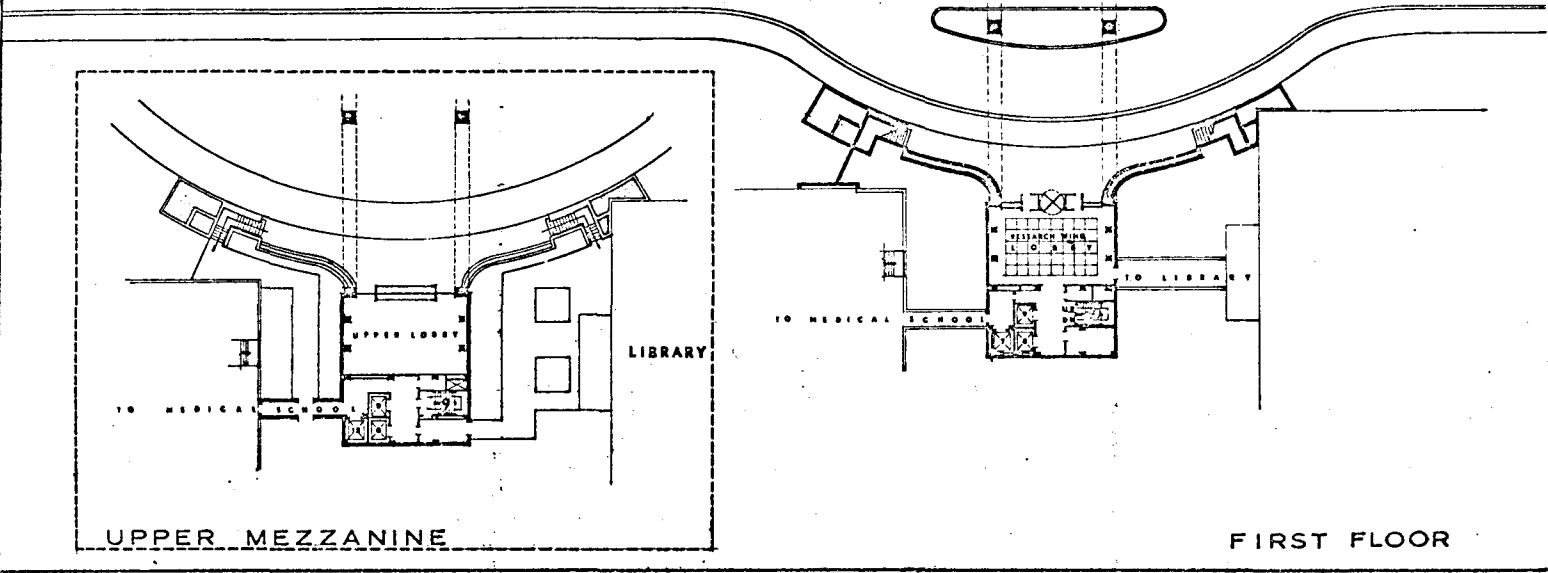


NINTH AVENUE



UPPER MEZZANINE

FIRST FLOOR

+

UNIVERSITY OF MINNESOTA
MINNEAPOLIS CAMPUS

12.0

To: Mr. John Westerman
From: Mr. Brasfield
Subject: Attached Memo

The enclosed is meant to assist in the continuing discussion of an outpatient central appointment system. I hope we have an opportunity to discuss the ideas presented here at a Tuesday luncheon.

OUTPATIENT DEPARTMENT APPOINTMENT SYSTEM

August 26, 1965

McCollum E. Brasfield

Introduction

Advantages of Decentral Appointment

Advantages of Central Appointment

Disadvantages of Central Appointment

Conclusion

The basic issue of decentralizing or centralizing a task is a decision of whether the logistics of the task outweigh the concrete particulars involved. In 1965, processing a large number of pieces of information relates to a decision of to what tasks the computer is relevant. Centralism of any type, even by computer, is not relevant when information needs to be conveyed and discussed in face-to-face contact. Centralism is relevant, however, when the mechanics of communication are primary and the need for face-to-face contact and consideration of particulars are secondary.

Advantages of Decentral Appointment

Decentralism is not a lack of order or planning, but relies on differing concepts and motivation than does a central system. The focus of decentralism is on the function performed, the person performing the task, and his increasing awareness of his part in the total organization. In a central system, that person's task is more determined by top-down authority.

The task of making an appointment now requires the face-to-face contact of a minimum of three persons: Patient, doctor, and clinic clerk. This face-to-face contact of persons directly serving the patient has value. Moreover, the doctor and clerk must have an understanding of the Outpatient Department in order to make the appointment. A clinic which relies on cooperation and face-to-face contact and is a group of persons with the common aim of serving patients can arrange its own schedule, fitting its schedule to the needs and desires of a medical director and staff.

Specific advantages of a decentral appointment system:

1. Each clinic of the Outpatient Department differs in mode of operation and may differ in philosophy. A decentral appointment system recognizes these differences.
2. The clerk of each clinic is responsible for making an appointment correctly. In the clinic, responsibility is easily determined in the decentral system.
3. The decentral appointment system is directed by the doctor. He decides the order in which the patient should visit various clinics.

Advantages of Central Appointment

If a goal of administration of the Outpatient Department is to standardize the clerical operation of the clinics, the advantages of central appointment in the Outpatient Department are as follows:

1. Centralizing the appointment system will emphasize uniformity and standardization.
2. Centralizing the appointment system presents the possibility of increasing the coordination of appointments for patients, doctors and other Hospitals employees.
3. Centralizing the appointment system separates one more task from the total work of an individual outpatient clinic. Defining the procedure by a computer or telephone system will enable an increased work load of ten or twenty times with only a small increase in the equipment and number of employees.

Disadvantages of Central Appointment

1. A central appointment system will increase immediate cost in the forms of increased personnel or equipment or both. (This is not an advantage of the decentral system, since the present system can continue and be improved with little additional cost.
2. If a central appointment system requires that the patient has "one more place to go," the advantages of mechanization of the task are more than offset by the inconvenience to patients, doctors and other employees. There are none of the advantages of centralization in this proposal.
3. There is not a strong tradition in the institution toward centralism of tasks which are mechanical and do not require face-to-face contact.

Conclusion

I recommend the Outpatient Department appointment system be centralized, but only if centralized by a computer or telephone system. The recommendation is made considering the increased uniformity and standardization required in clinics; the probability that decision making involved in appointments can be reduced to written procedures; the increased complexity of the organization and the need to organize the daily schedule of patients, doctors and other employees.

The alternative of central Outpatient Department appointments by a human system is unacceptable because centralism by this method only adds to the operational cost and complexity of the appointment system now encountered by the patient, doctor and other employees.

SECOND REPORT TO THE DEAN AND FACULTY
PROGRESS IN PLANNING A NEW OUTPATIENT FACILITY

February 17, 1967

On March 31, 1965, a report was submitted by Dr. Glenn Gullickson, Jr., Chairman, Clinic Directors Committee, to the Dean and faculty of the University of Minnesota Medical School telling of the progress in the deliberations of the Clinic Directors Committee with respect to a new outpatient facility. This communication is a follow-up on that initial report.

The Clinic Directors Committee (CDC) has been engaged, in conjunction with the Committee for the Study of Physical Facilities for the Health Sciences (Clinical Medicine and Hospital Subcommittee), in a study to increase the efficiency of the clinic facilities in terms of its goals as a teaching, research and service segment of the Medical Center. The CDC believes that a review of its study and of its goals for the outpatient facilities is appropriate at this time and that this review will assist the hospital staff in recognizing the concepts which the CDC is considering. The CDC also solicits the opinions and sentiments of the faculty regarding these concepts.

In the early summer of 1966 a proposal to utilize Powell Hall as an outpatient facility until the projected new ambulatory care center was built was rejected by the University Administration because of excessive cost and the existing student housing shortage. New methods of achieving an improved clinic facility were discussed. The principles and priorities which evolved included improved patient control, increased teaching space, an experimental multiphasic diagnostic clinic, a model clinic, patient waiting areas out of the hallways, new organization of the OPD centered around the patient. Subsequently,

the effects of newer methods of financing medical care led to a diminution in the size of the traditional OPD clinic population and created a need to compete for a sufficient volume of clinical material. This, in turn, led to appraisal of the parking problem and the creation of more attractive facilities.

It was felt that a unique opportunity to evaluate certain innovations had presented itself prior to the planning for the \$5,000,000 ambulatory care center. Fundamental discussions revolved about two concepts: the first was the concept of a multiphasic diagnostic clinic, and the second was the development of a multi-use clinic area, an experimental model clinic.

To assist in consideration of the first concept, Dr. Paul E. Strandjord was asked to prepare a report, a summary of which is attached. In his report, he discusses the rationale for such a battery of screening tests, a review of what has been done in this field elsewhere in the United States, and a possible approach at the University of Minnesota. It must be emphasized that Dr. Strandjord's report, as he himself states, represents just an example of what could be done here, not a definitive example of what should be done; that must be decided upon the basis of goals, experience and feasibility as determined by the clinical faculty. The inclusion of radiologic, dental, ophthalmologic and other screening procedures has been considered.

Since the decision as to what to include or exclude has not been approached, the volume of patients necessary to achieve a modicum of efficiency has not been determined. It is felt that the new patients seen in clinic for total evaluation, the patients of the Cancer Detection Clinic, and the newly admitted hospital patients would represent a substantial segment of the population to whom this service would be beneficial. In summary, this service would represent more than a battery of chemical analyses but would encompass a number of other studies useful in the diagnostic evaluation.

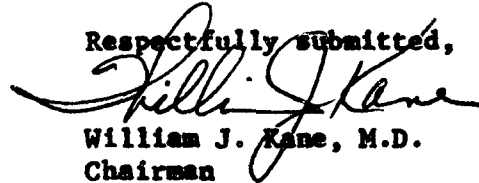
The second concept envisioned the remodeling of a large area of the present clinic area to try new patterns of staffing, new physical arrangements, new teaching devices, new patient service features, new organizational methods, and new approaches in materials and appearance.

Both of these concepts were accepted in principle by the CDC and a request for financial assistance to explore these ideas and to implement them was presented to hospital administration on October 3, 1966. Subsequently, \$200,000 was budgeted through the hospital administration to implement the proposals, and the Board of Regents approved the request for architectural studies relative to these same proposals. The University Administration chose Ellerbe as the architectural advisors for the project. On January 25, 1967, two subcommittees of the Clinic Directors Building Task Force were appointed to investigate the feasibility, desirability and implementation of these innovations in the clinics. These subcommittees consist of the Multiphasic Diagnostic Subcommittee chaired by Dr. B. Fuller, assisted by Drs. P. Strandjord, S. Olsen and C. Branthaver; and the Multi-use Model Clinic Subcommittee chaired by Dr. S. Chou, assisted by Drs. L. Adcock, G. Beaumont, and A. Leonard. Dr. W. Kans will serve as chairman of the Clinic Directors Building Task Force until July 1, and Mr. P. Sammond will coordinate the planning for the new facility in the Health Sciences Expansion Plan.

This, then, is the situation with respect to the deliberations of the CDC on these programs. In summary, the CDC has approved a study of methods by which present clinic facilities may be improved and by which fruitful research into future planning for the projected major clinic construction can be achieved. This decision to study the problems and opportunities facing the clinical faculties in the area of ambulatory care has been favorably received by the hospital administration and the Board of Regents.

The members of the CDC earnestly solicit faculty opinion and sentiment in order to evaluate their needs and wishes so that they may be incorporated into these alterations. As future progress is made, the faculty will be consulted, usually through their representatives to the CDC, for expressions of assent or dissent; the CDC is hopeful that by this step-by-step program of informing and listening, the assent will be kept to a maximum and dissent to a minimum.

Respectfully submitted,



William J. Kane, M.D.
Chairman
Clinic Directors Committee

Clinic Directors Committee

Dr. Leon Adcock	Dr. Theodore Grage
Dr. Richard Anderson	Dr. Glenn Gullickson
Miss Annie Laurie Baker	Dr. Eugenijus Gedgaudas
Dr. Graham Beaumont	Dr. Reynold Jensen
Dr. John Blum	Dr. William Kane
Dr. Charles Branthaver	Dr. William Knoblach
Dr. John Brantner	Dr. Frank Lassman
Mr. McCollum Brasfield	Dr. Arnold Leonard
Dr. Shelley Chou	Dr. Richard Magraw
Dr. Donald Creevy	Dr. James Moriarty
Dr. Edward Defoe	Mrs. Irmagene Starke
Dr. Arndt Duvall	Dr. Paul Strandjord
Dr. Robert Fisch	Dr. Luigi Taddeini
Dr. Benjamin Fuller	Dr. George Tani
Dr. Ramon Fusaro	Mr. Peter Sammond

STUDIES OF THE UTILIZATION OF
THE CLINICAL LABORATORY AS A ROUTINE ADJUNCT TO
THE HISTORY AND PHYSICAL EXAMINATION

Rationale¹

"Classically there are three major avenues of gathering information with reference to patient management: the history, the physical examination, and the laboratory examination. The roles of the history and the physical examination have become relatively well established. The role of the laboratory examination is rapidly changing, however, and may be expected to change even more dramatically in coming years. It is now accepted practice to gather historical information and physical findings concerning all of the major systems of the body at the time of a detailed clinical examination. It will soon be feasible to provide a similar laboratory examination which will reflect information regarding many of the major systems of the body. Such a battery of tests will be directly analogous to the current screening type of physical examination which provides information regarding heart, lungs, liver, etc. Laboratory examinations of this type will be performed at the time of hospital admission, as well as during periodic health examinations. Information gathered from such examinations will be recorded in a form facilitating retrieval and will be helpful in detecting asymptomatic pathology, in facilitating earlier diagnoses, and in shortening periods of hospitalization. Data will be considered not only on the basis of what is normal in the general population, but what may be considered normal for an individual of a specific age and sex. In addition, compilation of such information will facilitate establishing normal values for given individuals. Values which could be considered normal in reference to norms based on the general population may appear abnormal when considered in reference to a patient's own established 'normal values'."

Summary of Findings of Several Recent Screening Studies:²

- I. Glucose and diabetes mellitus.
 - A. Determinations of both blood and urine glucose concentration should be performed one hour after a "carbohydrate load".
 - B. A number of studies have shown that the average incidence of unsuspected diabetes is approximately 1.14% or 1 case of diabetes for every 100 people tested. (The number of undiagnosed cases of diabetes mellitus is probably equal to the number of known cases of this disease.)
 - C. False positive blood and urine glucose tests occur especially in young children and pregnant women.
 - D. Undisputed abnormalities in blood sugar tests--2%, in urine sugar tests--6%.

¹P.E. Strandjord, Lab. Med.--A Prospectus, Minnesota Med., May, 1966, 773.

²The data include only findings picked up as a direct result of the screening procedures under investigation.

- II. Serum calcium and parathyroid function.
 - A. The incidence of unsuspected hyperparathyroidism is about 0.15%; hypoparathyroidism about 0.03% and pseudohyperparathyroidism about 0.04%.
 - B. The incidence of unsuspected serum calcium abnormalities has been reported as being 0.96% or approximately 1 in 100 subjects tested.
- III. Serum uric acid and gout.
 - A. Unsuspected gout--0.6%.
 - B. Unsuspected abnormalities in uric acid--4%.
- IV. Kidney function tests and renal disease.
 - A. Unsuspected renal disease--0.5%.
 - B. Unsuspected abnormalities: BUN--1%, Cr--0.5%, Urine albumin--3.8%
- V. Hemoglobin and anemia.
 - A. The incidence of unsuspected anemia is about 0.8%.
- VI. Serologic test for syphilis.
 - A. The incidence of unknown syphilis is about 0.3%. (The incidence varies significantly in different areas of the United States.)
- VII. Chest X-Ray.
 - A. Unsuspected pulmonary abnormalities--0.8%.
 - B. Unsuspected cardiac abnormalities--0.5%.
- VIII. Blood pressure and hypertension.
 - A. Incidence of unsuspected hypertension--5%.
- IX. EKG and heart disease.
 - A. Unsuspected heart disease of various kinds--3%.
 - B. 6 or 12 lead EKG is usually recommended.
- X. Height, weight and obesity.
 - A. Approximately 6% of the population is overweight.

XI. Impaired Vision.

A. 16% of those tested are unaware they have faulty vision.

XII. Impaired Hearing.

A. Approximately 3% of the subjects tested are unaware of a hearing deficit.

The preceding outline mentions only some of the diseases and laboratory tests that have been studied. In most studies the incidence of unsuspected abnormalities is surprisingly high. Many of the people in these studies were considered to be well and healthy by themselves and by their physicians. Others may have been hospitalized during the study but not for the diseases or conditions that were discovered by the screening tests. In the majority of diseases or conditions discovered early diagnosis and early treatment are beneficial to the patient. Detailed information regarding the studies cited in this summary are presented in the following pages.

A PROPOSAL FOR ROUTINE DIAGNOSTIC SCREENING
 AT THE UNIVERSITY OF MINNESOTA HOSPITALS

<u>Test</u>	<u>I</u> All <u>Patients*</u>	<u>II</u> Tests Selected on <u>Basis of Findings in I</u>	<u>III</u> Age & Sex <u>Selected</u>
Height and weight	X	---	---
Blood Pressure	X	---	---
Visual Acuity	X	---	---
Intra-ocular tension	---	---	X
Retinal Photography	---	---	X
Audiometry	X	---	---
EKG	---	---	X
X-Ray, Chest	---	---	X
X-Ray, Abdomen	---	---	X
Dental Screen	X	---	---
Blood			
VDRL	X	---	---
Glucose (after carbo. load)	X	---	---
Urea	X	---	---
Calcium	X	---	---
Sodium and Potassium	X	(Bicarbonate & Chloride if Na or K is abnormal)	---
Cholesterol and Triglycerides	---	---	---
Total protein	X	---	---
Protein Electrophoresis	X	---	---
Uric Acid	---	---	X
Hemoglobin	X	---	---
White Blood Cell Count	X	---	---
Lactate Dehydrogenase	X	(LDH isoenzyme separation if LDH is abnormal)	---
Ornithine Carbamoyl Transferase	X	---	---
Alkaline Phosphatase	X	---	---
Acid phosphatase	X	---	X
Urine			
Glucose (after carbo. load)	X	---	---
Protein	X	---	---
Microscopic Examination	X	---	---

*Expanded or deleted as indicated by clinical judgment and economic considerations. It does not include, at present, tests such as motor performance which would be selected on the basis of age and sex for pediatric patients.

June 23, 1966

UNIVERSITY OF MINNESOTA OUTPATIENT CLINICS 12.0

Diagnostic Screening Clinic

The Diagnostic Screening Clinic will have two major sections. One section will be bio-chemical screening, which should be on-line to a computer, and the results from most tests will be available immediately. Decisions that need to be considered, however, are the speed of service and what tests will be on-line and what tests off-line, if any. For example, is it possible for a patient to go through the diagnostic screening clinic one day and return a week later for his first visit with the physician? On-line chemistry and other laboratory tests may produce results immediately. Cardiographs, reading retinal photographs, and other tests such as these, if they are read by a cardiologist and an ophthalmologist, will take longer. Of course, weight, height, temperature, blood pressure, MMPI or self-administered history will be included in the Clinic.

The second section of the multiphasic screening clinic will be ad-lib service. Tests which physicians request will have the results within a few hours.

Dr. Strandjord suggests 2,000 square feet for the Diagnostic Screening Clinic for laboratory, including data processing, and an additional 1,000 square feet for EKG, X-Ray, bathrooms, and dressing rooms. For the Clinic Director Building Subcommittee meeting the week of August 8, Dr. Strandjord will have a more detailed plan and a list of chemical tests.

~~Health~~
~~to Dr. Learn~~ file
12.

May 25, 1968

TO: John H. Westerman
FROM: Peter H. Sammond, Chairman
Hospital Planning Group
SUBJECT: Alternative Approaches to Clinical Services in New Construction

This report of the Hospitals Planning Group is in response to the request of Dr. Elmer Learn and the Design and Coordinating Committee that the Hospitals

- A. Examine the implications of Psychiatry, Pediatrics, and Family Practice being moved to new construction in the first phase as Alternative I.
- B. Suggest alternative proposals to number I.

A. Alternative I has the following statistical implications:

1. Existing and Additional Beds

	<u>Existing Beds</u>	<u>Added Beds*</u>	<u>Beds in Old Building</u>	<u>Beds in New Building</u>
Psychiatry	88	0	0	88
Pediatrics	159	1	76	84
Family Practice	0	20	0	20
All Other Services	<u>307</u>	<u>138</u>	<u>745</u>	<u>0</u>
TOTALS	654	159	821	192

2. Breakdown of beds in old and new buildings:

	<u>Old Building</u>	<u>New Building</u>
Present	854	0
Move Psychiatry	- 88	+ 88
Move Pediatrics	- 83	+ 84
Close and Move Station 12	- 24	
Close and Move Station 22	- 27	
SUBTOTALS	<hr/> 632	<hr/> 172
Med-Surg beds in Psych Space	+ 130	
Med-Surg beds in Peds Space	+ 59	
Add Family Practice		20
TOTAL	<hr/> 821	<hr/> 192

3. Square Footage Implications

Existing Nursing Units -	170,200 sq. ft.
less Station 12 - 4,800	
Station 22 - 5,400	- 9,700
plus 192 beds @ 260'/bed	49,400
	<hr/> 209,900 sq. ft.

4. Ratios Nursing Unit/Total Hospital Space

existing - 49/100
 alternative I - 43/100
 typical - 40-45/100

5. To accommodate alternative I hospital departments would have to be reduced an additional 23,000 feet.

6. Assumptions:

a) The figures for proposed increases in beds were taken from the French Committee report of February 7, 1968.

- b) That of the 159 beds assigned to Peds only the Eustis wing beds would be replaced in new construction leaving Masonic, Heart, and Newborn beds as is.
- c) 260 sq. ft. per bed in new construction is an average value. The precise value will depend upon final determination of service and design. To reach this figure it was necessary to assign 60 sq. ft. per bed back to the hospital departments from the 320 sq. ft./bed proposed by the patient unit design committee. Our present average is 200 sq. ft./bed.
- d) The conversions from Psych and Peds stations to Med-Surg are based on a ~~summary~~ evaluation by the hospitals staff and have not had benefit of architect's advice.
- e) The 23,000' reduction by hospital includes a reduction from 504,000 to 495,500 as the Hospitals share of teaching space.
- f) Stations 12 and 22 will have to be taken out of service due to the location of the central receiving and service building abutting the hospital at this point.

7. Evaluation by Hospitals Planning Group:

- a) Operating another small hospital unit is not ideal from the standpoint of efficiency.
- b) It is important to build some beds at this time.
- c) The assignment of service in the new construction should be based on the configuration and use of the building after Phase II when the main hospital will be on the Powell Hall site. This would imply services which can operate semi-independently. The only one fitting these criteria is Psychiatry.
- d) There is difficult rationale involved in moving Psych without increasing its beds if the present Psych stations will be remodeled to receive more beds.
- e) The Hospitals Planning Group suggests that the ultimate (1986) use of the Phase I bed construction be Psychiatry. This implies that the facilities assigned to it in Phase I be easily convertible to this purpose.

12.0

UNIVERSITY OF MINNESOTA HOSPITALS
Minneapolis, Minnesota 55455

May 28, 1968

TO: John H. Westerman

FROM: Peter H. Sammond, Chairman
Hospital Planning Group

SUBJECT: Alternative Approaches to Clinical Services in New Construction

This report of the Hospitals Planning Group is in response to the request of Dr. Elmer Learn and the Design and Coordinating Committee that the Hospitals

- A. Examine the implications of Psychiatry, Pediatrics, and Family Practice being moved to new construction in Phase I as Alternative I.
- B. Suggest alternative proposals.

A. Alternative I has the following statistical implications:

1. Existing and Additional Beds

	<u>Existing Beds</u>	<u>Added Beds*</u>	<u>Beds in Old Building</u>	<u>Beds in New Building</u>
Psychiatry	88	0	0	88
Pediatrics	159	1	76	84
Family Practice	0	20	0	20
All Other Services	607	138	745	0
TOTALS	<u>854</u>	<u>159</u>	<u>821</u>	<u>192</u>

2. Breakdown of beds in old and new buildings:

	<u>Old Building</u>	<u>New Building</u>
Present	854	0
Move Psychiatry	- 88	+ 88
Move Pediatrics	- 83	+ 84
Close and Move Station 12	- 24	
Close and Move Station 22	- 27	
SUBTOTALS	<u>632</u>	<u>172</u>
Med-Surg beds in Psych Space	+ 130	
Med-Surg beds in Peds Space	+ 59	
Add Family Practice		<u>20</u>
TOTAL	<u>821</u>	<u>192</u>

3. Square Footage Implications

Existing Nursing Units -	170,200 sq. ft.
less Station 12 - 4,300	
Station 22 - 5,400	- 9,700
plus 192 beds @ 260'/bed	<u>49,400</u>
	209,900 sq. ft.

4. Ratios Nursing Unit/Total Hospital Space

existing	- 49/100
alternative I	- 43/100
typical	- 40-45/100

5. To accommodate alternative I hospital departments would have to be reduced an additional 23,000 feet.

6. Assumptions:

- a) The figures for proposed increases in beds were taken from the French Committee report of February 7, 1968.
- b) That of the 159 beds assigned to Peds only the Eustis wing beds would be replaced in new construction leaving Masonic, Heart, and Newborn beds as is.
- c) 260 sq. ft. per bed in new construction is an average value. The precise value will depend upon final determination of service and design. To reach this figure it was necessary to assign 60 sq. ft. per bed back to the hospital departments from the 320 sq. ft./bed proposed by the patient unit design committee. Our present average is 200 sq. ft./bed.
- d) The conversions from Psych and Peds stations to Med-Surg are based on a cursory evaluation by the hospitals staff and have not had benefit of architect's advice.
- e) The 23,000' reduction by hospital includes a reduction from 504,000 to 495,500 as the Hospitals share of teaching space.
- f) Stations 12 and 22 will have to be taken out of service due to the location of the central receiving and service building abutting the hospital at this point.

7. Evaluation by Hospitals Planning Group:

- a) Operating another small hospital unit is not ideal from the standpoint of efficiency.
- b) It is important to build some beds at this time.
- c) The assignment of service in the new construction should be based on the configuration and use of the building after Phase II when the main hospital will be on the Powell Hall site. This would imply services which can operate semi-independently. The only one fitting these criteria is Psychiatry.
- d) There is difficult rationale involved in moving Psych without increasing its beds if the present Psych stations will be remodeled to receive more beds.

e) The Hospitals Planning Group suggests that the ultimate (1986) use of the Phase I bed construction be Psychiatry. This implies that the facilities assigned to it in Phase I be easily convertible to this purpose.

B. I believe evaluation 7.e) above summarizes the group's feelings as to alternative proposals. We would be happy to evaluate any other proposals in this light.

PHS/ch

July 1, 1968

TO: John H. Westerman

FROM: Peter H. Sammonds, *PHS* Chairman
Hospital Planning Group

SUBJECT: Alternative Approaches II and III to Clinical Services in
New Construction

On May 28, 1968 I sent you Alternative I (Psychiatry, Pediatrics, and Family Practice.) Since that date there has been general agreement among the planning groups to whom you sent it that Alternative I was a reasonable proposal although the French Committee recommended that pediatric surgery beds as well as all pediatric intensive care be included in new construction with the general pediatrics beds.

In reply to our request for review TAC has indicated that the remodeling of the Psychiatry stations presently adequate for their existing functions to other bed use would be almost prohibitively expensive. They have also found that they could carry out their Phase I plan without Nursing Station 22, an otherwise adequate nursing station.

With this additional information in mind we have examined other alternatives.

1. Alternative II (Medicine, Pediatrics, Family Practice)

Existing and Additonal Beds

	<u>Existing Beds</u>	<u>Added Beds*</u>	<u>Beds in Old Building</u>	<u>Beds in New Building</u>
Pediatics	159	1	76	84
Peds Surgery	0	20	0	20
Family Practice	0	20	0	20
Medicine (general) (Sta. 30,31,32)	140	10	78	72
All other services	<u>555</u>	<u>108</u>	<u>6⁶3</u>	<u>0</u>
TOTALS	854	159	817	196

* French Committee Report of February 7, 1968

2. Alternative III (Surgical Subspecialties, Pediatrics, Family Practice)

Existing and Additonal Beds

	<u>Existing Beds</u>	<u>Added Beds*</u>	<u>Beds in Old Building</u>	<u>Beds in New Building</u>
Pediatics	159	1	76	84
Peds Surgery	0	20	0	20
Family Practice	0	20	0	20
Surgical Specialties				
Eye	24	6	0	30
Dentistry	1	9	0	10
Transplant	27	3	0	30
All other services	<u>643</u>	<u>100</u>	<u>743</u>	<u>0</u>
TOTALS	854	159	819	194

* French Committee Report of February 7, 1968

3. The other bed and square footage data for Alternatives II and III would be fairly similar to I.

4. Assumptions

- a) The figures for proposed increases in beds were taken from the French Committee Report of February 7, 1968.
- b) That of the 159 beds assigned to Peds only the Eustis wing beds would be replaced in new construction leaving Masonic, Heart, and Newborn beds as is.
- c) Alternative II - that of the 140 beds presently assigned to Medicine, only the Station 30, 31, 32 beds would be replaced in new construction leaving Masonic and Heart beds as is. Further, that the 10 bed increase would be in the general medical service and would be in new construction.
- d) The conversions from Psych and Peds stations to Med-Surg are based on a cursory evaluation by the hospitals staff and have not had benefit of architect's advice.
- e) Station 12 would have to be taken out of service due to etc. same as f.
- f) Alternative III - almost any surgical subspecialty could be used. Eye was chosen because it would have to move anyway due to the closing of station 12. Dentistry is an expanding program with ecumenical

appeal, and also there would be a good relationship between beds in this location and the dental school. Transplant is an example of an expanding surgical service that will probably need more room and the new beds would have a closer relationship to dialysis in Masonic if that is where it turns out to be.

5. Evaluation by the Hospital Planning Group

- a) Operating another small hospital unit is not ideal from the standpoint of efficiency.
- b) It is important to build some beds at this time.
- c) After further thought and discussion with the architects we do not believe ultimate Phase III use of the space is the most important criterion because:
 - i) it is very difficult at this point in time to project the 1986 relative needs of the clinical services
 - ii) for almost any Phase II use Phase I construction will have to be remodeled. Within limits the cost of remodeling for most purposes will be relatively constant.

Nevertheless, Phase II use should be considered in making Phase I assignments to stay within those limits.

- d) Alternative II (Medicine, Pediatrics, Family Planning) has the following advantages:
 - i) it would lend itself to a consolidation of the general medical beds and the surgical beds which would be assigned to the vacated 30, 31, 32.
 - ii) there is a strong programmatic relationship between Medicine, Pediatrics, and Family Practice. The possibilities of an adolescent unit serving all three are intriguing.
 - iii) The vacated stations 30, 31, 32 have good access to the Operating Suite in that the architects now anticipate the east side of the suite being the main entry point. Further, stations 30, 31, 32 can be broken down well into small units to serve the surgical subspecialties; this may not be economical in the newly designed units.
- e) Alternative III (Surgical Subspecialties, Pediatrics, Family Practice) has the following advantages:
 - i) it may result in less disruption to existing services if the moving and expanding services are placed directly into new construction. This will not be certain, however, until the

actual bed assignments and reassignments are worked out.
ii) There will presumably be a close relationship between the expanded surgical suite and the new beds.

f) Another alternative (Intensive Care, Pediatrics, Family Practice) has been suggested. We believe this way has the same merit in that the existing suggested intensive care will need expansion and remodeling. But it would not make sense to isolate the intensive care of various services over in the new construction away from the rest of their beds. We cannot evaluate this alternative further until the following questions are answered.

- i) how will the 50 intensive care beds projected in the French Committee Report be broken down and assigned?
- ii) which service will have ~~direct~~^{discrete} intensive care units?
- iii) which intensive care units will be combined?
- iv) what relationships are important in the location of these units?

6. Recommendations

- a) We recommend alternative II (Medicine, Pediatrics, Family Practice) as the most logical alternative given existing facts.
- b) Regardless of alternatives we recommend that appropriate representatives of the hospital and the medical staff meet to answer the questions with regard to intensive care raised in 5f.

PHS/pd

September 24, 1968

To: Robert W. ten Bensel, M.D.
From: Richard A. Chilgren, M.D.
Subject: Planning for the new Clinics.

In general the request made by Dr. Branthaver for the projected 1973 and 1986 dates are very conservative. I will be more specific in these areas according to the following divisions or space names.

Audio-Visual Room:

The size of this room is not specified but it preferably would be at least as large as the current end room in our Pediatric Clinic. It would also be desirable to have a second room adjacent to it through which a one-way glass could be installed for direct observation of patients.

Play Area:

This area should be large enough to accommodate at least twenty children and five to six supervisory adults. By 1986 it is reasonable to consider that this area would have to be at least 50% larger.

Cloak Room:

Two cloak rooms instead of one should be requested, since one should be used for staff and one for patients.

Secretary's Office:

This area should be completely revised to include the secretary to the Clinic Director, the secretary to the Assistant Clinic Director and Director of Education, the secretary for out-patient admissions, and the secretary for in-patient coordination. There is no reason why all cannot be in a single room if there is proper consideration given to sound silencing devices, or to modified partitions.

Clinic Director's Office:

The Clinic Director's office should be large enough to have space for a five to six man conference. There also should be an office for the Assistant Clinic Director. In addition, offices should be provided for the Director of Education, and for the Director of the Neo-Infant Clinic.

all clinics

Memo: Robert W. ten Bensel, M.D.

Page 2

September 24, 1968

Conference Rooms:

This room should accommodate at least forty people, as our conference already numbers twenty to twenty-five participants. It would be desirable to have a movable partition that would allow two conferences to progress simultaneously.

Medical Students Work Area:

The number of student area should be increased from four to at least eight.

Toilet: OK

Soiled Utility: OK

Clean Utility: OK

Waiting Area for Patients:

This area should be large enough to accommodate thirty to forty persons.

Clerk and Secretarial Area:

This area should be adequate considering the above space allocation for the secretaries.

Consultation: Probably adequate

Nursing Station: Probably adequate

Treatment Room:

Since it is conceivable that the Pediatrics Out-Patient Department would also be the Pediatric Emergency Room it would seem desirable to have at least three or four treatment rooms instead of the requested two.

Examining Rooms:

This is obviously the area of greatest deficiency. Only twelve examining rooms are requested while it is evidently at least twice that many that are needed. By 1986 it is highly conceivable that four times the originally requested will be needed.

RAC/kmm

9.24.68

400 S. E. UNION
MINNEAPOLIS, MINN. 55455

A. B. BAKER, M. D.
DIRECTOR - NEUROLOGY
M. ALTER, M. D.
NEUROLOGY
G. FLORA, M. D.
NEUROLOGY
W. KENNEDY, M. D.
ELECTROMYOGRAPHY
A. KLASSEN, M. D.
NEUROLOGY

J. LOGOTHETIS, M. D.
NEUROLOGY
J. MORIARTY, M. D.
NEUROLOGY
J. RESCH, M. D.
NEUROLOGY

F. TORRES, M. D.
ELECTROENCEPHALOGRAPHY
M. BLAW, M. D.
PEDIATRIC NEUROLOGY
K. SWAIMAN, M. D.
PEDIATRIC NEUROLOGY
F. WRIGHT, M. D.
PEDIATRIC NEUROLOGY
R. SOLL, M. D.
NEUROLOGY

October 4, 1968

Mr. Peter Sammond
Associate Director

Dear Peter:

I would like to re-emphasize my previous statement to you regarding the design of modules in the proposed out-patient clinic. As you know I feel very strongly about the need in our neurology clinic for wide door ways and adequate bathroom facilities that will accommodate easily wheelchair and litter patients. In regard specifically to the lavatory, wheelchairs should be able to be positioned beside the toilet. Grab bars to assist in patient transfer should be carefully placed.

The examining room size should be large enough to accommodate at least seven persons comfortably at one time. One of these, of course, will be the patient himself and very likely he will be in a wheelchair. I previously mentioned most of the rooms that we now have in our neurology clinic are too small to accomplish this objective. If we are to perform the satisfactory teaching of medical students, I feel that these rooms should be about 12 X 15 feet. Conversely, the proposed rooms each occupying 108 square feet and representing a 9 X 12 foot measurement would be hardly any more adequate than the rooms we now have once an examining table and desk were placed in them.

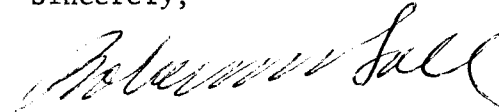
Since not all patients would require such a large room, a possible alternative would be to have rooms of two different sizes. I would suggest that eight rooms be constructed of a 9 X 12 foot size and 5 rooms be 12 X 15 feet. I realize this would reduce the total number of examining rooms by three per module, but if we are to be limited, fewer rooms would be a happier alternative than all rooms of inadequate size.

Another consideration that is of greater than usual importance in regard to the neurology clinic area is the waiting room. It is obvious that a higher percentage of our patients will be confined to wheelchairs than in many of the other clinics. Some accommodation either by modifying the size or arrangement of the area may be necessary to arrive at a comfortable waiting room.

Page #2
October 4, 1968

One further suggestion that I have is in regard to the new clinic is that provisions for strategically located emergency care stations be made for use in critical situations such as we encountered in our neurology clinic in the recent past. Although we managed to get the equipment that we needed, it easily could have been too late.

Sincerely,

A handwritten signature in cursive script, appearing to read "Robert W. Soll".

Robert W. Soll, M.D.

RWS/mh
cc: Dr. Baker

October 24, 1968

TO: Outpatient Committee
 FROM: Facilities and Services Subcommittee
 SUBJECT: Ten Per cent Reduction in Modular Space

As was previously announced, 10 per cent of new construction space has had to be deleted from all programs to provide for internal circulation space. Mr. Wilwerding has worked with the users of specialized space to make these reductions.

The Facilities and Services Subcommittee makes the following proposal as a way of achieving the 10 per cent space reduction in the modules:

A. That each module be increased by four examining rooms to a total of 20 from the original 16 and the number of modules be reduced to 8.

1. Space Saving

10 modules @ 4310 =	43,100 ft.
new module = 4310 + 432 =	4,742 ft.
(432 = 4 exam rooms)	
8 modules @ 4,742	37,936 ft.
Total modular reduction	<u>5,164 ft.</u>
10 per cent reduction needed	<u>4,300 ft.</u>
Balance	864 ft.

2. Balance would provide an additional 108 ft. room to each module.

3. Advantages to this proposal:

a. Examining rooms have not been reduced in size or number.

- b. It does not require whittling down other spaces bit by bit which when attempted did not seem to easily yield the required amount.
 - c. Only earlier planning principle violated related to number of exam rooms per clinic area which was somewhat arbitrarily arrived at. It would seem that 20 could be served by one set of services as well as 16.
4. Disadvantages to the proposal:
- a. These would be fewer, larger separate clinic areas thus decreasing flexibility and necessitating slightly greater sharing between clinical services.

/pd

December 3, 1968

Mr. Ken Taylor
The Architects Collaborative
46 Brattle Street
Cambridge, Massachusetts

Dear Ken:

I am writing to confirm the figures given you over the phone on Friday, November 29 related to the breakdown of the hospital increment of new space. I should also like to take this opportunity to respond to any specific questions raised in your letter of November 14th and Olga Petters letter of October 30th which have not yet been answered.

The attached sheet will summarize the assignment of incremental new space to the various hospital departments based on the overall reductions related to teaching space and internal circulation. You will note that the total of the new space increment is 136,316 the figure quoted in your letter of November 14 which was based on the TAC University of Minnesota Health Sciences Planning Report of June, 1968. The transition from the hospital supplement of February, 1968 to this breakdown was accomplished as follows:

1. We accepted the larger space requests of the special committees for the design of the emergency department and the patient care unit. The patient care unit request was further modified and the final figure was that submitted by Miss Petters in her report of October 31, 1968. For the November 29, 1968 breakdown the 43,011 square foot increment for patient care units has remained untouched.
2. While we accepted the larger figure submitted by the Emergency Room Planning Committee leading to an increment of 5,876 over existing, we submitted that figure to the overall percentage reduction for the November 29 breakdown.
3. In that the obstetrical and delivery suite has been assigned 1660 feet of clinical space which had formerly been a portion of clinical teaching and research, we include that additional increment untouched in the current breakdown.
4. Because of the special problems involved we have accepted the increments listed for operating rooms and recovery suite in the February report and have submitted them to no further reduction.

5. We have not reduced any individual space whose increment was less than 400 feet in the February report.
6. With the above exceptions we have reduced all other departmental spaces by approximately 29.8% to achieve the overall reduction necessary.
7. Since there was a difference of 1609 sq. ft. between the 136,316 figure derived by TAC in the gray book and the 134,707 sq. ft. figure derived from our February report (the difference largely related to existing space assignments). We have allocated this gain as follows:
 - a. 47 feet to the emergency department to adjust for an arithmetic mistake.
 - b. 1562 sq. ft. to lockers and lounges.
8. There is still some confusion as to the assignment of building services increment to net or gross. If it is true that this increment should be taken care of in gross and there is a balance of 825 feet available it should be assigned as follows:
 - a. 613 sq. ft. to lockers and lounges.
 - b. 212 to medical art and photography.

In reply to Miss Petters letter of October 30th, I believe the summary of classroom space as submitted is satisfactory, although due to the incremental cut there will be necessary reductions in specific class and conference room areas. We do wonder whether the 50% utilization factor might not be increased to absorb part of this reduction. The request of Medical Art and Photography has been noted and there should be adequate classroom/conference room space in the Outpatient Department to meet their needs.

In specific reply to your letter of November 14th I shall take the items in order:

1. BED ALLOCATION AND SURGERY SUITE. We would agree with the assumptions you make. One further assumption has been made and submitted to you, i.e., that by accommodating intensive care on stations 40 and 41 a number of general care beds equal to the existing total of 40 and 41 can be located in the vacated intensive care as contained in your original bed proposal. We do remain somewhat concerned that the assignment of beds to remodeled spaces may be somewhat unrealistic, particularly in the vacated pediatric areas.
2. NEW PATIENT CARE UNITS. We have reviewed the patient care units as submitted on October 31, 1968. We have no major space allocation suggestion, but do have some questions with regard to configuration which we will be raising shortly. This proposal is still under review by the clinical services involved, but again we can assume that there will be no major difficulty.

3. INTENSIVE CARE UNIT. The assumptions you make are valid and relate to those under paragraph one above.
4. HOSPITAL ADMINISTRATION. The proposal breakdown is as follows:

Conference Room (including kitchenette and bath)	400 sq. ft.
Library	150 sq. ft.
Administrative Offices 120 ft.	360 sq. ft.
Clerical Offices	240 sq. ft.
Duplicating and Storage	100 sq. ft.
5. BUSINESS OFFICE. See attached for functional breakdown.
6. ADMITTING. See attached for functional breakdown.
7. MATERIALS MANAGEMENT. The question of relationship to the health sciences is still an open one for central receiving and storage as it is for other shared facilities. We would agree with your assumptions that any functional participation in this area on the part of non-hospital users must be purchased with square footage from their programs. We would certainly prefer to have upwards of 23,000 square feet on site located preferably in the service building but due to severe space reductions for teaching space and internal circulation, this additional 10,000 feet does not seem to be available for this purpose. Therefore we will attempt to live with 10,000 sq. ft. as it exists at Rosemont.
8. CENTRAL TRANSPORTATION. It is still uncertain as to the administrative responsibility for central transportation service. Regardless of the decision on this question the location of the department should be made in relation to the bulk of its transportation functions rather than in relationship to the administrative offices of either of these particular units.

I hope this adequately summarizes outstanding questions at this time. The reductions in hospital departmental space were not made without difficulty and sacrifice. It is my intention to outline programmatic implications of this space reduction in the very near future.

Sincerely yours,

Peter H. Sammond
Associate Director

NEW SPACE REQUESTED 165,874 sq. ft.

NEW SPACE ALLOCATED 136,316 sq. ft.

	Existing Space	Increment ¹ February 1968	Increment with ² Reduction 29.8%
Administration	6,129	1,800	1,264
Admitting Office	2,248	457	321
Business Office	6,590	5,485	3,850
Building Services	7,545	1,200	825
Central Supply	4,439	5,311	3,728
Central Transportation	150	640	450
Dentistry		650	456
Electronic Data Proc.		900	632
Emergency Suite	1,269	5,876 ¹	4,172
Lockers, Lounges	12,532	6,962	6,449
Hospitality and Vend.	5,046	4,954	3,478
Maintenance	31,529	9,223	6,475
Med Art and Photo.	2,962	514	361
Medical Records	5,922	5,040	3,538
Newborn Nursery	1,394	0	0
Nursing Services	3,935	1,560	1,095
Patient Care Units	170,187	43,011 ¹	43,011
Nutrition	18,243	14,448	10,142
OB Delivery Suite	1,894	1,660 ¹	1,660
Personnel	685	500	351
Pharmacy	4,676	10,814	7,591
Purch. Rec and Stores	13,166	13,534	9,501
Recovery Suite	918	2,322	2,322

	Existing Space	Increment February 1968	Increment with Reduction 29.8%
Social Service	2,041	1,124	789
Chapel	751	0	0
Lobby	3,861	2,314	1,624
PBX-CID-Mail	720	205	205
Public School	1,283	0	0
Volunteers	830	710	498
OR Suite	13,210	13,913	13,913
Urology OR	2,974	0	0
VCHA	2,368	0	0
Class and Conf.	348,279	<u>7,000</u>	<u>4,914</u>
		165,874	136,316

1 Figure for Emergency Suite comes from Emergency Suite Planning Committee Report 3/1/68.

Figure for patient care units comes from TAC proposal of Oct. 31, 1968 less existing patient care units taken out of service.

Figure for OB-Delivery Suite is from CTandR space recently transferred to Hospital.

2 With the 29% reduction, the following areas are not reduced: Patient Care Units, OB, PAR, OR Suite and areas with increments under 400 sq. ft.

Analysis of Business Office and Admitting Office Areas by Function

Business Office

D-210	Cashier
D-211	Cashier
D-212	Credit Office
D-213	Cost Accounting
D-214	Patient Accounting Work Area
D-214-1	Patient Accounting Office
D-214-2	Patient Accounting Office
D-214-3	Data Processing Work Area
D-214-3a	Data Processing Supv. Office
D-214-3b	Data Processing Supv. Office
D-214-4	Financial File Work Area
D-214-5	Budget Office
D-214-7	Supv. Office
D-214-8	Supv. Office
D-215	Reception Area
D-215-1	Credit Office
D-219-10	Credit Office

Admitting Office

D-217	Appointments Office & Work Area
D-218	Soundex and Information Desk
D-219	Lobby
D-219-1	Interviewing Office
D-219-2	Interviewing Office
D-219-3	Passageway and Coat Room Shared with Business Office
D-219-4	Patient Relations Office
D-219-5	Interviewing Office
D-219-6	Interviewing Office
D-219-7	Bed Control Room
D-219-8	Supv. Office
D-219-9	Work Area

January 7, 1969

Mr. Ken Taylor
The Architects Collaborative
46 Brattle Street
Cambridge, Massachusetts

Dear Mr. Taylor:

I am writing to remind you of our conversation related to your communicating with the clinical department chairmen regarding allocation of clinical, teaching and research space to offices in the outpatient clinic area. I believe you agreed that it would be appropriate for you to contact each chairman to ascertain what they wished to do on this subject. It might be wise to send the letter to all clinical chiefs noting that there are some to whom it is not applicable, i.e., those who have specialized space and those who do not have activities in the clinics.

The Architects Collaborative has been advised by the Design Coordinating Committee that among the recommendations of the Out-patient Committee were the following:

1. That the maximum space possible in the new outpatient clinics be devoted to patient service and education functions.
2. That the clinics be designed for maximum flexibility of use (the modular concept).
3. That where possible offices of the individual clinic directors be located as near as possible to the clinic area of their service.

Resolution of these three recommendations has meant that we have been asked to locate offices for faculty members with a responsibility in the clinic as close as architecturally possible to the clinic area. However, this means that space for these offices must come out of

the office space allocation of the departments (clinical, teaching and research) as in the case of any other faculty offices.


In light of the above factors I should like to ask how much space for faculty offices your department wishes to be located in the outpatient area."

Ken, please feel free to change this if you wish and add to it anything that you need to. It is fairly important that we convey the idea that this is not an attempt by the Hospitals to lean on the clinical department for some additional space.

I am reminded that Olga had some questions to raise with us regarding hospital departmental space, i.e., central stores, etc. Am I correct that she was going to write us with her specific questions?

With best wishes for the new year, I remain

Sincerely yours,

A handwritten signature in dark ink, appearing to read 'Peter H. Sammond', written over a horizontal line.

Peter H. Sammond
Associate Director

PHS/pd

cc: ✓ Karen Levin
Robert Mulhausen

MEETING NOTES

SUBJECT: University of Minnesota Health Sciences Expansion
Outpatient Clinics and Emergency

DATE: January 29, 1969

PRESENT: Clinical Service Chiefs, Hospital Administrative Directors, Heads of Hospital Departments related to Clinics, TAC (Roland Kluver, Fred Larsen, Ken Taylor, Olga Petters)

1. Heliport location must relate closely to delivery of patients to the Emergency Department. Present helicopter pad is located in front of Coffman Union, a position remote and difficult of access for the future Emergency Department. TAC will investigate the relocation of the heliport. If a roof location is possible over the new buildings, a direct elevator access to Emergency would be desirable.
2. Dr. Winchell questioned the transmittal of specimens from Emergency to the Clinical Labs in Mayo. Consideration should be given to a Satellite Laboratory in the Emergency Suite.
3. Dr. Fuller feels that the Family Practice Clinic should relate closely to the main OPD entrance, placing the clinic on a lower level than is indicated in plans. Peter Sammond concurs. The Family Practice Clinic is not a referral clinic and requires good public access in a prominent location such as opposite the main entry point to the clinics on Level 5.
4. Dr. Sciarra is concerned with the arrival point for OB emergency patients. These patients will probably enter through the Emergency Room for immediate medical consideration. Length of travel and elevator transfers from Emergency to OB Delivery was discussed.
5. Length of travel and time interval from the proposed parking facility at Oak Street to Building C was discussed. Proposed method of mechanical conveyance for people was described.
6. Transfer of DOA's from Emergency to Morgue was discussed. An ambulance could deliver a body to the River Street loading dock in the Service Building for transfer to the Morgue or a body could be transferred from Emergency to the Morgue through the service corridor between Building C and Mayo at level 4.
7. The location of minor OR's in relation to Emergency and Hospital Employees' Health was discussed. Proximity as shown on the plans was considered excellent.
8. Inpatient traffic from Mayo to the clinics in Building C will be heavy. Since the access level is at Mayo 5, this traffic appears to conflict with traffic patterns in the new Radiology Suite in Building C.

IMPORTANT



MEETING NOTES

U. MINN. HEALTH SCIENCES EXPANSION

Outpatient Clinics and Emergency

Page 2

9. Miss Baker showed concern for the delivery of handicapped patients from vehicular access points to OPD central waiting since a vertical transfer is required. The indicated immediate availability of elevators would seem to overcome this problem.
10. Relation of Radiology and Surgery to Emergency was considered reasonable.
11. OPD Pharmacy should be planned with the consultation booths on the perimeter closest to patient waiting. Dr. Kabot feels snack bar location blocks good visibility and public aspects of Pharmacy from patients waiting. Other comments regarding snack bar cited a need to locate student and staff facilities in a less visible area to patients and visitors. Reserving this snack bar for patients and visitors would reduce overcrowding and allow staff and students to relax out of the public view. Hospital Pharmacy feels space allocation too small and is considering contributing space to increase OPD Pharmacy size.
12. Dr. Olsen inquired about the feasibility of a direct connection from Mayo to Owrie at Mayo 5. (This passes through Cysto.) TAC will investigate.
13. Hospital Administration offices in Building C should relate to OPD Administration and Hospital Admitting.
14. Dr. Fusaro inquired about location of proposed Educational Resources Center and relation to Diehl Hall, future hospital, present and future educational facilities. The future expansion of Diehl Hall was mentioned as a possible need. An inquiry was made as to the feasibility of achieving this by bridging Essex Street with an addition to Diehl library floors.
15. Inquiries were made as to the effect of mechanical equipment vibrations and structural movement in Building B (Philip Wangensteen) which might affect the use of electron microscopes.
16. The group was informed that the drawings would be placed in Powell Hall 2112 for their further consideration and later comments would be transmitted to TAC through Mrs. Karen Levin.

*H.S. EXP.
E.P. Clinic*

DIVISION OF DERMATOLOGY
MAYO MEMORIAL BUILDING • MINNEAPOLIS, MINNESOTA 55455

July 16, 1969

Received By
Assoc. Director's Office
AUG 2 1969
UNIVERSITY HOSPITALS

Mrs. Karen C. Levin
Health Sciences Planning Office
B310 Mayo

Dear Karen:

Thinking to simplify the situation for you I have used in the accompanying communication the same foremat which you used in yours of July 11, 1969. It seems to make it sound more formal than what ordinarily be my reply but it will make things easier for you to copy, if that is your desire for further dissemination. My modifications are based on discussion with Dr. Fusaro and we regard them as merely changing emphasis and suggesting priorities. Please call me if you have any questions as to the suggestions which we have made. Note the first and last sentences under Daylight and the second sentence under X-ray. On page 2 there is modification of the second sentence under Photography and the first under Ultraviolet.

Sincerely,

Francis W. Lynch, M.D.
Director

FWL/mf

cc: Mr. Sammond
Dr. Fusaro

Enc.

Peter

*I look forward, hopefully,
to further discussion of
the location for the
clinic's administrative base.
I will be on vacation the
latter 1/2 of August
FWL*

Received By
Assoc. Director's Office

AUG 2 1969

UNIVERSITY HOSPITALS

16 July 1969

TO: Mrs. Levin, Health Sciences Planning Office

FROM: Dr. Lynch and Dr. Fusaro

SUBJECT: Comments on Outpatient Facility for Dermatology

The following comments summarize our conversation 26 May 1969 concerning outpatient clinic facilities for Dermatology. Please review the list to make sure that the comments accurately express your point of view. We are pulling together information for the architects now in anticipation of renewed involvement in outpatient clinic planning after the NIH site visit next week. Dr. Fusaro's letter summarizing patient care unit modifications has been forwarded to TAC.

Daylight

Daylight is strongly preferred. Dr. Lynch would like evidence of instances where artificial light spectrophotographically identical to daylight is being used for dermatological purposes. Dermatology's lighting requirements are not confined to the spectrum and relate as well to diffusion and intensity. However, a combination of skylights and artificial lighting wall panels might be better than artificial lighting alone.

Superficial X-ray Treatment

Superficial x-ray treatment can be performed in a module examining room if adequate shielding is provided. Since the Department of Radiology is responsible for certain respects of radiologic procedures within the Hospitals, cooperation between the Departments of Radiology and Dermatology is necessary and discussions should begin as soon as possible.

Mycology

Since every dermatologist has mycology facilities in his office, such facilities must be provided in the clinics. Space is required for handling scrapings taken from patients for microscopic examination, transferring scrapings to culture tubes, storage of cultures for two weeks and bench area for microscopic examination.

Photopatch Test Room

A light-tight examination room can be converted for photopatch testing.

Darkfield Room

The light-tight examination room converted for photopatch testing can also be utilized as the darkfield room. Further definition of necessary modifications is required.

Photography Room

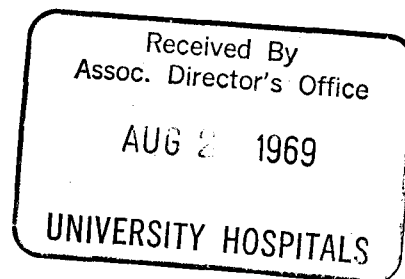
In order to record teaching material, one examining room should be designated for photography. Such utilization of this room would not exclude use for other services.

Ultraviolet Treatment Room

Two ultraviolet treatment areas similar to shower stalls can be located to an examination room, or (less desirably) both in one room, separated by dressing cubicles for privacy. The former would preserve the examination function of the rooms and the latter would eliminate utilization of one examination room for other than ultraviolet purposes.

cc: Mr. Peter Sammond

August 14, 1969



Mrs. Olga Petters
The Architects Collaborative
46 Brattle Street
Cambridge, Massachusetts

Dear Olga:

I am enclosing a summary of a meeting which we had following the meeting of the Outpatient Clinics. This meeting dealt with the Dermatology Clinic specifically and modifications which would be necessary in the module to accommodate them. I think we have agreement with them that most of the items can be accommodated in modular space without major alteration. We still must straighten out the question of their use of x-rays in the clinics, but we will do that and forward the information. We would be interested in your response on the daylight question as pointed up in the accompanying memo.

Sincerely,

A handwritten signature in cursive script, appearing to read "Peter H. Sammond".

Peter H. Sammond
Associate Director

PHS/js

cc: Mrs. Karen Levin
Mr. C. Thomas Smith, Jr.



October 16, 1969

Mrs. Olga Petters
The Architects Collaborative Inc.
96 Brattle Street
Cambridge, Massachusetts

Dear Olga,

I am forwarding to you some program details for the secretarial perception areas of the clinic modules. These were supplied by Mrs. Marilyn Condon, ~~Chief Clinic Coordinator~~ in consultation with Harlan Crouch, former Clinic Manager. I would suggest that the next time you are in Minneapolis that you plan a short meeting with Mrs. Condon and Mr. Lawrence Dingmann, the new Clinic Manager, to discuss these details. Secondly, I would advise that equivalent spaces should be provided in the specialized clinics which have largely been planned so far without administrative participation. If this creates any problem, I should be advised.

Sincerely,



Peter H. Hammond
Associate Director

PHS/lmc
Enclosures

cc/Mr. Ken Taylor Mrs. Karen Levin
 Mr. Larry Dingmann Mrs. Marilyn Condon
 Mr. Tom Smith

UNIVERSITY OF MINNESOTA HOSPITALS
OUTPATIENT DEPARTMENT

SEPTEMBER 30, 1969

TO: MR. SAMMOND

FROM: MARILYN CONDON *MC*

SUBJECT: SECRETARIAL AREAS IN NEW CLINIC MODULES

THE PRESENT PLAN FOR THE PROJECTED HEALTH SCIENCES CENTER ALLOWS A 300 SQUARE FOOT AREA IN EACH OF ~~FIVE~~^{EIGHT} MODULES FOR SECRETARIAL FUNCTIONS. IT WAS DECIDED BY MR. CROUCH AND MYSELF THAT THIS SPACE COULD BE USED BY BEING DIVIDED INTO TWO SEPARATE ROOMS - ONE APPROXIMATELY 21'x10' TO BE USED AS THE PRIMARY REGISTRATION AREA, AND THE OTHER ABOUT 10'x9' TO BE RESERVED AS AN OFFICE FOR THE AREA CO-ORDINATOR.

THE LARGER ROOM WOULD HAVE A STAND-UP SIT-DOWN COUNTER, SIMILAR TO THAT FOUND IN OUR PRESENT PEDIATRICS CLINIC, WHICH WOULD RUN THE LENGTH OF THE WALL FACING OUT INTO THE PATIENT WAITING ROOM. UNDER THIS COUNTER WOULD BE LEG SPACE FOR TWO SECRETARIES, AND A VARIETY OF NON-SECRETARIAL PERSONNEL FROM THE HALLWAYS.

THE AREA CO-ORDINATOR'S OFFICE WOULD HAVE AN ENTRANCE TO THE SECRETARIAL ROOM AND AN ENTRANCE TO AN OUTSIDE HALLWAY. THE WALL BETWEEN THIS OFFICE AND THE SECRETARY'S ROOM SHOULD BE GLASS. IN THE EXTENT THAT AN AREA CO-ORDINATOR WOULD NOT BE SPECIFICALLY ASSIGNED TO A MODULE, THIS ROOM COULD BE USED FOR STORAGE AND CONFERENCE PURPOSES.

OTHER BUILT-IN STORAGE OR WORK AREAS, WITHIN THESE ROOMS, WERE NOT DISCUSSED AT THIS TIME. WE FEEL THAT SUCH SPECIFIC DETAILS COULD BE WORKED OUT NEARER TO THE FINAL DRAWINGS, PARTICULARLY AFTER TRYING OUT THE ARRANGEMENTS IN OUR NEWLY REMODELED AREAS ON SECOND AND THIRD FLOORS OF THE PRESENT COMPLEX.

MC:JA

October 17, 1968

TO: Dr. Duvall Dr. Winchell Dr. Soll
 Dr. Sciarra Dr. Strandjord Mrs. Reynolds
 Dr. Fuller Dr. Sosin Mrs. Stark
 Dr. Fusaro Dr. Grage Mr. Crouch
 Dr. Chilgren Dr. Kane

FROM: Peter H. Sammond *phs*

SUBJECT: Design Suggestions for the Module

It was agreed at the first meeting at which the clinic module was discussed that I should summarize the design modifications which have been suggested prior to our next meeting. The design considerations listed herein and any others you may have will be discussed at a meeting of the subcommittee on Tuesday, October 22 at 7:00 a.m. in Dining Room III and at the next full Outpatient Committee meeting on Friday, October 25th. Please bring with you copies of the actual requests by the services as resource material (these were distributed at the last meeting).

- A. Suggestions pertaining to the design of all modules.
 - 1. Two coat rooms be provided, one for patients and one for staff.
 - 2. Doors adequate for stretcher and wheel chair clearance.
 - 3. Emergency stations located throughout.

- B. Proposed modifications to individual modules:
 - 1. Neurology
 - a. Alternative room sizes:



- (1) all rooms 12' X 15' (180)
- (2) eight rooms @ 9' X 12' (108') + 5 @ 12' X 15' (180')

b. Waiting room to accommodate more wheel chairs than average clinic.

2. Pediatrics

- a. Audio visual room - approx. 10' X 18' and observation room with one-way glass between.
- b. Playroom for 20 children and 6 adult supervisors.
- c. Offices for clinic director, assistant clinic director, secretaries for each, secretary for out-patient and inpatient admissions, Director of Education, Director of Neo-Infant Clinic - Total 8
- d. Conference room for 25
- e. Waiting area for 30 to 40
- ~~f. Three or four treatment rooms.~~

suggest T.V. can have 208'

CT+R -

out out

in E.R. + 1 treatment

3. Dermatology

- a. X-Ray Therapy
- b. Diagnostic lab.
- c. Histopath and dark field room.
- d. Photopatch and patch room.
- e. Photography room
- f. Exam rooms equipped with cautery and dissication equipment.
- g. U.V. treatment room.

in standard room OK
not in clinic CT+R
~~*open room*~~ *light tight*
dark open room
dark room
OK in exam room
~~*open room*~~

4. Physical Medicine and Rehabilitation

- a. Modification of exam rooms and equipment storage.

welcome to use modular space w.o. modification

TO: Mr. Peter Sammond

FROM: Dr. Henry S. Sauls

SUBJECT: Visits to Hospitals for the Purpose of Reviewing Outpatient Clinic Design

Hospitals visited in which outpatient clinics were reviewed include Children's Hospital at the University of Chicago, Loyola Hospital in Chicago, University of California in Los Angeles (The Marion Davies Clinic), the Kaiser Hospital in Bellflower, California, and the University of Colorado in Denver. All of the outpatient clinics were similar in design in that outpatient examining rooms were located around a service core. This arrangement is conventional and appears to work well. I believe that it will work well for our pediatric clinic. The best design appeared to be that of the University of Colorado with the Marion Davies Clinic also presenting some interesting innovations.

The University of Colorado's Children's Clinic had a large waiting room approximately 50 X 20. I believe that this room is much too large and several small waiting areas would be preferable e.g. (1) a waiting area for teenagers (2) a waiting area for young children who play with toys on the floor and (3) a waiting area for infants who need to be in playpens or cribs. These separate waiting areas could relate to one central reception desk. The modules of examining rooms were U-shaped. The central core units contained supply rooms, treatment rooms, examining and conference rooms. The University of Colorado had several patient examining rooms which were divided by folding doors. By joining two rooms, a larger space for conferences was possible. I do not think that this is as satisfactory as the planned conference room since it tends to be a smaller space than is usually needed for a conference and a larger space than is needed for two or three people to discuss a patient. Both the Marion Davies Clinic and the University of Colorado had examining rooms equipped with one way mirrors. This is certainly desirable if the clinic will have patients undergoing psychological testing or psychiatric interviews. For teaching the techniques of history taking and physical examination other techniques are available.

The Marion Davies Clinic had a room (equivalent in size to 3 examining rooms) containing a small kitchen. This room was used as a mother's lounge and a place where babies could be fed. It was much larger than was really necessary. A small device for heating the baby's bottle is adequate. I was not impressed that this was a significant addition to the clinic since an examining room could be used when this problem arises. This clinic also had an adolescent unit. Because the person who was interested in a separate clinic for adolescents was no longer on the staff, it was being utilized as regular pediatric clinic space. Modular design could provide a waiting area and a hallway that was specifically utilized for older patients rather than designating an area apart from the rest of the clinic for the adolescent age group. In the Marion Davies Clinic there was a nursing station on each of the two examining corridors. I liked this idea, although the nursing stations were not large enough in this particular clinic. Adjacent to the nurses' area were treatment room, supply room and medical student laboratory. This area was completely separate from the reception desk and waiting area therefore, it served as a substation from which the activities on the hallway were directed. There were three lights above each examining room door indicating (1) whether the patient was in the room, (2) whether the doctor was in the room or (3) whether a nurse was needed. This is the Mayo clinic system and functions best where the staff is stable. I noticed that the nurses and secretary were using this system. The one light that tended not to be used was the light the

doctor had to turn on when he went into the room. Doctors tend not to yield to regimentation and do not generally utilize new devices unless they designed them themselves.

The reception rooms for the University of Colorado were excessively noisy because of the tile walls and terazzo floor. This emphasized the necessity for noise control which I believe could be better accomplished by dividing the waiting rooms into smaller areas and by using soft wall and floor materials e.g. vinyl wall covering and carpet. The waiting room at the Marion Davies clinic was outstanding in esthetic design but too small for the number of patients served by the clinic. The waiting room was not large enough to divide into areas according to age group but it did have a fulltime play therapist and access to an outside courtyard. It is extremely important to have supervised play areas for children who come to Pediatric clinics. The effectiveness of the physician and nurse can be realized only when the patient is dismissed from the room and the parent can give his undivided attention to the instructions of the physician.

Conference rooms:

Both the Marion Davies and University of Colorado clinics had conference rooms for teaching of medical students and house staff. The Marion Davies clinic had a large conference room that would hold probably 50 people. This was a major departmental conference room. The size of a conference area needed in the future pediatric clinic of the University of Minnesota is difficult to predict, however, something approaching this size (with movable partitions) is probably desirable. Of greater importance is the necessity to have small conference areas for informal consultation of 1-5 persons directly concerned with the patients receiving care in the clinic. The usual procedure is to have the student or resident interview the patient and then retire from the examining room to discuss the patient's problems with the staff physician, nurse, dietitian, etc. A space other than the hallway must be provided for this purpose. The review of x-rays and the gathering of laboratory data by telephone is frequently necessary during this interim period. These functions would best take place in small office-like spaces (equipped with writing surfaces, dictaphone, telephone and x-ray view boxes, etc.) interspersed among the examining rooms. One such space for every 4 examining rooms probably would be adequate. These spaces should be at least as large as an exam room.

Clinic examining room size:

The size of the room in the Medicine clinic at the University of Colorado appeared to be quite adequate. The rooms in the Pediatric Clinic were too small. Also, the writing desks were hung on the wall. These were frequently placed in positions that were inconvenient for interviewing and writing simultaneously. I noted several that were loose and falling off the wall. In spite of the housekeeping convenience, permanently mounted desks on walls frequently do not serve the best interests of the function of the room. If it is possible to install a mechanism whereby the shelf for writing could be hung at any point around the room, this might prove satisfactory. The size of the room that we decided would be adequate was 10 x 11 feet. Eleven feet deep appeared to be the absolute minimum that could be considered adequate for either pediatric or adult patient. We also liked the arrangement of having the sink behind the door. In our visits through a number of clinic examining rooms it became apparent that fixed supply cupboards frequently were misplaced. These also should be behind the door and out of sight as much as possible if they are necessary at all. The space under the examining table is adequate for linen. Space for an instrument table is

desirable. Privacy curtains are usually not necessary in Pediatric clinics but are desirable for teen-agers.

In both the Marion Davies clinic and the University of Colorado, staff offices were located adjacent to the clinic modules. Those members of the staff permanently attached to the outpatient department were housed in these offices. There were no research laboratories in either of these clinics. In the Marion Davies clinic there was a small laboratory for office type procedures such as CBC, urin analysis and plating of throat cultures. I believe that the location of offices for staff who are attached to the pediatric outpatient department is extremely important. These doctors are responsible for the smooth operation of the clinic and consequently must be involved in an intimate way with its daily operation. Room for the staff offices and the secretarial support, therefore, must be included in the clinic design. In addition, at the University of Minnesota, it is anticipated that outpatient programs such as the Child Development Study, Birth Defects Clinic, a mental retardation clinic or any other program which is developed in the future will need space next to the pediatric clinic modules. Consequently, we are requesting that the space now assigned to the Child Development Study (approximately 2000 sq. ft.) be placed next to the Pediatric clinic modules. This will allow departmental activity which relates directly to pediatric outpatient functions to take place in close geographic proximity. Although we anticipate that the programs operating in this space may change, it is evident that such activity probably always will be an integral part of our pediatric outpatient department.

11 July 1969

TO: Dr. Lynch, Dr. Fusaro, Mr. Sammond

FROM: Mrs. Levin, Health Sciences Planning Office

SUBJECT: Comments on Outpatient Facility for Dermatology

The following comments summarize our conversation 26 May 1969 concerning outpatient clinic facilities for Dermatology. Please review the list to make sure that the comments accurately express your point of view. We are pulling together information for the architects now in anticipation of renewed involvement in outpatient clinic planning after the NIH site visit next week. Dr. Fusaro's letter summarizing patient care unit modifications has been forwarded to TAC.

Daylight

Dr. Lynch would like evidence of instances where artificial light spectrographically identical to daylight is being used for dermatological purposes. Dermatology's lighting requirements are not confined to the spectrum and relate as well to diffusion and intensity. However, a combination of skylights and artificial lighting wall panels could suffice.

Superficial X-ray Treatment

Superficial x-ray treatment can be performed in a module examining room if adequate shielding is provided. Since the Department of Radiology is responsible for all radiologic procedures within the Hospitals, cooperation between the Departments of Radiology and Dermatology is necessary and discussions should begin as soon as possible.

Mycology

Since every dermatologist has mycology facilities in his office, such facilities must be provided in the clinics. Space is required for handling scrapings taken from patients for microscopic examination, transferring scrapings to culture tubes, storage of cultures for two weeks and bench area for microscopic examination.

Photopatch Test Room

A light-tight examination room can be converted for photopatch testing.

Darkfield Room

The light-tight examination room converted for photopatch testing can also be utilized as the darkfield room. Further definition of necessary modifications is required.

Photography Room

In order to record teaching material, one examining room should be designated for photography. Utilization of this room would not be impaired for other services.

Ultraviolet Treatment Room(s)

Two ultraviolet light sources similar to shower stalls can be located either one to an examination room, or both in one room separated by dressing cubicles for privacy. The former would preserve the examination function of the rooms and the latter would eliminate utilization of one examination room for other than ultraviolet purposes.

16 July 1969

TO: Mrs. Levin, Health Sciences Planning Office

FROM: Dr. Lynch and Dr. Fusaro

SUBJECT: Comments on Outpatient Facility for Dermatology

The following comments summarize our conversation 26 May 1969 concerning outpatient clinic facilities for Dermatology. Please review the list to make sure that the comments accurately express your point of view. We are pulling together information for the architects now in anticipation of renewed involvement in outpatient clinic planning after the NIH site visit next week. Dr. Fusaro's letter summarizing patient care unit modifications has been forwarded to TAC.

Daylight

Daylight is strongly preferred. Dr. Lynch would like evidence of instances where artificial light spectrophotographically identical to daylight is being used for dermatological purposes. Dermatology's lighting requirements are not confined to the spectrum and relate as well to diffusion and intensity. However, a combination of skylights and artificial lighting wall panels might be better than artificial lighting alone.

Superficial X-ray Treatment

Superficial x-ray treatment can be performed in a module examining room if adequate shielding is provided. Since the Department of Radiology is responsible for certain respects of radiologic procedures within the Hospitals, cooperation between the Departments of Radiology and Dermatology is necessary and discussions should begin as soon as possible.

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Since every dermatologist has mycology facilities in his office, such facilities must be provided in the clinics. Space is required for handling scrapings taken from patients for microscopic examination, transferring scrapings to culture tubes, storage of cultures for two weeks and bench area for microscopic examination.

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Photography Room

In order to record teaching material, one examining room should be designated for photography. Such utilization of this room would not exclude use for other services.

Ultraviolet Treatment Room

Two ultraviolet treatment areas similar to shower stalls can be located to an examination room, or (less desirably) both in one room, separated by dressing cubicles for privacy. The former would preserve the examination function of the rooms and the latter would eliminate utilization of one examination room for other than ultraviolet purposes.

cc: Mr. Peter Sammond

July 16, 1969

Mrs. Karen C. Levin
Health Sciences Planning Office
B310 Mayo

Dear Karen:

Thinking to simplify the situation for you I have used in the accompanying communication the same foremat which you used in yours of July 11, 1969. It seems to make it sound more formal than what ordinarily be my reply but it will make things easier for you to copy, if that is your desire for further dissemination. My modifications are based on discussion with Dr. Fusaro and we regard them as merely changing emphasis and suggesting priorities. Please call me if you have any questions as to the suggestions which we have made. Note the first and last sentences under Daylight and the second sentence under X-ray. On page 2 there is modification of the second sentence under Photography and the first under Ultraviolet.

Sincerely,

Francis W. Lynch, M.D.
Director

FWL/mf

cc: Mr. Sammond
Dr. Fusaro

Enc.

HEALTH SCIENCES CENTER
MEDICAL SCHOOL

Peter -

*I look forward, hopefully,
to open the discussion of
the case to the for beam
clinic's administrative area
I will be on leave from the
letter 12 of August*

FWL

August 14, 1969

Dr. Francis W. Lynch
Professor and Head
Department of Dermatology

Dear Dr. Lynch:

Thank you for your letter to Mrs. Levin regarding her summary of our meeting on the Dermatology Clinic. There has been no further work with the architects during the time since the meeting but I would anticipate that when we are all back from vacation early in September conversations will again take place. I am forwarding your summary of the meeting to the architects for their use.

As to the location of your office space, I reiterate that we support its location as close to the clinics as architecturally possible. Its actual location will have to be taken up directly with the architects by yourselves as I have no jurisdiction over faculty office space.

Sincerely,



Peter H. Sammond
Associate Director

PHS/js

cc: Dr. Fusaro
Mrs. Levin



February 26, 1970

Mr. Ken Taylor
The Architects' Collaborative Inc.
46 Brattle Street
Cambridge, Massachusetts

Dear Ken,

I am attaching a copy of a memorandum recently received from Dr. Henry Sauls critiquing the Outpatient Clinic facilities which he has visited on the two clinical trips we have made. I am also sending this memorandum to the other members of the trip groups.

I want you to take particular note of Dr. Sauls' request "that the space now assigned to the Child Development Study (approximately 2,000 sq. ft.) be placed next to the Pediatric Clinic modules". Has this been previously noted?

Sincerely,



Peter H. Sammond
Associate Director

cc: Jane Felder - For Files
Eunice Halverson

PHS:eh

MODULAR CLINIC SPACE PLANNING MEETING

February 19, 1970

PRESENT: Miss Acton, Dr. R. Anderson, Dr. Brantner, Mr. Dingmann, Dr. Drage, Dr. Duvall, Mrs. Felder, Dr. Fusaro, Dr. Grage, Dr. Kane, Dr. Markland, Dr. McArthur, Miss Peters, Mr. Sammond, Dr. Satran, Dr. Sauls, Dr. Soll, Dr. Sosin, Mr. Taylor, Dr. Winchell, Dr. Wright.

Mr. Sammond reviewed the two basic types of clinics which will be built in the new facilities:

- 1 - General purpose, multi-use or modular
- 2 - Specialty areas

Presently the plans include eight modular areas with modifications and specialty areas for Family Practice, Eye, Audiology, ENT, and Dentistry. The original request for 150,000 square feet had to be reduced to 86,000 square feet leaving a minimal amount of space for physician's offices within the modular area.

Mr. Ken Taylor explained that the overall schematics of Phase I are presently being revised. The relocation of departments has not been completed inasmuch as not all of the input for modifications has been received. The clinic modules are planned for the lower three or four floors of Unit C with the specialties above that level and above Radiology on fourth and fifth floors.

Mr. Taylor displayed a proposed lay-out of a typical clinic floor with three modules and a more detailed diagram of a single modular area. Basically the standard clinic module includes two groups of ten exam rooms in the center with ancillary services such as the reception desk, dictating booths, conference rooms, etc. on the periphery.

General concensus of the committee was that the suggested structure of the module area should be reversed with the exam rooms surrounding the service area. Mr. Taylor agreed to draw these alternative plans and present them to the committee at the next meeting. An exam room mock-up will also be done in the future to determine exact room size and location of equipment.

Other items of discussion included the following:

- Minimum number of examination rooms needed to accommodate patient loads
- Flow of charts and x-rays in the clinic areas
- Hall width and right angle turns (considering litter patients)
- Waiting space - isolation and flexibility
- Number and size of consultation rooms, conference rooms, dictating booths, etc.

Such topics will be discussed at future meetings.

The floor plans of Colorado General Hospital in Denver and the Ambulatory Care Unit at the University of North Carolina were distributed.

Respectfully submitted,
Eunice Halverson, Secretary

March 3, 1970

Mr. Peter Sammond
Associate Director
University Hospitals
Box 606

Re: Outpatient Module Planning for Pediatrics

Dear Peter:

Thank you for sending me the clinic module sketch made by Dr. Richard Anderson. This is essentially the design that I favor. I believe that we can use it as a basis for design of a module that will suit most of the medical and surgical services. I have the following immediate reactions and am including a drawing to illustrate them.

I would favor making the waiting areas longitudinal rather than as shown on Dr. Anderson's drawing in order that zoning may be possible. As you recall I feel that several types of waiting areas should be designed for pediatric patients. Clumping of seating areas could be pleasant for adults also. I would put the public toilets in the hallway in order that they be available to all persons using the public corridor. Also it is less embarrassing to come out of a toilet into a hallway than into a waiting room where everyone looks up to see where you've been. The reception area should jut out into the waiting room so that there would be visual access to all waiting areas. If the waiting areas are to be partitioned as we anticipate in Pediatrics, glass should be used for sound control. On my drawing I have divided the waiting room into toddler, older children, and baby categories.

I agree with his arrangement of the central core in that reception doctors, nurses, treatment, seems a natural juxtaposition of these functions, particularly in regard to the interrelationship of doctors to the charts and nurses to the supply and treatment area. My arrangement is slightly different in that I put dirty utility rooms on both corridors, since all examining rooms generate dirty linen and supplies and for the most part, clean supplies are used for treatment. Another innovation, which I feel should be incorporated in some way or other is a "check in and out" substation specifically to be used by the nurses and the aides as opposed to the check in and out receptionist's area. This area would serve as a place to measure the child's height and weight, take his temperature, blood pressure, etc. and record these on the chart. This function is carried out by aides or nurses. When checking out it may be necessary for the child to produce a urine specimen or for the parent to receive a specimen bottle to take home. These supplies would be housed in this area.



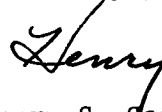
Mr. Peter Sammond
Page 2
March 3, 1970

The staff corridor is a concept that I support. It would be convenient to have a staff toilet on this corridor. These rooms perhaps could be deeper than regular examining rooms in order to accommodate special functions or offices or conference rooms, etc.

I feel that a secretary for transcription of the dictation generated in each module would be a welcome addition to our clinic function. I believe that she should have an office adjacent to the reception and doctor's area because her work will relate to patients and patient's charts. The provision of offices within each module for the medical staff directly responsible for the operation of the clinic is essential. This secretary could also serve the needs of these medical staff members. In the case of Pediatrics, we are locating a large block of departmental space next to the pediatric module. I have not thought out exactly how we should relate this to the module, but certainly we need to take this into consideration.

You will note that my drawing is not to scale and therefore the areas may be larger or smaller than necessary. It certainly appears that it's going to be difficult to get adequate numbers of examing rooms if we have all of these supporting functions in each module. I'm sure that our architects can solve this problem for us.

Sincerely yours,



Henry S. Sauls, M.D.
Assistant Professor
Department of Pediatrics

HSS/mjp
Enclosure
cc Dr. Leon Satran

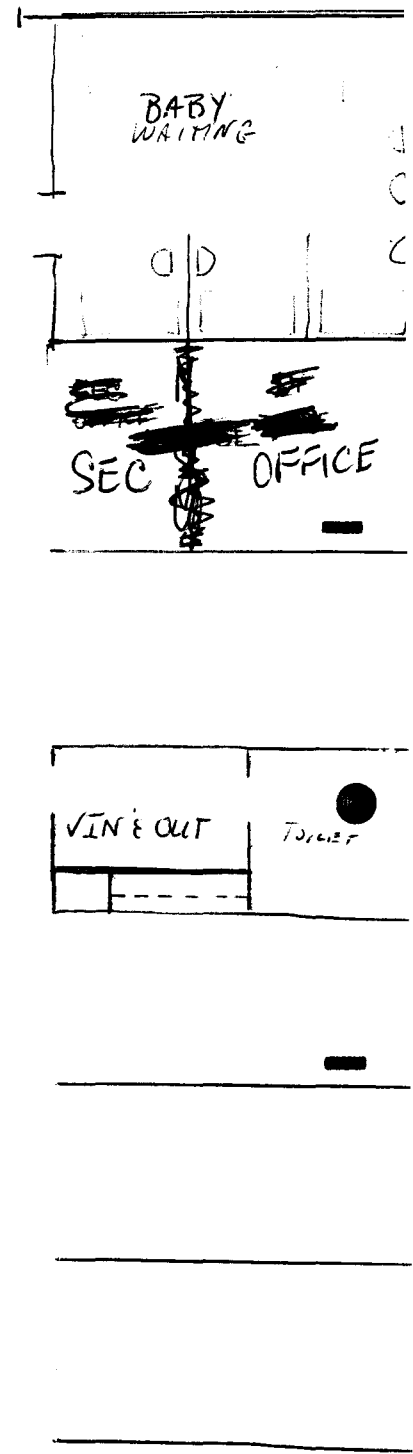
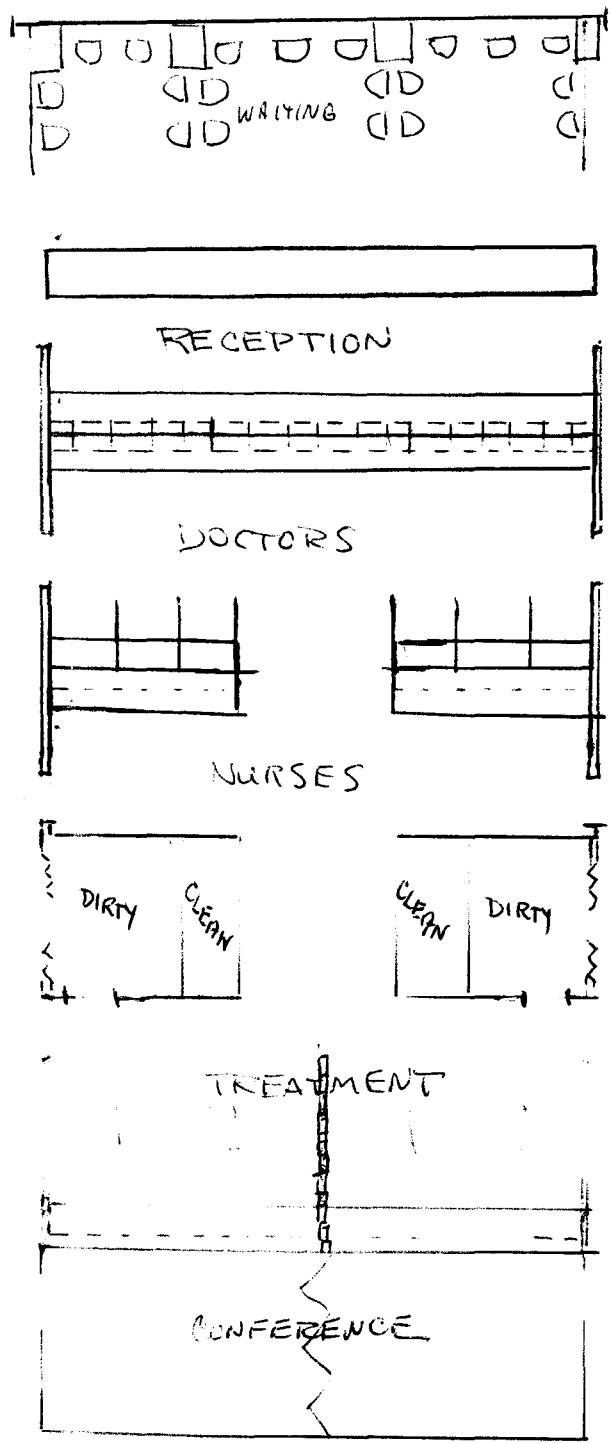
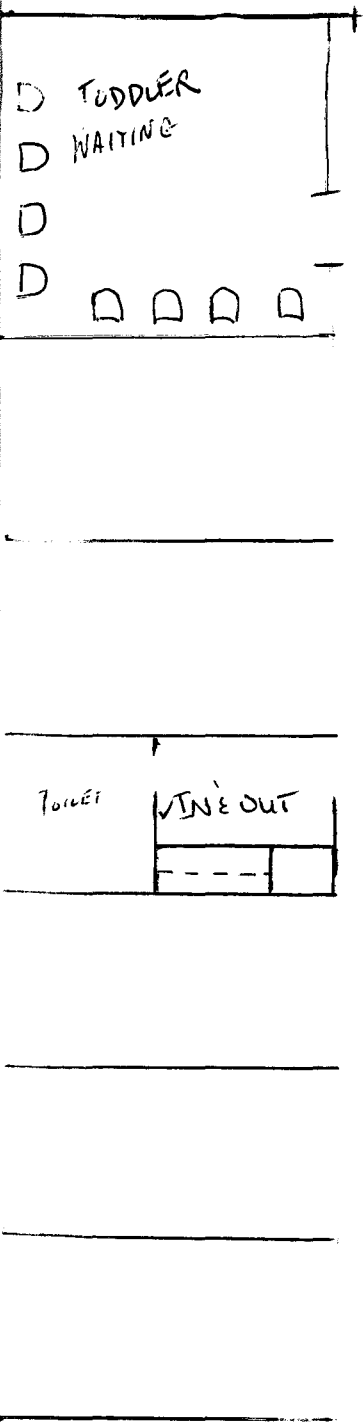
ELEVATORS

TOILETS

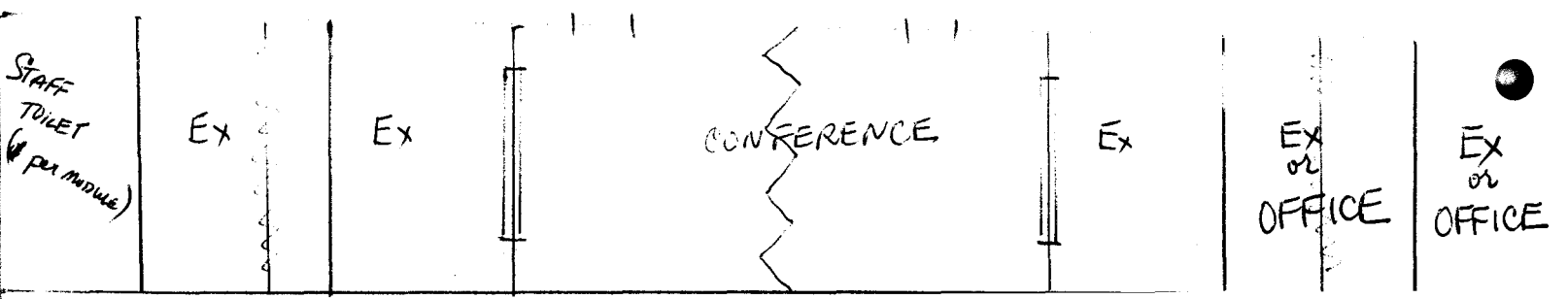
TOILETS

OFFICES

PATIENT CORRIDOR



STAFF CORRIDOR



UNIVERSITY OF MINNESOTA HOSPITALS

Doctor's Order Sheet

Date

Time

Order

Doctor

CLINIC
12.0

H.S. Exp.
file

March 3, 1970

TO: Richard Ebert
Lyle French
Mellor Holland
Roland Kluver
Karen Levin

Robert Mulhausen
Hugh Peacock
Peter Sammond
John Westerman

FROM: C. Thomas Smith, Jr.

SUBJECT: Health Sciences Expansion Program Clinical Component

Background

At the outset of planning for new facilities the need for hospital facilities (excepting outpatient) was the least well defined of all components. Administrative leadership in the hospital was in a transition phase and the future role of the institution was not clear. New Federal programs, changes in the state county program, shifting of national priorities from health research to health care delivery, and a strong interest in producing more health manpower caused the future of University Hospitals to be obscure and subordinate to other needs. In addition, nine of nineteen clinical medicine departments changed heads bringing to bear a new set of perspectives as to the role of University Hospitals.

In light of these changes and forces planning for additional hospital facilities received a low priority ranking in relation to other programs. Early planning documents stated that there would be a shift in clinical emphasis from inpatient to outpatient services. This was supported by stipulating the ultimate bed size of the hospital to be approximately 1000 with the balance of the need for clinical teaching occurring in affiliated institutions. At the same time there was planned to be a facility for outpatients capable of handling a 50% increase.

Assumptions

With the above as background, the Hospitals component of the Health Sciences expansion was planned. The following assumptions were generally accepted as guiding this planning effort:

- A. The ultimate bed size of University Hospitals will be achieved in Phase I development with the addition of 160 beds. The prospect of tighter planning controls over beds made it appear essential to achieve the bed increment in Phase I, rather than wait until Phase II.
- B. Since clinical medicine departments were minimal in Phase I, it was essential to include some bed expansion to show support of this area. *limited bed expansion proportional to CTR growth*
- C. Existing peripheral units (Masonic, Heart, Rehab) would remain as inpatient units. No other bed additions or replacements will occur prior to Phase II in the 1980's.
- D. Hospital support departments will achieve their ultimate size

in Phase I as ultimate bed size is reached. This requires extensive renovation.

- E. ^{Since} Phase II expansion will ^{not} occur ^{until} some time in the distant future (around 1986), ~~requiring~~ extensive remodeling ^{in Phase I} to keep the unit up to minimal standards.
- F. Clinical teaching needs not met within University Hospitals could be effectively met in affiliated Hospitals.
- G. Phase II expansion will move all Hospital elements out of the Mayo complex to the Powell Hall site.
- H. Funds for clinical facilities (particularly beds) will be easier to secure from non-governmental (private) sources than funds for non-clinical facilities.
- I. Although planning is a dynamic process, at some point a plan must be agreed upon in order to proceed with implementation. Factors emerging late in the planning process (after the initial presentation to the interim legislative building commission in July, 1966) were not allowed to modify the original Phase I program. Phase II was designated as the appropriate stage to consider additional program proposals.

Current Issues

- A. Changes in key faculty and staff have precipitated a reexamination of institutional mission with a strong emphasis on responsiveness and community orientation. Two issues which could significantly affect facility planning are an open admission policy and expansion of emergency services.
- B. Continual pressures for initiation of new programs and expansion of existing ones creates a financially untenable situation for University Hospitals. These demands on top of a significant cost escalation applied against a stable patient load have resulted in the Hospitals having to virtually price itself out of the market. Thus either other means of financing such programs must be found or the patient load must be measurably increased beyond the 1000 bed size.
- C. The state of the present hospital facilities, the need to be competitive with other hospitals and the demands for expanded services created by new faculty have caused the Long Range Hospital Planning Committee to request that the new hospital be built in the 70's instead of the 80's.
- D. From a functional and operational perspective Hospital administration opposed development of another "satellite" unit. Proliferation of inpatient buildings makes automation and standardization of systems costly and more complex. Ideally all inpatient units will be located in a tower with standard size modules.
- E. The Unit C. site does not readily accommodate bed facilities. It appears that certain major compromises in design will be required to fit the site.

CONCLUSIONS:

1. A modular design will work well for pediatric outpatients.
2. Waiting areas should be designed for each age group. An office for a play therapist and outside play space are desirable.
3. Special facilities (e.g. breast feeding room, gynecological room, one-way mirror rooms, rooms for special projects, etc.) should be designed within the confines of the module so that these rooms can be used for examining, counseling, diet instruction, etc. when not in use--or when the faculty leaves that has a special interest in the project.
4. The size of the pediatric examining room should be the same as the adult examining room. I feel that 10 x 11 is minimal.
5. Placement of certain facilities within the rooms was commented upon (see above).
6. Small conference spaces and large conference rooms should be available in the clinic area. The large room should be divisible.
7. Faculty associated with the operation of outpatient department should have offices adjacent to the clinic area.
8. Adjacent x-ray and lab facilities are very desirable.
9. Noise control using every means possible is highly desirable.
10. Gimmicks such as lights above doors, elaborate intercom systems, radio paging, one-way mirrors, and closed circuit TV for each clinic should be closely evaluated before such investments are made because of the transient nature of the faculty and house staff serving in outpatient departments.

F. The Student Health Service addition should add 30 acute beds and about 25-30 minimal care beds by 1971 or early 1972.

G. The Cardio-Vascular Research Center Planning Committee has proceeded with its development proposal with two major alterations from what was presented to the legislature in 1968 as a potential development through 1986:

1. Movement forward in time to submission of grant request in June 1970.
2. Movement of the proposed site for the center to Site E.

In addition, this planning effort has now embraced replacement of the beds in Heart Hospital as a part of the program.

H. A strong base of support has been generated for creating a Children's Center as a part of the development in the 70's. This is envisioned to require approximately 300 beds, 50% more than the present allotment plus clinics, labs, offices and teaching spaces associated with such a center.

I. A legislative committee is considering what to do with Gillette Hospital in light of several alternatives that have been proposed. In 1968, the University issued a statement to this committee indicating no interest in having Gillette on the University campus. The Children's Center Planning Committee however has advocated location of Gillette Hospital on campus as part of the Children's facility.

J. The Minneapolis Veterans Administration Hospital has asked the University to consider allowing it to co-locate a new facility within the health sciences center. The Deans V.A. Hospital Advisory Committee has supported investigation of this proposal.

K. Current indications are that Federal support of teaching Hospital facilities will be transferred from the Bureau of Health Manpower to Hill Burton. The impact of such a move will depend upon whether or not teaching hospitals are given any priority treatment within the Hill Burton scheme and the level of funding for the Hill Burton program. The current attitude of the State Health Department, administrator of local Hill Burton funds, is that the University has received more than its proportion of Hill Burton monies throughout the history of the program and therefore other institutions in the state should be given first priority

L. There is increasing recognition of the unwillingness or inability of the State Legislature to finance a major clinical facility at the University.

M. The exclusion of Units D, E, and Remodeling from initial approval by NIH raises questions about the likelihood of state funds for these components and validity of the rest of the program if they are not funded. Much of the space programmed for clinical, basic science and hospital departments is in remodeled areas. Without remodeling, it is questionable whether many programs will be able to function particularly with additional beds.

Questions

- A. Have the assumptions on which Phase I planning was based changed significantly enough to warrant reconsideration of the Phase I program? Are the priorities for new space the same now as in 1966?
- B. If the present program is not altered, can we give strong support to it both within and outside of the University as being a good response to Phase I needs despite recent developments?
- C. Is the Phase I program design flexible enough to respond to a major program alteration such as elimination of beds? Will it be able to respond to a later change, i.e. conversion of beds to other use or addition of beds?
- D. Would an alteration in either Phase I program or timing affect the likelihood (from NIH perspective) of realizing elements of the program in which no change is desired?
- E. Would elimination of beds from the Phase I program create hardships on clinical educational programs and thereby cause more reliance on affiliations than is desirable?
- F. If remodeling money is not available, can the program function as planned or will major alterations be necessary in new space to accommodate to the needs that derive from the lack of remodeling?
- G. Are there political considerations (commitments) within the faculty or with the legislature which would argue strongly against modifying the existing program?
- H. In light of considerations of commitments, timing, expense of program modification, political and funding realities what elements if any of the present program would be subject to alteration?

UNIVERSITY OF Minnesota

TO: C. Tom Smith

FROM: R. Muehansen -

SUBJECT:

Attached is a first draft approach
to our considerations of the other day. Not
meant to be complete & perhaps sketchy.
May be of some use

RM

I. Past Considerations

A. Phase I

1. A, B, C, D, E, L, & Renovation

Estimated cost about $\$120 \times 10^6$. to be matched by NIH and to specifically be a program for 60 new medical students per year.

2. If carried to fruition would include new facilities for a Dental School, mixed facilities for the Medical School and renovated area for Public Health and School of Nursing.
3. Implies completing entire Phase I program with all departments and units receiving allotted space in either new or renovated space - based upon 60 students as applied to Medical School and U Hospitals.
4. Presentation to legislature - $\$120 \times 10^6$ package - 60 new medical students, some hospital beds - 52-53% NIH match.

B. Phase II

1. Nebulous. Date: 1980's. Number of beds? Site?
2. Based mostly upon replacement with ? of slight increase in beds.

II. Present Considerations:

A. Phase I

1. Contracted to A, B, & C by NIH on basis of 60 students. No approval for D, E, L, renovation or affiliated hospitals.
2. Question of 50% match for renovation
 - a. Requires further grant request to NIH.
 - b. Question of priority for NIH construction funds.
 - c. Not based upon student increase. Will we need to increase student number for renovation?
3. Question of complete funding for renovation by State. $\$10.6 \times 10^6$ estimated now. Probably more. $\$15 \times 10^6$? Will State provide entire cost of renovation in 1973?

4. Faculty response to lack of renovation money in current approval.
Effect on planning? Effect on morale? Leaves matter completely unsettled until after 1973.

5. Political considerations - Less cost to state than previously thought.
66 2/3% match, but with less overall program.

B. Program Considerations:

1. A. Medical School teaching labs
Complete Dental School
Several department offices and labs

B. Research

C. Large OPD & Radiology and comparatively few, relatively inefficient² beds.

Are these our top priorities for Medical School at this time, at this site, if no renovation funds currently approved?

2. New Programs

VA, Cardiovascular, Childrens, Gillette, Original Phase II moved up.

3. NIH Considerations:

Even without current approval for beds in C, will NIH pull out bed money if after July 1 this should go to Hill-Burton². Construction money for medical education vs hospital will be short after July 1. Will NIH use above as excuse to channel all construction money to Medical School vs hospital beds? Are we better off making all of C Medical School related at this time?

Are we expected to negotiate with NIH now regarding programs in B & C?

4. State considerations:

What is impact of changing program now? 60 new students are insured with less cost to State than previously thought. Can we explain a better Medical School program for 60 students now without jeopardizing need for hospital beds in future?

III. Options:

A. Continue Program Phase I

1. Restricted by NIH
2. No foreseeable funding of D, E, L, Renovation, under current class size increase. Need to further increase class size.
3. Large cost of Phase I with only inefficient beds and a further need for large costs for better beds in Phase II.
4. Doubt, indecision, effect on faculty planning and morale.
5. Political considerations: If continue, University will appear to look better, decisive, answering previously expressed needs by faculty.
6. May give lower priority needs in wrong time sequence without assurances of completion of highest priority needs.

B. Remove beds from C - with planning for Phase II.

1. Allow higher priority needs in C. Remove inefficient beds. Effectively uses NIH funds as hedge against bed money withdrawal.
2. NIH - Require negotiation with NIH.
3. Political considerations
 - a. Faculty - need to have beds now (yet we run low occupancy of current beds)
 - b. State - negates our earlier expressed needs to have beds as soon as possible.

C. Keep beds in C with planning for Phase II - later converted to discrete bed units e.g. Childrens beds, Gillette etc.

1. Keep current NIH approval intact
2. Combining bed units
3. Places priority of beds over teaching, CTR, assuming lack of renovation funds in near future.
4. Planning for Phase II to include D, E, L etc.
5. ? of NIH fund withdrawal of beds with withdrawal of x dollars from currently approved program.

- D. Complete new program for B & C with planning for Phase II
 - 1. Need to establish priorities and needs for teaching and departmental functions.
 - 2. OPD ? Restrict space? Consider another location?
 - 3. Radiology? Reevaluation?
 - 4. Phase II to consider clinical functions now programmed in C & D, E, L, etc.
 - 5. Political considerations:
 - a. NIH - negotiation, possible jeopardy
 - b. Faculty - postpones clinical facilities, better than delay in CTR & teaching space?
 - c. State - negate bed and OPD needs previously stated.
- E. Other options

IV. Phase II Planning:

- A. Program - U Hospital, VA, Childrens, Gillette, Cardiovascular.
- B. Site - Central administration perspective?
- C. Funding - Federal, perhaps, - State, doubtful in 70's. Private?
- D. Need for U Hospital - replacement, faculty support. Clinical core, bed occupancy???

In summary - 1) should we continue our present direction in planning in both Phase I & II with all of the faculty, State, & NIH considerations as they currently exist, or as we see them occurring, and with all the planning shortcomings as we visualize them today, or, 2) should we modify our planning of Phase I to higher priority needs within current NIH approval of program and move ahead with an accelerated Phase II program related mostly to better clinical facilities?

ROUGH DRAFT - March 5, 1970

TO: C. Thomas Smith, Coordinator, Health Sciences Planning
FROM: Peter H. Sammond, Director, Hospital Planning
SUBJECT: Hospital Position on Phase I and Elements of Unit C

The hospitals planning group has concluded that there are two major reasons to reconsider the Unit C Program at this time. The first deals with NIH funding covering less than had been asked in the Phase I program; and the second, the same deficiencies in functional relationship and workability as noted in my memorandum of March 2.

The latest information is that even though Unit C was approved for inclusion ⁱⁿ NIH for grant funds, that there is a new ruling which will remove clinical facilities (principally beds) from this inclusion. Therefore, should we wish to build the beds on Unit C as planned, funding from other sources would have to be obtained. Their availability at this time is certainly problematical. Therefore, it would seem to us, that we are faced with a choice of building Unit C without the planned beds, and saying to NIH in the legislature that we will include the planned beds in a later portion of an extended phase I. The alternative to this would be to build an equivalent amount of square footage to the original proposal substituting other facilities for beds. This approach, while perhaps saleable to NIH, would have serious implications for our credibility with the Legislature. Our position would seem to be stronger if we say to the Legislature that federal funding did not come through as anticipated; therefore we felt it necessary to reanalyze the program, and have thus reduced the total program by the amount proposed for beds. The University should say that the clinical

portions of the program as originally proposed are still valid and that we would be coming back, probably to the next Legislature with them included in an overall clinical package, which most likely would also include the various separate hospital proposals presently under consideration. It would seem important to get University central administration to agree to and be committee to this approach.

While there are many functional reasons that beds on top of Unit C would be less than optimal, the Hospitals feel that the reasons originally presented for the new ambulatory facilities are valid, and that this portion of the Unit C Program should go forward. We feel that this unit makes sense functionally at the Unit C site and would relate well to the sites which have been mentioned for a future hospital.

Our proposal then for this step of Phase I would be to build the following elements in Unit C and remodel only those facilities absolutely necessary at this time. This proposal is based on the following assumptions:

1. That all new outpatient clinics would be build on the Unit C site for occupancy in 1973.
2. That a new hospital facility would be build for before 1980.
3. That there is negative correlation between the amount of money invested in clinical facilities at this time and the likelihood of funding a new hospital by 1980.

The Hospital planning group then would propose specifically that Unit C and remodeling at this time include the following elements:

1. All new outpatient clinics (Unit C).

2. An admissions office (Unit C).
3. A business office (Unit C).
4. Medical Records department (Unit C).
5. Such expanded radiology facilities as necessary to serve the increased outpatient load (Unit C or remodeled animal quarters space next to existing radiology).
6. Expanded laboratory facilities to serve the increased outpatients (Unit C or remodeled space next to existing laboratories).
7. New emergency facilities (Unit C).
8. Expansion of operating room only to the extent necessary to serve 1970's programs, possibly through installation of package operating rooms.
9. Remodeling of other extremely deficient present facilities such as pediatric wards, station 44 ICU, and as few others as possible.

PHS/cp

March 2, 1970

UNIVERSITY HOSPITALS • MINNEAPOLIS, MINNESOTA 55455

TO: Mr. C. Thomas Smith
FROM: Peter H. Sammond
REGARDING: Phase I Long Range Planning, Unit C

I. Original Assumptions

- A. That Phase II (any additional clinical facilities) would not be forthcoming until 1986 or later.
- B. That funds for clinical facilities (inpatient hospital particularly) would be far easier to come by from non-governmental sources than funds for non-clinical facilities.
- C. That the present bed compliment of University Hospitals would need to be increased by at least the 160 bed increment proposed in Phase I by 1973 or 1974.
- D. That the 160 bed increment proposed would serve adequately until 1986.
- E. That the disadvantages of another detached hospital unit would be outweighed by the advantages of the additional beds.
- F. That no additional beds would be available to University Hospitals before 1973.
- G. That whatever of existing space is vacated would be remodeled as part of the Phase I program.
- H. That the patient care unit program for Phase I could be accommodated without trouble on Site C.
- I. That the Outpatient Department was obsolete, needed replacing and needed expansion to handle twice as many visits as it presently does.
- J. That all the facilities necessary to the operation of Phase I would be built by the completion of that phase, i.e., receiving stores, etc. as planned for Unit E.



II. Changes in Assumptions Since Original Planning

- A-B There is considerable hope and thought that the Phase II new hospital might be built as early as 1976. Donations anticipated for other units such as the CVRC has not been forthcoming in the amounts anticipated. Earlier feelings that state appropriations will not be available to build a new hospital would seem to be justified. Federal government programs for this type of construction leave that source very much in doubt. Conclusion - funding for Unit C, much less a total new Phase II hospital, at this point would seem very much in doubt. It would appear that donations and borrowing will have to be rebid upon.
- C-D There is now interest on the part of many faculty members in more beds than contemplated in the Phase I Program. Examples of this are the proposed doubling of existing childrens' beds for the Childrens' Center, references to an expanded University Hospitals, etc. Unfortunately, as we all know, the census to date does not support these projections, although I think certain programs do give promise of increased numbers of patients for the future. However, it is hard to sell planning agencies and legislatures on the need for facilities based on promises.
- E The disadvantages of the additional small unit (increased walking and communication distances, difficulty of implementing automated transport systems, etc.) still make this a questionable assumption. Further study might be necessary here if this were the deciding factor.
- F The Student Health Service addition should add 30 acute beds and about 25-30 minimal care beds by 1971 or early 1972.
- G Funds for remodeling of existing space are very much in doubt.
- H We have experienced difficulty during the planning with fitting the hospital bed program to the Unit C site. As it appears now, certain major compromises will probably have to be made in the program to accommodate the beds on this site.
- I The OPD is obsolete and does need replacing. Whether it needs to see twice as many visits as at present is questionable, but probably cannot be answered any better than it has been until some overall programmatic directions for the Health Sciences Center are determined, i.e., increased use of satellite clinics, open referral, emergency program, etc.
- J The lack of funding for Unit E puts a great gap in the entire Phase I program and raises the same problems as the lack of remodeling money.

Alternatives

- A. Proceed with Unit C as programmed according to the existing time schedule and the assumption that adjustments of beds can be made later at such time as the new hospital is built.
Example: medicine beds moved; peds expand into medicine space.
- B. Proceed with Unit C converting the present program to all childrens' beds (reduce total program) allowing for future expansion vertically to encompass the entire childrens' program.
- C. Do not build any beds in Unit C in Phase I, and put all efforts toward building new hospital facilities in an earlier Phase II. This would have the advantage of allowing time to consolidate the various program elements, i.e., Childrens' Hospital, Gillette, new hospital, Unit C. expansion, Veterans Hospital, etc. into a total program master-planned at one time. It also might allow us to avoid the costly step of expanding hospital departments in Phase I and moving them shortly thereafter. I think we should proceed with C as an OPD-office building.

PHS/lmc

February 26, 1970

UNIVERSITY HOSPITALS · MINNEAPOLIS, MINNESOTA 55455

Mr. C. Thomas Smith
Coordinator
Health Sciences Planning
Box 605

Dear Tom,

I am writing following the general request of Vice President Champion for those of us at the Design Coordinating Committee meeting of last Wednesday to give you our thoughts on elements of the charge to the Long Range Hospital Planning Committee.

It seems to me that the overall charge to the Committee should be one of asking the four subcommittees, i.e., Children's Hospital, Cardiovascular Center, University Hospital and Veteran's Hospital (I don't know whether there is a committee for the last one) to attempt to define in general the size of the programs they are talking about as quantified in terms of beds, outpatient clinic exam room hours, faculty and staff and square footage - - - Tom, in the middle of this I have begun to change my mind, but I want to leave it in the letter so that you can understand my reasons for rejecting this approach. I think that it would lead to nothing but a catastrophic collection of wish lists which would not truly measure needs, educational or service. The only way that this would be viable, it seems to me, would be to have a full time planner or consultant for a period of months to guide this effort. I do not think that it would be successful just to have the individual units pull numbers out of the air and feed them into John's Committee.

A better approach, it seems to me, would be to take the bed projections and Outpatient projections such as they were estimated in the reports now in hand. Some of these may need slight refinement, but hopefully not through the general committee procedure. These then should be turned into projections of faculty, students, patients, visitors, square footage, cars etc. and from this total information some kind of judgement should be made by the Design Coordinating Committee, the Planning Office and the Architects as to the feasibility of such an expansion. I too worry about the saturation point like Mr. Champion.

Then if the decision is made to attempt to locate these facilities here, or certain ones of them here and others elsewhere, the Committee should set to work at refining their programs. I opt for this shorter approach in that I think there is going to be a hesitancy to proceed with the definitive planning of Unit C if there is a great deal of activity and



Letter to:
Mr. C. Thomas Smith
Health Sciences Planning

"2"

uncertainty related to "future new hospital." Therefore, I would like to see these projections made very quickly and the feasibility be determined very quickly.

Another charge to the Study Committee, seems to me, has to be to evaluate the impact of the requested programs on community commitments and obligations. I am not sure that the Long Range Hospital Committee has the representation on it to make this evaluation, but at least some University group ought to consider this quite seriously at this time.

Another question upon which we were asked to comment was, "What would the lack of remodeling money do to the Phase I development program?" My view is that such an event would make the successful operation of Unit C almost impossible. The inability of departments in old space to expand to serve the greater size of the Center would be just one factor. The new traffic pattern suggested by main entry at Unit C require the location of certain hospital departments in that building. These departments, the Emergency Room, the clinics and the bed floors would all require services of departments in existing buildings which could not expand or modernize. This, it seems to me, would make Unit C almost as inefficient as our present facilities.

The final point I should like to raise is one that I would like to underline. As you are aware the Hospital Planning Group recommended over two years ago that an additional small bed facility not be built. At that time, when the prospect of any more beds than the 200 plus bed Unit C seemed in the distant future, the Planning Group was advised that we had better take what we could get. Within the last year, when the same question was raised, the response was that the presentation had already been made to the Legislature and to NIH that this bed increment was a vital component of our ability to carry out the expanded student programs, and any change in that advice would raise questions of credibility about the whole program. Recently, I have had increasing comment that the small increment of beds in Unit C is not a particularly workable idea. I wonder if the possibility of building a new University Hospital on the Powell Hall site in the middle 70's rather than the middle 80's might not give us the rationale to reconsider putting any beds into Unit C between now and the construction of the larger hospital, (possible only 5 to 7 years hence). It might be wise to ask the Long Range Planning Committee to consider this question specifically as well as the functional relationships between potential Unit C, CVRC, Children's Center, Gillette, New University Hospitals and Veterans. It seems to me that we are talking of a new 213 bed unit, a 100 bed unit, a 300 bed unit, another 100 bed unit and a couple of 850 bed units. This, it would seem to me, is sensible planning. I think this needs looking at from an overall perspective.

Letter to:
Mr. C. Thomas Smith
Health Sciences Planning

"3"

The whole question of taking hospital construction out of the Health Manpower Training Act may also give us an opportunity to rethink Unit C. Nevertheless, I would like you to give real thought with me to asking the planning apparatus to review the Unit C beds as a part of their further study.

I will look forward to discussing these points with you at your convenience.

Sincerely,



Peter H. Sammond
Associate Director

PHS/lmc

University of Minnesota

Production and Billing Schedule - Health Sciences

<u>Estimated Cost</u>	<u>% Fee</u>	<u>Unit</u>		<u>1/1/70</u>	<u>2/1</u>	<u>3/1</u>	<u>4/1</u>	<u>5/1</u>	<u>6/1</u>	<u>Total</u>	
28,122,210	1,968,555	A	%	50 DD	60 DD	70 DD	80 DD	90 DD	100 DD		
			Amount	19,686	39,371	39,371	39,371	39,371	39,371	216,541	
24,740,000	1,731,800	B&C		30 DD	35 DD	40 DD	45 DD	50 DD	60 DD		
				17,318	17,318	17,318	17,318	17,318	34,636	121,216	
640,000	44,800	D		(No change - 100% SD)							
4,560,000	319,200	E		15 DD	20 DD	30 DD	40 DD	50 DD	60 DD		
				3,192	3,192	6,384	6,384	6,384	6,384	31,920	
6,730,000	471,100	F		(No change - 100% SD)							
2,308,500	161,595	L		10 SD	20 SD	40 SD	60 SD	80 SD	100 SD		
				2,424	2,424	4,848	4,848	4,848	4,848	24,240	
7,950,000	795,000	REM		(No change - 50% SD)							
	(10% Fee)										
Monthly Totals				<u>42,620</u>	<u>62,305</u>	<u>67,921</u>	<u>67,921</u>	<u>67,921</u>	<u>85,239</u>	<u>393,927</u>	

MODULAR CLINIC SPACE PLANNING SUB-COMMITTEE MEETING

March 4, 1970

PRESENT: Miss R. Acton, Dr. R. Anderson, Mr. L. Dingmann, Dr. C. Drage,
Mr. P. Sammond, Mr. K. Taylor

Mr. Taylor presented a proposed layout of a typical clinic module as requested by the committee at the February 19, 1970 meeting. This new plan locates the examination rooms on the periphery of the module with ancillary services in the center.

It was agreed that the planned patient waiting area was inadequate and that an additional 150 square feet were needed. To allow for this space, the following suggestions were given:

- reduce number of exam rooms from 20 to 18
- reduce consultation rooms from 4 to 2 or 3
- delete all two man cubicles
- reduce bathroom facilities from 2 seat to 1 seat

Dr. Drage stressed the need for office space for a Clinic Director and his secretary within the clinic area. To date, only Pediatrics has specifically requested this space. Other services desiring assignment of department space in the Outpatient Department should notify Mr. Sammond immediately.

Discussion was held on the basic idea and functions of a modular clinic set-up. The goal in planning is to arrive at an average of every service's needs. Three questions must be considered to fully define priorities:

- Who is in the clinic?
- What functions are performed in the clinic?
- Who has responsibility for what?

The next step of the planning is to set up a model of specific functions in the clinic, including such things as removal of trash, exam room set-up, flow of charts, flow of patients, etc.

Laboratory and x-ray representatives will be invited to attend the March 13th Outpatient Committee meeting to discuss the possibilities of having satellite facilities in the new building. Pharmacy is presently planning a satellite station.

Soon a large scale model of a 9' x 11' and 9' x 12' exam room will be available for study. The purpose is to determine exact room size and to discuss location of furniture and plumbing. Examination room equipment must be decided as to what is standard. Self-sufficient rooms would be ideal but past experience has been that the instruments are stolen.

Mr. Taylor also agreed to visit the existing clinics before the next meeting.

Respectfully submitted,

Eunice Halverson, Secretary

March 9, 1970

Mr. Kenneth Taylor
The Architects Collaborative, Inc.
46 Brattle Street
Cambridge, Massachusetts

Dear Ken,

I am attaching copies of a letter and a plan submitted since your last visit by Dr. Henry Sauls. He is using as reference the sketch drawn by Dr. Richard Anderson earlier.

Some of Dr. Saul's suggestions are unique to Pediatrics, but many of them are generally applicable to the module. It is unfortunate that Dr. Sauls could not be with us at our meeting last Wednesday, as I think that he would have been impressed with the fact that many of the suggestions that he is now making were anticipated in your latest scheme. At any rate, I pass this further information on to you for use as design development continues.

Sincerely yours,



Peter H. Sammond
Associate Director

PHS/lmc
cc/Dr. Richard Anderson
Dr. Charles Drage
Mr. Larry Dingmann
Miss Rosie Acton
Mrs. Eunice Halvorson
Mrs. Jane Felder
Dr. Henry Sauls

TAC

University of Minnesota
Health Sciences Expansion
TAC Job No. 68013

9 March 1970

Tabulation of Areas in Proposed Clinic Module Plan dated 3 March 1970

Proposed Medicine Clinic Module

18 Exam Rooms	2,017
3 Nurses-Doctors Consultation	318
Doctors' Charting and Dictation	400
Nurses' Station	179
Clean Utility	92
Soiled Utility	92
Waiting	428
Reception and Clerical	180
Coats	68
Storage	170
Janitor	54
Treatment	234
Seminar Room	343
Toilet Rooms and Specimen Collecting	<u>264</u>
Total Area, Clinic Module Proposal, 3 March 1970	4,839 SFN
Original Program Area for Clinic Module	4,742 SFN
Total Area, Ob-Gyn Clinic Module Proposal, 3 Mar. '70	4,956 SFN

April 22, 1970

Mr. Peter Sammond
Associate Director
Box 606 Mayo

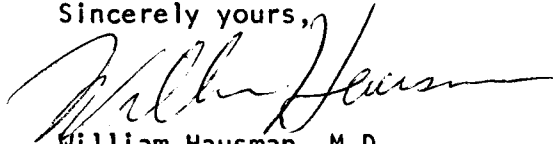
Dear Mr. Sammond:

Dr. Anderson brought to my attention the request of the Modular Planning Subcommittee that those departments desiring assigned space in the modules submit their requests.

The Department of Psychiatry is currently in the process of reorganization of its clinical program. We will soon have four separate firms or teams (Station 62, Crisis and short-term evaluation; Station 60, Psychotherapy; Station 61, Psychopharmacology; and Child Psychiatry). Each will evaluate new patients, hospitalize only when indicated, and provide its own out-patient and follow-up services. Eventually, this will shift firm activity more to the out-patient direction, and it is therefore imperative that each firm have a "headquarters" in the outpatient building now being planned. Routine visits can be scheduled into modular space, but the demands of rapid evaluation and consultation clearly require some space immediately available to each firm and for a coordinator of out-patient activities for the Department.

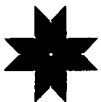
I am accordingly requesting that five examining rooms of the Psychiatry Module in the new building C be set aside for these purposes.

Sincerely yours,



William Hausman, M.D.
Professor and Head

WH:bjs



May 7, 1970

UNIVERSITY HOSPITALS • MINNEAPOLIS, MINNESOTA 55455

Dr. William Hausman
Professor & Head
Department of Psychiatry
Box 393

Dear Dr. Hausman:

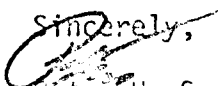
Thanks very much for your letter of April 22, 1970 relative to modular space in the new Outpatient Clinics.

I am not sure that I understand your request completely. Perhaps if I describe to you the history of the modular planning, it will help both of us in trying to achieve your objectives. As the total Outpatient space was reduced from an original request of 160,000 sq. ft. eventually to 87,000 sq. ft., many desirable features had to be eliminated. Among these were the assignment of space designated (for planning purposes) as Outpatient space to full time officing of faculty. The stated exception of the Outpatient Committee to this ruling was for a full time faculty member and secretary devoting substantially full time to the clinic teaching service program, i.e. an individual clinic director per department. We did not, however, design any particular space for offices, but rather made the examining room space flexible enough to accommodate this function.

Some departments wished more of their staff members officed in or near the clinic. To that end, they directed the architects to take some of their space designated (for planning purposes) CT and R space and locate it next to their clinic. If it is this latter type of space that you are requesting for 4 of your staff people (those other than the clinic director) we will be happy to pass your request on to the architects. If, on the other hand, you are asking that 5 clinic examining rooms be devoted to full time offices for the department, this would not be in keeping with the space allocation provided by the Outpatient Committee, unless these rooms would also serve as patient interview rooms for other than the office occupants.

I realize that the nature of Psychiatry makes the definition of office and interview space somewhat academic, and if you would like, I would be happy to meet with you sometime to discuss this whole situation further. I hope that what I have described above sheds more light than confusion on the situation.

Sincerely,


Peter H. Sammond
Associate Director

HEALTH SCIENCES CENTER

cc/Dr. Richard Anderson

May 26, 1970

Mr. Peter H. Sammond
Associate Director
Box 606 Mayo

Dear Mr. Sammond:

In response to your letter of May 7, regarding space in the new outpatient clinic, I would like to point out the particular value of allocating office space to representatives of each of our firms in that unit. Their full-time presence in the area will help to coordinate the use of the modular facilities and will, as we conceptualize the firms' planning as of now, assure maximal utilization of space and coordination of outpatient teaching functions during the time that students in various categories are working in the outpatient clinics area. This would be in contrast to our basing these same people in the Mayo Building, which would be more likely to have a deleterious effect on our hoped-for shift in priorities toward outpatient and community work within our field.

I realize the problems that you must deal with in planning for space but would greatly appreciate your giving serious consideration to this request.

Sincerely yours,



William Hausman, M.D.
Professor and Head

WH:bjs



June 4, 1970

Dr. Richard Anderson
Professor
Department of Psychiatry
Box 485

Dear Dick:

I am enclosing copies of letters from Dr. Hausman to myself dated April 22nd and May 26th with my reply of May 7th to his first. I am also enclosing a copy of the clinic modular assignments as last approved by the Outpatient Committee. This indicates that Psychiatry and Psychology would share a clinic module and make use of it approximately two-thirds of the clinic week. If you think that five rooms could be assigned as Dr. Hausman requests, without necessitating an overall increase in modular space assigned to Psychiatry, I don't believe that the Outpatient Committee would have any objection. I would appreciate your thoughts on this before discussing it with the Committee.

Thanks very much for your assistance with the Alice Paul case.

Sincerely,



Peter H. Sammond
Associate Director
University Hospitals

PHS/lmc

OUTPATIENT PLANNING

Minutes for Meeting July 8, 1970

Present: Rosie Acton, John Anderson, Richard Anderson, Annie Laurie Baker, Phillip Blume, Audrey Coulter, Charles Drage, Arndt Duvall, Ramon Fusaro, Eugene Gedgudas, Theodor Grage, Glenn Gullickson, Tom Jones, Gregory Kujawa, William Kane, Donlin Long, James McArthur, Colin Markland, Peter Sammond, Leon Satran, C. Thomas Smith, Robert Soll, Henry Sosin, Frederick Van Bergen, Francis Wright

SCHEDULE

The architects reviewed the Phase I schedule

November 1970	NIH Application
September 1973	Unit A
1974	Completion of Units B and C

SCHEMATICS

The Committee viewed proposed location for department and clinics space in Phase I of the Health Science Center expansion. It was requested that those present comment as soon as possible on the TAC drawings.

GENERAL COMMENTS

1. Circulation: Main circulation links between Mayo and Unit C will be located on the 2nd and 5th floors.
2. Beds: Present number of beds will be maintained in spite of loss of Station 12 by the expansion of other stations, for example station 32.
3. Fifth floor domes: Two will remain for teaching purposes and two will be phased out.
4. Location of surgery clinic with relation to the emergency room is in need of clarification.

INPATIENT CARE

It is noted that no significant portion of the millions of dollars being spent on Units B and C will go to inpatient care. Inpatient facilities are in fact at present not being emphasized on the assumption that legislation will appropriate funds for a new hospital before the end of the decade. At present instead, considerable improvements are being made in the medical school and outpatient care.

EMERGENCY ROOM

The desirability of locating the ER in Unit C was discussed. With reference to access of the ER to the OR and to complete radiological facilities in Mayo, and to placement of surgery clinic module in Unit C.

HELIPORT

The Committee was brought up to date on the question of location of a heliport for the Health Science Center. As yet none of the TAC site proposals has been approved. It has however been verified that there is not a heliport at present on top of the State Public Health Building. There appeared to be some feeling among those present that a heliport situated far enough away from the ER would require a special patient

conveyance system. On the other hand noise factors involved in locating a heliport on the roof of Unit C (directly over the ambulatory care unit) plus the expense, appear to preclude that alternative. The possibility of locating a heliport on Unit A was discounted because all the cooling equipment for the Health Science Center will be located on top of Unit A.

CORRECTION

The TAC schematics, July 7, show Station 35 as a converted area. Station 35 will remain in its present location, possibly with some expansion.

August 19, 1970

TO: Members of the Outpatient Planning Committee
FROM: Health Sciences Planning Office
SUBJECT: Clinic Module Design

A meeting of the Outpatient Committee will be held on Tuesday, August 25th at ~~2:30~~^{3:30} in Dining Room II to review proposals for design of the clinic module. It is hoped that members and guests will attend this meeting so that a representative committee recommendation can be secured.

/js

OUTPATIENT COMMITTEE

Minutes of Meeting August 18, 1970

Present: Rosie Acton, Larry Dingmann, Charles Drage, Terry Finzen, Ramon Fusaro, Dr. Gibson, Dr. Howe, William Kane, Hazel Karg, Dr. Malmquist, Colin Markland, Ron Palmer, Peter Sammond, Leon Satran, Ken Schlenker, Henry Sosin, Ken Taylor, Mark Wallace

AGENDA: 1. Location of the Clinic Modules
2. Emergency Room Planning

LOCATION

The committee discussed two alternatives for location of the clinic modules on the first nine floors of Unit C. Alternative I will involve a change in the location of Hospital Dentistry from the sixth to the ninth floor. Such a move has yet to be OK'd by the department. The Committee, however, feels that such a move is essential to the proper functioning of the other clinic modules in the Unit. The second alternative is agreed to be intolerable. Problems anticipated in planning the outpatient floors involved:

- a. Proctology location with relation to other two clinic modules on floor 1.
- b. Relocations of EKG

With regard to dermatology space, Dr. Fusaro indicated that he has no objection to locating Dermatology offices on the floor above the Dermatology clinics which will be located on Floor 4.

Recommendation was made by the Committee, with regard to location of the clinic modules in Unit C, that alternative I be pursued and alternative II rejected.

EMERGENCY ROOM PLANNING

With regard to the ER, Mr. Palmer presented the Committee with three proposals demonstrating spaces required to contain and service the ER functions indicated by the members at the last meeting. In light of these plans, the Committee recommends that every effort be made to triple the size of the existing ER so as to achieve a facility which will be functional for at least some ten years of use. This would involve some 3400 SF of space which must be secured from the Mayo Garage or by the removal of EEG space to another area of the hospital, possibly the fifth floor.

NEXT MEETING

It was agreed that the full committee would reconvene in one week to review proposals for clinic module internal design which will be drawn up by the architects and a small working subcommittee. This meeting will take place at ~~3:00~~ 3:30 p.m. on Tuesday, August 25 in Dining Room II.

September 14, 1970

TO: Outpatient Planning Committee Members
FROM: Peter H. Sammons *PHS*
SUBJECT: Meeting to Finalize Typical Clinic Module
Program and Design Relationships

The architects have taken the information gained from our previous meetings on the clinic module and revised the square footage assigned to various functions. They have also taken this time to examine different configurations of the various elements. They would like to report back to us, and a meeting for this purpose has been arranged for 7:00 a.m., Wednesday, September 16th in Dining Room III.

I hope that those of you who are concerned with the general configuration of the module will be able to attend.

PHS/lm1



September 14, 1970

UNIVERSITY HOSPITALS • MINNEAPOLIS, MINNESOTA 55455

TO: Mr. Robert Baker Dr. Henry Sauls
 Miss Rosie Acton Dr. Donlin Long
 Mr. Gregory Kujawa Dr. Richard Anderson
 Mrs. Jane Felder Mr. Leonard Leipus
 Mrs. Marie Perrault Mr. Robert Foster
 Miss Pfenninger Dr. Charles Drage

FROM: Peter H. Sammond *PHS*

SUBJECT: Outpatient Operations Planning Meeting

The architects have reached a stage in design development for Unit B/C where it would be helpful to raise and answer a number of inter-departmental questions related to patient flow in and servicing of the new Outpatient Clinics and related areas. In the group above we have attempted to identify those areas which would be most directly involved in this effort. Because of the importance of these questions and the need to bring continuity to bear upon them, we have been asked to arrange a long meeting, hopefully at a site which will remove us from obligations at the hospital during that time. This meeting has been arranged for 2:00 Thursday, September 17th at the Campus Club, 4th Floor. I do hope that you will be able to arrange your schedules so that you can attend a good portion of, if not all, of this meeting.

PHS/lm1



November 4, 1970

UNIVERSITY HOSPITALS • MINNEAPOLIS, MINNESOTA 55455

TO: Dr. Theodore Grage
Dr. Charles Drage
Dr. Richard Anderson
Dr. Arndt Duvall
Dr. Leon Satran
Dr. Donlin Long

FROM: Peter H. Sammond *PHS*

SUBJECT: Meeting on OPD Modular Assignment and
Space Allocation

The Department of Obstetrics and Gynecology has raised the question as to whether their laudatory increased census over the past year might not be justification for re-examining the space allocation in the new outpatient clinics. As a second alternative, they would like to re-examine the juxtaposition of clinic modules so that their space may be next to a clinic whose space they could more easily share than is the case with Psychiatry. I think that these questions should be considered by an inter-disciplinary group of the committee as they may be raised by other services which can justifiably point out that the original planning projections were made more than two years ago.

In the above group, I have attempted to assemble the members of the original Space Assignment Committee of the Outpatient Committee or else people who have replaced them. I would hope that we could get a substantial number of the above group together very soon to consider the questions raised. I shall ask my secretary to try to arrange such a meeting.

PHS/lml
cc/Dr. Robert Hilgers
Mr. Terry Finzen
Mr. Bob Baker



November 13, 1970

TO: The Outpatient Clinics Planning Committee
 Frederick Van Bergen, M.D. Richard Anderson, M.D.
 John Brantner, M.D. Henry Sosin, M.D.
 Thomas Alt, M.D. Theoddr Grage, M.D.
 Charles Drage, M.D. William Kane, M.D.
 James McArthur, M.D. Colin Markland, M.D.
 Robert Soll, M.D. Francis Wright, M.D.
 Donlin Long, M.D. Rosie Acton
 Henry Sauls, M.D. Robert Baker
 Leon Satran, M.D.
 Glenn, Gullickson, M.D.

FROM: Peter H. Sammond, Associate Direction

SUBJECT: Exam Room Mock-up Meeting

There will be a meeting on Wednesday, November 18, between 2:15 and 4:00 in the Powell Hall Green Room Lounge to study different configurations of the recently constructed general exam room mock-up. While you may examine the mock-up at your convenience at this meeting, the architects will be present as will a man from Maintenance and Engineering to make the kinds of changes in the mock-up which we may wish to study. Therefore, this is an important session and I urge your attendance, as we would like to decide finally on the exam room dimensions and layout.

PHS/ct



FLOOR PLAN REVIEW (Peter Sammond - April 6, 1971)

GENERAL COMMENTS

1. Wheel chair toilets on each floor
2. Would it be better to come off elevators and see clinic desks directly?
3. Where are coat racks for main clinic waiting rooms?

FLOOR 2

1. Shouldn't Telelift open into Reception, Records, Research, and Processing?
2. Soundex could be on 1st floor with medical reception file space if we need more space on 2.

FLOOR 9

1. Recovery room should be visible from corridor and nurses office?
2. Wheel chair toilets.

FLOOR 8

1. Nurse utility seems small and not central.
2. Has Frank Lassman reviewed?

FLOOR 7

1. Recovery room looks remote - should be reviewed by nursing.
2. Are 2 tray prep areas economical.

MEETING NOTES

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DATE: 17 February 1971
 PLACE: Dining Room No. 3
 TAC JOB: Unit B/C, #70046
 PRESENT: Dr. Don Long, Dr. Richard Anderson, Dr. Theodore Grage, Dr. William Kane, Dr. Bill Gentry, Dr. John Sciarra, Dr. Robert Hilgers, Dr. Robert Soll, Dr. A.B. Baker, Dr. Philip Leroux, Peter Sammond, Ken Taylor, Jim Block.
 SUBJECT: Proposed Revisions to Outpatient Clinic Program

Four proposed changes to the Outpatient Clinic Program were reviewed at this meeting. They were proposed revisions for the 1. Dermatology Clinic, 2. OB-Gyn Clinic, 3. Neurology Clinic, 4. Satellite Radiology Unit in B-C. The results of the deliberations were as follows:

1. Dermatology: Dr. Gentry requested additional exam rooms for the Dermatology Clinic because of their projected loads. He noted that seven rooms would be required for special purpose facilities including ultra-violet, x-ray therapy, and lab. Minor surgery could be performed in the treatment rooms. Three of the seven specialty rooms could function as examination rooms when they were not used for the special purpose. After a review of the projected clinic patient loads the committee voted to keep the dermatology clinic program at its current size of 15 examination - consultation rooms.

2. OB-Gynecology: Dr. Sciarra noted the growth pattern of the OB-Gyn Clinic and suggested that more than the 20 rooms now provided in OB-Gynecology would be required for that clinic. He recognized that OB-Gyn will have specialized space by adding toilets in every room and modified his plea to a request for consideration for additional modular space in light of the difficulties of breaking free more space. The committee voted that no additional rooms be added to the clinic module currently assigned to OB-Gynecology. The committee did reemphasize the continuing interest in interchangeable assignment of space and the modularity concept.

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DR. LONG	X

3. Neurology Clinic: Dr. Baker decided the need for additional clinic exam rooms to provide for the new teaching program which he currently does not have. He was concerned that both Neurology and Neurosurgery could not function in the module now assigned to those services. He was also concerned that Food Service on Floor 5 was occupying space that might potentially be modular clinic space. It was emphasized by the committee to Dr. Baker that the clinic program for Neurosurgery and Neurology had not been reduced and that the 21 rooms originally provided were still being provided. However, it was decided by the committee that 5 rooms would be added to the clinic modules on Floor 5 and reduced from the clinic modules on Floor 6 since the stated need of those services on Floor 5 were much greater. The committee directed the architects to modify the plans accordingly, subject to concurrence by Dr. Richard Anderson.
4. Radiology: Dr. Gedgudas has requested an additional 2 rooms totaling 800 square feet to be located in Unit B-C for Fluourosopy. Providing this additional space for Radiology is contingent on a reduction of other programs in Unit B-C by an equivalent amount of space. The unit most likely to be shifted back to Mayo or eliminated was suggested to be Employee Health Service which is now currently located contiguous to the satellite Radiology Clinic on Floor 1 of Unit B/C. The proposal approved by the committee was to defer the final decision until 2 weeks from today and to then either increase Radiology Satellite Unit by displacing the Employee Health Service to Mayo or eliminate it altogether, or to provide additional rooms for Radiology in Mayo and not alter the existing program or plan for the first floor of Unit B/C. The committee committed itself to making this decision by 3 March 1971.



UNIVERSITY OF MINNESOTA
TWIN CITIES

Health Sciences Planning Office
Physical Planning
Health Sciences Complex
Box 726 Mayo Memorial Building
Minneapolis, Minnesota 55455

(612) 373-8981

October 20, 1981

TO: Clint Hewitt
FROM: Paul J. Maupin *Paul*
SUBJECT: Unit B/C - Out-Patient Clinics

In response to your telephone call last week, we submit the following comments to the areas you inquired about:

1. What has been the general reaction of occupants regarding functional design and programming aspects?

The clinics have been extremely well received with no major problems.

2. Opinion of Patient Flow

The one major problem is the outside power doors; keeping them in a functional mode. With that exception, there are no other problems.

3. Layout of Work Area

Seems to be quite workable with sufficient amount of flexibility.

4. Are work areas effective with regard to program design of facilities?

Yes. There is one problem with the elevator wall surfaces. We need a more durable surface to withstand the constant placement of various notices. The tapes being used pull off the painted surfaces and some dry wall.

In general the clinics are spacious compared to the old Mayo quarters. The quiet and professional environment is pleasing to the patient and student alike. The clinics facilitate the staff in monitoring patients and students progress.

The major problem of the building, if there is one, is that the building is too quiet, needing a little more background noise. Also, we have a below grade problem with vibration. We pick up vibration below grade when the buses or trucks drive at a slow rate between Units A and B/C on Delaware Street. If they stop and go, as they should, there is no particular problem.

PJM:jmw