank programs. The complete information from the survey and facilities management is provided in Tables 1-2. A summary of information is provided below.

- Centrally scheduled classrooms are accessed by contacting the central scheduling office. Room schedulers for AHC programs are aware of available central classrooms but can not find out about availability without contacting central scheduling. The prioritization system for centrally scheduled rooms falls into approximately 4 levels:

  First Level (Automatic assignment if requested)

Medical School	-	Moos 2-650 (Except for 12:20-1:10 MWF)
	-	PWB 2-470 (Except for 12:20-1:10 MTWThF)
School of Dentistry	-	Moos 2-690
	-	Moos 2-620
	-	Moos 2-530
Biology	-	Moos 2-650 from 12:20-1:10 MWF
School of Public Health	-	PWB 2-470 from 12:20-1:10 MTWThF
		Moos 2-650 from 12:20-1:10 MWF)

  Second Level (Considered after first level assignments)

  School of Pharmacy - Remaining Space in Moos

  Third Level (Considered after second level assignments)

  School of Public Health
  School of Nursing

  Fourth Level (Considered after third level assignments)

  All Others

- Classes that request a specific centrally scheduled classroom at a specific time which they do not obtain during the first scheduling run do not perceive that the are given a chance to request that room at a different time before the rest of first run requests are completed, including those from non-AHC programs. Central scheduling is also unwilling or unable to efficiently provide faculty/room schedulers with information on when a given room is open.

- The unique scheduling demands of the AHC programs prevents Central Room Scheduling from using the University's computerized scheduling system. They are currently using an index card system to schedule AHC classrooms.
- The central scheduling office by policy will not reveal the name of the faculty who did obtain the classroom to room schedulers for a program or to other faculty, preventing negotiation between room schedulers.
- AHC scheduled classrooms are accessed by contacting the Health Sciences Learning Resources Office. Room schedulers from AHC programs are aware of most of the AHC classrooms, although there appears to be some confusion among faculty about who controls these rooms. As for centrally scheduled rooms, room schedulers can not find out about availability without contacting the AHC contact. AHC classes are stated to receive first priority for these classes with no ranking of priority between AHC schools, although Medical School classes are often scheduled first due to their earlier start date.. Horizontally scheduled classes (e.g., MWF 12:20-1:10) have priority over vertically scheduled classes (e.g., M 12:20-3:40, all day 2 times in a quarter, etc.).
- Collegiate/Departmental Classrooms are typically scheduled by a departmental office. Departments vary in the number of rooms controlled and their willingness and need to utilize these rooms as teaching space from policies against any teaching use, to limitations to same department use, to collaborative use among several departments. Room schedulers are typically only aware of those departmental rooms which they have used before and may be unaware of a number of these rooms.
- There is significant variation in AHC program academic calendars and in class times.

The following conclusions about classroom access were made:

- Effective access to appropriate classrooms is hindered by a variety of factors inherent in the current classroom management system which include:
  - incomplete knowledge of available space
  - variable access to departmental space
  - a central prioritization system that distributes space unequally across AHC programs irrespective of class need
  - a central prioritization system that schedules non-AHC classes before a second option choice is provided to AHC classes
  - lack of ability for negotiation after rooms have been assigned
  - multiple scheduling sources to contact based on room control without communication between sources

Future Needs

The following items address current and future needs.

- Faculty and/or program room schedulers need access to information about room availability, irrespective of who controls the room, in a single site.
- Responsibility, accountability and authority for room scheduling and support should reside in a single individual (or office) who is in ongoing contact with the individuals who use the room.
- Room schedules, once set, should be public knowledge to allow negotiation between faculty or programs for special circumstances.

- Priorities for room scheduling for AHC programs should be reviewed regularly (recommend annual for the next 4 years, follow by a review every 2 years or at the time of any major programmatic curriculum change) and revised to meet programmatic needs. Major collegiate contribution to room development or equipment buys only limited term priority.
- Priorities for room access should ensure that no program is consistently disadvantaged over others.
  Disadvantages to be avoided include:
  - 10-12 hour class days for students for lack of adequate classroom space.
  - division of large lecture classes for lack of adequate space.
  - restriction of progressive changes in curriculum design for lack of adequate space.
- AHC classes need the opportunity to refuse all available AHC space before it is scheduled for non-AHC classes.
- A one-stop shopping approach to classroom access should be adopted for all classrooms in AHC sites. This would include:
  - All rooms available for class use (central, AHC, collegiate or departmental) with descriptions of facilities and equipment should be listed on a single AHC web site. This site should be updated annually.
  - Rooms should be managed by a single AHC office who is responsible for scheduling space based on a revised prioritization scheme and who is accountable to AHC faculty, students and administration for equitable distribution of space between programs.
  - The central source may convey requests for departmental space to departmental representatives for times not specifically offered by the department for teaching purposes. Departments have the right to refuse as long as the minimum amount of teaching use is met
- All available classrooms, regardless of control, should be listed on a Central Web site.
- A web based calendar system (Meeting Maker or other) should be used to display room assignments and demonstrate space availability. Departments that are willing to provide space for classes may preserve preferred times for departmental business by blocking those times off.

Plan Recommendations

- An individual (with any necessary support personnel) within the AHC should assume authority, responsibility and accountability for scheduling (and support) of all classrooms in AHC facilities including those which are currently designated as centrally scheduled, AHC scheduled, or departmentally/collegiately scheduled.
  Effective implementation of this access recommendation would require:
  - maintained access to funds designated for support of centrally scheduled rooms.
  - accountability of the responsible individual to AHC administration and room users, as well as potentially to a central University Office or Officer.
  - authority to adjust resources to meet room needs.

  Additional considerations would include:
  - reconsideration of the definition of "centrally-scheduled classrooms".

- All requests for a classroom should first go to the AHC office described above. Requests should include enough details on the requirements for the classroom (preferred/acceptable times, enrollment, activities, equipment needs) to allow identification of acceptable second choices.
- A system of prioritization should be developed which ensures that classrooms in AHC facilities are equally supportive of all AHC programs. Such a system would include the following:
  - AHC programs should have first priority for classrooms in AHC facilities. AHC classes that do not receive their first choice room should have the option to choose from available AHC space before it is opened to non-AHC classes.
  - Assignment should be based on need and compliance with the principles of fair assignment (accurate reporting of class size, willingness to negotiate, contribution of departmental space for open use, etc.) rather than historical access.
  - Preference for a specific sized classroom should be given to classes of a size too large for the next smallest sized classroom over those that could fit into a smaller room.
  - All core/required courses should receive priority over elective courses.
  - Assignment of rooms should be based first on the ability of the room to meet the educational needs of the class (proper equipment, size, structure) followed next by considerations which enhance class quality/satisfaction (proximity of space to class/department location, class size is a high percentage of room capacity, support of overall program curriculum, room esthetics), followed by practical scheduling considerations (adherence to University schedule/class times, frequency and schedule of meeting of meeting).
- A system for regular review of the priority system should be developed that allows for changes to meet changing programmatic needs.
- A Web based scheduling system (Meeting Maker, etc.) should be adopted and maintained by the AHC individual/office responsible for AHC rooms.

III) EQUIPMENT IN CLASSROOMS

Background

Policies for provision of equipment in classrooms has apparently evolved along different lines based on the source considered to be responsible for the room and historical arrangements mounted at the time of room construction. The University, AHC and departments/colleges have recently recognized the rapid evolution in available presentation equipment and have, to variable degrees, made efforts to upgrade equipment in some rooms. Significant improvements have depended on individual budgetary allocations by University Regents, rather than a specific ongoing budgetary item. Similarly, funding for basic facilities upgrade (carpet, painting, chair replacement/repair) have received limited ongoing funding support and maintenance has been deferred for decades in many cases. These statements are true for both East Bank and St. Paul Campus facilities.

Current Status

Initial information on available equipment in classrooms was obtained through the table survey conducted by subcommittee members and validated, when possible, by direct evaluation of rooms by a subset of the subcommittee.

- Equipment available within rooms is highly variable, from chalk to Ethernet connections. Lack of reliable supply of very basic tools such as chalk was a common complaint. Many centrally scheduled rooms have control systems for overhead, slide projectors, and VCR, but equipment must be delivered (at a cost to the department requesting equipment) from Media Resources. Those centrally scheduled rooms which did have fixed, on site equipment are typically affiliated with a specific department, which supplies the equipment. Rooms designated as the responsibility of the AHC have been wired with Ethernet access, but access in other rooms is rare. Departmental rooms have the highest degree of variability in equipment, although those that are also used for departmental business typically have on site equipment and are well maintained.
- The means to access equipment varies based on the building, source of room control, and room user. The source of equipment is not the same, in most cases, as the source of control for room scheduling or room maintenance. Media Resources is the standard source of equipment for centrally scheduled rooms and may be used for AHC and departmental/collegiate rooms, although faculty often utilize departmental resources in departmental classrooms if possible.

- Efforts have been made to upgrade the technological capacity of AHC controlled classrooms. However, only one central classroom (on the St. Paul Campus) has received a major technology upgrade and this was not funded with central funds. The majority of classrooms lack efficient access to common presentation technology.
- Lack of required presentation equipment in each of the classroom sizes is perceived to be a source of conflict in room scheduling. Classes of a given size may not be able to access a room of appropriate size with the necessary equipment, either resulting in displacement of the class into a larger room than needed or a change in presentation format to a less advanced, and possibly a less effective, method. The latter has the additionally detrimental

effect of discouraging faculty investigation and development of technologically advanced teaching methods.

Future Needs

- There is a need for reliable stocking of a standard set of equipment in each room.
- A high priority for technologically advanced presentation and student access capabilities should be placed on distribution between classroom sizes and locations.
- Easy access to rapid support for equipment problems whenever classes are in session is mandatory.
- Individuals responsible for equipment support must be held accountable & must have authority to ensure that support is adequate.

Plan Recommendations

- An individual (with any necessary support personnel) within the AHC should assume authority, responsibility and accountability for scheduling, equipment provision, and support of all classrooms in AHC facilities including those which are currently designated as centrally scheduled, AHC scheduled, or departmentally/collegiately scheduled.
- A Web- or server-based listing of all available rooms with descriptions of relevant information, including available on-site and supportable equipment, should be established and maintained by the AHC individual/office responsible for classrooms.
- A standard of equipment should be established for basic classrooms, and potentially several additional levels, irrespective of current room control. The Health Sciences Learning Resources Program has recommended a minimum standard for equipment and these recommendations provide a reasonable starting place for room equipment changes.
- Departments which supply departmental space for teaching purposes should receive AHC support to achieve the appropriate level of equipment.

IV) CLASSROOM SUPPORT

Background

Items considered in this category included room cleanliness, short-term maintenance (replacement of light bulbs, repair of damaged chairs, replacement of basic room supplies such as chalk, chairs and tables), regular maintenance of facilities and furnishings (painting, carpet repair and replacement), regular checks to ensure equipment function, responsiveness to requests for major facility and equipment disfunctions (non-functional equipment or controls, extremes in temperature, missing equipment, water leakage), and ease of identification of the appropriate support office. Information on these categories was largely obtained from subcommittee members and direct room observation.

Current Status

- Room cleanliness was a common concern among subcommittee members and was often commented upon by survey respondents, although it was not a specific question on the survey. Over half of the rooms evaluated directly by subcommittee members during the Christmas break were not clean (dust on floor, trash on surfaces, trash cans unemptied, dirty chalkboards). Departmentally managed rooms which were also used for other functions were less likely to be dirty.
- Short-term room maintenance was also found to be inadequate, both on discussion with faculty and room schedulers and on direct room evaluation. On direct evaluation during quarter break, most centrally scheduled rooms had non-functional light sockets. Dimmers were not functioning in approximately 30% of rooms, with a more even distribution of problems between the different room sources. Lack of a predictable supply of basic room supplies (chalk, chairs, tables) was a commonly identified source of frustration. Several of the subcommittee members responsible for room scheduling indicated that the problem of missing chalk was so prevalent that the departments had assumed the responsibility of providing chalk to each instructor before they went to the assigned room. Missing chairs and tables was predominately a problem in small AHC and departmental rooms which were stocked with mobile chairs and tables. Many of the small and medium sized rooms had a mixture of types of chairs in variable states of repair.
- Regular maintenance of facilities and furnishings had apparently been deferred in many of the rooms, irrespective of control source. New carpeting was only observed in several rooms that had recently flooded. Stained and visibly torn carpeting was observed in approximately 40% of rooms with carpeting. Painting was less commonly recognized as a deficiency.
- A plan for regular evaluation of equipment function was not identified, although the correct questions may not have been asked to obtain this information. Equipment maintenance appeared to be driven by recognition of problems.
- Service from Media Resources, which is a central University service with an office in Malcolm Moos, was frequently perceived to arbitrary or inadequate. Concerns included:
  - Charges for delivery of equipment vary by building, with charges for delivery as much as doubling for rooms 50 yards apart in adjacent buildings (e.g., $14 to PWB and $7 to Moos).
  - Service is often perceived to not be provided at the time or in the nature requested.

Arrival of equipment less than 5 minutes before the scheduled class time was a common complaint. Frequent changeover in Media Resources staff (high percentage of student employees) may contribute to the variability of service.

- Service is particularly unreliable after hours and on weekends. Classes which start regularly at 7:45am frequently have difficulty in obtaining equipment.

- There is not a clear understanding on the part of the faculty of who to call for help if equipment is not working.
- Responsiveness to requests for major facility and equipment disfunctions was perceived to be a common problem, although an estimate of frequency could not be obtained through the processes used by the subcommittee. Some immediate response to requests for immediate assistance appears to have been assumed by departmental representatives.
- Rapid identification of the appropriate office for assistance with immediate problems was a frequently cited problem for faculty. This appears to be a result of a combination of factors including lack of posted contact numbers or phones in many of the departmental classrooms, confusion about which office is responsible for support of the different components involved in room function, inadequately rapid response time to meet immediate instructional needs, and reliance on departmental sources for assistance rather than attempting direct contact with the appropriate office.

Future Needs

Improvements in room support will rely upon development of a support system that can more effectively meet existing and future needs. This system should include:

- A single initial contact point should be established for all room support needs. This number should be immediately accessible in all classrooms.
- A single office should be responsible for ensuring adequate support of all AHC classrooms.
- The central office must receive accurate input on classroom needs and expenditures for support to establish a realistic budget for maintenance.

Plan Recommendations

- A single initial contact point should be established for all room support needs. This number should be posted in all space used as a classroom or in support of classrooms. Phones with direct access to this office should be accessible in all classrooms used for more than 15 hours of instruction/week.
- The single office responsible for ensuring adequate support of all AHC classrooms should be established and should have the following characteristics:

  Location - close enough to the majority of AHC classrooms to allow response within 5 minutes and to allow ongoing contact between office members and faculty/administrators responsible for providing instruction. A satellite office or individual may need to be placed in more remote classroom locations (i.e., St. Paul campus).

  Accountability - to AHC classroom users (instructors and students) and administration (departmental schedulers as well as departmental, collegiate and AHC administrators). This could be accomplished by a combination of regular meetings, individual problem reports, and regular service surveys. This office may also have

a level of accountability to a central University Classroom Office, although this is considered to be less connected to effective function that AHC accountability.

Authority - sufficient to accomplish the necessary room support in a timely fashion. This office should be able to prioritize needs and recruit support for other University Offices to achieve both routine and non-routine support. This individual should also have input on the evaluation of officers responsible for these University offices.

Resources - sufficient to meet ongoing maintenance needs with input on budgets for long-term maintenance activities. This office must maintain access to funds intended for support of centrally scheduled classrooms. Additional allocation of funds over existing budgets may be needed to adequately meet basic needs as well as necessary short and long-term maintenance needs, although more efficient and regularly scheduled management alone is expected to significantly improve support effectiveness.

Responsibility - to provide timely classroom support as well as to conduct regular needs and service assessments. Timely classroom support will require development of a regular classroom assessment schedule (to ensure adequate supply of chalk, etc.; assess the status of facilities, furnishings and equipment; and confirm function of controls, lights, temperature controls and equipment), maintaining a supply of rapidly consumable materials such as projector bulbs in each classroom, and establishing and effective rapid response system for emergency needs.

- Departmental representatives responsible for room scheduling must consistently report requests for assistance to the responsible office rather than assuming responsibility for support.
- A triage system for rapid support of "class-stopping" equipment needs should be established and monitored by the AHC Classroom individual/office.
- Simple directions for routine equipment use should be posted in all classrooms.

APPENDIX 1

SURVEY AND DIRECT EVALUATION OF CLASSROOMS

The following table includes information collected on survey or by direct evaluation [shown in brackets] of classrooms in 5 of the AHC buildings on the East Bank and the 4 AHC buildings on St. Paul Campus. Rooms for each building are listed as: A) Confirmed (found to be in use as a classroom on committee visit); B) Not Confirmed (committee unable to confirm use as a classroom on direct visit, often due to lack of access at that time); and C) Not in use for teaching at the time of committee visit. A key for use of the table is included by column below.

KEY

Room (column 1) - Indicates room location, scheduling source, and level of use for teaching
- Room number: ex Moos 2-650 or 4-215(A)
- Room control source: Cen = centrally scheduled, A= AHC scheduled, D= departmentally scheduled (department shown if know after "D")
- "*" before a room indicates restricted use for instruction (poor quality or departmental limitation in teaching use)

Capacity (columns 2-4)
- Lecture = Seating capacity in lecture format
- Sem = Seating capacity in seminar format
- Other = Seating capacity in other configurations
- "#1xJ#2" = Indicates the capacity of the room individually (#1), the rooms that can be joined (x), and the capacity when the rooms are joined (J#2). As an example, Moos 2-107 has a single room capacity of 14, but when combined with 2-113, has a capacity of 20.

Preference (columns 5-8) - indicates level of preference for use of this room
- # Dpts = number of dpts reporting use of this room
- # Classes = total number of classes reported on survey to be held in this room
- Pref = level of preference (3 highest) reported on survey for this room

Environment (columns 9-12) - describes factors related to comfort and ease of room use
- Visibility = average reported score (5 best) for line of sight and lighting
- Sound = average reported score (5 best) for acoustics and sound system
- Air = average reported score (5 best) for temperature control and ventilation
- Handicap = average reported score (5 best) for handicap accessibility

Student Facilities (columns 13-16) - describes facilities in direct use by students
- Seating = average reported score on quality (5 best) and type (M= mobile; F=fixed) of seating for students
- Table = average reported score on quality (5 best) and type (TAC=tablet arm chair; T=table; Bench) of work surfaces for students.
- Power = access to outlets at student seats
- Computer = access to computer ports at student seats

Presentation Facilities (columns 17-23) - describes facilities available for instructor presentation to students

Board = average reported score for quality (5 best) and type (W=white, C=chalk) of writing surface

OH = average reported score (5 best)for quality of overhead

VCR = average reported score for quality (5 best) and access (hook up or monitors indicate capacity without on-site equipment) for VCR

Computer = average reported score (5 best) for use of computerized projection equipment

Podium = average reported score (5 best) and type (M=mobile; fixed if no letter) of podium

Slide Projector = average reported score (5 best) & number (one/two) of projectors

Screen = number and quality of projection screens

Modifyers (all columns)

[C...] or [...] indicates comments or modifications of survey information based on direct observation. [C-] or [-] indicates that the quality was less on direct observation than indicated on survey.

(#) after a score indicates that only part of the respondents (number in parentheses) provided a score for this item

? indicates that there was conflicting information provided on survey for a given category and that the average score does not reflect individual responses

! or !! indicates a high or very high level of disagreement between survey respondents and that the average score does not reflect individual responses

~~2.5~~ indicates that this score was based on innacurate survey information. This typically indicates that the item (ex. Student computer access) was found to be absent on direct room evaluation and should not have been scored.

AHC CLASSROOM ASSESSMENT SURVEY SUMMARY																						
EAST BANK BUILDINGS																						
1) MALCOM-MOOS (#142)					(Public Health,Dentistry,Nursing,HSLR,Pharmacy,Surgery)																	
A) Rooms Confirmed by Committee Visit																						
	Capacity						Environment (5)				Student Facilities (5)				Presentation Facilities							
Room	Lectur	Sem	Other	# Dpts	# Classes	Pref (3)	Visibility	Sound	Air	Handicap	Seating	Table	Power	Computer	Board	OH	VCR	Comput	Podium	Slide Proj	Screen	
2-650Cen	346			4+C	9	2.77	3[C-]	3[C-]	2.25[C-	2.25	F2.77[C-]	TAC2.5(3	~~3(2)~~ [Cn	~~2?~~[Cnone]	Ch3.5	3	2.66(2)[	2.3(2)	2.66	[Ctwo]	[C3]	
2-620Cen	236			4+C	5	3(3)	3(3)[C-]	3.33(3)[	2(3)[C-]	2.66(3)	F3(3)[C-]	TAC3(3)	~~3(3)~~[Cn	~~1(3)~~[Cnone]	3.66(3)	2.66(3)	3.5(3)[Cr	1.5(3)	3(3)	[Ctwo]	[C3]	
2-690Cen	236			4+C	31	2.5	3.5[C-]	4	2.6(3)[	3.23I(3)	F3(2)[C-]	TAC2.5(2	~~2.5(2)~~I[	~~1(1)~~[Cnone]	3.5(2)	4(2)	4(2)[Cre	3(2)	3.25(2)	[Ctwo]	[C3]	
2-530Cen	200			3+C	17+	3(2)	3.18(2)[C-	3.66(2)	2(2)	2.66(2)	F3(2)[C-]	TAC3(2)	~~3(2)~~[Cn	~~1?(2)~~[Cnon	3.33(2)	2.66(2)	3(2)[Cre	1(2)	2.5(2)	[Ctwo]	[C3]	
2-520Cen	90			3+C	8+	3(2)	3(2)[C-]	3.5(2)	2(2)	2.5(2)	F2.5(2)[	TAC3(2)	~~1(2)~~[Cn	~~1(2)~~[Cnone]	4(2)	3(2)	3(2)[Cre	1(2)	3(2)			
*3-110Phys	125[C70]			3+C	11	3	3.83	3.33	2.33	2	F2.66II[	TAC3	~~2(2)~~[Cn	~~0.75II~~[Cnon	Ch2.66	3	2II[Crent	0.75II	3			
5-125Cen	56[C90]			5+C	30+	3(2)	4.1(2)	4.17(2)	3.07(2)	3.1(2)	F3.75(2)	T4.5(2)	~~4.1(2)~~[C	~~3.5(2)~~[Cnon	W3.33(	Elmo4.06(	VHS4.13	4.16(2)	3.76(2)	[Ctwo]		
2-580Cen	40	40		2+C		3(1)	3.5(1)[C-]	4(1)	3(1)	2(1)	F2(1)[C-]	TAC	none	none	4(1)	3(1)	[Chook up]					
*2-116DPath	40	40		C			[C3]	[C3]			[M(5)	[T for 12 (5)]			[Ch3]	[C33]	[Cnone]	[Cnone]	[M2]	[Cone]		
3-317D		35		1+C	40 hrs	3	4[C-]	3	1	4	M3	T[C3]	none	none	Ch4	4	[hook up	[Cnone]	MB4	[Chook-ups]		
2-585A	aJ60	32		2+C	3+40hr/wk	3.5	2.83[C-]	3	1	3.5	M3	TAC3	~~1(1)~~[Cn	~~2(1)~~[Cnone]	Ch3.3	~~3(1)~~[Cnon	3(1)[Cho	1(1)At p	3			
2-571A	aJ60	30		1+C	?40hr/wk	4	3[C-]	3	1	4	M3	TAC3	[Cnone]	[Cnone]	Ch3	none	none[Ch	At podiu	none			
2-154A		18		4+C	11+	1.75(3)	3.12	3[C-]	2.75	3.53	M2.33(3)	T2.66(3)	~~3.5(3)~~[C	~~3(3)~~[Cnone]	C4.5(3)	none	none	5[CEther	~~5?~~[Cnone]	[Cnone]		
2-146A		15		5+C	11+	1.75(4)	3.12[C-]	3[C-]	3.25[C-	3.53	M2.33(4)	T2.66(4)	[Cnone]	[Cnone]	C4(4)[C-	none	none	5[CEther	~~5?~~[Cnone]	[Cnone]		
2-680D		15[C12]	bJ20	3+C	6+	2(2)	2.75(2)	1.5(2)	2(2)	3(2)	2(2)	TAC(2)	~~3(2)~~[Cn	~~4(2)~~[Cnone]	C3(2)	none(2)	none(2)	none(2)[	none(2)	[Cnone]		
2-676A		10	bJ20	2+C	7	2.5	2.87	2.25	2	3	M2(1)	TAC(1)	~~3(1)~~[Cn	~~1(1)~~[Cnone]	C3(1)	none(1)	none(1)	none(1)[	none(1)			
2-107A		14	cJ20	4+C	7+	2(3)	3.25	3	3.25	3.5	M2.66(3)	TAC2.33(3)			C4.5(3)	none	none	5[CEther	5?	[Cnone]		
2-113A		12	cJ20	4+C	5+	1.35(3)	2.87	3	3.25	3.25	M2.66(3)	TAC2.33(	2(3)	2(3)	C4(3)	none	none	5[CEther	5?	[Cnone]		
2-672A	13			3	4+	1.5(2)	2.75(2)	1.5(2)	2(2)	3(2)	M2(2)	TAC(2)	~~3(2)~~[Cn	~~1(2)~~[Cnone]	C3(2)	none(2)	none(2)	none(2)	none(2)			
B) Rooms Not Confirmed as Classroom by Committee Visit																						
3-311D	150			1																		
4-170DD	62			2			2.5(1)	2(1)	1(1)	3(1)	M2(1)	3(1)	4(1)	1(1)	3(1)	1(1)	1(1)	1(1)	none(1)			
4-180DD	58			2			2.5(1)	2(1)	1(1)	3(1)	M2(1)	3(1)	4(1)	1(1)	3(1)	1(1)	1(1)	1(1)	none(1)			
4-210DD	52			2			2.5(1)	2(1)	1(1)	3(1)	M2(1)	3(1)	4(1)	1(1)	3(1)	1(1)	1(1)	1(1)	none(1)			
4-220DD	52			2			2.5(1)	2(1)	1(1)	3(1)	M2(1)	3(1)	4(1)	1(1)	3(1)	1(1)	1(1)	1(1)	none(1)			
2-242Cen	50			1	1	3	5	5	5	5	M5	T5		none	C5	OH4	none	none	none			
2-252Cen	50			1	1	3	5	5	5	5	M5	T5		none	C5	OH4	none	none	none			
2-262Cen	50			1	1	3	5	5	5	5	M5	T5		none	C5	OH4	none	none	none			
3-331Cen		30		1	40 hrs	3	4	3	1	4	stools	bench	60	none	C4	none	2monitor	none	MB4	screen 1		
3-337Cen		30		1	40 hrs	3	4	3	1	4	stools	bench	60	none	C4	none	2monitor	none	MB4	screen 1		
3-343Cen		30		1	40 hrs	3	4	3	1	4	stools	bench	60	none	C4	none	2monitor	none	MB4	screen 1		
3-349Cen		30		1																		
12-186DOb		30		1	1he/rotati	2	4	4	4	4												
2-252(A)Cen		30		1																		
3-245Cen		25		1																		
3-220Cen		20		1	5	3	3.5	4	3	4	M3	C3		none	C4	none	none	none	none			
3-226Cen		20		1	5	3	3.5	4	3	4	M3	C3		none	C4	none	none	none	none			
3-229Cen		20		1	5	3	3.5	4	3	4	M3	C3		none	C4	none	none	none	none			
12-109DNeu		20		1	1hr/wk	3	4	3	4	4	M4	C&T	2	none	M4	OH4	VCR4	none	lectern			
2-629A/D		19		2		1(1)	1.5(1)	1(1)	2(1)	3(1)	M2(1)											
2-622DS		18		1																		
2-584		17		1																		
3-244Cen		12		1																		
8-380(B)Cen		12		1																		
2-693D		8		1																		
12-132DNeu		8		1	4hr/wk	3	5	4	4	4	F4	C&T4	2	yes	M4	none	none	none	none			
2-663Cen		7		1	1	3	5	5	5	5	M5	T5		none	C5	OH4	none	none	none			
4-215(A)DS		1																				
4-215(F)D		1																				
1-332Cen		1																				
3-325		0		1	40hrs	3	4	3	1	4	Stools1	Bench		none	C4	none	2monitor	none	MB4	screen 1		
3-343(A)		0		1	40hrs	3	4	3	1	4	Stools1	Bench		none	C4	none	2monitor	none	MB4	screen 1		
x2-107(A)O		?		1	5	1	4	4	4	3	3	3	4	5	5	none	none	5	5			
1-752ITV						2																

					Demand		Environment				Student Facilities				Presentation Facilities							
Room	Capacity			# Dpts	# Classes	Pref (3)	Visibility	Sound	Air	Handicap	Seating	Table	Power	Computer	Board	OH	VCR	Comput	Podium	Slide Proj	Screen	
C) Rooms Reported as Classrooms but Found to be In Use for Non-teaching Purposes at the Time of Evaluation																						
2-639D		~~12~~	Office	~~2~~	~~1+~~	~~1(1)~~	~~1.5(1)~~	~~1(1)~~	~~2(1)~~	~~3(1)~~	~~M2(1)~~	~~T2(1)~~										
2-633D		~~11~~	Office	~~2~~		~~1(1)~~	~~1.5(1)~~	~~1(1)~~	~~2(1)~~	~~3(1)~~	~~M2(1)~~											
4-220DD			closet	1			2.5	2	1	3	M2	3	4	1	3	1	1	1	none			
2-237(D)		0		1	Media prep room																	
2-255(D)		0		1	Media prep room																	
2-265		0		1	Media prep room																	
2) MAYO (#074)				(Nursing, Public Health)																		
A) Rooms Confirmed by Committee Visit																						
*Mayo Audit	[C500]						[C3]	[C3]		[C3]	[F2.5]	[none]	[none]	[none]	[C3]	[none]	[none]	[?]				
*100Cen	90 [C170]			1	1	0	1.15	1	1	1	1.4	0.8	1.6	0.8	1.2	0.8	1	0.8	0.8			
*125Cen	90 [C170]																					
*EusticeD	[C140]						[good]	[fair]		[3]	[F4]	[no]	[no]	[no]	[C3]	[3]	[none]	[?]	[3]	[2]		
*ToddD	[C125]						[good]	[fair]		[3]	[F4]	[no]	[no]	[no]	[C3]	[3]	[none]	[?]	[3]	[2]		
D-325D	[dJ49]	[C20-30]		1+C	9	2	2.5	2[C+]	2	3	M4	T4+TAC	[Cnone]	Hardwired	W+C4	3	[Cnone]	[Hardwir	4	[Cnone]		
D-326D	[dJ49]	[C20-30]		1+C							M4	T4+TAC	[Cnone]	Hardwired	W+C4							
A-367D	35			1	7	2	3.5	2	2	3	M3			Hardwired	W4	OH3			2			
C-381D	30			1	?	3	2.5	2	2	3	M2	T2		none	C2							
*A-268DPH		[24-30]					[4]	[4]	[3]	[3]	[M3]							[yes]				
*A-270D	20			1	9	3	3.5	3	2	3	M4	T4		none	W4	OH3			2			
*A-387D	20			1	8	2	3	3	3	3	M4	T4			W4	OH3			2			
*D-260D	16			1	5	3	4	3	3	3	M4	T4			W4	OH3						
*A-395D	[C8]																					
B) Rooms Not Confirmed as Classroom by Committee Visit																						
D-231CA	reported 133			1	10	2	3	3	1	4	F2	C2	5	none	C3	none	none	none	1			
B-470-1D	30			1																		
HathawayD	used for 20			1	4	1	3	3	2	3	M3	T3	4	none	C3	none	none	none	P2			
D-282DCA	used for 20			1	6	3	3	3	2	3												
A675DCA	used for 20			1	6	3	3	3	2	3												
Station62DP	used for 12			1	6	1	3	3	1	3	M2	T2	2	none	none	none	none	none	none			
C-386D	8			1	?	1	2	2	2	3	M2	T2		none								
A-450?	6			1																		
A3-367-1D	1			1																		
C-338DM	?			1	?	1	4	4	2	3	M3	T3		none	none	none	none	none	none			
D417A	?			1	3	5	5	5	5	5	M5	T5	4	4	M5	5	5	5	5			
C) Rooms Reported as Classrooms but Found to be In Use for Non-teaching Purposes at the Time of Evaluation																						
1-250C/D	50-offices			3	11+	1(2)	1.75(2)	1(2)	1.5(2)	2(2)	M2(2)	T2(2)	1(1)	1.5(2)	C2(2)	OH2(2)	1(1)	1(2)	1(2)			
A-316Doffic	15			2		1(1)	1(1)	1(1)	2(1)	3(1)	M2(1)	T2(1)		none(1)								
D-330-5Doffi	10			2	?	2(1)	3(1)	2(1)	3(1)	3(1)	M3(1)	T3(1)		none(1)								
3) OWRE (#054)				(Dentistry, Public Health, Nursing)																		
A) Rooms Confirmed by Committee Visit																						
*2-230Cen	300			3	7+	1.33	1.9	1.43	1.43	1.66	F1.8	1.65(2)	1.35(2)	0.66?	2.4(2)	1.75(2)	1.5(2)	1.65(2)	1.25(2)			
*2-210Cen	153			3	4+	1	2.18	1.17	1.16	1.6	F1.66	1.45(2)	1.5(2)	0.77?	2.1(2)	1.74(2)	1.55(2)	1.25(2)	1.6(2)			

Room	Capacity			# Dpts	# Classes	Pref (3)	Visibility	Sound	Air	Handicap	Seating	Table	Power	Computer	Board	OH	VCR	Comput	Podium	Projector	Screen
4) WEAVER-DENSFORD (#147)					(Nursing, Pharmacy, Dentistry, Public Health)																
					Demand		Environment				Student Facilities				Presentation Facilities						
A) Rooms Confirmed by Committee Visit																					
4-180DN	60/75[C85-90]			2	9+	3.5	4.56	4.4[C-]	4.1	4.45	M4.4	[TAC]4.15	4.55	3.3I	4.55	4.6	4.4[none	3.65[C?]	4.25	[Cnone]	
7-135DP	[C80]																				
*3-150D [La	65			1																	
4-120DN	40			2	3+	3(1)	5(1)[C-]	5(1)[C-]	3(1)	4(1)	M5(1)	[TAC]5(1)	4(1)	1(1)	4(1)	2(1)[none]	4(1)[non	[none]	3(1)[none]	[Cnone]	
2-110A	eJ50	30		4	24+	2.5	2.77II	2.55	2.92I	3.82	M3	2.4(1)?	3.3(1)	3.5(2)	C3(2)	3.3(1)?	3.3(1)?	3(1)?	3.8(1)?		
2-140A	eJ50	30		3	16+	2.33	3.33	2.83	3.33	4.17	M3	T2.5(2)	4(1)	4(1)?	C3.5(2)	4(1)?	3(1)?	3(1)?	4(1)?		
2-120A	fJ50	30		4	20+	2.49	3	2.77	2.77I	3.75	M2.77	3(1)?	4(1)	3(2)	C3(2)	3(1)?	3(1)?	1(1)?	3(1)?		
2-130A	fJ50	30		4	20+	2.49	3.5	2.77	3	3.75	M3	T2.5(2)	3(1)	4(1)?	C3(2)	3(1)?	3(1)?	3(1)?	3(1)?		
4-155DN	20			1	15	3	3.75	4	2.6	3.5	3.8	3.6	3.3	1.6	3.6	3.7	3.3	2.3	2.7		
4-178DN		10[18]		1	5	2	3.7	3.9	2.6	3.5	3	3.1	4	1.8	3.9	4.2	3	1	2.3		
*5-140DN		[18]									[M4]	[T4]									
4-150DN		14[gJ25]		1	10	2	3.6	4.1	1.6	3	3.4	3.4	3.1	1.5	3	3.5	2.5	2	4		
4-176DN		14[gJ25]		1	10	2	3.45	3.9	1.6	2.8	3.1	3	3	1.8	3	3.1	1.5	2	2.52		
*5-130DPH		[8-14]																			
*7-164DP		[C10-12]																			
2-163A		10		3	13+	1.7	2.17	2.33	2.67	3II	M2	T2(2)?	2(2)	2.5(2)I	C1.5	1(1)?	1(1)?	1(1)?	1(1)?		
2-165A		10		3	13+	1.7	2.17	2.33	2.7	3II	M2	T2(2)?	2(2)	2.5(2)I	C1.5	1(1)?	1(1)?	1(1)?	1(1)?		
4-130DN		hJ4	2[Exam	2	3+	3(1)	4(1)	4(1)	4(1)	1.8(1)	4(1)	1.8(1)	4(1)		3(1)	3(1)	3(1)				
4-131DN		hJ4	2[Exam	2	3+	3(1)															
4-132DN		iJ4	2[Exam	2	3+	3(1)															
4-133DN		jJ4	2[Exam	2	3+	3(1)															
4-134DN		iJ4	2[Exam	2	3+	3(1)															
4-135DN		jJ4	2[Exam	2	3+	3(1)															
4-136DN		kJ4	2[Exam	2	3+	3(1)															
4-137DN		kJ4	2[Exam	1	3	3															
*7-193DP		10[iJ20]																			
*7-195DP		10[iJ20]																			
*4-140		mJ4	2[Exam																		
*4-142		mJ4	2[Exam																		
B) Rooms Not Confirmed as Classroom by Committee Visit																					
6-194							3.5	4	4	4		1	4								
4-151																					
4-153																					
C) Rooms Reported as Classrooms but Found to be in Use for Non-teaching Purposes at the Time of Evaluation																					
9-165work space							3.5	4	1	4	4	1	4		4						
4-138office																					
5) PHILLIPS-WANGENSTEEN (#144)					(Public Health, Pharmacy, Dentistry, Nursing)																
A) Rooms Confirmed by Committee Visit																					
2-470	325			3	2+	2.33	3.66	3.66[C-]	2.33I[C	1.33I	F2I	2I[TAC]	0.66(2)[	1[Cnone]	C3	3.33?[Cor	1?[Cord	2.33[non	0.66	B2II[C2]	
*5-224BMT	35			1	?	1	2	1	3	2	M2			none							
5-254A	14			1	?	1	1.5	2	3	2											
5-258A	14			1	?	1	1.5	2	3	2											
6-224A	[C20-30]			1	1	2	3	3	2	4	3	3	2.5	1	2.5	2.5	1.5	1	1.5	1.5	
B) Rooms Not Confirmed as Classroom by Committee Visit																					
5-211																					
5-268DOph																					
C) Rooms Reported as Classrooms but Found to be in Use for Non-teaching Purposes at the Time of Evaluation																					
5-206office	30			1	?	1	2	2	2	2											
5-264office																					
5-266office																					
6-210patient																					
4) DIEHL HALL (#111)					(Dentistry, Public Health, Surgery)																
K-110Cen	5			1																	

ST. PAUL CAMPUS BUILDINGS																					
	Capacity				Demand		Environment				Student Facilities				Presentation Facilities						
Room	Lec	Sem	Other	# Dpts	# Classes	Pref (3)	Visibility	Sound	Air	Handicap	Seating	Table	Power	Computer	Board	OH	VCR	Comput	Podium	Slide Proj	Screen
1) ANIMAL SCIENCE/VETERINARY MEDICINE BUILDING																					
135 Cen	120			5	6-10/qtr	2	4	3	1	3	F2	T4	no	no	W4	OH3	3	no	2	(n=2)2	(n=1)5
125 Cen	90		Coop le	5	6-10/qtr	3	4	2	2	5	M5	T5	yes	1 port/seat	W5	OH+Visua	5	5	4	(n=2) 4	(n=2)5
385(J/K0D	40			3	2-3/qtr	2	2	4	3	3	M 2	T4	no	no	C2	OH2	no	no	1	1	1
295D		20		3	0-1/qtr	2	4	3	3	2	M2	T3	no	no	W2	OH2	no	no	no	no	1
385(H)D		8		2	1-2/qtr	1.5	3	3	3	1	M2	T	no	no	C2	OH2	no	no	no	no	no
2) VETERINARY SCIENCE BUILDING																					
145 Cen	90			4	4-6/qtr	1	2	0.5	0.5	2	M2	T4	no	no	W3	OH2	no	no	1	(n=2)3	(n=1)3
325D			100Lab	1	1-3/qtr	1	1	0.5	0.5	0.5	M1	Lab Benc	yes	no	C1	no	no	no	no	no	1
225/227/229 D			76Lab	2	1-2/qtr	2	2	2	2	3	M1	Lab Benc	yes	no	C1	no	no	no	no	no	no
215D		25		2	2-3/qtr	3	4	4	2	3	M2	T4	no	no	W2	OH2	no	no	1	(n=1)3	3
3) VETERINARY TEACHING HOSPITAL																					
C308D		20		2	3-4/qtr	2	4	4	4	3	M3	T4	no	no	W4	OH3	no	no	1	(n=1)3	1
225(K)D		20		3	2-4/qtr	2.5	4	4	4	3	M3	T4	no	no	W4	OH3	no	port	1	(n=1)4	3
458D		20		5	0-1/qtr	3	5	4	4	3	M3	T4	no	no	W4	OH3	no	no	1	no	no
442D		15		4	2-5/qtr	2	3	3	3	2	M2	T3	no	no	W4	OH3	no	no	no	no	1
382D		12		1	5-6/qtr	3	4	4	3	3	M3	T4	no	no	W4	?	no	no	?	?	?
350D		12		1	5-6/qtr	3	4	4	3	3	M3	T4	no	no	W4	?	no	no	?	?	?
330D		12		1	5-6/qtr	3	4	4	3	3	M3	T4	no	no	W4	?	no	no	?	?	?
374D		12		1	5-6/qtr	3	4	4	3	3	M3	T4	no	no	W4	?	no	no	?	?	?
A310D		12		1	5-6/qtr	3	4	4	3	3	M3	T4	no	no	W4	?	no	no	?	?	?
LA Sx Conf		12		1	5-6/qtr	3	4	4	3	3	M3	T4	no	no	W4	?	no	no	?	?	?
LAMed Conf		12		1	5-6/qtr	3	4	4	3	3	M3	T4	no	no	W4	?	no	no	?	?	?
4) Veterinary Diagnostic Lab																					
280D	40	30		4	5-6/qtr	3	2	4	4	3	M4	T4	yes	no	W4	OH3	4	?	3	(n=1)3	4
250D		12		4	0-2/qtr	3	3	3	3	2	M4	T4	no	no	W3	no	no	no	no	no	no
KEY																					
Scheduling: #Cen=Central;D=Departmental(+Dpt initial if given);A=AHC;O=Other																					
Seating Capacity: From largest to smallest to not given																					
#Classes: Total given; + indicates not given in one or more departments																					
Faculty Preference: Average out of 3 for best																					
Visibility: Average of line of sight & lighting																					
Seating: Letter indicates type																					
Table: Letter indicates type																					
Comp: Computer ports for students; Computer connections for presentation																					
General symbols:																					
?= Information not given or conflicting information given																					
I= Wide or (II) very wide range between ratings																					
[ ] or [C] indicates input from direct evaluation of the subcommittee																					
[-] indicates that the subcommittee assessed the item at a lower quality than did the surveys																					

APPENDIX 2

DISTRIBUTION OF CLASSROOMS BY CAPACITY

The distribution of rooms provided below is based on confirmation by committee observation of use as a classroom ("Confirmed"), restricted use due to poor quality or departmental limitation of classroom use ("Restricted"), and rooms which were reported on survey to be in use as classrooms but which could not be confirmed to be in such use ("Unconfirmed"). Rooms which can be combined by removal of a temporary dividing wall are listed by their individual student seating capacity as well as by their combined capacity (indicated as "J" or joined).

EAST BANK CLASSROOMS

Capacity	Confirmed	Restricted	Unconfirmed
Very Large(≥200)	**5**	**2**	**0**
≥ 250	1 Moos	1 Mayo	
	1 PWB	1 Owre	
200-249	3 Moos		
Large (100-199)	**0**	**6**	**2**
150-199		2 Mayo	1 Moos
		1 Owre	
100-149		1 Moos	1 Mayo
		2 Mayo	
Medium (50-99)	**7**	**3**	**7**
75-99	2 Moos	1 Moos	
	2 WD		
50-74	1 Moos (1J)	1 Moos	7 Moos
	2 WD (2J)	1 WD	
Small-Medium (20-49)	**19**	**6**	**20**
40-49	1 Moos	1 Moos	
	1 WD		
	1 Mayo (1J)		
30-39	3 Moos	1 PWB	6 Moos
	2 Mayo		1 Mayo
	4 WD		
20-29	2 Moos (2J)	1 WD	5 Moos
	1 PWB (1J)	3 Mayo	5 Moos
	2 WD (1J)		3 Mayo
	2 Mayo		

Small (<20)	**28**	**10**	**15**
10-19	7 Moos	2 WD	6 Moos
	2 PWB	1 Mayo	2 Mayo
	8 WD		
<10	8 WD	6 Moos	6 Moos
	2 Mayo	1 Mayo	1 Diehl
	1 Diehl		
Unidentified (?)			**14**
			7 Moos
			2 Mayo
			3 WD
			2 PWB
Totals	**59(8J)***	**27**	**58**

*Because combinable rooms are counted in the columns for capacity in both single and combined forms, the total confirmed number of uncombined rooms would be 57.

ST. PAUL CLASSROOMS

Capacity	Confirmed	Restricted	Unconfirmed
Very Large(≥200)	**0**	**0**	**0**
Large (100-199)	**1**	**0**	**0**
150-199	0	0	0
100-149	1	0	0
Medium (50-99)	**5**	**2**	**0**
75-99	5 (4 labs/1J)	2	0
50-74			
Small-Medium (20-49)	**2**	**4**	**0**
40-49	2(1J)	0	0
30-39	0	2	0
20-29	0	2	0
Small (<20)	**9**	**4**	**0**
10-19	4	3	0
<10	5	1	0
Totals	**17 (2J)****	**10**	**0**

**Because combinable rooms are counted in the columns for capacity in both single and combined forms, the total confirmed number of uncombined classrooms would be 15.

4/28/97
11:45 am

UNIVERSITY OF MINNESOTA

Office of the Vice President for Research and Dean of the Graduate School

420 Johnston Hall
101 Pleasant Street S.E.
Minneapolis, MN 55455-0421
612-625-3394
Fax: 612-626-7431

March 27, 1997

Provost Frank Cerra
Academic Health Center
Box 501 Mayo

Dear Frank:

This is to follow up on what we have been discussing for over a year regarding the necessity to restructure the Conflict Review Committee for the Academic Health Center. As I have stated, the present committee is not operating in a manner consistent with the Regents' Policy on Conflict of Interest. I have the following specific concerns: The Committee seems to have taken the stance that proposals in which the investigators may have the potential for conflict of interest must be redone to eliminate all potential for conflict of interest. This is not what the policy says. It states that in fact we may proceed with activities where there is a potential for conflict of interest as long as there is a defined means to manage the potential for conflict of interest.

Secondly, the Committee appears to continue to look only at those activities that relate to industrial sponsors and not federal agency sponsored research. Our policy, in conformance with the NIH and NSF requirements, explicitly states that we must assure that all research sponsored by those agencies has been considered for potential conflicts of interest and, when identified, assure that appropriate means to manage those potential conflicts of interest are in place.

Further, our policy states that when NIH funding is involved and a potential conflict of interest has been identified and a means of managing a potential conflict has been put in place, we are to notify NIH that we have taken appropriate action. Since my office is charged with that notification, I should have documentation of such activities. I am quite surprised that, since the policy was approved on April 8, 1994, I have yet to receive a single such request to notify NIH. An additional concern is that the committee appears to be reviewing far more than what has been described as their responsibility in the Conflict of Interest Policy. Finally, the Committee is supposed to have representation from outside the affected units as well as representation from ORTTA. I do not believe this has been effectively implemented.

I fully appreciate that the hospital merger with Fairview consumed much of your time this past year. Now that that is behind us, it is essential that we move to address these concerns regarding the management of potential conflicts of interest.

Sincerely yours,

Mark L. Brenner
Vice President and Dean

cc: Marvin Marshak
Leo Furcht

A) **SCOPE**

1) **REGENTAL POLICIES**
- **CONFLICT OF INTEREST**
- **CONSULTING**
- **PRIVATE PRACTICE**
- **GIFT POLICY**

2) **OVPR COMMUNICATION 3/27/97**

(ATTACHMENT)

B) THE PROBLEM

1) CURRENT REGENTAL POLICY ON CONFLICT OF INTEREST IS ONLY PARTIALLY IMPLEMENTED, E.G. IN MEDICAL SCHOOL, FOR INDUSTRY-SPONSORED RESEARCH.

2) OVERSIGHT ON MANAGEMENT FOR IDENTIFIED CONFLICTS OF INTEREST IS ONLY PARTIALLY IMPLEMENTED.

3) INFORMATION CROSS-LINKING ON THE THREE REGENTAL POLICIES NEEDS TO BE IMPLEMENTED.

4) FAIRVIEW AGREEMENTS REQUIRE A FUNCTIONING CONFLICT OF REVIEW AND MANAGEMENT PROCESS VIA AHC.

C) **PROPOSED SOLUTION**

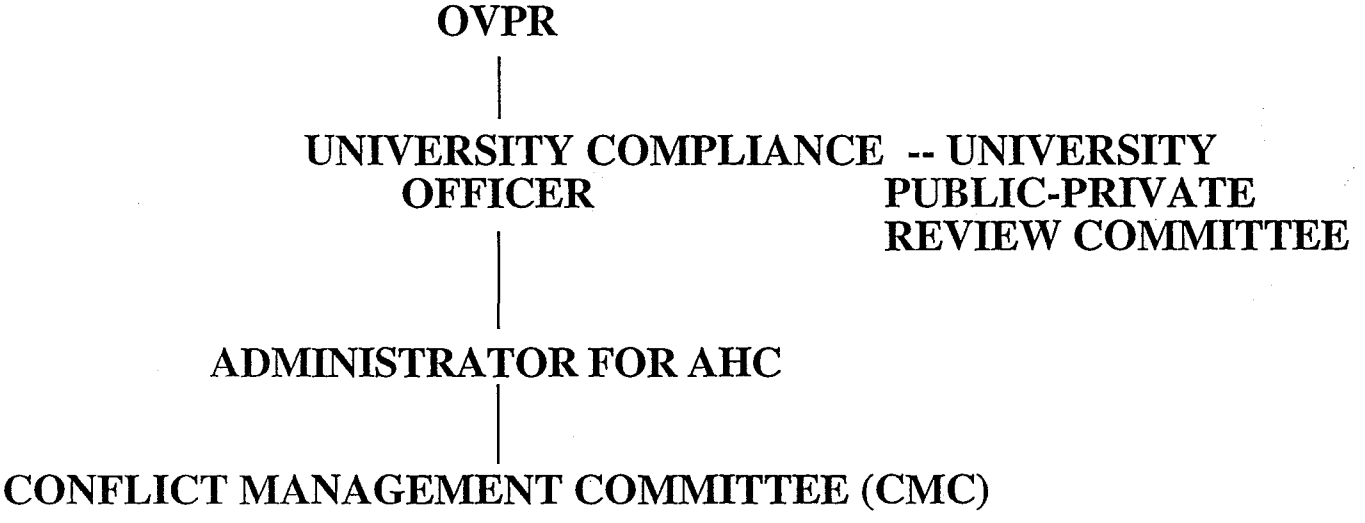
1) **MOVE WHAT IS CURRENTLY A MEDICAL SCHOOL OPERATION TO AHC LEVEL**

2) **BROADEN SCOPE TO ALL SPONSORED RESEARCH**

3) **PROVIDE INFORMATION INTERFACE FOR THE THREE REGENTAL POLICIES**

4) **PROVIDE MORE EFFICIENT ADMINISTRATIVE PROCESSING**

C) **PROPOSED SOLUTION**



C) PROPOSED SOLUTION

1) ADMINISTRATOR FOR AHC

A) FACULTY, 0.25 TO 0.50 FTE
B) DUTIES -

1) KEEP LOG OF EXTERNAL RELATIONSHIPS.

2) ESTABLISH AND OPERATE AHC-WIDE CONFLICT REVIEW MANAGEMENT COMMITTEE.

3) MAINTAIN CONFLICT MANAGEMENT LOG AND PROVIDE OVERSIGHT FOR SAME.

4) PREPARE REPORTS TO OVRP, UNIVERSITY COMPLIANCE OFFICER, AND OTHER PARTIES.

5) MAINTAIN CONFLICT MANAGEMENT, OVERSIGHT, ESTABLISH NECESSARY INTERNAL CONTROLS, AND PERFORM NECESSARY REPORTING FUNCTIONS.

6) MAINTAIN DATA INTERFACE BETWEEN POLICIES AND LOGS, E.G. LINK EXTERNAL RELATIONSHIPS REPORTING WITH CRMC AND WITH PRIVATE PRACTICE DUTIES.

7) COORDINATE EDUCATION AND TRAINING IN PROPER CONDUCT OF RESEARCH, CONFLICT OF INTEREST, COMPLIANCE, AND OTHER AREAS AS ARE DEFINED

C) **PROPOSED SOLUTION**

2) **CONFLICT REVIEW AND MANAGEMENT COMMITTEE**

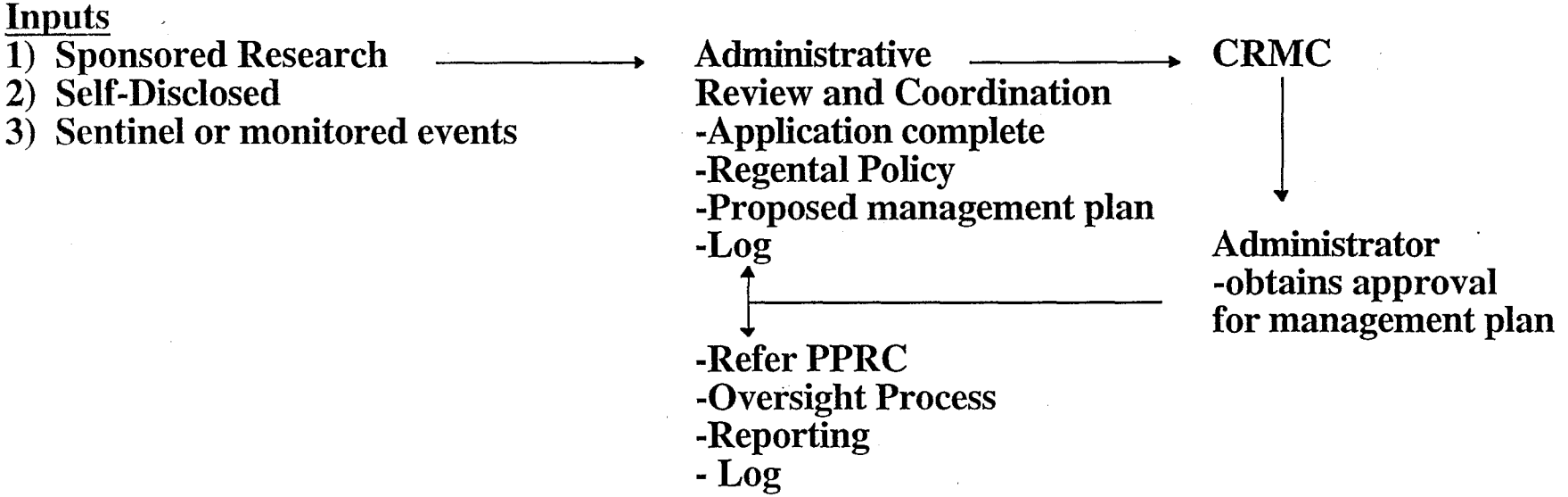
A) **PEER REVIEW, OUTSIDE MEMBERS, ORTTA MEMBERS**

B) **PROPOSES/RECOMMENDS MANAGEMENT PLAN, WHEN APPROPRIATE**

C) **PROVIDES OVERSIGHT ON PRIOR MANAGEMENT PLAN APPROVALS AND RECOMMENDS FURTHER ACTIONS AS REQUIRED**

C) PROPOSED SOLUTION

3) Process Flow



UNIVERSITY OF MINNESOTA

Twin Cities Campus

Office of Communications
Academic Health Center

Box 735
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Minneapolis, MN 55455

Office:
A395 Mayo Memorial Building

612-624-5100
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September 29, 1997

TO: Friends and Colleagues

FROM: Chris Roberts, Director
AHC Office of Communications

RE: Draft Communications Plan

Attached is the product of your hard work, an action plan for Academic Health Center communications. It is impossible for me to thank you enough for your advice, counsel, time, patience, and creative thinking. I am proud of this effort and equally proud of the spirit in which the plan was prepared.

I invite your reactions and suggestions. You may call me (626-2767) or e-mail me (croberts@mailbox.mail.umn.edu). My hope is to finalize the plan by Friday, October 17, 1997.

Now the work (and fun) really begins!!

Encl.

c: Senior Vice President Frank Cerra

University of Minnesota Academic Health Center Strategic Communications Plan: A Blueprint for Action

The mission of the Academic Health Center is to be a leader in the ethical, innovative and efficient discovery and dissemination of knowledge to enhance the health and well being of Minnesota, the nation, and the world.

DRAFT
September 1997

AcademicHealthCenter

UNIVERSITY OF MINNESOTA

CONTENTS

Preface 3

About the University of Minnesota Academic Health Center 4

Situation Analysis 5

AHC Communications Strategy Statement 6

AHC Audiences 7

AHC Positioning Statement 8

AHC Communications Goals and Objectives 9

Attachments

- Guiding Principles
- Components of an Effective Communications Program
- What is Communications?
- Planning Process Design
- Participants
- Work Group Reports
- Meeting Summaries

Preface

Dear Friends,

The plan you are about to read is the work of 208 individuals who have given precious time over the past several weeks to create a new blueprint for University of Minnesota Academic Health Center communications.

Especially important to the success of this process are the attached recommendations of five work groups, which were organized to give more specific consideration of issues related to internal communications (Dr. Judy Garrard and Ms. Jeanette Louden, co-chairs), communication technology (Dr. Larry Kushi and Dr. Stuart Speedie, co-chairs), strategic partnerships (Dr. William Jacott, chair), legislative advocacy (Dean Michael Till and Mr. Vic Vikmanis, co-chairs), and media relations (Dr. Jeffrey Kahn, chair).

Although the plan covers two years, the goals clearly are longer term and key to our overall success. The plan advances the vision described in "Academic Health Center Strategic Issues," published in February 1997. It also strives to support the objectives of AHC colleges, schools, institutes, centers, and programs.

We have articulated four goals, which are listed in no particular order. Each builds on the others, and none is complete without the other three. The goals are

- to build broader appreciation of and active support for the University of Minnesota through its Academic Health Center;
- to strengthen the sense of community within the AHC, and to enhance the teaching, learning, and working environment;
- to advance the AHC research and education mission by supporting initiatives to create additional sources of financial support; and
- to improve the AHC's internal capacity to identify and seize upon communications and marketing opportunities.

Writing this plan is just the beginning. To achieve the goals, we will need to work smart, work fast, and work together. This is a wonderful opportunity to strengthen the internal and external image of the University of Minnesota Academic Health Center. It also will bring needed and deserved public attention to outstanding programs and people.

For those of you who have contributed so generously to this effort, thank you a thousandfold. Together, I believe we have created a plan of which we may all be proud.

As always, I encourage your ideas, suggestions, insights, and advice.

Warmest regards,

Christine Roberts, Director
AHC Office of Communications

About
the University of Minnesota
Academic Health Center

In 1851, the seeds of the Academic Health Center were planted with territorial legislation that created the University of Minnesota and named medicine and science among five original academic disciplines. Over the past century and a half it has taken root, grown, and flourished to become one of the most prominent health centers in the nation.

The University of Minnesota Academic Health Center now serves over 5,000 students in its School of Dentistry, the Medical School-Twin Cities, the School of Medicine-Duluth, the School of Nursing, the College of Pharmacy, the School of Public Health, and the College of Veterinary Medicine.

Students are enrolled in professional and graduate programs that will prepare them for careers as biomedical engineers, scientists, dental hygienists, dentists, health care administrators, medical technologists, morticians, nurses, occupational therapists, pharmacists, physical therapists, physicians, public health practitioners and veterinarians. The Academic Health Center prepares approximately 80 percent of Minnesota's health care professionals.

All seven of the AHC schools rank in the nation's top 20. AHC faculty bring in over $175 million a year in federal research funds, more than all but eight of American research universities.

This is a challenging era for academic health care, but also one of great opportunity. In January of 1997, the University of Minnesota and Fairview Health System became partners. The University Hospital, sold to Fairview, is now Fairview-University Medical Center. Turning over management of patient care to the Fairview Health System enables us to focus on our strengths--education and research. As we move into the next century, developing partnerships will be key to our success. We welcome opportunities to work with health care organizations, community groups, and industry to strengthen our education, research, and outreach programs.

Situation Analysis

The University of Minnesota Academic Health Center comprises a respected, productive faculty teaching more than 5,000 students and conducting research in seven schools, colleges, and interdisciplinary institutes, centers, and programs. Dedicated staff members serve students, support education and research, direct programs, and manage the AHC's human, financial, and physical resources.

- is internationally known for education programs and scientific discoveries.
- is one of the building blocks of the Minnesota economy.
- is distinguished by the successes of the alumni of its schools and colleges.
- educates upwards of 80 percent of Minnesota's health professionals.
- benefits from the leadership of new University President Mark G. Yudof; Senior Vice President for Health Sciences Frank B. Cerra; the deans of the AHC schools and colleges; and from contributions of faculty, staff, and students.
- is implementing a strategic plan that emphasizes interdisciplinary programs, education and research excellence, effective community outreach and clinical service, and responsive internal operations and services.
- is still defining its new relationship with Fairview Health System.
- struggles with issues related to managed health care and changes in health policy that affect the University and its Academic Health Center.
- is rebuilding internal morale and its public image in the wake of several serious problems, both in the AHC and in the University as a whole, that received widespread media attention.
- desires to become more user-friendly for students, more supportive of faculty and staff, more attractive to prospective employees, and more accessible to visitors and friends.
- has tremendous potential to build a new identity based on the achievements and accomplishments of its faculty, staff and students.
- receives significant financial support from the Minnesota Legislature and the federal government, but relies on significant additional funding to support its mission--income received from gifts, public and private grants, contracts, and clinical services.
- is making internal changes to improve financial and administrative systems.

AHC Communications Strategy Statement

The University of Minnesota Academic Health Center is one of the nation's finest and most distinguished health centers. A collection of seven distinctive schools and colleges and a wide range of outstanding programs, the AHC is world-renown for research, and valued by Minnesotans for its contributions to the state's economic health, preparation of the majority of the state's health care professionals. That reputation has been earned by the faculty, staff and students who research, teach and learn here.

The Academic Health Center strategic communications plan will strengthen this national reputation for excellence by focusing on the AHC's achievements, reinforcing the value of the AHC and its benefits to our citizens, and creating a highly visible identity for the AHC, its schools, colleges, institutes, centers, and programs. This will be accomplished through a variety of carefully targeted initiatives to position and promote the University of Minnesota through its Academic Health Center.

While information about the AHC will be seen, heard, and read by hundreds of thousands of people, the plan focuses primarily on reaching opinion leaders, those individuals whose decisions and influence have an impact--positive or negative--on the University. Opinion leaders include state and national leaders in government, business and industry, philanthropy, K-12 and higher education, health care, bio-medical engineering, science, media, communities of color, and non-profit organizations. In special circumstances, campaigns may be directed at highly specific audiences for a single purpose (e.g.--recruiting students of color to the Medical School; increasing the numbers of clients for the Dental Clinics).

It is equally as important to strengthen the sense of community within the Academic Health Center and to enhance the environment for students, faculty, staff, and administrators. We understand that this goal cannot be accomplished solely through effective communications. Even so, effective communications is a significant component of a healthy community. We will begin with new internal communications initiatives to improve information flow and to emphasize the accomplishments and contributions of AHC students, faculty, staff, and administrators. A longer-term priority will be to make the AHC a welcoming, unifying, and user friendly place. Every effort will be made to support the collaborative governance focus of the senior vice president for health sciences.

Planning and implementation of AHC-wide projects will be highly participatory and inclusive. Leadership and support will come from the senior vice president for health sciences, the AHC Office of Communications, the deans of AHC schools and colleges, faculty, staff and students. The AHC Office of Communications will work closely with the deans, department heads, directors and communicators to assure that school, college, and program objectives as well as AHC-wide goals are met. AHC projects will also be closely coordinated with central administration, the University of Minnesota Foundation, Minnesota Medical Foundation, University of Minnesota Alumni Association, University of Minnesota Physicians, and Fairview Health System.

The communications plan is a blueprint for action beginning September 1, 1997 and ending June 30, 1999. We envision that each school and college will develop a communications plan to achieve its own goals and to complement the AHC plan.

Audiences

Internal Audiences:

President Mark G. Yudof and staff
Board of Regents and staff
Vice presidents and key administrators
Institutional Relations vice president and directors
- --Office of University Relations
- --Office of State Relations
- --Office of Federal Relations

University of Minnesota Foundation director, staff, and board
University of Minnesota Alumni Association director, staff, and board
Minnesota Medical Foundation director, staff, and board
Academic Health Center students, faculty, staff, and administrators
University of Minnesota-Duluth chancellor and vice chancellor for university relations

External Audiences:

Biotechnology and health care business and industry
- --executive leadership
- --research and development vice president and staff
- --government relations vice presidents
- --corporate communications vice presidents
- --foundation directors

Biotechnology, health care and professional associations: director, staff and board
Fairview president, board(s) and executive leadership
Other key state and national business and professional associations: director, staff and board
Government leaders
- --congressmen and staff
- --Federal and quasi-governmental agencies (e.g.--NIH, NSF)
- --Governor and staff
- --Commissioner of the Department of Health and staff
- --Commissioners of Departments of Finance, Employee Relations, Planning, and Children, Families and Learning
- --Legislators and staff
- --Other appointed officials
- --MERC
- --Hennepin and Ramsey County commissioners
- --Minneapolis and St. Paul mayors and city councils
- --Other commissions or offices

Print and electronic media: reporters, editors, producers, and publishers
College and university presidents, governing boards
Higher Education Services Office
Midwest Higher Education Commission
Labor leaders
Communities of color
Philanthropy
AHC schools and colleges: major donors, significant alumni, project partners, others
Selected community leaders
Selected customers and prospective customers of AHC programs and services

Academic Health Center Positioning Statement

The University of Minnesota Academic Health Center is world-renowned for scientific discovery, innovation, and health-related education, research and service.

The nation and world benefit.....from the knowledge created here.

Minnesota benefits.....from the health professionals educated here.

The economy benefits.....from the technologies created here.

.....from increased numbers of jobs.

The people benefit.....from access to quality education delivered by a highly respected and innovative faculty.

...from new therapies and treatments developed here.

.....from care delivered by University of Minnesota health professionals.

Academic Health Center
Communications Goals and Objectives

GOAL 1: To build broader appreciation of and active support for the University of Minnesota through its Academic Health Center.

Objective 1A. To review existing public opinion surveys and studies related to levels of appreciation of and support for the Academic Health Center, its schools and colleges, and its programs and its people; to establish baselines for evaluative purposes; and to conduct an additional survey only if needed.

Objective 1B. To increase public awareness by expanding Minnesota media coverage by 50 percent by July 1, 1999.

To achieve this objective, we will

1. identify, prioritize, and seize upon story opportunities to promote AHC people and programs; publicize faculty, staff and student accomplishments; advise and/or support faculty, staff and students who seek media assistance.

2. build new relationships with reporters, editors, and producers--including those in Greater Minnesota--while continuing to strengthen current relationships.

3. prepare faculty, staff, and students to work successfully with media; identify models of positive relationships; minimize time commitments for AHC personnel to a minimum.

4. build an AHC culture where media relations is valued, appreciated, and recognized.

5. develop and post an AHC media guide on the web.

6. begin a postcard campaign alerting reporters to story ideas.

7. systematize story collection from AHC sources.

8. write and place more guest editorials; secure more positive editorials; write and place more letters to the editor; meet with editorial boards.

9. explore the possibility of a weekly newspaper column on health issues to be published in greater Minnesota newspapers.

10. expand coverage in publications and newsletters produced by Minnesota professional associations and organizations, such as the Minnesota Medical Association.

11. continue the highly responsive and professional program now in place.

12. establish a system to track and evaluate media coverage.

We will know we will have succeeded when

1. all major Minnesota media regularly report our stories, publish our editorials, recognize our faculty as experts, and use us as resources;

2. Vice President for Health Sciences Frank B. Cerra, the deans and faculty are primary spokespeople on issues related to health policy;

3. we have solid, productive relationships with publishers, editors, reporters, producers, and others in print and electronic media; and

4. we are able to serve reporters and respond to them in a timely and and professional manner.

Objective 1C. To build a national presence by increasing national media exposure by 100 percent by July 1, 1999.

To achieve this objective, we will

1. explore options for staffing a program or retaining an outside agency to increase national media exposure.

2. identify AHC story opportunities with national interest.

3. build new and strengthen existing relationships with reporters, editors and producers.

4. identify and focus on the relationships that have the greatest potential.

We will know we have succeeded when

1. reporters and producers for national media seek our story ideas or use us as a source particularly in those areas identified as nationally prominent; and

2. stories about the AHC's programs and people appear regularly on network television and in major national newspapers.

Objective 1D. To increase the visibility of the AHC by 25 percent in all University of Minnesota publications, periodicals, and projects, including those of the University of Minnesota Foundation, the University of Minnesota Alumni Association, and the Minnesota Medical Foundation.

To achieve this objective, we will

1. build relationships with the editors of University publications and periodicals.

2. suggest stories on a regular basis.

3. support writing and photography for feature stories.

We will know we have succeeded when

1. University of Minnesota publications and periodicals regularly contain stories about the Academic Health Center; and

2. we have a collegial and mutually supportive relationship with editors of University publications.

Objective 1E. To strengthen the appreciation of the AHC among Minnesota and national opinion leaders by showcasing AHC achievements and communicating the benefits of the AHC.

To achieve this objective, we will

1. build a mailing data base of opinion leaders.

2. conceptualize, publish, and distribute a new quarterly periodical to showcase achievements of people in the University's Academic Health Center. The summer issue each year will serve as the AHC annual report.

3. conceptualize, publish, and distribute a quarterly AHC research publication targeted at business, industry, policy makers and health care leaders.

4. write personalized letters to opinion leaders from the senior vice president focusing on an important issues.

5. produce a video that can be used for speech support and special programs.

6. conduct an AHC "roadshow" in communities around Minnesota and in the Twin Cities.

7. identify opportunities for partnerships, relationships, and projects with key organizations and businesses.

8. exhibit at the Minnesota State Fair.

9. host meetings at the University; conduct tours.

10. evaluate "Health Talk and You"; complete three-year plan for its growth.

11. organize a full day of promotional and community-building activities during President Yudof's inaugural week.

We will know we have succeeded when

1. opinion leaders appreciate the AHC and act on its behalf; and

2. that support can be measured.

Objective 1F. To meet priority community needs by creating an AHC community relations program, and to develop up to six strategic partnerships by July 1, 1999.

To achieve this objective, we will

1. define a strategic partnership as a mutually beneficial relationship based on two-way communication, respect, involvement, and sharing of resources that are vital to the missions of the AHC and its strategic partners.

2. identify and make connections with strategic community partners; survey their perceptions of the AHC; determine their expectations.

3. support existing AHC programs with strong community connections; encourage more interdisciplinary interaction.

4. identify opportunities to promote and strengthen the AHC through community relationships; form a community advisory group.

5. recognize community partners and successful models where health is a goal.

6. identify additional partnerships with business and industry, professional associations, and advocacy groups.

We will know that we have succeeded when

1. partnerships are in place; and

2. those partnerships are meeting community and University needs and goals.

Objective 1G. To support policy development and increase the likelihood of increased public investment by strengthening and expanding relationships with state legislators, members of the U.S. Congress and Senate, other elected and appointed public officials, and their staff members.

To achieve this objective, we will

1. build a comprehensive, year-round communications and advocacy program under the leadership of Tom Etten, Donna Peterson, and Vic Vikmanis.

2. organize a grassroots lobbying effort that can be activated on behalf of University and AHC initiatives; recruit and train volunteers.

3. strengthen relationships with legislators and public officials who are supporters of the Academic Health Center; find ways to help them to do their jobs better, especially constituent services.

4. host legislators at the AHC as appropriate; hold orientation sessions for new legislators.

5. build community and business coalitions to support AHC initiatives.

6. produce legislative support materials.

7. anticipate and help shape issues.

8. articulate consistent, simple, positive messages about the University, the AHC and its schools, colleges, institutes, centers, and programs.

9. explore the possibility of an internship program to place AHC students in congressional offices.

10. nominate mid-career faculty for Robert Wood Johnson Health Policy Fellowships.

We will know we have succeeded when

1. public officials and legislators understand the importance of the AHC and are willing to serve as our advocates;

2. public policy is consistent with the values and goals of the University and the AHC; and

3. there is regular, ongoing communications--both formal and informal--between the AHC and public officials.

Objective 1H. To build awareness of the AHC as part of the University of Minnesota by creating an AHC logo by August 1997, producing an AHC family of publications and collateral materials by January 1, 1998, and developing other collateral materials for targeted audiences.

To achieve this objective, we will

1. retain a designer and select a new mark consistent with the University's guidelines.

2. produce banners, podium signs, folders, presentation covers and other items using the new logo.

3. use new logo on all AHC (not school and college) publications and periodicals; make it available to the schools, colleges, institutes, centers, and programs.

4. create and distribute a new family of AHC brochures, one for the Academic Health Center as a whole and individual companion pieces for each school and college.

5. work with Tom deRanitz, Associate University Relations Director for Marketing, to determine other appropriate uses.

We will know we have succeeded when

1. the AHC has a distinct identity within the University of Minnesota that supports the University's goals;

2. we have published and used an array of brochures to provide information on the AHC and its schools and colleges; and

3. we have coordinated all identity initiatives with University Relations.

Objective 1I. To support AHC school/college communications initiatives.

To achieve this objective, we will

1. continue to publish alumni newsletters for the College of Pharmacy, School of Nursing, School of Public Health, and College of Veterinary Medicine.

2. determine long-term alumni communications needs for the schools/colleges.

3. be available to deans, department chairs, communicators, and others for communications advice and counsel.

4. provide support (to be determined) for major college and school events.

5. establish a creative services function in the AHC Office of Communications to connect schools and colleges with designers, writers, photographers, and communications and marketing consultants available under contract.

6. define the relationship between the AHC Office of Communications and the schools, colleges, institutes, centers and programs.

We will know we have succeeded when

1. we have determined the long-term needs of the schools and colleges;

2. a creative services function is fully operational in the Office of Communications; and

3. we provide the appropriate level of support for schools and colleges.

GOAL 2: To strengthen the sense of community within the AHC, and to enhance the teaching, learning, and working environment.

Objective 2A. To significantly increase communications between the senior vice president and the AHC community, and to encourage

regular personal interaction between the senior vice president and faculty, students, and staff.

To achieve this objective, we will

1. create regular opportunities for the AHC community and the senior vice president to discuss issues and to learn more about each other.

2. publish and distribute a monthly newsletter from the senior vice president to the AHC community; post on the web.

3. support the senior vice president's initiatives to enhance communication and collaborative governance and decisionmaking.

We will know we have succeeded when

1. the senior vice president meets regularly and often with groups of students, faculty, staff, and administrators.

2. the newsletter is well-read.

Objective 2B. To improve understanding between and among students, faculty, staff, and administrators from AHC schools, colleges, programs, centers, and institutes.

To achieve this objective, we will

1. suspend publication of "this thursday" and replace it with a monthly AHC community newsletter and a bi-weekly version of "Brief"; post new periodicals on the web.

2. create an editorial board to develop content policy for internal publications.

3. explore ways to improve the involvement of the School of Medicine-Duluth.

We will know we have succeeded when

1. employees are receiving the information they need;

2. when information is trusted; and

3. the School of Medicine-Duluth is more involved.

Objective 2C. To make the University of Minnesota AHC more welcoming and user-friendly though improved signage. This will begin in fall, 1997, with a banner campaign and monthly postings of "AHC Points of Pride"--faculty, staff, and student achievements--displayed in prominent sites throughout the AHC. New building signage is also planned.

To achieve this objective, we will

1. complete a plan to improve AHC signage in cooperation with Loree Wederstrom from AHC Facilities Management, Sam Talbert from U Facilities Management, and Tom deRanitz from University Relations.

2. construct boulevard banners for the seven AHC schools and colleges on the Delaware entrance to the Mayo Circle.

3. replace signage on the second floor of PWB in cooperation with the Minnesota Medical Foundation.

4. work with Fairview and UMP on new hospital/clinic signage.

5. begin a monthly poster campaign to recognize the accomplishments of AHC faculty, staff, and students.

6. post temporary internal and external signs welcoming students back to school and welcoming visitors to the AHC.

7. propose a plan to place names of AHC colleges and schools on the outside of buildings.

We will know we have succeeded when

1. banners proclaim and define the seven schools and colleges;

2. students feel welcome;

3. employees, students, and visitors can find their way around the AHC more easily; and

4. posters are produced and displayed monthly.

Objective 2D. To provide students with better and more relevant information.

To achieve this objective, we will

1. survey students to learn their attitudes and needs.

2. use the results of the survey to define a student communication plan.

3. work closely with the Student Consultative Committee to continually improve information flow.

We will know we have succeeded when students receive the information they need and want.

Objective 2E. To support faculty, staff, and student recruitment.

To achieve this objective, we will

1. offer assistance and counsel as appropriate.

2. create information packets on the AHC that can be given to candidates for positions.

We will know we have succeeded when we

1. are called upon for assistance on a regular basis; and

2. have a packet available for multiple uses.

GOAL 3: To advance the AHC research and education mission by supporting initiatives to create additional sources of financial support.

Objective 3A. To support growth of clinical volume for University of Minnesota Physicians (UMP) by assertively publicizing member achievements and services, and by supporting the UMP communications and marketing program as requested.

To achieve this objective, we will

1. meet regularly with UMP leadership to define needs.

2. respond to those needs as in-house communication consultants.

3. create a coordinated public relations team using expertise of the AHC Office of Communications, Fairview Public Relations and Marketing, and University of Minnesota Physicians.

4. include UMP in all major AHC special projects and promotions.

We know we will have succeeded when

1. stories about University of Minnesota Physicians appear regularly in the media and in professional publications; and

2. a seamless and successful promotional team is created from the three different organizations.

Objective 3B. To increase government and corporate grants by supporting faculty and the Research Services Office as appropriate.

To achieve this objective, we will identify opportunities to support research.

We will know when we have succeeded when we have taken advantage of those opportunities.

Objective 3C. To increase gifts to the University of Minnesota Foundation and the Minnesota Medical Foundation by supporting the communications objectives of the two organizations as appropriate.

To achieve this objective, we will identify opportunities to support private fund raising.

We will know we have succeeded when we have taken advantage of those opportunities.

Objective 3D. To increase revenues for AHC programs dependent on customers, such as the Dental Clinics and the Veterinary Hospital, by supporting their communications and marketing objectives.

To achieve this objective, we will identify opportunities to support these programs.

We will know we have succeeded when our support results in increased revenues.

GOAL 4: To improve the AHC's internal capacity to identify and take advantage of communications and marketing opportunities.

Objective 4A. To enhance internal and external communications by expanding the use of technology.

To achieve this objective, we will

1. evaluate and expand the AHC web site.

2. explore the feasibility of a center to advocate efficient use of communications technologies; to coordinate technical service resources; and to coordinate training and professional development resources.

3. encourage the use of e-mail as a communications tool.

4. develop relationships with IVI and Channel 4000 to maximize AHC visibility on the "OnHealth" website.

We will know we have succeeded when

1. the AHC web site meets internal and external needs;

2. effective uses of technology have been identified; and

3. communications is enhanced by various technologies.

Objective 4B. To build an effective, skilled team of AHC communicators by holding monthly communicators meetings beginning in September, 1997; by offering professional development and skill building opportunities at least quarterly; by including a broad representation on all AHC project planning groups; and by starting a monthly communicators newsletter beginning in October 1997.

To achieve this objective, we will

1. create the Academic Health Center Communicators Roundtable, which will meet monthly to network with other professionals, review AHC initiatives, share problems and ideas, and to hear "best practices" presentations.

2. identify professional development and team building opportunities for this group.

3. publish a monthly public relations newsletter, "Opportunities".

We will know we have succeeded when

1. the AHC has an integrated team of communications professionals; and

2. the communications team contributes to the research and education mission of the Academic Health Center.

Objective 4C. To array the human resources necessary to support a strategic communications program by January 1, 1998.

To achieve this objective, we will

1. hire two student workers.

2. hire managers for public relations, marketing, and communications technology.

3. redefine roles and responsibilities of existing communications staff.

4. define relative roles of central administration, AHC staff, and college/ school personnel.

We will know we have succeeded when

1. the AHC Communications Office is adequately staffed; and

2. roles and responsibilities are well defined.

Objective 4D. To secure the financial resources necessary to achieve the FY 1998 goals and objectives.

To achieve this objective, we will

1. determine FY 1998 AHC Office of Communications budget and space needs.

2. gain approval of the proposal.

We will know we have succeeded when we have secured adequate funding to achieve goals.

Objective 4E. To complete a plan and evaluation mechanism for Academic Health Center communications.

To achieve this objective, we will

1. discuss the draft communications plan widely.

2. finalize the plan; begin implementation of new initiatives.

3. define an evaluation mechanism for the plan.

We will know we have succeeded when

1. a plan is in place; and

2. our success has been evaluated.

Academic Health Center

Strategic Communications Planning Process

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.

What are the characteristics of an effective AHC communications program?

1. It is holistic.
2. It is strategic.
3. It is collaborative.
4. It has both internal and external dimensions.
5. Its impact is measurable (reach, behavior change, action).
6. We all win.
7. Other?

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
Representatives of AHC Colleges, Schools, Centers, Institutes, Programs
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.)
AHC Staff Representative (s) from P & A, Civil Service, AFSCME
AHC Provost's Office
Dean (s) of AHC Colleges and Schools
University of Minnesota Institutional Relations
University of Minnesota Alumni Association
University of Minnesota Foundation
Minnesota Medical Foundation
Fairview
University of Minnesota Physicians
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.

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

3. Organize work groups to address specific issue areas. By July 25, 1997, each work group will
   - --complete a simple needs analysis
   - --assess current initiatives
   - --identify issues and opportunities
   - --make recommendations

4. Convene Strategic Planning Team to finalize process and timeline, complete an environmental analysis, 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., in the East Wing of the Campus Club in Coffman Union)

5. Hold meeting of the planning Leadership Team to define strategic questions and finalize work group topics. (Tuesday, July 1, 1997, 9:00 a.m.-noon, in the East Wing of the Campus Club in Coffman Union)

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., at the Radisson-University Hotel)

7. Re-convene the Leadership Team to articulate specific goals and objectives and to begin creating a tactical action plan. (Wednesday, July 23, 1997, 9:00 a.m.-noon, in the East Wing of the Campus Club in Coffman Union)

8. Draft plan, including work group recommendations, by August 1, 1997.

9. Complete review and comment process by September 19, 1997.
   - --Provost's Operations Council
   - --AHC Deans Council
   - --PFCC/PSCC
   - --University Relations
   - --UMF, MMF, UMAA, UMP, Fairview
   - --Department heads
   - --External communications advisors
   - --Other?

10. Make revisions; distribute final plan.

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Communications Planning
Legislative Work Group Issues

Issue	Priority	Action Recommended	Difficulty	Person Responsible
The importance of working closely with central administration and the alumni association to coordinate legislative lobbying efforts.	high	Bring all AHC alumni associations together to build a coalition for lobbying efforts. Continue coordinated effort with central administration.	easy	Les Heen will contact AHC associations to set up a joint meeting.
The need to anticipate and shape issues rather than only being responsive.	high	Issues need to be identified and brought together in one location (legislative office). Meet in fall to plan. Issues presented to deans council for strategic planning. (Example: How Medicare issue was handled.) Speak with one voice. Article in This Thursday. Communications piece that faculty/staff understand. Bring in players early so they are part of the process.	medium	Vic to solicit issues from AHC faculty.
The need to have consistent, simple, positive messages about the University, the AHC and the schools/colleges; the usefulness of a common theme.	high	A statement that emphasizes research contributions to state's economy. U brings funds into the state via new jobs and technologies. Value of health care to Minnesotans. Articles in This Thursday with positive messages from each school.	easy	Communications Office
The importance of building relationships with legislators - possibility of having new legislator orientation. Value of having legislators, members of congress and senators, local officials, etc., on campus.	high	Legislative day during Yudof inauguration. Have students invite legislators to campus. Get faculty stories out, aggressive public relations. Sports events, i.e., Final Four.	medium	Vic to coordinate
The need to be better listeners to understand the needs and interests of legislators.	high	Set up briefing sessions with faculty/staff to inform about legislative protocol when testifying. Publicize sessions.	easy	Mike Finch?
The importance of serving legislators; helping them do their jobs better; assisting them in solving Minnesota's problems; providing them with high quality information and research; providing non-partisan testimony and briefings on issues.	medium	Make available central funds to support work with legislative staff members. Meet, brief, and tour staff members and background them on important issues.	hard	Frank Cerra/Terry Bock

Communications Planning
Legislative Work Group Issues

The success of rural health initiatives, which have helped to build significant legislative support in rural areas.	medium	Pick 4-5 communities and have Sr. VP and faculty/staff/deans/student recruiters from those areas visit schools, speak to groups, and plan events. Have a monthly column written by Frank Cerra distributed to local newspapers. Emphasize Vet Med/Ag connection to expose high school science students to the AHC. Run a bus of "high tech" equipment to the high schools/county fairs. Build partnerships with rural schools to donate outdated equipment and glassware.	medium	Rural Health Initiative Communications Office Tony Faras
The need to strengthen our connections to metropolitan area legislators and those in the population corridor from Duluth to Rochester.	medium	Strengthen ties to Medical Alley. Work in conjunction with Medical Alley on legislative issues that effect health care.	hard	Frank Cerra/Terry Bock
The value of the voice of business and business associations, especially in the bio-tech industry, in support of our legislative initiatives.	high	As new members are licensed, offer vouchers for continuing education courses.	easy	Deans
The need to organize coalitions with professional societies and others sharing interests; the need to encourage faculty to join their professional society. The importance of year-round legislative program.	high	Meet with president/president-elect, board chair, exec. director, government affairs committee chair. Invite on campus to meet experts and build lobbying coalitions for common legislative issues.	easy	Vic Vikmanis to coordinate
The importance of assisting legislators with constituency service.	low	Lawn signs during campaigns, financial support, thank-you letters.	hard	Individual decisions
The importance of working at a federal level in cooperation with Tom Etten's office.	medium	Bring government officials from Washington (NIH, FDA) to U. Invite executive and legislative branch of government as monthly guest speakers.	hard	Tom Etten
The need to expand our work with the executive branch of state government, including the Governor and his staff, the Minn. Dept. of Health and other state agencies.	high	Volunteer to be part of transition team. Brief potential legislative and gubernatorial candidates about AHC before elections.	medium	Individual decision. Vic Vikmanis

LEGISLATIVE WORK GROUP - 7/24 8-10 a.m.; 7/28 3-5 p.m. both in 488 Children's Rehab

Co-chairs: Mike Till, 625-7678; Vic Vikmanis, 626-3700; Staff: Chris Roberts, 626-2767

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ACADEMIC HEALTH CENTER STRATEGIC PARTNERS WORK GROUP REPORT

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The Strategic Partners Work Group was chaired by Dr. William Jacott, from the Department of Family Practice. It met on July 9 and again on July 15, 1997. The process involved 1) identifying current partners, 2) defining Strategic Partnership, 3) Identifying vital partners, 4)identifying issues and 5) making recommendations.

The Work Group realized that more time needs to be spent on examining Strategic Partnerships in the AHC, and that the report of the group is a starting point of a work in progress.

Everyone in the Work Group was surprised and impressed with the amount of partners and relationships that exist already in the Academic Health Center. This discovery underscored the importance of a strategic communications plan as well as coordinating our efforts.

Current Partners of the AHC (*= Our perception of a good partnership)

People

*People in Minnesota (feel ownership -pride -)
Neighborhoods, families, children
Students, parents of students
*Donors
Alumni
Patients - potential and already served
Opinion leaders

Health Care Professionals
*Professional societies
Community practitioners
Referring practitioners
*Mentoring and clinical preceptors
Community
Service organizations - Rotary, Lions, etc.
Community organizations, societies
Community resource bureaus
Support groups (health related) that drive research
Faith communities
Complementary care practitioners
Community Transition Interagency
Community hospitals, Boards
*Fairview
*VA, *HCMC-teaching hospitals
Schools
*(K -12)
School districts and libraries
School boards
Community colleges - MNSCU
Coordinate campuses
Students, parents of students
Alumni
Other AHC's in the USA (AAHC)
Business and Corporate
Businesses
*Medical alley
Payors
Sub contractors and vendors
Private foundations
Pharmaceutical companies
Health service organizations - HMO's, Home Health, etc.
Health Care Systems
Government
Legislature and legislative staff
Community governments, county and hospital boards
Lobbyists
Governor Carlson
County Boards
Federal granting agencies
Health care agencies-MN Dept. Health, HHS
Media
Film industry
TV, radio, newspaper

At the UofM
Cross/Interdisciplinary programs
MN Extension Service
UMP
Unions
Faculty
Employees
Board of Regents
Central administration
MN Alumni Association
U of M Foundation
Other
International Service, exchanges, etc.
Regional partners (neighboring states)
Animal Rights groups

DEFINITION OF A STRATEGIC PARTNERSHIP

A mutually beneficial relationship based on two-way communication, respect, involvement, service and sharing and exchanging of resources that is vital to accomplishing the mission of the AHC as well as the missions of the strategic partners.

(AHC MISSION: To be a leader in the ethical, innovative, and efficient discovery and dissemination of knowledge to enhance the health and well-being of Minnesota, the nation, and the world.)

Issues surrounding strategic partnerships

Scarce or decreasing resources in the Academic Health Center.

Decreasing clinical revenues which have traditionally supported other AHC activities.

AHC's need to provide service to community and to have a participatory relationship with community. Partnerships help meet the University's land grant mandate.

Conflict between fulfilling land grant mission with limited resources.
Patient access - both geographically as well as keeping a consistent patient base.

AHC needs political support in order to function.

Information is not exchanged (internally or externally) or disseminated in a coordinated, consistent manner.

Partnerships increase negotiating power-together we are stronger that solo.

Partnerships increase levels of expertise-with teaching, research, outreach and clinical care.

Vital Partnerships

Government and elected officials
U of M
- alumni
- students
- parents and families of students
- employees of AHC
- University College (Continuing Education)

Fairview
Payors
- Medicare
- BCBS
- Others (Medica)
- U Care

Community groups, schools, agencies (United Way)
Community health care practitioners
Businesses and corporations
Donors
Foundations
Media

Recommendations

- Survey the community to determine their perceptions of the AHC (perception is reality).

- Determine what the partners expect of AHC. (Don't assume that what we think is what they think.)

- Identify successful AHC programs involving partners. Take the best aspects and use as model for other programs, when possible.

- Communicate to the AHC and the community about successful programs.

- Prioritize our dissemination of information-what's going out into the community.

- Identify strategic messages and use them!

- Communicate the AHC's strategic plan!!!

- Focus attention on public or community health model which provides health care to a targeted population.

- Don't establish strategic partner for service only - should accomplish the three parts of our mission

- Develop strategy for communicating Fairview/University partnership initiatives, especially internally.

- Determine how to interact with community groups - (determine how and communicate internally)

- Clarify roles of community/volunteer groups- too often they struggle for a purpose to exist.

- Form an statewide community advisory group partnerships in the AHC.

- Involve the community early in project planning that relates to them.

- Regularly recognize community partners. Show we appreciate them!

- Better understanding of culture of education - there needs to be a closer tie between health care and education (healthy kids learn better). Curriculum changes may need to be made.

- Facilitate more interdisciplinary interaction-between students, faculty, and the community. Curriculum changes may need to be made so that involvement in community projects is part of certain course work.

Strategic Communications Planning
Media Relations Work Group
First meeting, July 15, 1997
Second meeting, July 21, 1997

I. Why deal with the media?

- Visibility for funding (University requires public trust).
- Patient referrals.
- Builds reservoir of good will with news media - very helpful in times of crisis.
- Helps build prestige - even among scientists. (Research has shown that scientists tend to cite other scientific papers more often if the paper received consumer coverage, such as the New York Times.)
- Good for internal morale.

II. Challenges to effective media relations

- How do we define media? How can we utilize Fairview PR and balance responsibilities?

University/AHC issues:

- U is very big - smaller identifies more understandable and relevant to the public. e.g. Person sees news story and wants to call for more information, it helps to have a smaller unit of the university mentioned in the story.
- "Competition" among parts of the AHC:
  -- Separate and multiple entities want individual identities. Media often doesn't want other names, they'd be happy with UofM as sole identifier. Complicated by the fact that faculty are often part of multiple entities - school, department, interdisciplinary programs.
  -- Separate and multiple entities have their own constituencies (which can be reached through the mass media) and these entities have their own needs for visibility.
- AHC faces increasing competition for money.
- How make our business relevant? (Esp. some basic research.)
- Mission conflict - public institution vs. Private marketing (need for proprietary information)
- Perception of fallen prestige.
- Loss of faculty.
- Ethics problems.

- Tenure
- NIH exceptional status
- Fairview
- Internal politics hinders issues management.
- Internal morale.
- How do we overcome the last five years?
- Medical community perception of U.
- Open meeting laws - especially compared to the private entities we compete with.
- PR needs of the organization vs. Public information office
- Maintaining the POSITIVE perceptions of the U.
- Looking beyond the medical school - increasing publicity opportunities for other schools/colleges.
- How we relate with government/legislative issues - opportunity next election?
- Hospital identity as F-U
- How increased visibility for AHC benefits UMP and Fairview. How supplies resources?

Faculty issues:

- Faculty not aware of benefits and limits of publicity. (Difficult to educate reporters or to try to use the news media to "educate" the general public.)
- Overcoming faculty reluctance to over simplify the news.
- Minnesota heavy managed care environment (also an opportunity).

Media issues:

- Overzealous watchdog media
- Reporter deadlines.
- Finding patients or people to personalize the story.
- Location for film crews.

III. What we need to do better

- Faculty preparation/ training - Who should they call? When? What's the process when they have papers to publicize or when reporters call them?
  -- Someone to screen media - help provide background so faculty spends less time.
  -- Someone to do follow-up. Need to determine which experts/faculty are willing and able to do media relations - "the folks you can beep to meet deadlines."

- Better efforts to promote model programs - improved approach for choosing which programs to provide public relations support. Now seems that the squeaky wheel gets the grease.

- Better media relations organization at the school level - people within the schools, departments, etc. don't know what is going on that might be newsworthy. Public Health example of school doing it right by having communications committee.

- Clearer sense of AHC prioritization about the criteria for news.

- Improved and increased public relations resources.

- Help reduce time commitment required by faculty to do media relations.

- Make clear the institutional commitment to media relations and the benefits to individual faculty of working with the media. (Not compensated or considered important for tenure.)

- Reduce real and perceived disadvantages and disincentives to faculty - in addition to taking up time, too much publicity can been seen as a negative by academic colleagues. "Grandstanding"

- We take for granted media coverage.

IV. Media Perspective on AHC Communications Efforts

- Resource guides very helpful, but outdated. The web is a good place for a resource guide.

- Media likes having one-call source saves reporters time; however, others can respond to the call. They prefer it when the public relations person does the leg work -- calling to find experts available rather than give the reporter the name and phone number. However, they do not want PR people to serve as gatekeepers.

- Very pleased with AHC media representatives, current and predecessors.

- Be sensitive to deadlines and time pressures that drive media. For television, they decide to do a story at 9 or 10 a.m. and need to be done by 3 p.m. Interviews need to be conducted before 2 p.m.

- If AHC has a local expert for a national story, inform the media via voice mail or fax.

- Media like "heads ups" for U studies more notice gives them more time to do a better story (esp. print). Providing embargoed releases advance notice helps media do a

better job. Media almost always honors embargoes, but to be safe, good to get a verbal commitment in advance.

Criteria for a news story:

- National news drives a lot of stories. Media needs someone to respond immediately and provide the local angle. Often looking for a quick, short response faculty don't need to see the whole study to provide the kind of response they are looking for.
- Medical stories are often study driven news.
- Stories that appeal to target audience/consumers: women 18 to 49; also younger men, older teens. That's why media are more likely to do a story on breast cancer or infertility than prostate cancer or Alzheimer's Disease.
- news hook
- local study or angle important
- high human interest
- Someone famous dies or is diagnosed with the disease. For example, Charles Kuralt's death provided an opportunity for the media to do stories on Lupus.

Some of the most interesting health topics for the media:

- Research studies
- HIV
- Cancer, esp. breast cancer
- infertility
- people (experts) willing to talk

Reasons media won't cover a story:

- Failure to meet deadlines.
- Promise one story, but deliver another.
- Other breaking news.

What the AHC needs to do:

- Need to build trust - tell both the good and the bad news. You will have bad news, it helps if you can build a reservoir of trust.
- "Bunker mentality" doesn't make media go away, it has an opposite affect.
- Put a human face on bad news too. Someone from the institution is important. one.

- If the faculty provides notice of pending news, the news service people can do the leg work-- find the visuals, prepare the backgrounders, Parkinson story good example.

Tips for working with the news media.

- Give them the sound bites we want rather than the sound bites they are looking for. (Stick to your guns if you don't agree with the angle the media is taking, but still provide your message in 30 seconds.)

- Assume the media know nothing about the topic.

- It is up to us to "slip in" the education with the news.

- Provide a thorough handout/backgrounder and release. This helps a lot to avoid inaccuracies.

- Most media aren't comfortable going "off the record." Always assume everything is on the record. If you go off, be explicit and get the reporter's agreement first. Print sometimes will go off the record to get more information, but usually not necessary with broadcast because the don't go into that much detail. An exception would be the need to share patient information that is off the record as a matter of sensitivity.

Committee discussion:

- Media interest can be divided into three kinds of stories
  1) U expert response to an existing story
  2) U stories; research published by U faculty--we provide news
  3) U proactive stories

- More preparation helps, interviews much easier if you've done a press release

- Ask for review? (Most media won't allow you to review the story, but you can always ask to clarify.)

V. Recommendations (combination of both meetings)

- Build a culture where media relations is an obligation and a privilege. (This is the case with many other major universities.)

- Need more proactive PR.

- More issues management.

- Develop proactive and reactive media teams.

- Consider internal media at Fairview. Consider other media, like web pages, electronic sources, organizational newsletters.

- Media preparation -- no one should ever do an interview cold. Always call the reporter back and in the meantime prepare three key messages relevant to the story. Revamp media guide for faculty to prepare for an interview.

- Media is a main communications vehicle to reach the community. Need to use media effectively. Results of PR are gradual like research, they don't come over night.

- AHC Communications staff should go to departmental meetings once a month. Clearly identify what AHC Communications can do for faculty.

- How do we get the faculty savvy to the process?

- Look for other models. How do Harvard, Johns Hopkins, Duke, others handle media relations? At Harvard, it is part of the culture and it comes to the attention of the department chairs. At Hopkins and Duke, you feel a sense of community, you're willing to take the time for the "group good."

- Faculty need to feel appreciated -- administration needs to re-earn the goodwill of faculty.

- News is not the only way to work with the news media to get message, esp. education message, out. They also do PR, community service campaigns, etc.

- Consider advertising as part of the media relations strategy.

- Need to set goals for media relations. What do we want to accomplish? Just more coverage? Different kind of coverage?

Afterthoughts
(recommendations that came in after we sent the document out to the group):

- pay more attention to outstate media (Jim Boulger, UMD)

- make notifying AHC Comm regarding a paper coming out "seamless" - requiring no additional effort from faculty. Routine e-mail reminders? Responsibility of secretaries to copy gallies to AHC? (Tom Sellers, epidemiology)

INTERNAL COMMUNICATIONS WORK GROUP REPORT

co-chairs: Judy Garrard, Jeanette Louden
staff: Gayle Bonneville, Peggy Rinard, Ann Benrud
members: see attached list

meeting #1
assess current initiatives and identify needs
Jeanette Louden, moderator
July 14, 1997

current internal communications

- "this thursday"
- web page
- e-mail reports from Frank Cerra
- Deans Council to dept. heads to faculty and staff
- faculty and student consultative committees
- meetings between Frank Cerra and small groups of faculty
- word of mouth
- school & departmental web pages, newsletters (see inventory)

needs:

What is internal communication? What are the parameters? What kind of communication do we need? What communication do we have?

(Note: The purpose of this meeting was to focus on identifying communications needs and assessing current communications, but discussion also covered issues and recommendations. Recommendations made the first day are merged with recommendations from the second day.)

group comments:

• With whom do we want to communicate? There's a huge gap between the information haves and have nots. How did we become such a multilayered culture? There's a gap between communicators and their audiences. Internal communication is designed to help administrators communicate with each other. Need to address research, service, outreach.

• Research stories don't get communicated internally or externally. Lots of word of mouth communication.

• Administration is largely self-serving. Their salaries went way up while faculty salaries were frozen. The people [administrators] who have responsibility for communications don't really know what's going on. Some of the most original bio science is happening here. It needs to be conveyed.

Excitement is not conveyed. Real, solid achievements that go on here daily need to get out.

• Need an infrastructure to facilitate communications. This is a big place, there's lots going on here. Would enhance research to let faculty know what other faculty are doing.

• Could link all research program web pages to support interdisciplinary research.

• Do people receive, read and understand newsletters? Need interpersonal communications as well as newsletters. Multifaceted communications to reach everyone.

• Need a communications system in which every dean/school has a communications office and a system--lateral and vertical-- for communications. Everyone with $3 million or more in funding should have their own info officer. Need to put faculty in control of communications. Brain Awareness Week, which was faculty driven, is an example of how well that can work. Distribution of existing communications is okay, content is shallow.

• Communications is a two-way responsibility. Faculty need to take responsibility for articulating and communicating their research.

• True, but people who do research don't think about publicity.

• There's no incentive to communicate. Infrastructure and leadership aren't there.

• Culture has changed--used to be considered gauche to seek publicity.

• More communications isn't necessarily better. We're flooded with data.

• Need to communicate research to promote growth of interdisciplinary programs.

• What about student communications?

• We need to communicate more with the regents. The tenure fiasco, which damaged the AHC, happened because that we weren't communicating effectively with the regents. Bring regents to the AHC, show them what's happening here.

• The Communications Office only wants to do stories about the Medical School. I called to suggest nursing stories and they said "we'll get back to you." Stories aren't worthwhile unless they have Medical School written on them.

• There is a lack of communications leadership from the top down for communications infrastructure, incentive to communicate.

• I don't use the web page because it's out of date.

• When I was on the advisory board for Health Sciences, we didn't always do a good job of bringing ideas to the writers and editors. The writers did a good job with what we gave them.

• The AHC has been through the gristmill over the past several years. Problems are not entirely internal. Lots of external forces have produced pressures on us--HMOs, etc. The legislature is reluctant to fund us because the system is broken. We need to go back to find the reason why we exist: research, education, and outreach. We need to start over.

• It's hard to separate internal from external communications: i.e., communications with hospitals and clinics we work with. Are they external or internal?

• We often don't get information we need to do our jobs, like changes in administrative procedures or forms.

• We need to communicate about four areas: research, teaching, outreach, and the work environment.

• Why communicate? I agree our organization is broken. in some ways it was never formed. What is the AHC? We know in general, but don't have a sense of what it means to work in the AHC. Name "AHC" came when Brody came.

• It was broken when Bill Brody got here. That's why we hired him. It's been broken for a long time. Back in the 1950s, there was more communication between basic and clinical sciences. Surgeons trained in the physiology department. Then when Lyndon Johnson created the Medicare/Medicaid programs in the 60s, they began to split apart. The ranking of the physiology department went from 5th in the nation to 72nd.We need to ask: what's science? what's applied science? There's a lack of appreciation for true basic science research. In the '50s, UM was a the school for science. do we have the motivation to create an integrated institution?

• The fragmentation of our organization is reflected in the ways we communicate. I wouldn't be here if we made widgets. We work here because we believe in this.

• Departments are not connected. We need to break down compartmentalization of the AHC.

• We have a name/identity problem: AHC or Health Sciences? Especially now that Frank Cerra is Sr. VP for Health Sciences.

• People really like Brief. I also like Kiosk: features, no politics, all groups are represented--faculty, staff, etc., calendar of events.

• How do people get their information? i.e., on elevators. Post news in or near elevators.

• More info is not necessarily better. Need to look at diverse population. We're doing lots of things in seven schools. Maybe we need to break it down, individualize, personalize.

• Web page info doesn't seem current. Takes too long to find information.

• Webmaster can't do it all. Need a database driven web page that allows people to post their own info. Decentralize input for web page.

• Where's the incentive to keep it updated?

• Send out e-mails letting AHC community know about TV coverage, newspaper stories before.

• Create e-mail lists for different interests.

• What do we want "this Thursday" to accomplish. If it has too many objectives, it will fail.

• Honesty in communications? Who do we want to be honest with? If we put everything on the web page, it's accessible to anyone. Need an intranet to share information with each other that we don't want to share with the public.

• Where's the commitment to communicate? How do we get people to make a commitment?

• Cultural problem: information is power--I have it, but I don't want to share it.

• Human element is important in communications. I may not come to an event because I get a flyer or e-mail notice--need personal touch. Also, we need better access to students.

• How do we value and support everyone in such a large community?

• Suggest faculty information officer in each dept. who could meet with someone from the communications department on a regular basis. The person could also be a filter--what's good, what's bad.

• I think "this thursday" is very informative. I look forward to it.

• Add a rumor column to "this thursday."

• Why do rumors appeal? Exciting, new information, dramatic, two-way communication, focused, relevant. Something people care about.

• Use e-mail to address rumors. "What's hot" e-mail news.

• Write about relevant issues for faculty, staff, and students.

• More about work force issues: retirement plans, health insurance programs, ie, Medica plan to pull out. Why are they doing it? What's the loss to U employees. AHC should be a source for this info to rest of U.

• CHIPS -- what communication unifies that group across schools?

• Some of these issues are much broader than communications.

• More HR news.

Meeting #2
Issues and Opportunities
Judy Garrard, moderator
July 15, 1997

Why do we want to or need to communicate at all? Why should the organization make a commitment to communication? Answers from the work group included:

• Our work has no value if we don't communicate it.

• Our strength is in our diversity and the many layers of the AHC, but we have to promote this and make it known.

• Employees are unable to brag about or speak intelligently about the U if they don't know what's going on here. We need to make our news known internally so it can be known externally.

• As the largest employer in the seven-county metro area, the U of M has many ambassadors – including faculty, staff, and students – who go out into the community and talk about the U of M, both in over-the-back-fence conversations with friends and family and on the job.

• Communication can help create a sense of community. This was a recurring theme within the discussions. How do we develop this sense of community in the AHC? Some argued we don't have it now because we're not

effectively communicating and because we don't have a customer service mentality. While one attendee said efforts at communications in the AHC have been impressive lately, another believes that if faculty and staff were surveyed, they would call AHC communication "abysmal."

Other key issues included:

• Trust and respect: Past practices in the AHC lead some to question whether the whole story is being communicated. Attempts at filtering and controlling information are perceived as creating a morale-deflating parent/child relationship that only serves to keep the rumor mill running. Has the institution been less than honest for so long that now people won't believe even the straight message? Does everybody want the truth except when it's about them? Can damage be done by letting information out prematurely? Will information leak out anyway?

• Customer service/personal interactions: We interact –and therefore communicate – with one another across departments, across halls, across workstations. What is our commitment to this service? All too often we're treated like "a bother" when we deal with other departments within the AHC, which can sometimes be "unfriendly" and "downright hostile," explained one participant.

• "Go Navy": Like the AHC, the Navy is large. But unlike the AHC, the Navy has a common language and great institutional pride among its ranks. Although the military operates under a command structure while we operate under a consultative structure, can we find ways to join together over what we do have in common?

• Academic culture: Ph.D.'s and others are taught to argue a point and discern for themselves. By its nature, an academic institution will be a place of great debate, so we may never have a "Navy" culture. Another conundrum is that some faculty see themselves as competing with one another for funding, grant money, or pay raises, and thus may not take pride in colleagues' accomplishments. This "if you get more, I get less" attitude also exists between P and A staff and faculty. Do we have to have second-class citizens to have a first-class institution? The multidisciplinary nature of the AHC – and the necessary partnerships that result from it – can help resolve this.

• Direction: Who can articulate the priorities of the AHC? Where are we going, and how do we know when we're there? What's the individual employee's role on this team?

• Confounded communication: Our democratic system may actually stymie communication and effective decision-making. In other words, if I don't like what you said, I label it bad communication, scuttling attempts at forward movement.

• False hopes: Does "creating community" set us up for a fall? The impact of "lopped off" hospital employees is still fresh, and some people now anticipate a similar fate in their areas. Yet a sense of real community, not merely an illusion of it, may enable us to support one another in tough times.

• Leadership, management, supervision, conflict resolution, organizational development, and interpersonal relationships all need to be addressed. Otherwise, communication alone cannot help the AHC.

Recommendations (from both days)

• Be honest and straightforward in communications. If a person knows the process behind the decision making, he or she is more likely to respect it, even if he or she doesn't agree with the end result.

• Find a "common enemy" or common goal to pull people together. Common "enemies" right now include other academic health centers and the effect managed care is having on our AHC. The Gopher basketball team generated widespread pride because we knew what the goal was and believed we could reach it. Find the AHC's goal, and figure out how we reach it.

• Provide "pep talks" or training about customer service attitudes.

• Provide methods for faculty to get acquainted in small groups.

• Expand pizza lunches and other gatherings with the senior vice president to include civil service staff, P and A staff, and students, as well as faculty. Consider gatherings by topic or common interest groups as well as employment groups.

• Find more ways to include students as well as clinical and adjunct faculty in our community and in our communications.

• Offer more face-to-face/one-on-one communications.

• Provide the big picture of the AHC – i.e., mission, goals, etc.

• Survey AHC faculty and staff to find out why they stay here and what they think is positive about the AHC/U of M.

• Help staff and faculty adapt to change and become more flexible.

• Recognize our diversity as a strength.

• Find ways to help the rest of the University to see the importance of the AHC and understand why our priorities may differ.

• Disseminate information faster and more frequently. Provide weekly AHC news in a format similar to "Brief." Many employees are already overloaded with information.

• Help staff, faculty, and students individualize and prioritize information with such mechanisms as computer technology, a rating/coding system for messages ("stat," urgent, five stars for information needed by the entire AHC community, etc.), or links to other sources for those who feel they need in-depth reports.

• Make a commitment to using top technology throughout the organization.

• Schedule more town meetings.

• Provide information in a variety of formats, including small and large meetings, print, personal contacts, and electronic methods, to meet diverse needs and preferences. Use "low-tech" options, such as bulletin boards by elevators.

• Take advantage of the rumor mill and "elevator" grapevines, and address issues people are talking about among themselves. Start a "Rumor Mill" column.

• Ensure that communications are accessible throughout the AHC.

• Define who is on the various e-mail lists used by the senior vice

president's office; make sure messages are distributed across the board so that employees don't have to depend on information trickling down from supervisors, deans, etc.

- Set up TV kiosks in heavy traffic areas. Consider broadcasting meetings. Also set up electronic maps/computers in traffic areas that provide info about AHC schools, departments, programs
- Establish a clear mission for our publications that connects them to the AHC community.
- Acknowledge the importance of internal communications, and back up our commitment with resources and actions.
- Make sure the web sites feature the most up-to-date information; alert AHC community when something new is on the homepage.
- Conduct a survey on web page usage and "this thursday" readership.
- Continue meetings such as these. Consider creating a Communications Consultative Committee.
- Create an infrastructure to support communications between schools, departments, faculty and the communications office.
- Establish a communications office in each school supporting a lateral/vertical communications system.
- Provide an information officer for everyone with $3 million or more in funding.
- Put faculty in control of communications.
- Designate a faculty communications officer for each department. Schedule monthly meetings between faculty officers and communications staff member.
- Invite regents to AHC to visit labs and learn about research.
- Communicate more about research, education, outreach, and the work environment.
- Survey people to find out how they get their information, how they want to get it.
- Notify all faculty, staff about AHC TV and newspaper stories in advance by e-mail.
- Create e-mail lists for different interests.
- Do more articles on work force issues.
- Create an intranet for sharing information internally.

Survey tally

My top three concerns about internal communications in the Academic Health Center are:

Summary
- honesty, trust, clearness, easy access are lacking
- communication is an afterthought
- resources are lacking
- sense of community is lacking
- unresponsiveness of receiver
- decision making/communication are confounded
- lack of understanding of internal communication's importance and power
- communicate across all job categories and cultural boundaries
- Is it current, accurate, relevant, complete, consistent?
- information overload/lack of time
- diversity of audiences
- need more "we"
- stop blaming
- mammoth task
- better coordination
- need mission statement for internal communications
- inappropriate sources
- creating false sense of community
- use variety of methods
- lack of customer service; poor personal interactions
- building community, spirit, morale, attitude
- lack of time and money for technology
- united mission
- developing pride
- Who are we? Clarify goals.
- lack of one-on-one opportunities
- lack of availability of employee information

My top three recommendations for internal communications are:

Summary
- coordinate flow of info upwards and downwards
- find messages applicable across AHC
- continue these groups
- create sense of community
- define roles and responsibilities on communication and decision making
- small group meetings and one-on-ones
- commit to technology
- communicate to all AHC employees
- individualize/prioritize/personalize communications
- develop and encourage two-way communication
- be brief

- highlight successes, "person on the street" interviews, from throughout AHC
- "brown bag" gatherings
- town meetings
- update web info.
- publicize existing communications
- TVs in strategic places
- e-mails from deans, provost
- use supervisors
- invest money in communications in important areas
- use all forms of media
- communicate process as well as decision
- publicize goals, mission, and how people are contributing
- survey communication needs, relevance, and values
- postings in/by elevators
- ongoing meetings on employee concerns
- workshops on customer relations techniques
- share job postings within AHC

Internal Communications Work Group members

Kären Alaniz – School of Nursing/P and A committee
Verla Goeden – School of Public Health (epi)
David Thawley – College of Veterinary Medicine
Debbie Johnson – Medical School (family practice)
Jenny Meslow – CHIP
Susan Hayes – School of Public Health (IHSR)
Bill Robiner – Medical School (neurology)
Jack Stack – School of Dentistry
Pat Snodgrass – Medical School (peds)
Judy Peterson – School of Public Health
Jean Niemiec – Medical School (ophthalmology)
Cindy Henrikson – Biomedical Library
Robert Miller – Medical School (physiology)
Mark McCann – Medical School (peds/lab medicine)
Jean Murray – Minnesota Medical Foundation
Annette Mace – AFSCME/Medical School (peds)
Bruce Benson – College of Pharmacy
Bob Copeland – AHC Human Resources
Mary Jane Towle – Civil Service/Medical School (surgery)
Philip Portoghese – College of Pharmacy
Bernie Feldman – School of Nursing

Communications Technology Work Group Report for the AHC Strategic Communications Plan

August 15, 1997

www.ahc.umn.edu/ahcctwg

- Introduction
- Issues and Needs Analysis
- Help Resources and Training
- Communications Technologies: Skills Development and Use
- Reaching Target Audiences
- AHC Communications Technology Unit
- Recommendations
- Conclusion
- General References
- Appendix - Comments and Feedback

Introduction

As part of the AHC Strategic Communications Planning effort, a Communications Technology Work Group was formed to

- **complete a simple needs analysis**
- **assess current initiatives**
- **identify issues and opportunities**
- **make recommendations.**

Our work group was constituted of the the following individuals throughout the AHC who volunteered or were recommended and recruited.

Stuart Speedie, Ph.D. -- Medical School - Health Informatics (co-chair)
Larry Kushi, Sc.D. -- School of Public Health - Epidemiology (co-chair)
William Hoffman -- AHC/Med School - Communicatons Technology & Biomedical Engineering (staff)
Alan Hirsch, M.D. -- Medical School - Medicine - Cardiology
Coleen Southwell -- Cancer Center - Director of Communications
Marilyn Johnson -- Sr. VP for Health Sciences Office - Principal User Specialist
Bob Copeland -- AHC Human Resources
Kate Hanson -- School of Nursing - Student Recruiter
Andrea Szalay -- Medical School - RPAP - Student Support Associate
Bashar Bakdash, DDS -- School of Dentistry - Preventive Sciences
Kristin Hansen -- Medical School - Computational Biology Centers
Ernie Retzel, Ph.D. -- Medical School - Computational Biology Centers
Mary Krick -- School of Nursing - Executive Assistant
Clint Hartman -- Medical School - Pediatrics, System Software Programmer
Marshall Hertz, M.D. -- Medical School - Medicine
Jim Waddell, Ph.D. -- Veterinary Medicine - Clinical and Population Sciences

Skeeter Burroughs -- Med School - Family Practice & Comm. Health - Off. Specialist
Michael Armstrong -- Medical School - Graduate Student
Crystal Heublein -- Veterinary Medicine - Director of Info. Services
Paul Yakshe, M.D. -- Medical School - Medicine
Jason Knauss -- Medical School - Obstetrics & Gynecology
Jim Carey -- Medical School - Physical Medicine & Rehabilitation

We held three 90-minute meetings in the 6th floor conference room of BSBE: July 3, July 14, and July 21. This report reflects the consensus view of our group on some of the current issues, needs, and opportunities for the Academic Health Center posed by the revolution in communications technology and what we recommend to address these issues/needs and exploit these opportunities. Individual participants may have differing points of view concerning specific issues and recommendations.

Issues and Needs

We found that the key issues and questions concerning communication and communications technology were centered around the following:

- AHC Communications Philosophy: Is it controlled or open? What is the role of communications technology?
- The Message: What is the message we want to get across? How can technology help?
- The Audiences: Who are our audiences? How can technology help us to reach them?
- Internal vs. External Communications: What is the appropriate level of integration? How can technology facilitate integration?
- AHC Communications vs. AHC College/School Communications: What is the appropriate level of integration.? How can technology help?
- AHC Communications vs. U of M Communications: What is the appropriate level of integration? How can technology help?
- Resources: What are our current technology resources? Are they adequate or inadequate?
- Skills: What are our current skills standards for using technology? Are they adequate or inadequate?
- Initiatives: What are our current communications technology initiatives?
- Technologies: What specific technologies are we or should we be using?

Needs Analysis

For a needs analysis of information technology and networking in the Academic Health Center, we refer to the AHC Information Technology Team report "Information Technology at the University of Minnesota Academic Health Center: Assessments and Recommendations," September 14, 1996. This is a comprehensive analysis of the current state of computer and associated technologies in the AHC. It is described as a "starting point for continuing discussion about how information technology can best be employed to accomplish the mission of the University of Minnesota Academic Health Center." Assessments and recommendations are made in the following arenas:

- General
- Education
- Research
- Clinical Service/Outreach
- Management

Although we have concerned ourselves largely with the "General" arena, elements of the other arenas that deal with AHC-wide concerns (eg. quality, timeliness and quantity of technical support described in the "Research" section and the value of skilled human resources vis-a-vis hardware and software described in the "Management" section) are also taken into account.

Help Resources and Training

Current help lines, help resources and training resources include:

- **Office of Information Technology** - www.umn.edu/oit/ - The Office of Information Technology (OIT) plans, develops and manages the centrally provided computer, network, phone and other information technology systems of the University of Minnesota. OIT provides a comprehensive range of services to students, faculty, staff and departments through its service units.
    - Microcomputer Center - microcomputer and workstation support - microcomputer training
    - Digital Media Center - www.umn.edu/dmc/ - The Digital Media Center promotes the innovative use of learning technologies at the University of Minnesota and supports faculty who are developing multimedia (including Internet) teaching and learning projects.
    - OIT Consulting and Training
- **AHC Academic Computing** - www.cbc.umn.edu/ - The Computational Biology Centers are a structure designed to foster research in all aspects of biology and medicine.
- **AHC Administrative Information Services**
- **Professional Development and Conference Services** - University College - www.cee.umn.edu/pdcs/index.html - The department develops and delivers, in traditional and non-traditional formats, conferences, short courses, and seminars for professionals from around the world, in collaboration with faculty and other experts from colleges and research centers at the University of Minnesota, and with state, national and international organizations.
- **Biomedical Library** - www.biomed.lib.umn.edu/ - The mission of the Bio-Medical Library is to enhance the teaching, research, and service activities of the University of Minnesota and to support the University of Minnesota Academic Health Center in its quest to improve health, by facilitating timely access to information needed by library clients on campus, throughout Minnesota, and nationwide.
    - Classes
- **Human Resources** - www.umn.edu/ohr/ - Career Enrichment Programs
- **Biomedical Graphics** - www.biomedgraphics.umn.edu/ - Biomedical Graphics is a full service department specializing in biomedical and scientific communication utilizing Art, Computer Graphics, Photography and Video.
- **Department/Division/Center IT personnel**
- **Peer groups**

Communications Technologies: Skills Development and Use

With a growing number of communications tools to choose from, today's workers grapple with decisions about which tools to use in which situations. A recent study found that how workers decide is a complex process involving the work place, the work task, personal relationships, available communications tools and other factors. [Institute for the Future, "Managing Corporate Communications in the Information Age," June 1997]. "To remain productive in an information technology-rich workplace, each worker, by default or design, must pursue a strategy for choosing what tools to use for sending and receiving business communications."

Specific communications technologies

Specific communications technologies were identified as follows:

- **phone**
    - in person (real time)
    - voice mail
- **fax**
    - fax broadcasting
- **e-mail**
    - one-on-one

    - listserve
- **video**
    - video conferencing
    - video-on-demand - VOD
    - video mail
- **audio**
    - audio tapes
- **CD-ROM/digital video disks - DVD**
- **web**
    - web pages (text, images, audio, visual)
    - chat rooms and IRC
- **cellular**
    - PCS
    - pager

Communications technology hardware, networks and interfaces

Hardware, networks and interfaces were identified as follows:

- handheld computers - PDAs
- mobile
- workstations
- networks
    - Internet
    - Internet 2
    - wireless
- network computer (NC)

Skills development and use

We regard development of skills in using different communications technologies as a critically important factor for expediting the move of AHC personnel into the new communications arena. Table 1: AHC Communications Technologies: Recommendations for Skills Development and Use represents a consensus view of the skills expectations of faculty, staff and students in the not-too-distant future. The analysis presumes a significant upgrade in the overall availability and use of communications technologies.

Reaching Target Audiences

Key target audiences were identified as follows:

- AHC faculty
- AHC students
- AHC staff
- rest of University
- alumni
- public
    - patients/study participants
    - prospective students
    - prospective faculty
    - strategic partners
    - business community
    - legislators
    - community leaders
    - general public

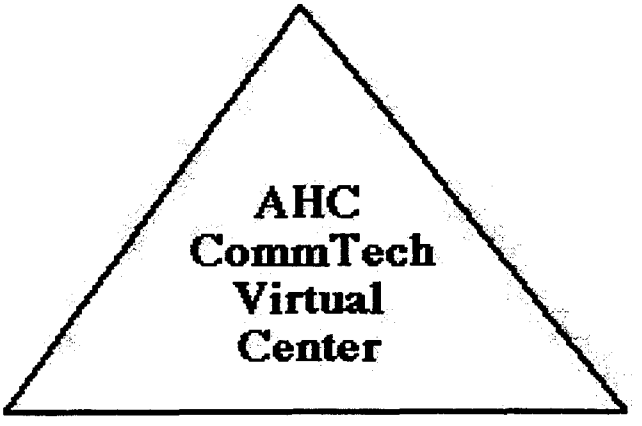
Table 2: AHC Communications Technologies: Reaching Target Audiences represents a consensus view of which communications technologies may be most effective in reaching different AHC target audiences. This matrix presumes a significant upgrade in the overall availability and use of communications technologies.

AHC CommTech Virtual Center

We believe that communications technology needs to be acknowledged and supported as a critical strategic activity for all AHC personnel. As a first step, we propose that an AHC CommTech Virtual Center be created to

- Advocate the appropriate and efficient use of communications technologies
- Coordinate technical service resources
- Coordinate training and professional development resources

as illustrated below:



The AHC CommTech Virtual Center would exist at the interface of AHC information technology services and the communications functions of the Academic Health Center.

One of the key goals of the AHC CommTech Virtual Center would be to coordinate and integrate existing service, training, and outreach programs -- from the AHC department/division level to University-wide activities and programs. Local or college/school programs, such the departmental initiatives described in the Appendix, could be monitored and emulated in total or in part if they prove successful. The Center could also serve to advocate University-wide programs (OIT) and the appropriate and efficient use of specific communications technologies for specific tasks within the AHC.

In its capacity of coordinating and promoting training, the AHC CommTech Virtual Center would focus on the aspects of communication that are principally the domain of the Communications Office - e.g. training people in the use of these technologies for communicating with the public. In its service capacity, it would develop online public information and public service resources as well as coordinating internal help resources.

The AHC CommTech Virtual Center would also play a role in

- tracking communications technology use patterns by faculty, staff, and students
- comparing relative efficiencies of different technologies for internal and external communications through follow-up, feedback, and surveys.
- monitoring new developments in communications technologies that may have near-term applications in the AHC

Recommendations

1. Adopt the "Overall Recommendations" listed in the report by the AHC Information Technology Team, "Information Technology at the University of Minnesota Academic Health Center: Assessments and Recommendations," September 14, 1996. Specifically:

- Regard information and its supportive technologies as a strategic resource and critical success factor for the AHC that is funded and maintained just as equipment or staff.
- Establish 100% intranet connectivity across the AHC.
- Develop mechanisms that facilitate interactions among and coordination of IT personnel and that provide training to existing technical coordinators at a high technical level and with more attention to customer service issues.
- Partner with the Bio-Medical Library in determining information needs, sources and functions by making it an integral part of the AHC.
- Support development of AHC help services provided by web, mail, or phone.
- Hire and provide/rent webmasters with publication experience [with technical support from AHC Academic Computing and AHC Administrative Information Services]

Consistent with the above recommendations:

2. Emphasize open communication and the free flow of information throughout the AHC consistent with University policies.

3. Emphasize and invest in communications technology as a critical strategic activity throughout the AHC. As a first step, create an **AHC CommTech Virtual Center** that would coordinate and integrate existing services, programs and initiatives from the AHC department/division level to University-wide activities. The Center would:

- Serve as an advocate for the appropriate and efficient use of communications technology by all faculty, staff and students through seminars, workshops, and community interaction.
- Coordinate University service resources for AHC personnel.
- Coordinate University training resources for AHC personnel.
- Implement tracking and monitoring measures to provide data on technology use patterns and to stay

abreast of new developments in the field.

4. Emphasize the use of communications technologies to connect AHC colleges and schools with strategic partners, clinics and other affiliate sites, alumni, prospective students and faculty, and the wider community.

5. Address infrastructure needs as articulated in previous IT task force reports.

Conclusion

The concurrent revolutions in communications technology and health care pose critical challenges and opportunities for the University's Academic Health Center [AHC Information Technology Team report, Sept. 1996] as they do for all academic health and medical centers. The opportunities are abundant. "Recent innovations in computation and information technologies, in networked communications and databases, and in computer-based methods and tools for collecting, analyzing and visualizing data originating from multiple sites offer unprecedented opportunities for enhancing the quality of research and the efficiency with which results can be generated, analyzed, and integrated into health education and delivery." [Council on Competitiveness, "Highway to Health" report, March 1996].

Our recommendations in the broad AHC communications arena represent an acknowledgement of the rapidly changing information landscape and an attempt to provide impetus and guidelines consistent with current University-wide initiatives. The need to endorse communications technology as a strategic resource and move forward expeditiously is fully consistent with, and indeed essential to, our goal of becoming one of the top 10 academic health and medical centers in the U.S.

The recommendations we offer presume that the pace of change in communications technology, unsettling as it is, will continue to increase. Yet our most valuable assets are not our networks, computers and other communications tools, valuable as they are, but our faculty, staff, and students. As William Wulf, President of the National Academy of Engineering, wrote recently, "Thinking about the current [technologies], in fact, can be misleading; it's all too easy to assume that something won't change just because today's technology doesn't support that change. It's almost better to hypothesize a change and then ask how soon the technology will support it." ["Warning: Information Technology Will Transform the University," 1995].

Our personnel at work in classrooms, laboratories, offices, clinics, and in community settings are in the best position to imagine how new technologies can be used to improve the work they do and save time in an era of rapid change. They should be encouraged and supported in their efforts to find creative uses for new communications tools. These tools will play an ever-larger role in teaching, training, patient care, administration, and the discovery, dissemination, and application of knowledge. The challenge is to bring specialized knowledge, general knowledge, and communications tools together. "To make knowledge productive, we will have to learn to see both forest and tree. We will have to learn to connect." [Peter Drucker, *Post-Capitalist Society*, 1994].

General References

AHC Information Technology Team, "Information Technology at the University of Minnesota Academic Health Center: Assessments and Recommendations," September 14, 1996.

Council on Competitiveness, "Highway to Health: Transforming U.S. Health Care in the Information Age," March 26, 1996. [http://nii.nist.gov/pubs/coc_hghwy_to_hlth/title_page.html]

Drucker, Peter. *Post-Capitalist Society*, New York: HarperBusiness, 1994.

Institute for the Future, "Managing Corporate Communications in the Information Age: Executive Summary,"

June 1997. [http://www.iftf.org/media_choice/]

Minnesota Office of Technology, "Achieving Minnesota's Vision for Information and Communications Technology," October 8, 1996. [http://www.ot.state.mn.us/strategy/esummary.html]

Negroponte, Nicholas. *Being Digital*, New York: Alfred A. Knopf, 1995.

Wulf, William A. "Warning: Information Technology will Transform the University," *Issues in Science and Technology*, Vol. XI, No. 4 (Summer 1995), pp. 46-52. [http://w3.scale.uiuc.edu/scale/library/Wulf.html]

Appendix

Comments and feedback from CommTech Work Group participants

Coleen Southwell, recommendations, July 18

My main recommendations would be for AHC communications to play a coordinating role in helping people most effectively use communications technology to achieve their communication objectives and to bring everyone up to a certain base level -- people must have personal access to email and voicemail, not rely on secretaries. Also, I've noticed that email has a whole different aura to it when it is printed out and given to faculty vs. having them read it on the screen.(I've worked with people who didn't have email and then did. Unless you see it on a computer screen, it loses the informality that makes this such a great medium.)

Skeeter Burroughs, Family Practice initiatives, July 18

Here is a brief summary of what we have done in FP with e-mail.

Family Practice
URL: http://www.med.umn.edu/fp/

Facts in Brief

- Department offices in six different locations
- Clinic operations in five different locations
- 14 fileservers (2 dedicated mail servers)
- 450+ workstations, approximately 550 users
    - 90% Windows 3.1
        - 100% upgrade to Windows 95 planned by late fall
    - 75% Novell 4.10, 25% Novell 4.11
    - minimum system configuration is 486, 66MHz, 16MB
    - 50% Pentium

GroupWise

To encourage faculty members to become familiar with and utilize GroupWise, our department head informed them that official electronic correspondence from his office would be sent via GroupWise only.

There was concern from faculty members, especially from those not very familiar with computers, as to how feasible it would be to require all faculty members to utilitze GroupWise. Faculty who were familiar with computers were discouraged by the fact that they were initially only able to access their GroupWise mail and calendar from a computer at their home location. Several faculty members precept at more than one clinic, or spend frequent amounts of time away from their home location, preventing them from checking their e-mail. Approximately eight months after we had been using GroupWise we completed the installation of a GroupWise web server allowing all department faculty,

residents, and staff the ability to access their e-mail and calendar from any computer with Internet access and a web browser.

The installation of GroupWise has also facilitated document and file transfer between servers. Users can now more easily attach and detach enclosures than via the other several different e-mail packages which were in use. Our Help Desk frequently fielded calls about file conversion formats from users trying to send or receive enclosures. Often times our network administrator was required to transfer larger files between servers.

By requiring everyone to use GroupWise, our Information Services division was required to hold numerous training courses over the first several months of implementation. Most courses were taught centrally, but in some instances our instructor needed to go on location. Many people have also had one-on-one training by various members of our staff. Although most faculty, residents, and staff have now had training, GroupWise and PC Basics courses are still occassionally offered when needed to train new department personnel.

Jason Knauss, OB-GYN initiatives, July 18

In an attempt to improve inter-Departmental communication, as well as prepare our Department for increasing technological developments, a strategic plan/vision was first established and instituted. We chose Meeting Maker, the Medical School-mandated Scheduling software package, as our means of communicating schedules. We also polled the faculty electronically to observe how many of them access their accounts daily. We have, since the plan's inception, also offered instructional topics/items of interest.

It is our goal that all of our faculty, fellows, residents and staff have access to e-mail and to use their accounts daily. Once having accomplished this, we will ease them into receipt of Departmental memos via e-mail entirely. Individual calendars, as well as Departmental/Divisional events are kept on Meeting Maker and updated frequently.

In the beginning we took an inventory of our machines (mostly Macintosh) and the available network connections/etherjacks. Once all of the machines had been upgraded to the point that they could support Meeting Maker and POPmail, we installed the software. Several instructional courses covered the basic knowledge to access the schedule and e-mail, and each user was provided a manual.

I would estimate that 75% of our faculty use Meeting Maker, whereas less than 50% access their e-mail accounts frequently.

Crystal Heublein , general comments, July 18

I have reviewed the web page changes looks like you have put some good thought into these issues. After reading I have just a couple of thoughts that passed over me and would like to share these with you. In the area of communications technology I have in the past implemented programs where in each division a resource person is available and well trained to handle the first line of questions on a specific topic. For example email. If you were the resource person for this topic you would field all questions, problems and issues that deal with email from your desginated area. This type of peer-to-peer assistance seems to go over fairly well.

In the skills list I see Electronic/Automated Calendar, I would recommend that this be identified as Electronic/Automated Calendar systems for Groups. We want to promote group communications and this is a great way to achieve this result.

From our last meeting I reviewed the list of audience and I am not sure if by Business Community you mean supporters of the college or if this includes Partners and Alliances. If not, I feel that we should add to this list "Partners and Alliances".

AHC task forces have been created to focus on the Rural Health School, alternative care, allied health programs, a managed care institute with St. Thomas, and Health Services Research.

He stated that it is easy to lose sight of progress that has been made. In the past the administration reacted to crises. There may have been too much planning/administration. But ground work has been laid for new initiatives to improve education, research and service programs.

In the coming year, priorities will include renovating classrooms; developing new teaching technology improving curriculum; supporting corporate sponsorship for research; streamlining grants management and marketing AHC capabilities and services.

All About University Relations

Marcia Fluer, director of University Relations, gave an overview of her department. UR serves a variety of functions, but is usually identified as the news service for the campus. In addition to the news service, they produce publications and periodicals (M, Kiosk, Brief), coordinate special events, and plan marketing initiatives. She said that questions or concerns should be directed to Chris Roberts and AHC staff, who will work closely with the U Relations staff to solve problems. She emphasized the importance of proactive communication to deal with problems before they become crises.

Fluer reminded the group that even though we focus on our jobs or departments, we need to remember that we work within a greater organization: the University of Minnesota.

U of M Marketing Initiative

Tom de Ranitz, marketing manager, described three levels of "branding" publications with the U wordmark and other U symbols. (Refer to Marks of Excellence sheet.)

de Ranitz said that the wordmark and the U symbols are available on disk and can be obtained from U Relations. They should not be recreated. The wordmark should be included on all University publications. Tom and Chris have discussed creation of an AHC logo.

AHC Communications Strategic Planning Process

Chris distributed the AHC Strategic Planning Process document (see draft form) and guided the audience through it.

The plan identifies process participants and outlines tasks and target dates for completion.

Work groups include:
Internal Communications
Communications Technology
Strategic Partnerships/Fairview
Media Relations
Legislative Relations

The groups will include volunteers who have an interest in the subject area. The question was asked as to where community relations fits into the process. Chris stated that it would be part of the Strategic Partnerships/Fairview group, since that group will be dealing with external relations.

Participants in today's meeting were invited to volunteer for one or more of the groups.

Academic Health Center
Strategic Communications Planning Team
Meeting Summary
June 24, 1997

Participants: College of Pharmacy - Henry Mann, Karen Meyer, Laurel Mallon (Nursing/Pharm),
School of Public Health - Susan Hayes
School of Nursing - Cynthia Gross
Medical School - Ann Benrud, Debbie Johnson
School of Dentistry - Laura Boland
Cancer Center - Coleen Southwell
Academic Health Center - Vic Vikmanis, Bill Hoffman, Marilyn Johnson
Academic Health Center Human Resources - Jeanette Louden
Academic Health Center Communications - Peggy Rinard, Teri Charest, Gayle Bonneville
Mary Kenyon, Maureen Lally, Amy Olson
Student Faculty Consultative Committee - Mike Armstrong
The Rowland Company - Johnny Thompson

Moderator: Chris Roberts, Academic Health Center Communications

Tasks:
1. Finalize process plan and timeline
2. Complete environmental analysis (SWOT - strengths, weaknesses, opportunities, threats).
3. Prepare materials for Leadership Team Meeting (July 1).

Strengths - What do we do well? Our resources?

We're getting used to changes
U focus/resource for media
Faculty and staff creativity - intellegence
Size of the organization - number of people, finances in AHC (% of U budget) - making something new
Doing research that others can't do
Only school in state (pharm., dent., mort. sci., etc.)
Number of schools/colleges in AHC - diversity
Community support
Efforts to improve undergraduate experience
New University president
Top ten institution nationally for private support
Pride - expertise
Legislative support
Innovative in response to managed care? How to position the AHC?
Top 10 in research funding
Faculty brings in top students
Interdisciplinary programs
Loyalty of faculty to research - dedication
Highly educated workforce
AHC leadership
Leader in allied health sciences
New Basic Sciences Building and Cancer Center
Success of alumni

Minnesota "ownership" of U
National focus on Minnesota in managed care
Physical proximity of schools - atmosphere of health team
Individual accomplishments {peer recognition/faculty research/research related to citizen needs/dedicated to the betterment of mankind}
Quality of programs - many are top ranked
History of firsts - world renowned
New technology spin-offs
Minnesota managed care leaders?
Part of the Big 10
Biotechnology leaders
Educate 80% of the state's health professionals
Facilities
Location - TC campus
Quality of student applications

Weaknesses - Where do we need work?

No historical collaborations or shared visions
Size - unwieldy system - bureaucracy
Work not understood by general public
Public perception of physicians
AHC seen as just medical school or hospital
Facilities
Location/parking
Lack of focus - all things to all people
Educate and alienate students/alumni
Brody residue (reengineering/tenure) - lost good things he was trying to do - interdisciplinary programs
Silos
Not tooting horn/faculty modesty/no incentive to communicate
Self promoters - relevance - loyalty divided
Faculty do not see themselves as employees
Clinicians importance/attention
Faculty and staff not seen to interact - no social skills
Public institution (threat?)
Faculty taught to be "lone rangers" rather than team players - competition among faculty
Institutional barriers to cross-discipline education, collaboration
Merger/sale of hospital
Lack of strategic planning (ineffectual) - leadership turnover
Faculty being recruited away
Tradition-bound curriculum - need different type of professor for new environment
Space
Behind the times education - flexibility/technology
No reward for community outreach
Disconnect - funding vs. expectations
Risk averse
Difficult to reward people
Conference rooms and building facilities
No technology support
Graduate School support based on teaching assistance - $
Vulnerability of faculty - being lured away
Conflict between "old" thinkers and "new" thinkers

Lack of focus on students and their futures (note: AHC funds come generally from other sources than tuition).

Opportunities - What could we be if we waved our magic wand?

Yudof
Other colleges have higher tuition
Changes in health care - community's need for education
Distance learning technology - telemedicine/business and corporate relations
National and international collaborations
Health care providers and payers need information
Community is interested in medical topics
Specialists under one roof
U is seen as neutral at the legislature for testimony, convening other organizations for discussions
Cooperation with Mayo Clinic
Promote ourselves better
Positioning to Mayo Clinic
Improve alumni relations
Student relations/exposure to administrators
State is proud of our accomplishments
Growth of educational technology
Opportunity for collaboration -distance learning, interdisciplinary, strategic external partnerships
Sale of hospital?
Refocus on research and education
Corporate sponsorship for research
Development of new technologies or drugs

Threats - What could derail our progress?

Public financial support
Morale/unrest
Media criticism - public perception becomes reality
Graduate medical education funding problems
Top 12 media market - too much attention
Research organization competition/marketing
Facilities
Funding for technology - infrastructure
Student perceptions
Campus isn't user friendly
National competition for learning and information
Faculty doesn't want to assume administrative positions
Fairview's impact on us - name recognition
Cost of education
Managed care
Health professions may not be as attractive as they were in the past

AHC COMMUNICATION PLANNING TARGETS

AUGUST 1	**Draft plan completed**
AUGUST 8	**Tactical development begins**
SEPTEMBER 13	**Review and comment completed**
OCTOBER 3	**Final plan distributed**
OCTOBER 10	**Phase II planning begins**

Strategic Planning Leadership Team
Meeting Summary
July 1, 1997

Participants:

Dentistry: Laura Boland, Gale Shea
Medical School: Cheri Perlmutter, Mary Knatterud, Ann Benrud, Mary Jane Towle
Nursing: Karen Alaniz, Cynthia Gross, AHC-FCC
Pharmacy: Marilyn Speedie, Karen Myers, Laurel Mallon, Pharm/Nursing
Public Health: Susan Hayes
Veterinary Medicine: David Thawley, Phil Oswald
Student Faculty Consultative Committee: Mike Armstrong
CHIP: Jenny Meslow
Sr. VP Health Sciences: Terry Bock, Marilyn Johnson, Bill Hoffman
UMP: Lisa Jetland
Alumni Association: Tom Garrison
University Relations: Tom deRanitz
AHC Communications: Chris Roberts, Peggy Rinard, Gayle Bonneville, Mary Kenyon, Teri Charest, Amy Olson, Susan Papanicolaou, Maureen Lally

Moderator: Johnny Thompson, Rowland Company

Meeting Objectives:

Identify major issues that the communications plan will address.
Define strategic questions for each major issue.

Major issues:

Faculty/workforce recruitment/retention - communication of strengths, national reputation in academic circles
Diversity/complexity of AHC - Fairview clinics/size/range of disciplines, ages, etc.
Dissemination of information
Public/legislative perceptions (entire state)
Responsiveness to needs of state (how do we know what they are?)
Alumni recognition/tracking
How are we treating our students - what message are they carrying out?
Greater affiliation with colleges than the whole AHC
Building alumni/student/donor relations
Faculty and staff feel they don't know what's going on (morale)
Getting all our "good news" out to the external and internal audiences
Complex issues don't lend themselves to "snapshots"
Complex coordination - "where do I go?"
Defining our market
Partnerships - risky?
How do we strengthen our national and international reputation?
What does "land grant mission" mean, anyway?
Translating what U of M does so public understands it
Public perceptions
Internal morale
Funding
Exchange of information

Retention of employees
Students' perception of their value to the University
Rewarding good work
Relationship between the AHC and the rest of the University
Limited resources for communications
Relationship of AHC with practitioners and alumni
Employee morale
Image - positioning AHC and U, department enhancement vs. institutional enhancement, community perception, satisfaction vs. loyalty, positioning with the media

Summary of Major Issues:

Morale
Public Perception
Dissemination of Information
Definition of Communication Roles and Responsibilities
Building External Relationships/Fairview
Customer Service
Funding

Questions Related to Major Issues:

Morale

What role do communications and marketing play in dealing with morale issues?
What characteristics of the morale "problem" are solvable?
How do we build pride and create a positive identity?
How do we define and create community?
How do we restore trust?
How do we recognize achievement?
How do we value people?
How do we empower and include people?
How do we create a climate to deal with change?
How do we maintain, measure and improve student morale?
How do we maintain a healthy environment for our students, faculty and staff?
How do we support recruitment and retention of faculty, staff, and students (also a perception question)?

Public Perception

What is the "public?" Who are our audiences?
How do we build a national reputation?
How do we promote the good news?
What are the common messages? How do we encourage our constituencies (students, faculty, alumni) to send same messages?
What is our current image? What do we want it to be?
How do we get brand "buy-in?" How do we convince people and programs, departments, schools/colleges they won't be harmed by it?
How does perception compare to reality? (gap analysis)
How do we build credibility? What is our perception history? How has it changed over time?
Who are the other players (e.g. media)? Who else helps create perception about us?

Radio - provide service via talk shows
Quarterly meetings with faculty and staff
Supervisors disseminate information
"Brief" format for publication
Bathroom bulletin boards - elevators
Coordination of community/media relations
Electronic and print clips
First contact to the University

Tactics

Creating community groups within health center - students/faculty
Connectedness - voice to non-faculty
Market research
"Walk the walk" - deans/administration
Sharing information
Outstate news
Information officer
Consistent signage
Consumer health information
Community within AHC - students, staff
Community talks - faculty
Ambassadors for U
Phone courtesy
Economy impact - research
Let employees know before TV- media
AHC communications staff talk to depts/groups
Simplify name - AHC
Consistent branding
Communicate student orientation - same with faculty and staff
Research data base - internal and external
"Brief" format publication
Personal contact - human element
Know each school and U
Reward system - faculty and staff
Define criteria for branding
AHC identity
Common goals - outreach
Rebuild trust - open meetings
Service - outreach - mentoring - prospects
Support coordination between colleges
Sense of pride
Display of accomplishments
Student facilities - housing/classrooms
Customer service
Alumni contact
Speakers bureau
Telemedicine promotion
Public information line
Clinical trial promotion
Health Talk and You
Training in communications for faculty/staff
College/school names

U and AHC tied ?
Faculty columns in media
K-12 partnerships - model in Raptor Center
Commitment to fund recognition events
Define criteria for branding AHC - more important internally shared resources - message
Benchmarking communications program with other AHC's nationally
AHC health fair
Funds/time for staff development
K - 12 outreach - model from raptor center
Best practices models - replicate
Lost and Found (CHIP)
Use organizational names that can be understood externally
More information desks
Reward for customer service
AHC page in the Daily - events
Poetry contest
Videos - news clips
Comings and goings - open houses
Thanking/recognition of employees - events/rewards
Strategic communication support
Communication plan in each school
Faculty/staff communications/supporting each other across depts/school
Cerra visible internally
Banners - bldg - signage
More letters and e-mail (personal - short)
Reading room - coffee bar
Technical training
Web page enhancement
Facilities - clean
Volunteers - guest services greeters
Focus on interdisciplinary curriculum - add community projects to curriculum
How do we emphasize what we do with our name
Comprehensive teaching is what we do

Themes

We contribute to Minnesota Health through innovation, education and research
We have all the answers to your health related questions
We're helping Minnesota's biotechnology industry develop the next generation of medical devices
Partnerships for better health
World class_____
Serving Minnesota and the world through innovations in health care, research, and education
Minnesota's pride
We're second to Mayo - we try harder
Birth to death and your pets too (life to death at the U and your little dog too)
Innovations are us
Minnesota's health resource center
Education for now - research for the future
Ask the AHC
U are part of uS

Communications Planning
Meeting Summary
July 17, 1997

Participants:
MMF: Jodi Olsen Reed, Jean Murray, Dan Saftig
Medical School: Mary Tate, Ann Benrud, Carolyn Rask, Dale Cooper, Ross Janssen, Debbie Johnson, Mary Knatterud, Chet Whitley,
School of Public Health: Susan Hayes, Peg Dematteo
School of Nursing: Sharon Vegoe, Chris Mueller, Karen Alaniz, Cynthia Gross
College of Pharmacy: Karen Meyer, Bruce Benson, Cathy Ostlund
School of Dentistry: Laura Boland, Bonnie McCallum,
College of Veterinary Medicine: Phil Oswald, Jill McPhillip, Beth Garrigan
AHC Student Consultative Committee: Mike Armstrong
CHIP: Jenny Meslow
Biomedical Library: Julie Kelly, Cindy Hendrickson
Biomedical Engineering: Bill Hoffman
ORTTA: Jim Severson
UMP: Pat Board
University Relations: Tom deRanitz
Institutional Relations: Donna Peterson
Office of the Sr. Vice President: Terry Bock, Vic Vikmanis, Marilyn Johnson, Steve Johnson
Fairview Health System: Barbara Nye
Alumni Association: Tom Garrison
Cancer Center: Coleen Southwell
AHC Human Resources: Bob Copeland
AHC Communications: Chris Roberts, Peggy Rinard, Gayle Bonneville, Teri Charest, Susan Papanicolaou, Amy Olson, Mary Kenyon, Maureen Lally

Guest speaker: Karl Speak, Beyond Marketing Thought
Moderator: Johnny Thompson, Rowland Company

Objective:
Brainstorm ideas; identify key audiences and articulate messages.

Key Audiences

Internal: faculty, students, staff
Minnesotans: health professionals
Media
Students: prospective/current
Alumni
Legislative bodies
Opinion leaders
Providers
Biomedical and health care industry
Fairview board
Board of Regents

Payers
Referring physicians
Donors
Patients
Government officials
Professional associations
Users of services
Business community
Education community
People of the state

Messages

We educate most of the states health care professionals
We contribute to the economic and physical health of the state
There's a good return on any investment in the AHC
We carry out our land grant mission through outreach services such as rural health
We are family (total picture of U)
University of Minnesota has played a critical role in the "lead of the nation" health of Minnesotans
Today's investment in your health makes Minnesota strong
Economic resource to state, nation, world
Provide the best education, research, and service
AHC values faculty, staff, students
We are a valuable community resource
Wealth spring of innovation - care and technology
Customer/community-driven (entire state of Minnesota) community = state
Foundation for health care in Minnesota
Only University, world class AHC in State
Uniquely positioned to be your comprehensive provider of health care information
Continuing to serve the state and still going strong
Providing top health care professionals to the world
National leader which is vital to the health and economy of Minnesota
We offer state of the art education, research and service
Leading innovator in all types of health care for all (species)
We're training and maintaining tomorrow's health care professionals.
We are a unique resource that serves the entire State of Minnesota "billions and billions of people"
We provide interdisciplinary educational opportunities for the state's future health care practitioners
We are Minnesota's resource for a healthier environment, community and state
We are a world leader in developing innovative health care advances and technology
Our research brings in millions of dollars allowing us to be one of the states largest employers
Making research relevant
Environment that tackles lengthy, complex issues that cost money
Teaching is what we do

Channels

Update campus phone system
Environment/atmosphere
Meet with customers - testimony
E-mail vs. phone
Minnesota Daily - AHC column
State Fair - Alumni

How do we convey idea of service?

Dissemination of Information

How do we distribute information fast, accurate, and without a public relations slant?
Who decides what we need to know? Gatekeeper or dispatcher?
How can we build communication "trees" to improve information flow (how can we convince people they are not at the bottom of the chain?)
What investment in capabilities, training or technology need to be made?
How do we build a feeling that people are in the loop?
How do we know information is enough, legitimate, true?
What are the best communication vehicles? How do we know?
How do we build ambassadors (40,000 potential)?
How do we educate people about how to find information?
How do we manage rumors?
How do we define audiences?
How do we get out the positive information without sounding naive?
How do we establish a feedback loop?
How do we manage the negatives - crisis management?

Definition of Communication Roles and Responsibilities

Who does what? How and when? Who has the final word?
How do we maximize opportunity by combining resource pools?
How do we "capture the moment" resulting from a new president?
How will President Yudof "change" communication?
What is the AHC community? How do we define ourselves within the AHC?
How is information exchanged?
What is our role as a provider of publications and information?
Is control a good or bad thing? How do we respect differing views/needs?
How do we piggy-back on already existing initiatives like Gopher?
How do we fit into the U's plans and other units of the U?

Building External Relationships/Fairview

Fairview

What are the marketing and communication dimensions of the Fairview relationship?
How do we define the interface?
What opportunities does the relationship present?
Where do we compete; where do we cooperate?
What is the relationship with UMP?
What is the definition of the AHC without the hospital?
How do we share credit?

Building External Relationships

Other

What relationships do we have around the state?
How do we build and maintain good will with our various partners?
How do we define "partnership" in a way that respects both partners needs and contributions?
What do our audiences think, feel and want?
What do we think, feel and want and need?
How do we build ownership?
How do we share credit?
What can we do to support legislative initiatives?
What are critical relationships?
What other relationships are important?
How do we build student loyalty and alumni relationships?
How do we compete with and at the same time build relationships with the community physicians and partners?
How do we track and recognize alumni achievements?
How do we build cooperation in interdisciplinary relationships?
How do we use communications and marketing to cultivate potential donors and investors?
How do we cultivate relationships with the employers of our graduates?
How do we function internationally?

Customer Service

Who are our customers? What are their needs? How do we meet those needs?
How do we want them to feel?
How do we know when we have met those needs?
How do our customers access us?
What is our product? Are we providing it?
How do we become more customer service oriented?
How do we serve our fellow employees?
How do we serve those wanting to access our intellectual property?
How do we encourage faculty/staff to become more service oriented?

Funding

How do we fund broad based projects when departments are more and more responsible for their own funding?
What is the future for our revenue pool?
How do we convince people that an investment in communications and marketing is a valuable one?
How much is enough? Who decides?
Is funding only money? (people, time, equipment, facilities)
What are the priorities?

AHC Communications Planning
Leadership Meeting Summary
July 23, 1997

Participants:

School of Dentistry	Michael Till, Laura Boland, Gail Shea
School of Nursing	Cynthia Gross (AHCFCC),
College of Pharmacy	Karen Myers
School of Public Health	Mary Hayes
Medical School	Ann Benrud, Mary Knatterud, Debbie Johnson
Sr. Vice President Office	Vic Vikmanis
AHC Information Services	Marilyn Johnson
Biomedical Engineering	Bill Hoffman
CHIP	Jenny Meslow
AHC Student Consultative	Mike Armstrong
University Relations	Marcia Fluer
Institutional Relations	Donna Peterson
U of M Physicians	Pat Board
Fairview Health System	Barbara Nye
AHC Communications	Gayle Bonneville, Peggy Rinard, Mary Kenyon, Amy Olson, Teri Charest, Susan Papanicolaou, Maureen Lally
Moderator	Christine Roberts, AHC Communications

Objective:
Identify goals, objectives, and primary components of the plan.

Review of Communications Plan Strategy Statement
First paragraph needs to be positive
Emphasize collection of schools, economic impact on the people of the state
Quit apologizing
Strengthen community vs. rebuild
Leverage what we have
University name should be out there
Name should be contingent upon audience
Technology and research cross colleges
Any mention of Fairview needs clarification of partnership
Strategy statement should not list specific partners/programs
Third paragraph - expand campaigns - initiatives
Plans don't create
Internal/external audiences don't understand AHC meaning
Communities - not color
Message via media - media is an audience
Decision makers vs. audiences
Reach all people of the state
"Primary" audiences = targeted campaigns
Schools communication plans - alumni/donor focus
K-12 emphasis - why singled out?
Use personnel vs. personal
Use strengthen vs. rebuild
Building signage - user friendly environment
More emphasis on research
Strengthen and encourage pride

Goals

Market-based communication - invest in research data
Efforts support goals (dept., AHC, institution) - need baseline measurement
Determine how to communicate
Improve national rankings in each school/college
Create welcoming identity - unify, user friendly
Work environment issues - technology, facilities, infrastructure
Establish and implement coordinated communication plans for each school/college
Improve person-to-person interaction (division between faculty, staff, students)
Improve information flow - framework, infrastructure
Faculty, staff, (employees) students as customers
Improve atmosphere - signage, greeters, gateway to AHC, kiosk, information center
Provide Total Quality Management office as resource

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September 10, 1997

TO: AHC Faculty Consultative Committee

FROM: Maureen Lally, Academic Health Center Communications

RE: AHC Strategic Communications Plan

Chris Roberts, director of communications, will discuss the communications plan at tomorrow's Faculty Consultative Committee meeting. Attached is a draft copy for your review.

Please contact me if you have any questions, 624-9619. Thank you.

Encl.