APPENDIX 1

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals
Minneapolis, Minnesota 55455

September 24, 1974

TO: University Clinics Committee

Chairman, Department of Medicine	Richard Ebert, M.D.
Chairman, Department of Surgery	John Najarian, M.D.
Chairman, Department of Pediatrics	John Anderson, M.D.
Chairman, Department of Family Practice	Edward Ciriacy, M.D.
Chairman, Clinical Services	Michael Paparella, M.D.
Chairman, Clinical Services	Eugene Gedgaudas, M.D.
Chairman, Out-Patient Committee	David Eifrig, M.D.
Chief of Staff	Paul Winchell, M.D.
School of Nursing	Sharon Wilford
School of Public Health	Alma Sparrow
General Director, University Hospitals	John Westerman, Chairman
Staff	Robert Dickler, Greg Kujawa, Janet Shapiro, Bev Dorsey
	Tom Jones

FROM: Michael Paparella, M.D., Chairman, Council of Chiefs of Clinical Services, Paul Winchell, M.D., Chief of Staff, University Hospitals, John H. Westerman, General Director, University Hospitals

Now that Building B-C is funded, the various component parts must proceed with the final planning stages. The components of B-C include Animal Hospital, Department Office Space, Learning Resources Center, Department Research Space and University Clinics.

Our responsibility is for University Clinics. The task of the Committee will be to consider the:

1. Development of movable equipment list and allocation of limited capital resources to competing interest groups (i.e. laboratories, radiology, operating rooms, clinics).

2. Space utilization assignment of the reduced number of general clinic modules/exam rooms, and development of critieria for considering the inclusion of a multi-specialty clinic.

3. Question of how to handle requests for design change.

4. Planning for occupancy and for beginning operation in the new building.

5. Operational suthority/responsibility and planning of the new ambulatory surgery suite.

6. Examination of alternate organizational arrangements.

In fulfilling this assignment the Committee will have the option of utilizing resources outside the University. The multispecialty clinic study would be referred to the Patient Care Committee, under the chairmanship of Dr. Ciriacy. It is anticipated that other study groups may be needed.

MP/PW/JW/sjg

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals
Minneapolis, Minnesota 55455

September 24, 1974

TO: University Clinics Committee

Chairman, Department of Medicine
Chairman, Department of Surgery
Chairman, Department of Pediatrics
Chairman, Department of Family Practice
Chairman, Clinical Services
Chairman, Clinical Sciences
Chairman, Out-Patient Committee
Chief of Staff
Chairman, Health Services Administration

FROM: Michael Paparella, M.D., Chairman, Council of Chiefs of Clinical Services
Paul Winchell, M.D., Chief of Staff, University Hospitals
John H. Westerman, General Director, University Hospitals

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MP/PW/JW/sds

Mon @ 7:00 AM.

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals
Minneapolis, Minnesota 55455

September 25, 1974

TO: University Clinics Committee

FROM: John H. Westerman, Chairman JHW

SUBJECT: First Meeting of Committee

The first meeting of the University Clinics Committee will be held at 7:00 a.m., on Monday, September 30, 1974 in Dining Room III. The purpose of this meeting will be to discuss the scope of our assignment, review the existing state of clinic planning and receive guidance and information from the University Planning Office. An agenda is attached.

At this time it would appear that the committee will have a very active agenda for the next 12-18 months. Therefore if you cannot attend it is important that you have an alternate who is prepared to vote on agenda items. The Oak Street Parking Ramp should be available for patient parking by November 1974. The excavation for the clinics should begin in November. The clinics are scheduled for occupancy in 1977. In addition, while supporting the clinics committee the Health Sciences Planning Committee suggested that some health sciences representation be pursued.

JHW/sds

Enclosure

MINUTES

UNIVERSITY CLINICS COMMITTEE

September 30, 1974

PRESENT: John Westerman, Dr. Edward Ciriacy, Dr. John Anderson, Dr. David Eifrig, Dr. Eugene Gedgaudas, Dr. Robert Goltz, Dr. Robert Howe for Dr. Ebert, Robert Dickler, Thomas Jones, Gregory Kujawa, Paul Maupin, Lee Schultz, Janet Shapiro, Sharon Wilford, Paul Rader

INTRODUCTION - MR. WESTERMAN

The Chairman introduced individuals who would serve as staff to the Committee and define their functions. It was decided that discussion be deferred on several matters until Dr. Ebert can join the group.

Mr. Westerman outlines the conditions set forth in the Certificate of Need for the B-C Building and the work of the Health Sciences B-C Implementation Committee.

PLANNING OVERVIEW - MR. JONES AND MR. DICKLER

The floor plan of the building was discussed and a utilization plan for clinics was detailed. Mr. Maupin presented some timing factors, and Mr. Dickler reported on the equipment list and continued the review of the facility.

PLAN FOR ACCOMPLISHMENT - MR. WESTERMAN

A schedule of implementation was presented and summary remarks were made about the process. Mr. Kujawa was appointed as equipment/facility coordinator following a motion to that effect by Dr. Gedgaudas.

CONSIDERATIONS FOR NEXT MEETING - MR. WESTERMAN

1. A financial committee should be established.
2. Future committee meetings will be held on Thursdays at 7:00 a.m., in D.R. III, beginning October 10th.
3. A definition of "multi-specialty clinic" should be formulated.
4. An issue list to be prepared by Mr. Dickler will be discussed.

FILE

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals
Minneapolis, Minnesota 55455

October 1, 1974

TO: University Clinics Committee

FROM: Greg Kujawa

SUBJECT: Fixed and Movable Equipment List Development

Over the next several months Health Sciences Planning will require detailed equipment lists, mechanical requirements, room layouts, etc. for all space to be completed in Unit B-C. The intent of this memo is to briefly outline a methodology for achieving this task.

I. Ambulatory Care Support Areas

For non-clinic ambulatory care areas of Unit B-C (i.e. Laboratory, Radiology, Admissions, Pharmacy, Ambulatory Surgery, etc.) it is proposed that each department work directly with Committee Staff (i.e. Greg Kujawa) in updating and finalizing the equipment list compiled in 1971. Each department will be contacted to determine the appropriate person (s). The finalized lists will then be submitted to UCC for final approval.

II. Ambulatory Clinic Areas

In relation to clinic module areas two alternative approaches seem feasible.

Alternative # 1 - This methodology assumes that although the total space to be completed in Unit B-C has been temporarily reduced by five specialty modules, it is forseen that each specialty will have a specifically designated module with completion of shelled area at a future date.

Therefore:

1) Clinic areas to be completed in the first phase of B-C construction will retain their specialty designation.

2) Each specific department with a module to be completed will designate an individual to work with Committee staff (i.e. G. Kujawa) to update and complete the previous equipment lists and design plans.

3) Those specialties whose clinic areas will not be completed in the first phase of B-C construction will be contacted to determine their minimum special purpose room needs. (Note: Special Purpose rooms are defined as those rooms requiring unique basic construction and/or totally unique to the service fixed/ movable equipment). Temporary space will then be made available in finished clinic areas which will be determined by the UCC. It is assumed that clinics will meet primarily in those areas where their specialty rooms are located until their specific modules are completed.

4) Final equipment lists for general and special purpose clinic areas will be submitted to UCC for final approval.

Alternative # 2 - This methodology assumes that all clinic module space to be completed in the first and subsequent phase of Unit B-C construction is not at this time designated for any specific specialty (with the exception of Audiology, ENT, and Eye). Space allocation is on a temporary basis subject to periodic review.

Therefore:

1) University Clinics Committee will appoint a task force to determine equipment lists for all exam rooms, administrative, and public areas except approved special purpose rooms.

2) All clinical departments moving to Unit B-C will be contacted by Committee staff to determine their special purpose room needs. These requests will be reviewed and subject to final approval by the UCC.

3) The task force will recommend to the UCC a plan for location of approved special purpose rooms. Upon review and approval of this plan each department with approved specialty rooms will be contacted by Committee staff to develop a final equipment list. (Note: location of special purpose rooms will in all likelihood result in a certain specialty meeting primarily in that clinic area).

4) Audiology, ENT, and Eye will be contacted independently by Committee staff to finalize equipment lists.

5) Final equipment lists for general and special purpose clinic areas will be submitted to UCC for final approval.

Due to the constrained time limits it is proposed that the process relating to support areas be implemented immediately and clinic areas as soon as the UCC approves one of the above or an alternative methodology.

Minutes

University Clinics Committee

October 10, 1974

Present: John Westerman, Dr. John Anderson, Dr. Edward Ciriacy, Robert Dickler, Dr. Eugene Gedgaudas, Dr. Robert Goltz, Dr. Robert Howe for Dr. Dr. Richard Ebert, Tom Jones, Gregory Kugawa, Janet Shapiro, Alma Sparrow, Sharon Wilford, Dr. C. Paul Wincell, Paul Rader

I. Issues List - Mr. Dickler (See Handout)

Mr. Dickler explained the derivation of the list and presented the issues under two groupings: 1) the Role of Ambulatory Care; 2) Operations Issues.

The committee discussed the issues list in relation to existing models and requirements. A need was seen for separation of issues in to educational and service components.

II. Multi-Specialty Clinic Developments - Mr. Westerman

Mr. Westerman outlined progress and discussion in this area and enumerated a number of changes which were needed.

III. Planning Office Report - Mr. Westerman

There was nothing significant to report, but Mr. Paul Maupin will report to the Committee at next week's meeting.

IV. University Clinics Organization

The respective responsibilities of UH and the Medical School were delineated. The needs for coordination were discussed, and the requirement for a philosphical base was presented.

It was decided to explore organizational purpose alternatives. Mr. Dickler offered to being an outline of study for the Committee's approval.

V. Fixed and Movable Equipment List Development - Mr. Kujawa (See Handout)

Mr. Kujawa recommended the implementation of Alternative #2. After discussion, paragraph #1 was approved, and paragraph #2 was left on the agenda and it will be considered at the next regular meeting.

VI. Financial Projections

There was little to report in this area other than the fact that Mr. Van Hulzen is continuing his efforts.

NOTE:

The next meeting of the University Clinics Committee will be held on Thursday, October 17, 1974 at 7:00 a.m. in DR III.

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals
Minneapolis, Minnesota 55455

October 15, 1975

TO: University Clinics Committee

FROM: Roby Thompson, M.D. - Chairman, Ambulatory Care Medical Staff Reorganization Task Force

SUBJECT: Task Force Report

Attached is the report of the Ambulatory Care Medical Staff Reorganization Task Force. The Task Force has attempted to fulfill, during the past 10 months, the original charge given to it by University Clinics Committee and feels that the recommendations contained herein reflect both a realistic and feasible solution to many of the problems which continue to impinge on the maximization of service, education, and research in ambulatory care activities.

The members of the Task Force would like to thank the University Clinics Committee, Council of Chiefs of Clinical Services, and Medical Staff-Hospital Council for the opportunities provided by this effort. We would be happy to reconvene if necessary in the future.

Roby Thompson, M.D., Chairman
Robert Goltz, M.D.
Ellis Benson, M.D.
David Eifrig, M.D.
Robert Howe, M.D.
Leon Satran, M.D.
Preston Williams, M.D.
Robert Dickler
Everette Janssen

AMBULATORY CARE REORGANIZATION

-A Report by the Ambulatory Care Medical

Staff Organization Task Force-

October 15, 1975

I. Introduction

The intent of this report is to summarize the discussions and conclusions of the Ambulatory Care Medical Staff Organization Task Force (ACMSOTF) since its inception in December 1974 and its interim report of April 1975. It is hoped that the materials presented and the recommendations made will permit the Council of Chiefs of Clinical Services, the Medical Staff-Hospital Council, and the University Clinics Committee to decide upon the next stage of activity.

The major recommendations of the Task Force include:

1. A proposed set of Roles/Goals and Objectives for Ambulatory Care.
2. An organization structure in which:
   A) The present Medical Staff Organization; as determined by the bylaws adopted in May, 1975; retains responsibility for Ambulatory Care Medical Staff but undergoes some organizational modification to better fulfill this responsibility.
   B) An Ambulatory Care Management Council is formed to deal with other aspects of Ambulatory Care operations.
   C) A communication link is developed between the structures.
3. Financial considerations which are prerequisites for clarifying and supporting an Ambulatory Care organization's financial role.

The recommendations of the Task Force have been formulated to be consistent with the parameters and structures required by the Bylaws of the Medical and Dental Staff (May, 1975) and the Bylaws for the Board of Governors (July, 1974). It should be noted that recommendation 2 A will have its most immediate impact on the Medical Staff-Hospital Council and 2B-C and 3 will impact more directly on the Council of Chiefs of Clinical Services.

II. Background

The ACMSOTF (and the Ambulatory Care Hospital Organization Task Force) was established by the University Hospitals Committee in December 1974 to analyze alternative forms of Ambulatory Care organization. Specific tasks outlined in the original charge included:

1. The development of a role definition for Ambulatory Care .
2. An indepth investigation of the current Ambulatory Care organization and the resultant problems and unresolved issues.
3. A delineation of actions, commitments, and changes necessary to deal with the role, problems, and issues so identified.

The early activities of ACMSOTF were outlined in the interim report of April 1975 (see Appendix A) and preliminary recommendations made. In essence, the recommendations stated that the Task Force believed that some type of overall Ambulatory Care organization should assume responsibility for defining the parameters within which clinical department, ancillary, and support activities should be conducted in Ambulatory Care. This report was reviewed by the University Clinics Committee, Council of Chiefs of Clinical Services, and Medical Staff-Hospital Council and the recommendation accepted. At the same time the Task Force was charged with developing the parameters for this organization.

In response to this charge, the Task Force has concentrated its activities for the past several months on three primary tasks:

1. Development of a role, goal and objective statement for the Ambulatory Care organization.
2. Development of an outline describing in some detail the organization's structure, scope, authority, etc.

3. Investigating the present financial structure of Ambulatory Care and possible financial options in relation to the new Ambulatory Care organization.

The discussions and conclusions reached in relation to each of these topics is addressed in the remainder of the report.

III. Roles, Goals, and Objectives

In developing roles, goals, and objectives for an Ambulatory Care organization, ACMSOTF relied heavily on the extensive efforts and reports of the Clinic Directors Group in 1965 and 1966 when the initial discussions of the need for re-orienting Ambulatory Care programs and facilities took place. Some updating and revision has occurred both to reflect the changed health care environment and the Task Force's own investigtigations and discussions. No priority is implied by the order in which the statements below are listed.

THE FOLLOWING ROLES, GOALS, AND OBJECTIVES ARE RECOMMENDED FOR ADOPTION:

Roles/Goals

1. To provide a state and regional consultation service for patients referred by physicians and agencies.
2. To provide a primary and secondary care service to state and local residents when appropriate and requested or required.
3. To provide an Ambulatory Care setting for the education of health professionals and students. Such education would deal with the concepts, skills, knowledge, and attitudes required for health care maintenance, promotion, and prevention in addition to medical management.
4. To provide an environment for research dealing with both clinical and delivery aspects of health care.
5. To develop and maintain a program which through its facets and total scope, can serve as an important and model facility for patient care, education, research and management.

Objectives

1. To provide exemplary care to all ambulatory patients consistent with their needs and desires.
2. To develop and upgrade standards relating to Ambulatory Care.
3. To encourage, promote, and initiate research which will be of value to patients, the institution, and other aspects of the health care delivery system.
4. To provide a setting which permits all health professionals to participate in new delivery configurations, expand and experiment with their role, and integrate effectively with other health professionals and patients.
5. To provide a setting which enhances educational opportunities for:
   A. Health sciences students
   B. Health professionals seeking continuing education
6. To assure financial viability of the organization and provide care at equitable and reasonable prices to the patients.

IV. Organizational Structure

In developing the parameters for an overall Ambulatory Care organization (as proposed in the April report) the ACMSOTF sought to fulfill four objectives:

A) To minimize the confusion and difficulties now encountered due to multiple lines of authority and responsibility.

B) To build upon the present organizational strengths in University Hospitals-especially the Medical Staff and Clinical Chiefs organizational structures.

C) To preserve, to the degree possible, the current flexibility and diversity of Ambulatory Care activity and to preserve an environment which encourages innovation and change.

D) To develop an organization which is capable of fulfilling the roles, goals, and objectives outlined in Section III for Ambulatory Care.

While no organizational structure is capable of maximizing the fulfillment of these four objectives simultaneously, the Task Force has concluded that the single most critical element necessary for the success of any organizational structure in achieving those objectives is more extensive involvement by the physicians providing ambulatory care in its overall management. To bring about this involvement, a dual (Medical Staff and Management Policy formulation) organizational structure is proposed.

MEDICAL STAFF

IT IS THE RECOMMENDATION OF THE ACMOSTF THAT THE PRESENT MEDICAL STAFF ORGANIZATION: AS DETERMINED BY THE BYLAWS ADOPTED IN MAY 1975; CONTINUE TO FUNCTION AS THE MEDICAL STAFF ORGANIZATION FOR BOTH INPATIENT AND OUTPATIENT ACTIVITIES.

It is the Task Force's conclusion, after considering various options, that the Bylaws of the Medical and Dental Staff-University of Minnesota Hospitals provide an adequate organizational framework for both assuring an integrated and harmonious medical staff, while at the same time permitting an upgrading of Ambulatory Care Medical Staff affairs. While the bylaws do encompass both Inpatient and Ambulatory Care activity the Task Force is aware that the present focus of both the language and activity required represent an inpatient orientation.

IT IS THEREFORE, ALSO RECOMMENDED THAT THE MEDICAL STAFF ORGANIZATION CONSIDER AND REVIEW ITS PRESENT STRUCTURE AND ACTIVITIES SO THAT AMBULATORY CARE REQUIREMENTS WILL BE EFFECTIVELY AND CONTINUALLY DEALT WITH.

The areas of authority and responsibility relating to Ambulatory Care which the Task Force feels will require increased attention include:

1. Ambulatory Care Medical Staff privileges, responsibilities, standards, and controls.
2. The development of standards related to medical care delivery in Ambulatory Care. These standards would include such things as medical record completion criteria, timely prescheduled attendance to assigned clinics, audit procedures, private records in research and other clinic activities, consultation procedures etc.
3. The development of clear and enforceable sanctions if responsibilities are not fulfilled.

To accomplish these and other activities some revamping and reorientation of the present Medical Staff organization is probably appropriate. The focus of Task Force discussions in relation to such changes have been on the present Medical Staff - Hospital Council (MSHC) component

Chiefs of Clinical Services (CCCS). It was felt that since the CCCS organization would also be affected by the Management Council discussed in the following pages; any organizational changes should be considered by the CCCS in tandem with that Management Council's development.

Changes which the MSHC may wish to consider in relation to its present structure might include:

1. Alteration of the present Outpatient Committee to a Medical Staff (or Professional Staff) Ambulatory Care Standards and Activities Committee. This Committee in addition to simply supervising the clinical work of the Outpatient Services (as stated in the present By-Laws), would be delegated the responsibility and authority for many of the items listed above. Membership should probably be revamped to more effectively reflect the Medical Staff activity orientation. It might also be appropriate to designate or elect the chairman of the revamped Outpatient Committee as Vice Chief of Staff.
2. Increasing the attention given by key MSHC Committees to Ambulatory Care needs. This could be done by changing the Committee's charges, developing joint subcommittees with the revamped Outpatient Committee, or having a specific Outpatient Medical Staff representative on each committee. Key committees at this time, beyond MSHC and Outpatient, include Credentials, Medical Records-Medical Audit, Nominating, Pharmacy and Therapeutics, Operating Room, and Bylaws.

It is hoped that both the MSHC and CCCS will review their present structures and make appropriate changes both to provide an Ambulatory Care emphasis and interface appropriate with the Management Council. It is recognized that such

changes may require modifications in the present bylaws and the Bylaws Committee should therefore be involved as necessary.

MANAGEMENT

With the retention of Medical Staff activities in the present Medical Staff organization:

> THE TASK FORCE RECOMMENDS THAT ALL OTHER AMBULATORY CARE ACTIVITIES SHOULD FALL UNDER THE PURVIEW OF A SINGLE AMBULATORY CARE MANAGEMENT COUNCIL.

This Council would assume responsibility consistent with delegated authority from the Council of Chiefs of Clinical Services and the General Director, as affirmed by the Board of Governors, for:

1. The financial viability of Ambulatory Care.
2. Operational decisions relating to Ambulatory Care.
3. Effective performance standards of support and service departments impacting or being utilized by Ambulatory Care.
4. Establishing the parameters by which education, research, and service programs will be conducted in Ambulatory Care;including space assignment, staff support, and financial support; to assure a balanced program.

The scope of the Council's authority would include:

1. Clinics presently assigned to Unit B-C.
2. Clinics presently not assigned to Unit B-C unless it is deemed appropriate not to include them. (i.e. Rehabilitation,Cardiac, etc.)
3. Ambulatory research projects and clinics on the East Bank related to Hospitals activity.

4. New ambulatory programs on the East Bank related to the Hospitals:

   A. Proposed

   B. Which the Council deems necessary.

In sum, the Ambulatory Care Management Council would be delegated authority by both the CCCS and the General Director to determine the parameters, policies, guidelines, and standards within which Hospital related ambulatory care activity occurring on the East Bank campus will operate. The decision made by the Council would then be implemented, and the clinics managed, through an appropriate organizational structure - i.e. a director and/or medical director of ambulatory care jointly appointed by the CCCS, the Management Council, and the General Director.

The structure of the Ambulatory Care Management Council, in terms of size, selection process, etc. has been discussed by the Task Force but no definitive recommendations were arrived at. It is felt that two equally viable mechanisms are available to resolve the structural parameters. The first would be the establishment of a select steering committee charged exclusively with the task of determining the structure of the Management Council. The second would be the appointment of an Interim Management Council which, in addition to defining the structure, would also be responsible for initiating the actual activities of the Management Council. These two options are amplified in the draft charge letters attached to this report. (Appendix B & C)

No matter which option is chosen, though, because of its emphasis, the Management Council must be an organization created by, and responsible to, the Council of Chiefs of Clinical Services and the General Director. Either the steering committee or the Interim Management Council should therefore be appointed by the Clinical Chiefs with representation from the General Director's office and the Chief of Staff.

INTERLINK

The dual organizational structure proposed above obviously has a certain lack of clarity in situations where certain issues and activities do not fall distinctly into one area or another. For example, the conditions of, and sanctions related to, Medical Staff participation will clearly have both Medical Staff quality and Management complications.

In addition, while the attempt is to provide an increased focus for Ambulatory Care management and Medical Staff activities, a large number of organizational structures will simultaneously retain responsibility and authority in this area.

The Task Force feels that it is imperative that as the Management Council is develope and the Medical Staff organization reviewed and possibly restructured, an adequate mechanism be developed for interface during both the developmental and operational phases.

> IT IS, THEREFORE, RECOMMENDED THAT THERE BE SOME TYPE OF LINK DEVELOPED BETWEEN THE MEDICAL STAFF ORGANIZATION AND THE MANAGEMENT COUNCIL.

This is not to say that such a link must be overly structured or formalized. Rather it is to assure adequate communication, and a mechanism as simple as the Chief of Staff or his designee sitting on the Management Council might be all that is required.

V. Financing

Finally, in addressing the issue of financing Ambulatory Care, it became apparent to the ACMSOTF that this subject area must be kept in perspective in relation to its overall import to Ambulatory Care. There is a tendency on the part of all parties to automatically view this area as one of preeminent importance due both to its magnitude and assumed ongoing deficit status. The Task Force therefore feels it is important to make the following points:

A) That the basic financing issue before the institution is how to align expense and revenue. Expense would include all personnel and supply costs in providing Ambulatory Care from all sources - i.e. Hospital, Clinical Department, and others. It is important to remember that for these programs professional income and housestaff stipends would be considered expense. Revenue would include all money collected as a result of Ambulatory Care or available to support Ambulatory Care (i.e. legislative funds).

B) The assurance of adequate financing for Ambulatory Care was neither the motivation for the reorganization study or the construction of Unit B-C. Rather, financing is only of import to the degree that it impedes the fulfullment of patient care, educational, and research goals and/or threatens the viability of Ambulatory Care (and inpatient) activities.

C) That no method of financing Ambulatory Care necessitates or mandates any particular organizational form. Some methods of financing do, of course, interface with certain organizational structures more easily than others.

D) At the present time, and by present accounting methods, expense incurred by the Hospitals in relation to Ambulatory Care activities are covered by available sources of Hospital revenue-including appropriate legislative funds. While the lack of data from clinical departments prevents a similar assessment of financial status in this area, the Task Force feels it might

be appropriate to assume that at the current time Ambulatory Care is a break-even operation in toto.

The above comments are not intended to negate the importance or difficulties financing may present to the current or future organizations involved in Ambulatory Care. In fact, it is evident that with the completion of Unit B-C, and the resultant capability of enhancing the quality and quantity of patient care provided, an expense increment will occur for which additional revenue sources must be budgeted.

It is the Task Force's conclusion that financing must be dealt with in three separate stages:

1. The role and responsibility of an Ambulatory Care organization in financing.

> IT IS THE TASK FORCE'S RECOMMENDATION THAT IF ANY REORGANIZATION EFFORT IS TO BE EFFECTIVE, THE CCCS THROUGH THE MANAGEMENT COUNCIL SHOULD HAVE INCREASED RESPONSIBILITY AND AUTHORITY TO ASSURE THE FINANCIAL STABILITY OF AMBULATORY CARE.

Without such responsibility the ACMSOTF feels that no matter how an Ambulatory Care organization is structured it will lack the mechanism by which to assure adequate fulfillment of the goals and objectives detailed earlier.

2. The Hospital's and Clinical Department's financial interface with the Ambulatory Care Management Council.

If any change occurs in actual financing, it is essential that the Management Council develop, in cooperation with the Clinical Departments and Hospitals, the philosophy and parameter under which financing arrangements will be acceptable. Thus, issues such as joint billing, total organization or individual clinic financing, educational costs, etc. need to be addressed prior to the development of specific financing configurations. Financial issues must eventually be decided in a Council of Chiefs of Clinical Services - Hospital Contract which can be implemented by the Management Council.

> IT IS THEREFORE RECOMMENDED THAT THE MANAGEMENT COUNCIL'S INITIAL ACTIVITIES IN FINANCING ADDRESS THE PARAMETERS AND PHILOSOPHY UNDER WHICH THE COUNCIL, HOSPITALS AND CLINICAL DEPARTMENTS CAN MUTUALLY AGREE TO OPERATE.

3. Actual Financing Arrangements

Once the role of the Council has been clarified through the above, actual consideration of alternative financing mechanisms can be made. This will, of course, require the development of enhanced cost data and accounting methods (already in progress). It is premature, therefore, to recommend any specific arrangement. The Task Force has considered a number of possible options, however, and these are outlined in Appendix D.

VI. Summary and Future Action

The foregoing report has:

1. Provided a recommended set of Roles/Goals and Objectives for Ambulatory Care.
2. Proposed an organizational structure in which:
   A. The Medical Staff organization continues responsibility for Ambulatory Care medical staff and undergoes some organizational modification to better fulfill this responsibility.
   B. An Ambulatory Care Management Council is formed to deal with the policy and decision-making aspects of Ambulatory Care.
   C. A formal organizational link is developed between the structures discussed above.
3. Provided several recommendations on financial commitments and responsibilities which are prerequisites for clarifying and supporting an Ambulatory Care organization's financial role and the parameters for developing financial arrangements.

In addition, if these recommendations are accepted, initial activities have been discussed which would initiate the next stage of the Ambulatory Care reorganization process. In brief these activities are as follows:

A. Medical Staff

1. Consideration by MSHC of organizational changes related to Medical Staff Ambulatory Care activities.
2. Consideration by CCCS of organizational changes related to Medical Staff Ambulatory Care activities.
3. Involvement of the Bylaws Committee into implementation of any needed Medical Staff organizational changes which require Bylaws modification.

B. Management - Initiation of an Ambulatory Care Management Council (by one of two options) with primary emphasis on Council organization and financial issues.

C. Interlink - Development of an adequate, ongoing, communication mechanism between the above structures.

4/7/75

APPENDIX A

Interim report

Ambulatory Care Medical Staff Organization Task Force

I. Introduction

The intent of this report is to summarize the activities of the Ambulatory Care Medical-Staff Organization Task Force (ACMSOTF) since December of 1974, outline some initial recommendations, and to discuss future areas of inquiry which the task force feels are appropriate. In addition, the task force is seeking comments and guidance on several subjects. The committee is chaired by Dr. Roby C. Thompson and composed of Dr. Robert Goltz from Dermatology, Dr. Ellis Benson from Laboratory Medicine, Dr. David Eifrig from Ophthalmology, Dr. Robert Howe from Internal Medicine, Dr. Paul Quie from Pediatrics who subsequently requested his position be filled by Dr. Leon Satran, Dr. Louis Filiatrault representing Family Practice, Dr. Preston Williams representing Obstetrics and Gynecology, and Mr. Robert Dickler representing the University Hospitals.

Since its inception an attempt has been made to comply with the original charge given to the Task Force by the University Clinics Committee, i.e. to analyze and recommend alternative medical staff organizational forms for ambulatory care. In addition, the task force has also dealt with the additional charge from the Council of Clinical Services Retreat to investigate mechanisms by which primary care delivery could be enhanced and expanded.

To this end the ACMSOTF has:

1) Reviewed past planning documents relating to the roles and objectives of ambulatory care and the Mission of the Health Sciences.
2) Reviewed and discussed the extensive list of problems now existing in delivering ambulatory care as well as the present ambulatory care organization.

3) Reviewed all available studies relating to the Outpatient Department and Ambulatory Care activities at University Hospitals.

4) Reviewed several major national studies in ambulatory care organization and reorganization efforts.

5) Investigated with representatives of the Clinical Departments now providing the majority of primary care, various organizational options.

In terms of primary care the task force members concluded that there were three broad options (conceptually) for primary care delivery organizations:

a) Total reorganization of all clinic programs and staff (medical and hospital) to provide primary as well as secondary and tertiary care.

b) Separation of current and future primary care activities into a semi-autonomous organization with participants from the major departments involved in primary care.

c) A continuation of the present organization where each of the departments involved continues its activities on a separate basis. It was discussed that this option may necessitate the assumption of expanded obligations by both departments providing primary care and consultation services.

After considerable discussion it was concluded that only Option C was feasible at this time but that some mechanism was required to enhance communication between primary care providers and consultants to both close gaps in care and deal with common problems more effectively.

Finally, it should also be noted that several members of the task force attended a special seminar on ambulatory care reorganization. In addition outside consultants have been sought and one group interviewed. The conclusion

stemming from both of these meetings was that outside assistance could be useful except in very specific areas; but only if the parameters that the consultants were to deal with were specifically defined.

II. Recommendations

It is on the basis of these discussionsand investigations that the ACMSOTF developed the following preliminary recommendation:

That the overall ambulatory care program be under the jurisdiction of a single, combined hospital and medical staff, ambulatory care organization which consolidates all present committees and ad hoc groups dealing with ambulatory care.

A. That each clinical department continue to retain primary responsibility for the educational, service and research programs of that department within the parameters defined by the overall organization. This responsibility includes all levels of patient care.

B. That the overall ambulatory care organization assume responsibility for the direction of ancillary and support activities in ambulatory care.

C. That the overall ambulatory care organization assume responsibility for the direction and possible operation of appropriate external ambulatory care operations.

Future Activities

It is recognized that the above recommendation for an overall ambulatory care organization necessitates attention to the parameters of that organization as well as other questions. Foremost of these parameters is the organization's level of activity and responsibility. Questions in this area

include whether it should be the equivalent of the Medical Staff Hospital Council and how it should relate to the Council of Chiefs of Clinical Services and other entities?; whether it will be separate from these organizations or a subbody?; whether there should be a Chief of Ambulatory Care?; Whether the medical staff is the same as the Hospital's present staff?; and whether the organization is appointed, elected, etc.?

It would be the intent of the ACMSOTF to address these organizational issues and others such as the role of a Health Appraisal or Multi-phasic screening program in the clinic's organization;if the concept of an overall ambulatory care organization and its implications is accepted.

DRAFT

Appendix B

TO:

FROM: Chairman, Council of Chiefs of Clinical Services
Chief of Staff, Medical Staff-Hospital Council
General Director, University Hospital

SUBJECT: Ambulatory Care Management Council Steering Committee

The intent of this memo is to ask your participation in an Ambulatory Care Management Council Steering Committee. The functions of this steering committee would be to develop the structural parameters for the Ambulatory Care Management Council as proposed in the Ambulatory Care Reorganization Report. (attached)

It is hoped that the committee can accomplish its charge within a two month period. Specific issues which need to be addressed include:

1) The Size of the Council
2) The Membership Corporation
3) The Selection Process
4) The Chairperson Role and Selection Process
5) The Tenure of Membership
6) The Position of the Council in the Existing Institutional Structure.

Unless we hear otherwise we will assume your willingness to participate in this effort. Thank you for your cooperation.

APPENDIX C

TO:

FROM: CHAIRMAN, COUNCIL OF CHIEFS OF CLINICAL SERVICES
CHIEF OF STAFF, MEDICAL STAFF-HOSPITAL COUNCIL
GENERAL DIRECTOR, UNIVERSITY HOSPITALS

SUBJECT: INTERIM AMBULATORY CARE MANAGEMENT COUNCIL

THE INTENT OF THIS MEMO IS TO ASK YOUR PARTICIPATION IN AN INTERIM AMBULATORY CARE MANAGEMENT COUNCIL. THE FUNCTION OF THIS INTERIM COUNCIL WOULD BE TO BOTH DEVELOP THE STRUCTURAL PARAMETERS FOR THE COUNCIL AND INITIATE THE COUNCIL MANAGEMENT ACTIVITIES - ESPECIALLY FINANCIAL - AS PROPOSED IN THE AMBULATORY CARE REORGANIZATION REPORT. (ATTACHED)

IT IS ANTICIPATED THAT THE INTERIM COUNCIL WOULD FUNCTION FOR A PERIOD OF NO LONGER THAN 9 MONTHS. DURING THIS PERIOD, SPECIFIC ITEMS WHICH SHOULD BE ADDRESSED INCLUDE:

1) THE DEVELOPMENT AND DEFINITION OF FINANCIAL PARAMETERS FOR OPERATION OF AMBULATORY CARE.
2) INITIATION OF THE NEW FINANCING MECHANISMS
3) THE DEVELOPMENT OF OPERATIONAL CONTROL OF SUPPORT AND SERVICE DEPARTMENT ACTIVITIES
4) REVIEW AND ANALYSIS OF PROGRAMS, SPACE UTILIZATION AND SYSTEMS.
5) DEFINITION OF THE ACTUAL SCOPE OF ACTIVITIES OF THE COUNCIL
6) OTHER ACTIVITIES AS OUTLINED IN THE AMBULATORY CARE REORGANIZATION REPORT.

DURING THIS PERIOD THE INTERIM COUNCIL WOULD ALSO BE EXPECTED TO CONTINUALLY EVALUATE THE ADVISABILITY AND PRACTICALITY OF THE AMBULATORY CARE MANAGEMENT COUNCIL CONCEPT. IF, PRIOR TO OR AT THE END OF 9 MONTHS, IT IS ADJUDGED TO BE A PRACTICAL AND VIABLE ORGANIZATION THE INTERIM COUNCIL, ON THE BASIS OF THEIR EXPERIENCES, SHOULD PROPOSE THE PERMANENT STRUCTURE OF THE COUNCIL. THIS WOULD INCLUDE:

1) THE SIZE OF THE COUNCIL
2) THE MEMBERSHIP CORPORATION
3) THE SELECTION PROCESS
4) THE CHAIRPERSON ROLE AND SELECTION PROCESS
5) THE TENURE OF MEMBERSHIP
6) THE POSITION OF THE COUNCIL IN THE EXISTING INSTITUTIONAL STRUCTURE

UNLESS WE HEAR OTHERWISE WE WILL ASSUME YOUR WILLINGNESS TO PARTICIPATE IN THIS EFFORT. THANK YOU FOR YOUR COOPERATION.

APPENDIX D

Ambulatory Care Financial Options

Types of Revenue

1. Hospital Charges
   a. Clinic Fee
   b. Procedure Charges
   c. Ancillary
2. Professional Fees
3. Legislative Funds
4. Other
   a. Grants
   b. Donations
   c. Other Hospital Funds
   d. Other Departmental Funds

Types of Expense

1. Hospital
   a. Direct (Personnel, suppli
   b. Indirect (Depreciation, medical record etc.)
   c. Ancillary (Revenue produc ing, lab, x-ra
2. Departmental
   a. Professional income
   b. Billing, Staff and Other
3. External activities support

Options

I - Present Arrangement

A. Hospital collects hospital charges, legislative funds and some of other revenue. Medical Departments collect professional fees and part of other separate bills.

B. Hospital covers all Hospital and most of external activities expenses. Medical Departments cover Departmental expense.

C. Hospital deficit covered by Hospital revenue
Departmental deficit or net revenue unknown

II - Same as I except for combined billing either by Hospital or Medical Departments - Revenue, Expense, and Deficit-Net Revenue still handled in present fashion.

III - Same as I except Hospital and Medical Staff or Departments agree to pro-rating either expense or deficit of either - i.e. Hospital deficit borne in part by Medical Departments or vice-versa.

IV - Hospital assumes responsibility for all expense and all revenue. Departmental expenses negotiated with Hospital and covered by total revenue.

V - Medical Departments or Staff may flat fee for visit to Hospital to cover expenses.

a. Can be in addition to Hospital charges so continue separate billing.

b. Can be sum which includes hospital charges either in total or part (i.e. only Hospital charges for procedures - no clinic fee - this is included in professional fee)

VI - Medical Department or staff assume total responsibility for all expense and revenue - Hospital expense and revenue only through contracts.

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals
Minneapolis, Minnesota 55455

October 15, 1975

TO: University Clinics Committee

FROM: Robert Dickler RD

SUBJECT: Clinic Census

Attached are a comparison of the 1973-74 and 1974-75 annual outpatient census and the first quarter 1975-76 compared with 1st quarter 1974-75 census. In reviewing these materials the following comments are necessary.

1. Format -

   Clinic census is now tabulated both by Clinical Service and Physical Area. These two formats permit better utilization of the information for budgeting, management, space adjustments, and service adjustments. It is believed that census by physical areas, which has not been maintained previously, will be especially helpful in final space allocation for Unit B-C.

2. 1974-75 Census

   While the total census reflects an increase of 8 .8+% this is due to the inclusion of Employee Health Census for the first time. Without this figure,total census actually declined about 1% from 1973-74.

3. 1st quarter 1975-76

   Rapid increases in Radiation Therapy and Child Psychiatry census reflect new reporting systems rather than actual increase in census of that amount.

If you have any questions please feel free to contact me.

APPENDIX [illegible]

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals
Minneapolis, Minnesota 55455

OCTOBER 15, 1974

TO: UNIVERSITY CLINICS COMMITTEE

FROM: BOB DICKLER

SUBJECT: EDUCATIONAL JUSTIFICATION & RATIONALE FOR UNIT B-C

AT THE OCTOBER 10, 1974 MEETING I WAS REQUESTED TO DRAW TOGETHER THE MOST RECENT DISCUSSIONS OF EDUCATIONAL PROGRAMS AND HOW THEY WILL FUNCTION IN UNIT B-C. IN ACCORD WITH THAT REQUEST THE FOLLOWING DOCUMENTS ARE PROVIDED:

1) PROJECTED UTILIZATION FOR MEDICAL EDUCATION OF CLINIC EXAMINING ROOMS IN BUILDING B-C: MARCH 5, 1974

2) JUSTIFICATION OF B-C SPACE: DEPARTMENT OF FAMILY PRACTICE AND COMMUNITY HEALTH: FEBRUARY 25, 1974

3) AVAILABILITY OF RESOURCES FOR CLINICAL STUDIES: UNIT B-C GRANT APPLICATION: APRIL 1, 1974.

4) SPACE LOGIC - OUTPATIENT CLINICS: UNIT B-C GRANT APPLICATIONS: APRIL 1, 1974

IN ADDITIONAL EARLY PLANNING DOCUMENTS DATING FROM 1964 ARE AVAILABLE INCLUDING ALL PREVIOUS GRANT AND CERTIFICATE OF NEED APPLICATIONS.

MINUTES

UNIVERSITY CLINICS COMMITTEE

October 17, 1974

Present: John Westerman, Dr. C. Paul Winchell, Robert Dickler, Beverly Dorsey, Dr. Richard Ebert, Dr. Louis Filiatrault, Dr. Eugene Gedgaudas, Dr. Robert Goltz, Dr. Robert Howe, Thomas Jones, Gregory Kujawa, Paul Maupin, Dr. John Najarian, Dr. Michael Paparella, Janet Shapiro, Alma Sparrow, Paul Rader

I. Educational Justification and Rationale for Unit B-C - Mr. Dickler
(Document Distributed)

Four reports were assembled and distributed by Mr. Dickler which were derived from recent discussions. These documents were to be treated as information items.

Student usage and space reductions were discussed, and Dr. Gedgaudas' Committee will consider this issue.

The respective roles of the regulatory agencies and the University in education were considered.

II. Ambulatory Care Reorganization Study Proposal - Mr. Dickler
(Paper Distributed)

The document presented a general problem definition which focused on the goals in the area of Ambulatory Care Reorganization, and discussed the scope of such activities now going on.

A study methodology was outlined. Mr. Dickler and Dr. Winchell will meet to prepare recommendations for the process to be followed.

III. Fixed and Movable Equipment List - Mr. Kujawa

Mr. Kujawa is currently working on space allocation in relation to equipment needs. Mr. Dickler distributed a letter from the Department of Psychiatry which dealt with that department's perspective.

IV. Planning Office Report - Mr. Maupin

Mr. Maupin reported on cost considerations and construction time-tables and guidelines. Drs. Howe and Filiatrault will meet to discuss equipment and will report to the group. Mr. Kujawa will assist in this project.

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals
Minneapolis, Minnesota 55455

October 16, 1975

TO: University Clinics Committee

FROM: Robert Dickler, Associate Director RD

SUBJECT: Alternative Deduct List

In May, the University Clinics Committee discussed the implications of possible alternative deducts for Unit B/C and appropriate priorities for those deducts. (see attached).

The finalized list from Health Sciences Planning is attached with the items listed in priority (# 1 is least priority). Overall the list represents a reasonable compromise in considering all party's needs and comments.

The eventual impact of these deducts cannot be determined until the bidding process is complete. However, it is possible to state that:

1. The elimination of items 15, 20, 24 - 29 would probably impair the building to the point where any efficiency in movement and delivery programs would be impossible and costs of operation seriously escalated. These items total $840,000.

2. The elimination of items 8, 16, 17, and 21 would increase future operating costs and, while no precise figures are available, are probably not cost beneficial to eliminate in the long run. These items total $98,000.

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals
Minneapolis, Minnesota 55455

May 27, 1975

TO: University Clinics Committee

FROM: Robert Dickler

SUBJECT: Potential Deduct Alternates

Attached is a list of deduct alternates for Unit B/C which total approximately $2,000,000. This list will be submitted with the contract bid documents to assure that, if necessary, a sufficient number of items can be deducted to assure awarding of the contract within present dollars available.

To assure equity among bidders this list must be submitted in order of priority with #1 being the least important item. If there must be deducts the list will be gone through in order until the needed dollar amount is accumulated. The priority of items is therefore very important.

Three possible priority listings are provided in the attached:

1) TAC/HSAE - This is the architects proposed priority listing.

2) Alternate I - This priority list attempts to place all items important for clinic functioning as far down on the list as possible.

3) Alternate II - This priority list attempts to view all components of the buildings future functioning.

It is important to note that, with very few exceptions, none of the items on this list can be deducted without affecting the functioning of Unit B-C either now or in the future.

POTENTIAL DEDUCT ALTERNATES

	Est. Cost	TAC/HSAE	Alternate I	Alternate II
1. Omit all supply and reutrn air ductwork in shafts serving floor 13-15	16,000	1	2	3
2. Omit 15th Floor Emergency Generator.	65,000	2	3	4
3. Omit chiller and pumps and associated electrical provisions.	132,000	3	10	11
4. Omit 15th Floor substation including 15 KV primary feeders and switches.	37,500	4	4	5
5. Omit normal power bus duct, transformers, distribution panels, lighting 13, 14, 15th floors.	50,000	5	5	6
6. Omit two cooling tower cells and assoc. electrical provisions.	107,000	6	11	12
7. Omit radiation covers in shell space.	100,000	7	6	7
8. Omit Floor 2 Mayo connection thru Garage. (Ventilators and separating wall)	30,000	8	29	29
9. Omit wood paneling (Replace with ½" plaster board painted)	20,000	9	9	10
10. Omit one elevator selection control per car.	2,000	10	20	15
11. Reduce Casework units by 1/3.	130,000	11	26	25
12. Omit heat recovery provision including electrical provisions. (conservation)	55,000	12	14	19
13. Omit 50% Vinyl Asbestos tile (Replace with concrete)	75,000	13	22	22
14. Omit electric snow melting installation. (handicapped item)	8,000	14	21	17
15. Omit non-plaza exterior brick pavers. (replace with concrete).	50,000	15	15	2

	Est. Cost	TAC/HSAE	Alternate I	Alternate II
16. Reduce lab equipment by 1/3.	50,000	16	16	14
17. Omit interior pre-cast concrete.	52,000	17	8	9
18. Omit escalators (2) Floors 1 to 2.	110,000	18	23	23
19. Omit one elevator (Staff)	120,000	19	24	24
20. Omit 5th floor link (Unit A-B/C)	170,000	20	12	13
21. Modify window const. - Omit thermal break. (Windows will frost)	20,000	21	17	21
22. Omit interior brick pavers. (Replace with concrete)	25,000	22	1	1
23. Omit trash chute.	15,000	23	18	16
24. Omit Auditorium Seating Allowance.	30,000	24	13	20
25. Omit duplex clinic vacuum pump, connect system to lab vacuum system.	10,000	25	19	18
26. Omit metal soffits - substitute plaster.	50,000	26	7	8
27. Omit one elevator (Public)	120,000	27	27	27
28. Omit escalators (2) Floors 2 to 3.	110,000	28	28	28
29. Omit 5th floor link (Mayo to B/C)	170,000	29	25	26
30. Possibility of reducing by deduct alternate programmed finished space which has been added since the Grant Application.		30	30	30

UNIVERSITY OF MINNESOTA
HEALTH SCIENCES EXPANSION

HEALTH SCIENCES PLANNING OFFICE
4103 POWELL HALL

JUNE 10, 1975

UNIT B/C
POTENTIAL DEDUCT ALTERNATES

			EST. COST	ACU. COST
1.	Omit all supply and return air ductwork in shafts serving floor 13 - 15.	D	16,000	16,000
2.	Omit 15th floor emergency generator.	D	65,000	81,000
3.	Omit chiller and pumps and associated electrical provisions.	D	132,000	213,000
4.	Omit 15th floor substation including 15 KV primary feeders and switches.	D	37,500	250,500
5.	Omit normal power bus duct, transformers, distribution panels, lighting 13, 14, 15th.	D	50,000	300,500
6.	Omit two cooling tower cells and associated electrical provisions.	D	107,000	407,500
7.	Omit radiation covers in shell space.	D	100,000	507,500
8.	Omit trash chute.	D	15,000	522,500
9.	Omit interior brick pavers.	Q	25,000	547,500
10.	Omit metal soffits - substitute plaster.	Q	50,000	597,500
11.	Omit wood paneling.	Q	20,000	617,500
12.	Omit non-plaza exterior brick pavers.	Q	50,000	667,500
13.	Omit 50% V.A.T.	D	75,000	742,500
14.	Omit elevator selection control - 1/Car.	Q	2,000	744,500
15.	Omit escalators (2) floors 1 to 2.	D	110,000	854,500
16.	Omit electric snow melting installation.	Q	8,000	862,500
17.	Omit heat recovery provision including electrical provisions.	D	55,000	917,500
18.	Omit 5th floor link (Unit A - B/C).	D	170,000	1,087,500
19.	Omit interior pre-case concrete.	Q	52,000	1,139,500
20.	Omit escalators (2) floors 2 to 3.	D	110,000	1,249,500

21.	Modify window cost. - Omit thermal break.	Q	20,000	1,269,500
22.	Omit auditorium seating allowance.	D	30,000	1,299,500
23.	Omit duplex clinic vacuum pump, connect system to lab vacuum system.	D	10,000	1,309,500
24.	Omit 5th floor link (Mayo to B/C).	D	170,000	1,479,500
25.	Omit floor 2 Mayo connection thru garage.	D	30,000	1,509,500
26.	Omit one elevator. (Staff)	D	120,000	1,629,500
27.	Omit one elevator. (Public)	D	120,000	1,749,500
28.	Reduce lab equipment by 1/3.	D	50,000	1,799,500
29.	Reduce casework units by 1/3.	D	130,000	1,929,500
30.	We have not addressed ourselves to the possibility of reducing by deduct alternate programmed finished space which has been added since the Grant application.	D	700,000	2,629,500
		TOTALS -	2,629,500	2,629,500

D - Identifies deferred savings which can be added back to the project during construction period or at a later date.

Q - Identifies quality omissions which are a permantent loss.

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals
Minneapolis, Minnesota 55455

October 20, 1975

TO: University Clinics Committee

FROM: Dr. Howe, Chairman of Special Task Force of UCC

SUBJECT: Special Task Force of the University Clinics Committee - Activity Recap

The charge given to the Special Task Force by the UCC to develop moveable and fixed equipment requirements for B/C is close to completion. The following is a brief summary of the Special Task Force's activities:

A. General Clinic Rooms

The Special Task Force concentrated on the development of the following general clinic rooms:

1. Exam
2. Treatment
3. Consultation
4. Clean Utility
5. Soiled Utility
6. Patient Education
7. Nurse/Clerical
8. Seminar
9. Physician dictation
10. Reception
11. Patient waiting
12. Toilets
13. Clinic Corridors

B. The following is a listing of plans developed for each of the above noted general clinic rooms.

1. Room access/doors/corridor requirements

   A. Width
   B. Height
   C. Position of door and exam table

2. Utility requirements and specific location/layout:

   A. Electrical
   B. Lighting
   C. Plumbing
   D. Gases (Oxygen/vacuum)

3. Equipment requirements and specific location/layout:

   A. Built-in casework

B. Built-in equipment
C. Moveable equipment
D. Furnishing equipment
E. Communication systems - intercom, public address, nurse call and telephones

C. Major issues developed by the Special Task Force include:

1. Elevator size

Issue: Elevator must be large enough to accommodate litters or large supply carts.

Resolution: Elevator # 6 will accommodate litters or large supply carts.

2. Floor covering of main patient/public non-clinic walkways

Issue: Floors in B/C must eliminate Bldg A main pedestrian concourse floor covering problems in terms of roughness, ease in movement, life-safety and noise control.

Resolution: Quarry tile will be provided.

3. Information Desk and other patient facilities at 3rd floor entrance

Issue: No patient oriented facilities adjacent to 3rd floor entrance.

Resolution: The following facilities will be provided: Information desk, public waiting lounges, public telephones, and wheelchair storage.

4. 3rd and 4th floor windows (Floor to ceiling)

Issue: Lack of privacy in 3rd and 4th floor outside rooms.

Resolution: The glass will be translucent.

5. Lighting levels

Issue: The lighting levels as developed by the Special Task Force for each type of general clinic room are in conflict with the lighting levels planned by the architect.

Resolution: The Health Science Planning office is reviewing STF recommendations for action.

D. Major areas pending - For Development by the Special Task Force

The only major area for Special Task Force development is - <u>B/C Graphics.</u>

The Health Sciences Planning Office has requested that the Special Task Force plus representatives from the Medical School and the University Interior Design Office develop a total Graphics plan for B/C.

This Graphics plan is to encompass all B/C orientated signs - exterior, interior and connecting links. Some areas for determination include:

1. Sign construction (materials, colors, sign size, letter/number size, etc.)

2. Sign location (ceiling, wall, major entrances, etc.)

3. Sign type (Building directories, limited Departmental designation, routes to B/C departments and/or to other buildings, special utilities such as elevators/escalators/toilets/telephones, etc.)

Future Special Task Force meetings will be scheduled to develop and complete this Graphics plan.

B/C - Graphics

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals
Minneapolis, Minnesota 55455

October 21, 1975

TO: University Clinics Committee

FROM: Greg Kujawa

SUBJECT: Clinic Name Designations - B/C

For graphics purposes, there is a need to determine the exact name designation of all B/C clinic areas.

The following are some options that are submitted for your consideration and review:

1. Clinical Department Name Designation
2. Floor Directional Name Designation
3. Color Name Designation

Note: Please see attached sheet for examples of the above options.

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals
Minneapolis, Minnesota 55455

October 21, 1975

TO: University Clinics Committee

FROM: Greg Kujawa

SUBJECT: Final Departmental Review and Approval - B/C Contract Documents, Drawings and Specifications

The architect has completed all Final Design contract documents, drawings and specifications for B/C. The plans include departmental:

- Layouts and wall/casework elevations
- Plumbing and lighting
- General design specifications

All of these plans must be approved by the first week of November, 1975.

The following is a brief recap of University Hospital's review and approval procedures:

1. Initial Review/Approval - Final Plans

   Greg Kujawa and Bob Swanson of the Health Sciences Planning office to compare all final plans with preliminary/updated user approved plans.

   All deviations from preliminary/updated plans to be noted and discussed with Departmental representative.

2. Departmental Review/Approval - Final Plan

   Departmental representative, Greg Kujawa and Bob Swanson to compare all final plans with preliminary/updated user approved plans.

   All deviations to be acted upon. Addenda to general contract prepared as required.

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals
Minneapolis, Minnesota 55455

October 21, 1975

TO: University Clinics Committee

FROM: Greg Kujawa

SUBJECT: B/C Construction Schedule

The following is a listing of important B/C construction schedule dates:

October 9, 1975	Bidding for General construction contract starts
November 1, 1975	Completion of Departmental Review/Approval of Final Contract Documents
November 25, 1975	Bidding for General Construction contract ends
January 8, 1976 (or before - contract to be awarded within 45 days of Bid completion deadline date.)	Awarding of General Construction contract
Mid January, 1976	Final Stage of ECX Contract to Start (cavity and footings)
Mid January, 1976	Start of general contract construction
Feb/March, 1976	Start of steel (ECS) installation
July, 1976	Reopening of Delaware Street
February, 1977	B/C totally enclosed
December, 1977	B/C completion

Floor	Clinical Department Name Option # 1	Floor Directional Name Option # 2	* Color Name Option # 3
1	Obstetrics/Gynecology Clinic	1 South Clinic	1 Red Clinic
1	*Neurosurgery/Orthopedics Clinic	1 Center Clinic	1 Blue Clinic
1	*Dermatology/Surgery Clinic (Urology)	1 North/East Clinic	1 Yellow Clinic
1	*Ambulatory Surgery/ Treatment/Colon-Rectal Clinic	1 North/West Clinic	1 Brown Clinic
2	Medicine Clinic	2nd Floor Clinic	2 Orange Clinic
3	*Family Practice/Neurology Clinic	3rd Floor Clinic	3 Pink Clinic
4	Pediatric Clinic	4th Floor Clinic	4 White Clinic
8	*Audiology/Clinical Psychology/ Psychiatry Clinic	8 West Clinic	8 Green Clinic
8	Otolaryngology Clinic (or ENT Clinic)	8 East Clinic	8 Grey Clinic
9	Ophthalmology Clinic (or Eye Clinic)	9th Floor Clinic	9 Black Clinic

* In multi-service clinics, the order of service names must be determined.

*Clinic corridors/reception could be painted to coordinate with clinic's name.

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals
Minneapolis, Minnesota 55455

DRAFT

October 22, 1974

TO: Dr. Filiatrault
Dr. Lee
Dr. Satran
Dr. Grage
Nancy Omundson
Dr. Howe
Dr. Williams
Dr. Serposs
Beverly Dorsey, R.N.
Greg Kujawa

FROM: John H. Westerman - Chairman, University Clinics Committee

I would like to take this opportunity to ask you to be a member of a Special Task Force of the University Clinics Committee.

The charge of the Special Task Force is to recommend to the UCC moveable and fixed equipment requirements for general clinic rooms and public rooms in Building B/C. The specific areas for review include:

*General Exam Rooms
*General Treatment Rooms
*General Consultation Rooms
*Clinic Support Rooms - including utility and storage
*Physician Dictation Rooms
*Patient Clinic Reception Rooms
*Patient Waiting Rooms
*Other Public Rooms

Due to constrained time limits, it is proposed that this Special Task Force meet at least on a weekly basis for the next several weeks to finalize recommendations.

Unless I hear to the contrary, I will assume that you are willing to serve on this Special Task Force. Mr. Greg Kujawa, staff to the University Clinics Committee, will contact you within the next few days to arrange for the first meeting.

Thank you for your co-operation.

APPENDIX II

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals
Minneapolis, Minnesota 55455

October 22, 1974

TO: University Clinics Committee

FROM: Greg Kujawa

SUBJECT: Special Task Force of University Clinics Committee

At the October 17, 1974 meeting of the UCC, I was directed to organize a Special Task Force. The charge of this Special Task Force is to recommend to the UCC moveable and fixed equipment requirements for general clinic rooms and public rooms in Building B/C.

The membership of the proposed Special Task Force should include a cross section of Clinical Services and the Outpatient Departmental staff.

I propose that the following Services/Departments and individuals be considered for membership on this Special Task Force:

Family Practice	Dr. Louis Filiatrault
Medicine	Dr. Robert Howe
Neurology	Dr. Myoung Lee
OB/GYN	Dr. Preston Williams
Pediatrics	Dr. Leon Satran
Psychiatry	Dr. Alan Serposs
Surgery	Dr. Theodore Grage
Outpatient Dept.	Beverly Dorsey, RN; Nancy Omundson
UCC Staff	Greg Kujawa

If the above list is acceptable the UCC should designate a chairman. Attached is a draft of an appointment letter for the task force.

MINUTES

University Clinics Committee

October 23, 1975

Present: Dennis Countryman, Dr. Michael Daly, Robert Dickler, Bev Dorsey, Dr. Richard Ebert, Russ Farrell, Dr. Eugene Gedgaudas, Greg Hart, Dr. Robert Howe, Tom Jones, Greg Kujawa, Paul Maupin, Sherry Perlmutter, Paul Rader, Dr. Roby Thompson, John Westerman, Dr. Paul Winchell, Don Van Hulzen

1. Ambulatory Care Reorganization Report - Dr. Thompson

The Ambulatory Care Medical Staff Reorganization Task Force has completed its report. The two major recommendations include: (a) the Medical Staff - Hospital Council should perform the same functions in relation to outpatient activities as they currently perform for inpatient activities, (b) a Management Policy Council should be developed, with Clinical Chief and Administrative representation, for the purpose of dealing with areas such as financing, manpower utilization, etc. The Clinical Chiefs will be asked to appoint an interim task force to further develop the Management Policy Council concept. The report will be presented to the Council of Chiefs of Clinical Services on Tuesday, October 28th, with probably further discussion occurring at a future retreat.

2. B/C Construction Schedule - Mr. Kujawa

The proposed constuction schedule for the B/C complex was distributed and briefly discussed. The bid process for general construction is expected to go well, and is scheduled to close on November 25th.

3. Alternative Deduct List - Mr. Dickler

The alternative deduct list distributed will be used only to the extent necessary, as determined by the bidding process. It was noted that elimination of some of the items (Nos. 15, 20, 24-29) would significantly decrease the efficient functioning of the building, and that elimination of several other items (Nos. 8, 16, 17, 21) would increase operating costs and thus impair long-run efficiency. Dr. Ebert objected to the priorities established in the list, with particular reference to those related to the 13th-15th floors. Mr. Westerman noted that the Medical School and the Hospital received equal priority in development of the list, to the extent that each unit was consulted in the process. Final determinations with regard to deductions will be made once the bidding process is complete, at which time there will be 120 days to "buy back" whatever deducted items are seen as necessary. Our Committee is limited in scope to clinic areas.

4. Equipment List - Mr. Dickler

Input from many parties has been received in the development of the list. The equipment falls into 4 categories with the following associated costs:

1) changes in fixed equipment and redesign - $300,000
2) movable equipment - $1,600,000
3) furnishings - $360,000
4) other (transport, communication, etc.) - $1,400,000

Some of the above needs ($100,000 - $200,000) can be met through equipment transfers. The present budget includes $800,000 to $1,000,000 for equipment, thus another source of funding will be necessary. It was noted that most of the equipment needs involve expansion, and that the portion of the building which is federally funded must be fully functional upon opening of the complex. It was also noted that upon completion of B/C the focus of funding efforts will be on inpatient facilities.

5. Completion of Shelled Space - Mr. Jones

Space for Medical Records and the Business Office were originally programmed for Unit B/C; it now appears that it would be more efficient to complete the planned shelled space along with the rest of the building to serve these two functions. Cost figures for shelled space completion are now being developed.

6. Mechanical Transport System - Mr. Dickler

The mechanical transport system was eliminated from Unit B/C planning when sources of funding were changed. Studies have recently been completed which indicate that the system and associated capital costs are justified by reductions in operating expenses which would result from the use of the system. Other considerations are now being investigated related to purchase of the transport system.

7. CUHCC and Northwest Clinic - Mr. Farrell

The CUHCC expansion which started on July 14th has gone very well. The Northwest Hennepin project is in the "planning for planning" process, with a group from the Health Sciences Meeting weekly in October with Northwest area community groups. A community-University task force will be put together to develop the program following this series of meetings.

8. Clinic Census - Mr. Dickler

The format for the census report includes data by major service and physical area.

The '74-'75 census report shows an increase of 8.8% over the previous year. This, however, includes employee health visits; when these visits are excluded, the actual census declined slightly less than 1%.

The first quarter 1975-76 reports have also been completed; large increases in Radiation Therapy and Child Psychiatry result primarily from improved reporting systems.

Questions regarding the clinic census report should be directed to Mr. Dickler.

9. Department Review and Approval - Mr. Kujawa

The process of departmental review of architects' drawings and layouts must be completed during the first week of November. The process suggested and approved will involve comparison of final plans to approved preliminary plans by Mr. Kujawa, with subsequent discussion of deviations from approved preliminary plans with the appropriate parties.

10. Special Task Force Report - Unit B/C Graphics - Dr. Howe

An activity recap sheet indicating the task-force's progress was distributed and discussed. The task force will be reviewing the specifics for lighting, directional signs, etc. in the future. The committee approved permission for the group to discuss these items with the architects.

11. Name Designation of Clinic Spaces - Mr. Kujawa

There is some concern over designation of names of clinics in Unit B/C, especially in areas where several titles are needed to describe the specialty functions of the area. Options presented included designation by clinical department, floor and directional name, or color. Dr. Ebert suggested designation by combination of floor number and clinical department; this suggestion was accepted by the committee.

Further meetings will be held no later than shortly after reception of the bids.

Greg W. Hart
Assistant to the Director

GWH/sjg

Paul Maupin
c/104 Powell Hall

MINUTES

UNIVERSITY CLINICS COMMITTEE

October 24, 1974

Present: John Westerman, Dr. C. Paul Winchell, Dr. Edward Ciriacy, Robert Dickler, Beverly Dorsey, Dr. Richard Ebert, Dr. David Eifrig, Dr. Eugene Gedgaudas, Dr. William Gentry for Dr. Robert Goltz, Dr. Robert Howe, Thomas Jones, Gregory Kujawa, Paul Maupin, Janet Shapiro, Margery Sloan for Alma Sparrow, Sharon Wilford, Paul Rader

Absent: Dr. John Anderson, Dr. John Najarian

1. Grant Limitations on Space Use - Mr. Maupin

The details of space allocation and the various specialties involved were discussed, and the rationale behind the cutbacks was outlined. The questions of the Certificate of Need and Grant requirements were discussed along with the basis for the Metropolitan Health Board's findings and stipulations.

Design considerations were explained and the construction process was outlined.

The Committee still had questions on grant limitations and asked for further clarification by the next meeting.

2. Organization Study Process - Dr. Winchell, Dr. Paparella

Two alternative methods of structuring the study process were outlined. Dr. Ebert moved that two committees with mixed representation be formed to examine Administrative and Medical Staff concerns respectively. Following Dr. Eifrig's second, the motion was carried. Dr. Winchell and Dr. Paparella are to submit names for the two committees.

3. Equipment List Process - Mr. Kujawa (See Handout)

Mr. Kujawa said the Committee will be receiving updated floor plans and equipment lists as they are developed.

4. General Room Equipment Task Force - Mr. Kujawa

The special task force was approved after the addition of consideration of representatives from the departments of Dermatology and Orthopedics. This group will meet weekly.

NOTE: The next meeting of the University Clinics Committee will be November 7th at 7:30 A.M. in Dining Room III.

Paul Rader, Administrative Resident

UNIVERSITY CLINICS COMMITTEE

November 7, 1974

AGENDA

1. Further Discussion of Grant Limitations on Space Use - Mr. Westerman
2. Ambulatory Study Committees - Dr. Winchell, Mr. Dickler
3. Construction Report - Mr. Maupin

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals
Minneapolis, Minnesota 55455

October 22, 1974

TO: Paul Maupin

FROM: Greg Kujawa

SUBJECT: Concerns regarding B/C

The following is a listing of various concerns that the University Hospitals Clinics Committee has in reference to Building B/C.

I request that you review these concerns with me at your earliest convenience. Thank you.

1. Update of B/C Grant Application of April 1, 1974

The following are inconsistencies or errors in the Grant application:

A. Page 17, Item F

Elevators should extend to floor 12.
Floor 12 will be completed in Phase I.

B. Page 277

Outpatient Facilities space is 132,455 SFG.

C. Page 280

Social Service offices are not planned for floor 1. They are planned for floor 2.

D. Page 281, Floor 5 (Page 318, Floor Plan)

The horizontal connection between A and Mayo is to be completed - not shelled.

E. Page 281, Floor 8

Otolaryngology departmental space will be unfinished in Phase I.

F. Page 307, Floor 2

The pedestrian corridor from B/C to Mayo through the unfinished food service area (connecting to the ER corridor via the garage) is to be completed during Phase I.

H. Page 310

The business office is not to be completed. Consequently there would be a change in the TOTALLED SFN by 2,500; and the TOTALLED - ASSOC - SFG by 10,260.

I. Page 314 - Floor 4

The middle section of the clinic module should be fully completed. Consequently the following areas should be unshaded:

- 3 exam rooms
- 1 consultation room
- 2 connecting corridors

J. Page 319-- Floor 6

The completed Family Practice Departmental space includes some rooms that appear to be part of the shelled clinic module.

These rooms consist of:
- 2 consultation rooms
- 1 Playroom
- 2 offices

These rooms should be shaded.

2. Main Entrance Concerns - 3rd floor B/C

Note: By 1981/82 up to 1200 patients per day will be entering B/C. (252 / 298,000). Additional traffic would include visitors, students and staff.)

A. Exterior

1. Delaware Street should be widened adjacent to B/C to allow several vehicles to be temporarily stopped without conjesting regular traffic.

   Since the tunnel from B/C to the Oak Street ramp will not be completed during Phase I, the 3rd floor entrance will be the major entrance to B/C. Autos/taxis/Medi-cab vans will be stopping to drop off or pick up patients, special supplies and employees.

2. There should be no steps (other than the street curb) between the street and B/C entrance door.

   If steps are absolutely necessary, the edges of the steps should be covered with metal for safety reasons to avoid chipping and crumbling as is apparent in Bldg. A exterior steps.

3. For wheelchair access to B/C, there should be a section of the street curb deleted and an incline installed.

   If steps are necessary between the curb and the B/C entrance, a wheelchair ramp should be provided.

B. Main door entrance

1. At least two automatic doorways with pressure plates should be provided.

   Bldg. A has only one such door. This would be inadequate for B/C needs.

2. An air curtain may be necessary for each of the doors. This forced hot air may help to provide relief from excessive drafts inside the 3rd floor and also the "wind tunnel" effect as is apparent in Bldg. A.

C. Immediately inside main entrance

1. Paver Brick has many disadvantages.

2. There is a need for an "Information Center."

   Some requirements of this center are: adjacent to the entrance, protected from cold and drafts, accommodate a minimum of two employees, wheelchair storage, several telephone capabilities, facilities to provide handout literature, and computer terminal potential.

   Some activities of this center include: provide general information to patients and visitors, direct traffic, call taxis, provide University Hospitals literature, provide requested wheelchairs, and access the computer for Outpatient needs.

3. Patient waiting area - while waiting for vehicle pick-up.

   This waiting area should be close to the main entrance for easy visual contacts. Public phones should be available. Cold drafts and the wind tunnel effect should be eliminated in this area.

   Note: Both the Information Center and the patient waiting area noted above would be required even if the tunnel from B/C to the Oak Street Ramp was completed during Phase I.

3. Paver Brick Floors

Building A has paver brick floors in some major pedestrian and staff thoroughfare areas and concourses.

This type of flooring may be a hazard to:

A. Patient walking
B. Wheelchair and litter movement
C. Supply cart movement
   (I observed a specimen bottle fall from a cart due to the "rough" ride caused by the paver bricks).
D. Noise control

In addition, the cost of these bricks must be relatively high.

Perhaps a different type of floor cover should be considered for B/C - including all pedestrian concourses (even those that connect to Building A).

4. Escalators

A. Speed

The B/C escalators should have an adjustable speed mechanism with the slowest speed being slower than the speed usually used for primary use floors in Department stores.

Infirm and/or confused patients must be considered in setting the ultimate speed.

B. Emergency

There must be easy access to an "emergency turn off" switch in the event of an accident.

A built-in gate bar should be provided to close off the escalators when they are non-functional.

C. On each floor, there should be a very short route to get from the "up" escalator side to the "down" escalator side on the same floor.

In Building A, if the user goes in error to the "up" escalator, he must walk many yards (even through a corridor) to get to the "down" escalator.

5. Access for litters, inpatient beds and wheelchairs

All building connections, elevators, hallway corridors and University Hospital Clinic rooms must have entrances, depths, and widths to accommodate litters, wheelchairs and inpatient beds.

Note: Some inpatients may be wheeled from and to Mayo while in their bed.

A. Beds (Electric retractable, Hillrom 7270-3, 150 on hand)

width: 36"
length: 91&3/4" (horizontal position, fully extended)
Note: folded : 75&3/4"

B. Litters

width: 28"
length: 81"

C. Wheelchairs

width: 25"

6. Sound Control

All clinical rooms must be totally free from outside-the-room induced noises. This is of course necessary to alleviate patient fears about lack of privacy and to avoid distractions.

Sound control is apparently somewhat of a problem in certain office areas of Building A. Conversations, telephone dialing, and typing sounds can be heard in adjacent rooms and in some instances several rooms away.

7. Elevators

A. Elevators should be wide enough and deep enough to accommodate an inpatient bed or litter.

B. Elevators should open on all patient floors - including floor 5.

C. In the elevator lobbies, the "up" and "down" buttons should be readily observable and accessable to all users - including people in wheelchairs.

In Building A, these buttons are immediately below the ashtray. These buttons may be confusing for patients to find.

D. Speed of elevators should adjust to the slowness used in Department stores.

In Building A, the elevators are extremely fast and may cause patient discomfort.

E. Inside the elevators, both sides should have floor selection panels including a panel for a wheelchair user. (as noted in Building A)

F. Inside the elevator, over the door, there should be floor numbers that light up as the floor is reached (as noted in Building A).

In addition, a B/C directory by floor, should be maintained above the specific floor number. This directory should be always lit for easy user reference.

8. Public Toilets

A. Clinic Toilets - (Single unit in a room)

Each side of a clinic module should contain at least one toilet room - preferably two rooms - for patient use.

All clinic module toilets should be designed for a wheelchair user: (See toilet room near Outpatient lab in Mayo - A 268)

1. Doorway wide enough for a wheelchair.
2. Enough of space inside the room for an attendant to push the wheelchair in and then come around to help the patient move from the wheelchair to the toilet.
3. Handicapped patient gripping and safety bars.
4. Toilet at appropriate height for wheelchair transfer.

B. General toilets - (Several toilets in room)

All public toilets to have a specifically marked stall for wheelchair users.

1. The doorway must be wide enough for the attendant to push the wheelchair into the stall and then enter the stall to assist the wheelchair user. (See toilet near Mayo Admissions area - D 290.)

   Note: In Building A, the wheelchair stall entry door is 30&1/4" wide (from doorpost to divider panel). This is not wide enough to allow an attendant to get into the stall once the wheelchair is pushed into the stall's doorway.

2. It may be easier to use a cloth curtain for privacy as compared to a very wide metal stall door.
3. Handicapped persons gripping and safety bars.
4. Toilet at appropriate height for wheelchair transfer.

9. Mercury vapor incandescent lights

Building A has several patient waiting lobby areas that are lit with mercury vapor incandescent lights. It appears that the lights may cause some problems:

A. The blue color tone of the bulbs is very difficult to read by.

B. Several of the units have a distracting continuous humming sound.

MINUTES

UNIVERSITY CLINICS COMMITTEE

November 7, 1974

Present: John Westerman, Paul Winchell, John Anderson, Robert Dickler, Beverly Dorsey, Richard Ebert, Thomas Jones, Gregory Kujawa, Janet Shapiro, Sharon Wilford, Paul Rader

1. Further Discussion of Grant Limitations on Space Use - Mr. Westerman

Functional planning for various areas of the B-C Building was discussed and the question of future utilization of shelled space was considered. The Health Sciences Planning Committee is the group with overall authority for B-C. It was suggested that Mr. Dickler serve as a liaison to that committee.

The function of the multi-specialty clinic and related considerations were addressed. It was pointed out that the consideration of a multi-specialty clinic is an independent event. The Outpatient Department, Robert Dickler, Gregory Kujawa, and staff will examine the amount of space each of the specialties is using now, and relate these findings to B-C space.

2. Ambulatory Study Committees - Dr. Winchell, Mr. Dickler

Two task forces are being created for the purpose of examining the present organizational structure of University Hospitals. One of the groups will focus on medical staff organization and the other will study the situation from an Administration point of view. These will be parallel committees with some cross-over in membership.

The following have been nominated to serve as members of the Medical Staff Organization Committee.

a. Roby Thompson, Ellis Benson, and Robert Goltz from the Council of Chiefs of Clinical Service.
b. Robert Howe, David Eifrig, and a person yet to be named from the Medical Staff Hospital Council.
c. Paul Winchell
d. Robert Dickler

Serving as members of the Hospital Organization will be: John Westerman, Beverly Dorsey, Nancy Omundson, Cliff Fearing, Robert Dickler, and two physicians to be selected from the membership of the Medical Staff Organization Committee.

3. Information Items

a. The ground-breaking for the B-C Building began this week.
b. The task force will meet to determine which equipment will go into the various modules.
c. The Council of Clinical Chiefs' Retreat will be held on December 23rd.
d. The Board of Governors of Univesity Hospitals will be announced on Friday, November 8th.

NOTE: The next meeting of the University Clinics Committee will be in December at the call of the Chairman.

Paul Rader, Administrative Resident

PR/sjg

UNIVERSITY OF MINNESOTA
TWIN CITIES

Health Care Systems Research and Development
Health Sciences
432 Morrill Hall
Minneapolis, Minnesota 55455

November 19, 1974

TO: Health Sciences Planning Planning Committee

FROM: John H. Westerman
Chairman, University Clinics Committee

SUBJECT: First Interim Report on University Clinics

This report is intended to inform the Health Sciences Planning Committee of the progress of the University Clinics Committee. The charge of this committee and its membership is found in Appendix I. The tasks of the Committee are wide in range and it was decided at the first meeting that it would be necessary for special task forces to be formed in order to proceed in an effective, efficient manner. A review of the existing planning overview was an essential part of the committees first meeting. This review was necessary because Committee members had substantially different perspectives about the present stage of the Clinics since the B/C modifications.

An immediate need was for a Special Task Force of University Clinics Committee with the responsibility of moveable and fixed equipment requirements for general choice and public rooms in Building B/C. While assignment of rooms is not complete, there is an early deadline for ordering the equipment. Greg Kujawa was made responsible as organizer and coordinator of this committee.

Appendix II states the committee membership and its charge. At the suggestion of U.C.C. committee members representatives from the Department of Orthopedics and Dermatology were added to the committee.

A discussion of the educational justification and rationale for Unit B/C brought forth Appendix III. This was complimented by an Ambulatory Care Issues List. This list, Appendix IV, specifies the issues of ambulatory care and defines for the committee the many areas that deserve serious exploration and study. It seemed essential to the committee that an in-depth analysis of alternative forms of ambulatory care organization was necessary. The intent of the study is "how can the University Hospitals, medical staff, Health Sciences and other related parties organize most effectively to fulfill the goals, objectives and roles of the ambulatory care program?" Appendix V is the accepted Ambulatory Care Reorganization Study Proposal. Mr. Robert Dickler will be the Project Study Director.

The committee felt that in order to be most effective and acceptable to all parties the studies of both Hospital Organization and Medical Staff organization must include committee members from both areas. Mr. Dickler and Dr. Winchell have worked together to develop these committees.

Appendix VI is the charge to the Ambulatory Care Medical Staff Organization Task Force and Task Force Membership. Appendix VII is the Ambulatory Care Organization Task Force and Task Force Membership.

There are issues still facing the University Clinics Committee that have been discussed at each meeting since the committees inception. The space utilization assignment of the reduced number of general clinic modules/exam rooms, the handling of requests for design change, the possible inclusion of a multi-specialty clinic are all items not easily resolved.

In summary, the committee is faced with a reduction of 228 to 156 exam rooms. Of the 156 rooms 89 are general purpose, 37 special purpose (Eye, ENT, Audiology) and 30 Family Practice. There are now 77 general exam rooms, 18 specialty, and 7 Family Practice. Neurology, Neuro Surgery, Dermatology and Psychiatry have no space assignments in University Clinics.

Meanwhile grant restrictions need clarification. The clinical chiefs of service are about to undertake a study to the feasibility of a multi-specialty clinic. The committee will seek further clarification in working toward a spring-summer completion date.

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals
Minneapolis, Minnesota 55455

December 10, 1974

TO: University Clinics Committee

FROM: John H. Westerman, Chairman

SUBJECT: Update Report

The intent of this memo is to provide an update on progress in the various activities which were set in motion by the committee during November, 1974. It is not felt that a meeting is required at this time but a meeting is being called for January 9, 1974 at 7:00 a.m. in D.R. III to receive reports from the various task forces.

1) Equipment Lists -

   a) The special task force on general clinic module equipment needs is meeting regularly under Robert Howe, M.D. and with the staff assistance of Greg Kujawa. Progress is good and all deadlines should be met.

   b) All departments with areas in B-C which are not covered by the Special Task Force have been contacted by Mr. Kujawa. A methodology for developing equipment lists has been developed and departments are currently pursuing the completion of prioritized fixed, movable, and furnishings equipment lists.

   c) Some equipment list decisions are being delayed in anticipation of tentative space allocation decisions by the Committee. While these decisions are not minor they are small in number and can be delayed by at least one month.

2) Space Allocation

   As per the Committee's direction, Mr. Dickler and the Outpatient department staff are currently preparing estimates of departmental space needs by various methodologies. These results will be presented to the Outpatient Committee on December 20, 1974 and it is hoped that some recommendations on space allocation will be agreed on by this group by mid-January, 1975 whereupon it will be presented to the UCC.

3) Reorganization study

   Both the Medical Staff and Hospital task forces have been appointed and will have their initial meeting during the week of December 9, 1974.

4) Ambulatory Surgery Unit

A task force appointed by the Chief of Staff, Chairman of Clinical Services and Chairman of UCC has been appointed to study and make recommendations on present and future needs for both inpatient and outpatient operating room and PAR facilities.

The committee staff continues to work closely with Health Sciences Planning on building plans and architect's drawings; possible ambulatory care reorganization consultants are being sought; and grant clarifications are being pursued.

In addition a report of our activities has been prepared and presented to the Health Sciences Planning Committee, the Clinical Chiefs, and the Medical Staff Hospital Council. The report contains the committee structure, charge to the Medical Staff and Hospital Organization Task Forces, the Equipment List committee, and the material comprising the planning assumptions for Unit B-C. Finally, the report was an agenda item at the semi-annual Medical Staff meeting.

If you have any questions or comments please feel free to contact me.

MINUTES

UNIVERSITY CLINICS COMMITTEE

January 9, 1975

PRESENT: Mr. Westerman, Dr. Winchell, Dr. Ebert, Mr. Dickler, Dr. Howe, Ms. Dorsey, Mr. Jones, Mr. Kujawa, Dr. Eifrig, Dr. Paparella, Dr. Daly, Ms. Shapiro

Dr. Winchell was elected Vice Chairman by acclaim.

1. Report on Clinical Chiefs Retreat - Mr. Westerman, Dr. Ebert

After extended conversation at the retreat it was agreed not to develop a multi-specialty clinic as a separate clinic not involved in teaching. It was felt that at this time the Family Practice Clinic was serving the population that would be served and that this duplication was not indicated. It was agreed that the present clinic structure should be evaluated in terms of improving service to the patient and promoting co-operation between specialties.

2. Administrative Task Force Report - Mr. Dickler

There is a meeting with Dr. Brown set to discuss the setting up of laboratory areas to provide the best service for the least cost. Radiology, Pharmacy and other services will follow to outline an approach to improved clinic services.

It was suggested by Dr. Daly that membership in the American Association of Medical Clinics be explored and that the association had many advantages to be offered. The "little six" group will also be investigated (Mayo, Ford, Ochsner, etc.)

Dr. Ebert expressed concern over billing and patient cost and suggested this be studied.

Mr. Dickler reported that there is an in-depth study of the real cost of outpatient care. This would give a base line to understand the effect of change from the financial perspective. Mr. Dickler went on to explain that the committees are trying to break roles and problems apart, fit together alternatives and see how real charges would work. He explained that there is a dearth of consultants in the area of the clinic's concerns.

Another area being studied involves legal questions as it concerns clinic activities in the areas of finance and organization.

3. Equipment Task Force Report - Dr. Howe

The committee has reviewed the general outline of the clinics, specifically how the examining rooms should be designed and equipped.

Mr. Kujawa reported that Examining Rooms, Treatment Rooms, Waiting Rooms and Soiled and Clean Utility Room work has been completed. Nurse, clerical, patient-education, transcribing alcoves and Physician alcoves are still being worked on.

There is presently work being done on supply cabinets, lights and examining tables.

Consultation with clinical directors and nurses is in progress as to the unique need of the general clinics as well as the needs of the non-general clinics (E,N.T., Ophthalmology, Audiology).

Mr. Dickler stated that by February 1 all plans must be in to the Health Sciences Planning office.

5. Redesign Requests - Mr. Dickler

A 1/8/75 design modification memo was passed out and explained. Some of the proposed changes involve errors in the original plan and distinction between clinic and department space. All modifications recommended are of a nature that will not delay building construction. A motion was made and passed to proceed on design modification.

6. Space Allocation - Dr. Eifrig, Mr. Dickler

1. Mr. Dickler explained the 1/7/75 B/C Space Allocation memo. It is necessary to proceed as if the clinic building were already built, the floor plans in totality cannot be changed. Dr. Paparella noted the difference between shared space and space allocation agreeing that certain space cannot be shared after it is constructed but could be reallocated before construction.

2. The space allocation committee recommended that four modules could be shared. The University Clinics Committee recommended that this be expanded to include Ophthalmology and Audiology.

3. Mr. Dickler and Dr. Eifrig will meet prior to the Clinical Chiefs to present Dr. Winchell with some alternatives to the space allocation issue. The alternates should take into consideration the concept that all space is theoretically available for assignment, but design and use patterns will dictate that only some of the areas be shared.

University Clinics Committee

MINUTES

January 17, 1975

Present: John Westerman, Paul Winchell, Edward Ciriacy, Dennis Countryman, Robert Dickler, Beverly Dorsey, Louis Filiatrault, Eugene Gedgaudas, Theodor Grage, Robert Goltz, Robert Howe, Thomas Jones, Paul Maupin, Paul Rader

Space Allocation - Dr. Winchell

A. Discussion of motion passed by the Chiefs of Clinical Service.

The essential points of the resolution were discussed. These included: the definition of clinical space in the B-C Building on the basis of programmatic need and the establishment of a permanent committee for the purpose of allocating and reallocating space through consideration of both service and educational functions. It was stated that a sub-committee of the University Clinics Committee, or the Committee, itself, would probably assume this function.

The criteria which were cited for space assignment are more complex than mere bed allocation considerations. A standard of 5 patients/room/day has been used historically and has been a criterion which included both educational and service components. However, other criteria, such as current utilization, were suggested.

A need was seen to evaluate other factors such as census projections, but it was observed that the validity of much of the data is questionable.

The Medical School is represented on the Committee by Dr. Gedgaudas, the Chairman of Clinical Services.

B. Timetable

At present, all clinical floor plans are defined and the architects will proceed on the basis of these. February 1, 1975 has been set as the deadline for the completion of equipment lists. Any changes in this list and any room design alternations will adversely affect the chances for a timely completion. It was suggested that a tentative gross allocation of space be made by February 1st, with allowance made for later refinements.

Consultants are developing a Critical Path chart for the B-C Building. Currently, the architects have a staff of 34

people working on the project. Since the time that the drawings were completed, a number of code changes have necessitated many design alterations which have caused time to be lost. It was estimated that the architects will be able to meet the July 24th bidding schedule if they work 10 hours per day until then.

C. Discussion

For planning purposes the Ophthalmology area and possibly some audiology space are immutable. All other space is subject to allocation and reallocation.

The University Clinics Committee is ultimately responsible for allocation decisions regardless of who formulates the actual plan. The sense of the group was that Dean Gault would not be represented directly, but that Dr. Gedgaudas will serve as liaison with him. However, Dean Gault will remain, as always, an ex-officio member of the Committee.

The Heart Hospital, Masonic, Rehabilitation 74, Urology, T.O.P., and the Dental Clinic areas should be included as parts of a total consideration of space needs for ambulatory care.

There was discussion about whether equipment lists should be submitted to Mr. Maupin based on the way the Building is currently conceived, or if the necessary modifications could be made in time for the architects to begin work within 10 days. It was observed that the issue resolves itself into a consideration of the specialized rooms.

Mr. Maupin stated that the best way is to keep the plans on target, finalize any changes, and implement these changes only once.

It was decided that the membership of the sub-committee was to be selected following this meeting by Dr. Winchell and Mr. Westerman.

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals
Minneapolis, Minnesota 55455

January 28, 1975

TO: Dr. Gullickson, Chairman
Dr. Eifrig
Dr. Howe
Dr. Filiatrault
Ms. Dorsey
Dr. Najarian
Dr. Erickson
Dr. Gentry
Mr. Dickler

FROM: University Clinics Committee
John Westerman and Paul Winchell, M.D. - Chairmen JW PW

SUBJECT: Ambulatory Care Space Allocation Committee

The intent of this memo is to ask you to serve on an Ambulatory Care Space Allocation Committee.

The purpose of this committee is to establish :

1) Programmatic standards by which space can be allocated for clinic activities.

2) A plan for relocating all designated clinical services to Unit B-C in the space available.

In addition, this committee is viewed as a permanent body which will periodically review all ambulatory care space needs,both in Unit B-C and for clinics remaining in their present location, and make adjustments in allocations which are determined to be appropriate and necessary.

You are asked to complete the development of standards and initial B-C space allocation plans as soon as possible so that any equipment or design changes required can be initiated.

We have asked Dr. Gullickson to serve as chairman. The initial meeting is scheduled for Wednesday - February 5, 1974 in D.R. II at 7:00 a.m.

If you are unable to accept this appointment or attend the initial meeting please contact Mr. Dickler at 3-8959 as soon as possible.

Thank you for your cooperation.

cc: University Clinics Committee

University Clinics

Thurs. February 13, 1975

Present: John Westerman, Cheri Perlmutter, Tom Jones, Paul Maupin, Nancy Ammundsen, Greg Kujawa, Bob Dickler, Richard Ebert, Bev Dorsey, Ted Grage, Louis Filiatrault, Russ Farrell, Janet Shapiro, Lois Seedan

1. Equipment List Task Force Report - Mr. Kujawa

Went through sample rooms in each category as found in Feb. 11 report from Fixed, Moveable and Furnishings equipment recommendations for General Clinic rooms in B/C. It was noted that specialized services will require modifications.

Suggestions for review:

1. Re-examine number and placement of
   Not enough planned and often in areas that might not be accessible when needed.
   Should be in halls
   Should be in examining rooms
   Should be in doctor alcoves

2. Necessity of some identifying system to know where physicians are.

3. Individual thermostats in examing room.

Flexibility in equipment furnishing was stressed.

The guidelines list was okayed and the committee will proceed to talk to each clinic to make specific changes.

It is understood that the entire plan is for ideal clinics and it is likely that it will be necessary to cut back due to economic constraints.

2. Medical Task Force Report - Mr. Dickler

Meets weekly discussing full spectrum of problems. Is trying to identify ways of enhancing delivery of primary care.

3. Hospital Task Force - Mr. Westerman

Labs are going to computer printout. The Radiology setup will be greatly improved in B/C. Pharmacy, Social Service, Nursing sees greater role for themselves in ambulatory care service. Discussion of Ambulatory Care Board as health authority for clinics need for this to participate in control of funds.

4. Space Allocation - Mr. Dickler

Establishing criteria of how to allocate space.

5. Construction - Mr. Maupin

Steel drawings almost completed

Steel to be purchased in 2½ weeks. Will be assigned to erect in July. Complete list of meetins for interface of architectural firm and medical staff.

Progress considered favorable

Cost consulting firm hired. Going through drawings for alternative for deductions

Can cut aesthetically but not programmatically

Everything should be ready by July

6. Mental Health - Mr. Jones

Development of program in Child Psychiatry with Larry Greenberg

Remote site

Outpatient Day Care Center
Residing Treatment Center

50 day
50 resident

MINUTES

University Clinics Committee

February 28, 1975

PRESENT: John H. Westerman - Chairman, Dr. Winchell-Vice Chairman, Dr. Ebert, Dr. Ciriacy, Dr. Gentry, Dr. Gullickson, Dr. Howe, Dr. Filiatrault, Mr. Dickler, Ms. Dorsey, Mr. Kujawa

Dr. Gullickson presented to the committee the Space Allocation Committee proposal for initial allocation of Unit B-C. In addition the principles for present and future allocation adopted by the committee were also presented. (see attached).

Dr. Gullickson also noted that he had directed a letter to Mellor Holland - Chairman, Health Sciences Space Allocation Committee on behalf of the Committee requesting the retention of some present clinic areas for new program development.

Dr. Ciriacy at this point raised the questions of whether the administrative decision that all clinics originally scheduled to move to Unit B-C must still move and vacate their present space had been made. Several committee members stated that it was their belief that both Dr. French and the Health Sciences Planning Committee had stated that the accomodation of all services originally designated for relocating to B-C was necessary in B-C with the accompanying vacating of present space. Furthermore, it was this decision which necessitated the present space allocation effort. It was agreed that Drs. Ciriacy, Dr. Winchell, and Mr. John H. Westerman should clarify this issue with Dr. French.

On the presumption that all services considered by the Space Allocation Committee must relocate to Unit B-C the UCC endorsed Space Allocation Committee report and requested it be presented for information to the Council of Clinical Services. In addition the Committee felt that the Chiefs should be asked to endorse the request to the Holland Committee so such endorsement could be transmitted to the Medical School.

Respectfully submitted,

Robert M. Dickler

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals
Minneapolis, Minnesota 55455

February 28, 1975

TO: Council of Clinical Services

FROM: University Clinics Committee

SUBJECT : B-C Space allocation

At its January 14, 1975 meeting the Council of Chiefs of Clinical Services moved and unanimously approved , "That the University Clinics' spaces be assigned on the basis of programmatic need and that a permanent Outpatient Allocation Committee be appointed with the responsibility of allocating space and re-allocating it according to need."

In accord with that charge the UCC appointed a sub-committee to deal with the questions of Unit B-C space allocation and subsequent on-going reallocation. At its February 21, 1975 meeting the Ambulatory Care Space Allocation Committee adopted a set of principles for space allocation and a plan for initial B-C allocation. This plan has been approved for implementation by the UCC pending clarification of prior administration decisions (see UCC minutes - February 28, 1975). This plan is now presented to the Council for information and comments.

In addition the Space Allocation Committee has transmitted a letter to the Health Sciences Space Allocation Committee requesting that some present clinic areas be retained for new programs. Since this space will be a critical element in promoting new programs and increasing census for completion of additional space in Unit B-C the Council is requested to endorse this request so that this endorsement can be transmitted to appropriate Medical School and Health Sciences representatives.

Attachments :

1) Ambulatory Care Space Allocation Committee minutes
2) UCC minutes
3) Letter to Health Sciences Space Allocation Committee

AGENDA
University Clinics Committee
April 24, 1975
7:00 a.m., D.R. III

Posted on your calendar. tm

1. Interim Report: Ambulatory Care Medical Staff Organization Task Force

2. Interim Report: Ambulatory Care Hospital Reorganization Task Force - Direct Patient Care Support Departments

3. Equipment Report - Mr. Kujawa

4. Tucson Conference Report - Mr. Westerman/Mr. Dickler

4/7/75

Interim Report

Ambulatory Care Medical Staff Organization Task Force

I. Introduction

The intent of this report is to summarize the activities of the Ambulatory Care Medical-Staff Organization Task Force (ACMSOTF) since December of 1974, outline some initial recommendations, and to discuss future areas of inquiry which the task force feels are appropriate. In addition, the task force is seeking comments and guidance on several subjects. The committee is chaired by Dr. Roby C. Thompson and composed of Dr. Robert Goltz from Dermatology, Dr. Ellis Benson from Laboratory Medicine, Dr. David Eifrig from Ophthalmology, Dr. Robert Howe from Internal Medicine, Dr. Paul Quie from Pediatrics who subsequently requested his position be filled by Dr. Leon Satran, Dr. Louis Filiatrault representing Family Practice, Dr. Preston Williams representing Obstetrics and Gynecology, and Mr. Robert Dickler representing the University Hospitals.

Since its inception an attempt has been made to comply with the original charge given to the Task Force by the University Clinics Committee, i.e. to analyze and recommend alternative medical staff organizational forms for ambulatory care. In addition, the task force has also dealt with the additional charge from the Council of Clinical Services Retreat to investigate mechanisms by which primary care delivery could be enhanced and expanded.

To this end the ACMSOTF has:

1) Reviewed past planning documents relating to the roles and objectives of ambulatory care and the Mission of the Health Sciences.
2) Reviewed and discussed the extensive list of problems now existing in delivering ambulatory care as well as the present ambulatory care organization.

3) Reviewed all available studies relating to the Outpatient Department and Ambulatory Care activities at University Hospitals.

4) Reviewed several major national studies in ambulatory care organization and reorganization efforts.

5) Investigated with representatives of the Clinical Departments now providing the majority of primary care, various organizational options.

In terms of primary care the task force members concluded that there were three broad options (conceptually) for primary care delivery organizations:

a) Total reorganization of all clinic programs and staff (medical and hospital) to provide primary as well as secondary and tertiary care.

b) Separation of current and future primary care activities into a semi-autonomous organization with participants from the major departments involved in primary care.

c) A continuation of the present organization where each of the departments involved continues its activities on a separate basis. It was discussed that this option may necessitate the assumption of expanded obligations by both departments providing primary care and consultation services.

After considerable discussion it was concluded that only Option C was feasible at this time but that some mechanism was required to enhance communication between primary care providers and consultants to both close gaps in care and deal with common problems more effectively.

Finally, it should also be noted that several members of the task force attended a special seminar on ambulatory care reorganization. In addition outside consultants have been sought and one group interviewed. The conclusion

stemming from both of these meetings was that outside assistance could be useful except in very specific areas; but only if the parameters that the consultants were to deal with were specifically defined.

II. Recommendations

It is on the basis of these discussionsand investigations that the ACMSOTF developed the following preliminary recommendation:

That the overall ambulatory care program be under the jurisdiction of a single, combined hospital and medical staff, ambulatory care organization which consolidates all present committees and ad hoc groups dealing with ambulatory care.

A. That each clinical department continue to retain primary responsibility for the educational, service and research programs of that department within the parameters defined by the overall organization. This responsibility includes all levels of patient care.

B. That the overall ambulatory care organization assume responsibility for the direction of ancillary and support activities in ambulatory care.

C. That the overall ambulatory care organization assume responsibility for the direction and possible operation of appropriate external ambulatory care operations.

Future Activities

It is recognized that the above recommendation for an overall ambulatory care organization necessitates attention to the parameters of that organization as well as other questions. Foremost of these parameters is the organization's level of activity and responsibility. Questions in this area

include whether it should be the equivalent of the Medical Staff Hospital Council and how it should relate to the Council of Chiefs of Clinical Services and other entities?; whether it will be separate from these organizations or a subbody?; whether there should be a Chief of Ambulatory Care?; whether the medical staff is the same as the Hospital's present staff?; and whether the organization is appointed, elected, etc.?

It would be the intent of the ACMSOTF to address these organizational issues and others such as the role of a Health Appraisal or Multi-phasic screening program in the clinic's organization;if the concept of an overall ambulatory care organization and its implications is accepted.

Interim Report

Ambulatory Care Hospital Reorganization Task Force

-Direct Patient Care Support Departments-

During January and February the Ambulatory Care Hospital Reorganization Task Force met with representatives of the hospital departments which provide an extensive degree of direct ambulatory patient care. Specifically, discussions were held with representatives of Laboratory Medicine, Radiology, Pharmacy, Social Service, and Nursing. It should be noted that these departments were selected because of their current high volume of ambulatory service and not because of any presumed greater importance than other departments, such as Nutrition and Occupational Therapy, which provide direct patient care.

The intent of these discussions was to evaluate each department's current activities in ambulatory care and perspectives on how these roles should be altered both conceptually and within Unit B-C. All departments responded within the context of the task force's overall charge of considering reorganization options for ambulatory care.

The specifics of each department's input is documented within the task force's minutes. The intent of this report is to summarize the conclusions reached by the task force concerning areas of common agreement between all departments. These areas of commonality were extensive and represent a majority of input from each service. They are as follows:

1) All Departments desire to be part of a treatment team with physicians in the care of ambulatory patients. However, while cooperative and integrated programs are desired such efforts should not negate the ability of all services to retain some autonomy in defining roles and carrying on activities.

   The task force recognizes that the dual concepts of "team" and "autonomy" may be inherently contradictory. This contradiction though is easily negated if it is understood that each department has a spectrum of activities which vary by clinic, and services provided in different clinics may be appropriately organized and delivered through alternative mechanisms.

2) The present activities of the departments represented in this report are not the result of any overall ambulatory care program or role and goal statement. Rather, they are the result of ad hoc relations with specific clinics and responses to existing conditions and traditions.

3) None of the departments feel that autonomous inpatient and ambulatory care departments are desirable, practical, or economically efficient. To be responsible to the ambulatory care program it is felt that ambulatory care divisions of the present departments are logical.

4) All departments strongly recommend that a central ambulatory care policy and operational authority be developed to define relationships, program parameters, financing, etc. Such an organization should not, however, negate totally the flexibility each clinical specialty (Medical and Health Care) and

subspecialty now has in developing their teaching, research, and care programs.

5) It was evident from the discussion that all services need to be considered more extensively in finalizing and planning clinic schedules, clinic loads, and clinic information and materials systems for optimum efficiency in providing ambulatory care.

6) None of the services interviewed felt that autonomous professional charges (not including product charges - i.e. pharmacy) were appropriate or necessary at the present time. (Laboratory and Radiology exceptions in light of present systems).

7) All departments interviewed felt that since the majority of clinic activity will be located in Unit B-C that it would be necessary to relocate physically and functionally the aspects of each department involved in ambulatory care to that facility.

8) All departments felt that their present roles in providing patient care were too narrowly restricted and provided inadequate professional role fulfillment.

It is important to note that the above points represent conclusions and recommendations which may or may not be implementable and appropriate when the final reorganization plan is developed. The task force does believe, though, that these represent valid interpretations of present circumstances and suggestions for future change. It is hoped that all can be incorporated in the final plan.

3-25-1975

MINUTES

University Clinics Committee

April 24, 1975

Present: Edward Ciriacy, Dennis Countryman, Robert Dickler, Beverly Dorsey, David Eifrig, Cliff Fearing, Glenn Gullickson, Robert Howe, Evertt Janssen, Tom Jones, Gregory Kujawa, Cherie Perlmutter, Janet Shapiro, John Westerman, Paul Winchell, Paul Rader

1. Equipment Report - Mr. Kujawa

Progress in regard to casework for most of the departments was detailed and design and evaluation considerations were discussed. The work of the Specifications Task Force was explained.

A number of systems are being examined. Casework drawings will be sent to Departments for review in the near future, and equipment lists will be prioritized at that time.

Various additional funding and equipment considerations were discussed.

The judgement of the Committee regarding impact and commitment levels will have to be reviewed by the Board of Governors.

The efforts of Mr. Kujawa and the thoroughness with which he has carried out the studies were commended by the Committee.

Cost factors in regard to outpatient activities were considered and it was stated that a study is being done in relation to the ambulatory care areas. This study should be completed by early summer. Information was provided about Medicare reimbursement rulings.

2. Interim Report: Ambulatory Care Medical Staff Organization Task Force - Dr. Howe for Dr. Thompson

A document was distributed which reported the results of the Task Force's work. The Task Force was chaired by Dr. Roby Thompson, and was composed of Dr. Goltz, Dr. Benson, Dr. Eifrig, Dr. Howe, Dr. Quie (who was replaced by Dr. Satran), Dr. Filiatrault, Dr. Williams, and Mr. Dickler.

The Task Force examined reorganization of the medical Staff in regard to ambulatory care. The document, on page 2, listed three broad options. The third option was recommended by the group.

Recommendations for implementation were detailed in the Report. These were explained and the distinctions between them were delineated. It was stated that the Report has already been

approved by the Medical Staff Hospital Council.

3. Interim Report: Ambulatory Care Hospital Reorganization Task Force - Direct Patient Care Support Departments - Mr. Dickler

A report document was distributed to members of the Committee. The specifics of the Report were summarized and discussed. The report has yet to be distributed to the Medical Staff Hospital Council and the Council of Chiefs of Clinical Services.

It was suggested that the specific groups involved in parts of the Report should be named. The work of merging the two Task Forces will proceed.

4. Tuscon Conference Report - Mr. Westerman/Mr. Dickler

The Conference dealt with the areas of ambulatory care, medical staff organization, and governance. The position of Univeristy Hospitals relative to other teaching hospitals was discussed. The specific concerns of the Conference were listed.

A printed report about the Tuscon Proceedings will be relased soon.

The University Clinics Committee will meet again in 30-60 days at which time the deliberations will continue. Also the reports of the Task Forces will be considered.

Paul Rader, Assistant to the General Director

MINUTES

University Clinics Committee

May 29, 1975

Present: Richard Ebert, Greg Kujawa, Dennis Countryman, Tom Jones, Robert Dickler, Bev Dorsey, Cheri Perlmutter, Paul Winchell, Dave Eifrig, Janet Shapiro

1. Discussion of B/C Reduction Alternates Caused by Cost Over-runs - Mr. Dickler

It was explained that there is presently a $2 million deficit that must be met. When it was initially discovered that the $34 million estimate was insufficient there was drastic budgetary non-construction reduction including landscaping, carpets, moveable equipment design changes. These modifications did reduce the cost by the necessary $2 million. In the meanwhile there have been considerable building cost changes requiring a total sprinkling system, fire walls and ceilings, a fire alerting system and stair well changes. The cost of meeting these specifications comes to $2 million.

Attached is the Potential Deduct Alternates. After some discussion, it was agreed upon that Robert Dickler should continue to work with the architects and Medical School as to what the list of priorities should finally be. It was pointed out that the prioritization was extremely important in the future decisions of the Medical School and the economic feasibility of completely shelled space at a future date. A report of this will be sent to Lyle French and James Brinkerhoff.

No - Talk to Bob D.

The question of employing a professional fund raiser to raise the deficit was discussed. It was noted that the decision had already been made that the only source of funds for the cost over-run was either the Medical School or the Hospital.

2. Equipment Report - Greg Kujawa

In the ambulatory area almost all areas are completed. The waiting rooms and reception desks are not yet completed in the clinic space. The security system, stair wells, public address and intercoms, fire alert and codes are presently under review.

Rough drawings of the treatment and exam rooms were distributed. It is expected that there will be two more preliminary drafts before the final plans are submitted to each department for their last review. All of this must be completed before submission to the Chicago office in mid-summer.

- more -

3. Discussion of process employed in Phase II of Task Force Study - John Westerman

The Medical and Hospital staff task force will be merging under the chairmanship of Roby Thompson. Two general approaches discussed for organization of the clinics were:

1. Autonomous Clinics Health Authority with fiscal authority and responsibility. Would be accountable to Board of Governors and ultimately Board of Regents.

2. Strengthen Outpatient Committee.
   Need of bylaws change.
   Roby Thompson, Bob Dickler, Paul Winchell and John Westerman will meet to discuss the alternate ambulatory organization alternatives.

Under the ambulatory care study Russ Farrell is now responsible for external ambulatory programs.