RALPH J. STEPHENSON, P.E.
CONSULTING ENGINEER

April 9, 1975

Subject: Monitoring Report #1

Hennepin County Medical Center Move-In

Minneapolis, Minnesota

Project: 75:29

Dates of Monitoring: April 3, 1975 and April 4, 1975 (working days 66 and 67)

Actions taken:

- Conferred with Medical Center technical staff re nature of move-in
- Set preliminary early move-in dates
- Established basic character of move-in functions
- Established pre-move functional organization patterns

This two days of meetings was devoted to an in depth review of the elements required to move into the Hennepin County Medical Center which includes Center Hospital and General Hospital. Representatives from both projects were present at this meeting.

Our early discussions isolated the need to consider two basic moves - a people move and a things move. It was quickly established that the people move which has been termed the patient move-in will be a very short duration action - probably a matter of hours. The total length of time this will take has not yet been established but will be set as a part of the ongoing study of the entire process.

Next, we reviewed the various bases by which we might identify the nature of the move-in. We considered a functional basis, an area basis, a patient type basis and also, reviewed some non-normal elements that might form a bases for the move. Some of these included traffic patterns, weather conditions, legal problems, sabotage potential, security elements, peripheral personnel needs and emergency requirements. After extensive discussion it was decided to initially plan the move pattern on the basis of area availability,

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and move character.

The major move points were depicted on sheet 2A of the flip chart series dated April 3, 1975. Move type boundaries were defined as follows:

Patient Move - The several hour long actual move of patients from the existing hospital to the new facility.

Basic Move (patient contact) - The move of essential support equipment in normally direct or close contact with patients and required to maintain proper medical services to the individual patient.

Administrative Service Move - The move from the existing hospital to the new of equipment, materials, records, and other physical objects that have a direct relationship to patient services without being in direct contact with the patient.

(Note: It is generally thought by the move managers that the administrative services move, the basic move and the patient move will be accomplished over a short period of time measured in days or possibly a few weeks. It is a very compressed period of time.)

Pre-Move - The period of time after which areas are punched out and owner is occupying (not bought) spaces. During this period the owner will be moving in and installing:

- medical equipment
- furnishings
- carpeting
- blinds
- interior signing
- exterior signing
- mobile case work
- accessories
- landscaping
- scheduled delivery system
- making the systems check out.

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Contractor Construction Completion

- The point at which the space has been completed by the contractor. By this time it is expected that the area may be partially punched out with corrections made. Presently we have assumed a relatively short period of time between the contractor construction completion and the pre-move start. This matter will be reviewed in more depth at subsequent meetings.

The various moves were depicted as concentric circles with the patient move at the center, and the circle indicating contractor construction completion as the outer ring. At the point just inside the pre-move circle, it was decided to insert a move date decision point which is the time by which a precise patient move date must be set officially. Since other influences on the move date will constantly be in action throughout the entire pre-move area, an abort move date which was the last date on which the patient move date could be revised was set as being just outside the administrative services move concentric circle line. This is substantially after most pre-move activities have been completed.

Once the various kinds of moves were identified, a tabulation was made of completion targets for all areas under construction in General Hospital and Center Hospital. These are shown on the flip chart series dated April 3, 1975. By further using present projected scheduled dates for contractor construction completion, we identified four major area blocks and gave these the designation of 1, 2, 3 and 4. Thus, contractor construction completion points for area #1 would be designated CCC1. The pre-move point for area #1 was designated PM1. These are also referenced on sheet #2 of Issue #P1 network dated April 4, 1975 for the Hennepin County Medical Center Move-In.

On flip chart #6 we established the four major areas into which moves are made. Generally it was decided on a preliminary basis, subject to change, that the administrative services move and the abort patient move date point would occur probably after the pre-move activities have been completed for areas 1, 2 and 3. There is not total agreement on this matter as yet and it must be studied in greater detail before a final decision can be made. This decision making is a function of the hospital agencies involved and the move managers.

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Regarding the boundary for the contractor construction completion relative to the pre-move period start, a brief discussion was held of the steps to be taken in turning over space to the owner. These are shown on flip chart #9 dated April 4, 1975 and encompass the following:

1 Complete construction
2 Prepare punch lists
3 Correct punch list items
4 Complete punching out
5 Owner approve space
6 Owner buy space

The difference between items 5 and 6 should be clearly defined. This matter will be reviewed in detail and negotiations conducted with contractors to insure that the buying of the space which generally means release of the retention is not done prematurely.

Next, an analysis in depth was made of all of the pre-move activities, materials and equipment relative to how and when we could expect action on them. This information is shown on sheet 1 of the network model for the Hennepin County Medical Center Move-In, Issue #P1 dated April 3, 1975.

The following dates were abstracted from this diagram as a delivery average. It is not intended that these are firm at this time but are to be used for preliminary discussion purposes.

Item		Delivery or Activity to Start (average)
Medical equipment	-	December 5, 1975 (working day 238)
Furnishing	-	October 23, 1975 (working day 208)
Carpet	-	August 21, 1975 (working day 164)
Blinds	-	September 23, 1975 (working day 186)
Interior signing	-	October 1, 1975 (working day 192)
Exterior signing	-	September 24, 1975 (working day 187)
Mobile case work	-	not yet defined
Accessories	-	December 9, 1975 (working day 240)
Landscaping	-	October 24, 1975 (working day 209)
Scheduled delivery system (SDS)	-	January 28, 1976 (working day 274)
Move contract let	-	September 4, 1975 (working day 173)
Demolition of Elliott Building to start	-	June 2, 1975 (working day 107)

The above dates are tentative and are presently being used to project the basic phased targets for early planning operations. These dates, along with the area designations, were next used to set projected date targets for the CCC (contractor construction completion) and the beginning of the PM (pre-move) dates. This is shown in tabular form on flip chart #12 dated

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April 4, 1975. These dates are as follows:

	1	2	3	4
CCC (contractor construction completion)	9/17/75 (w/d 182)	12/22/75 (w/d 249)	1/28/76 (w/d 274)	3/15/76 (w/d 307)
PM (pre-move) to start	10/1/75 (w/d 192)	1/12/76 (w/d 262)	2/16/76 (w/d 287)	4/1/76 (w/d 320)

We did not define on flip chart #12 the dates of the administrative service move, the patient contact or basic move, nor the patient move. There is still considerable discussion to be held regarding these dates and over the next few weeks, it will be our obligation to firm up the specific points of starting each.

Our last duty for the two day work and planning period dealt with the definition of responsibility and authority patterns for various pre-move functions. On flip chart #13 dated April 4, 1975 the pre-move operational functions were found to include (not totally inclusive) the following:

1. Install new owner equipment
2. Install old and renovated owner equipment
3. Train personnel
4. Control physical traffic
5. Manage the visual, aural and written communications
6. Manage public relations
7. Manage governing authority contacts
8. Exert management control over equipment
9. Provide technical backup control
10. Manage the overall program

It was found that items 1, 2, 8 and 9 were similar in nature and could be grouped in one functional operation entitled equipment management and control. Item 3 was the training and orientation function. Item 4 is the physical traffic control function. Item 7 is a governmental authority liaison element and items 5 and 6 were communications and public relations functions. Thus, we have five major functions:

Equipment management and control

Training and orientation

Physical traffic control

Governmental authority liaison

Communications and public relations

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All managed from a central control point entitled overall management. This information is shown on flip chart 14. We also identified the person in charge of the overall project as Mr. Richards who also is shown presently in charge of equipment management and control, training and orientation and communication and public relations. The person in charge of physical traffic control is Peter Levy with assistance from Art Burke and the governmental authority liaison is in charge of Peter Levy with help from Bill Schroeder.

An assignment given to all parties that were involved in this conference was to exhaustively list functions that would properly be within the responsibility and authority of the five functional areas. It was requested that each person at the conference identify these and submit their lists to Mr. Richards at an early date, preferably within the next two weeks. (Note: This was not a formal request at the meeting but is being established as a recommendation for the time limit on the submission.)

We closed the meeting by reviewing in summary fashion the elements covered during the session and it was agreed that another major move meeting should be held sometime within the next month. I shall be in touch with Mr. Tom Mattison regarding the date of this conference. Meanwhile, it is expected that all parties participating in this project will begin outlining, studying and identifying their various roles. The flip charts and colored floor plans were left in the charge of Mr. Richards who will see that they are photographed or reproduced, where possible, and distributed to those involved.

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RJS/m

To: Mr. Peter Levy
(Original and 2 copies)

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June 11, 1975

Subject: Monitoring Report #2

Hennepin County Medical Center Move-In

Minneapolis, Minnesota

Project: 75:29

Date of Monitoring: June 5, 1975 (working day 110)

Actions taken:

- Reviewed work to date with members of Patient Move Committee and others involved in total move
- Continued refining definitions of move phases
- Set basic planning elements of various moves

Early in our discussion Mr. Richards described the organizational work done to date with the Patient Move Committee. This committee is a small organization of two physicians, two nurses, the chief of the ambulance service and the head of the pharmacy. The committee has the responsibility for doing the detailed planning for the patient move. From the activities of the Patient Move Committee, other assignments will evolve and be assigned to hospital staff task forces.

Two members of the Patient Move Committee were present so it was decided to try to set the basics of the patient oriented move sequences during this conference. Essentially we hoped to develop the following information:

1) Approximate time spans for the patient move and the moves directly preceding and concurrent with the patient move.

2) The seasonal time frame within which the patient move and the patient contact move would occur.

3) The elements critical to the patient move and the patient contact move.

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4) The constraints upon entering the patient service move. (Note: It should be pointed out that a revision in definition was agreed upon today that displaced the former administrative service move with the patient service move. The patient service move relates primarily to furniture, equipment, records and other daily use items essential to maintaining proper patient services. The beginning of the patient service move identifies the point at which the activities must move through to completion of the patient move without stopping. Essentially the start of the patient service move is the abort point.)

5) The factors affecting the patient move.

6) The political ramifications of the move-in.

7) The critical nature of public relations relative to the various moves.

8) A review of the abort point concept.

9) Definition of the functional elements of the actual equipment moves including:

A) Inventory

B) Point of origin

C) Identification

D) Packing

E) Moving

F) Unpacking

G) Placing

H) Move priority

I) Consignment target

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10) Duties of various functional organization elements. These elements are as defined on page 5 of Monitoring Report #1.

11) Establish the major diagramming divisions to allow start of detail network planning for the patient service move.

12) Consideration of splitting the patient service move.

Most of the early discussion revolved around how to plan the patient service move which is the move that starts the clock ticking up through the patient move. It was decided that the patient service move would be built around the degree of criticalness of the service unit to the patient. The start of the move would be where the least critical service elements were to be relocated on through to the start of the patient move where the most critical elements to the patient would be relocated. Criticalness was to be established by dependencies generated from the planning. A preliminary evaluation showed that these dependencies rested upon such items as:

- number of moving vans
- capacity of vans
- hoisting capacity at existing hospital
- hoisting capacity at new hospital
- van speed
- crew size
- consignment target
- originating location

There are undoubtedly other elements that influence the patient service move dependencies and these will be identified as it is planned in detail.

A preliminary analysis of the timing shows it might be possible in an ideal condition to load a van in something like 60 minutes, to transport it to the new hospital in 7 minutes, to unload the van in 52 minutes and to return the van to the existing facility in another 7 minutes which gives an ideal 126 minute time from starting the loading process at the existing facility to the van's return to that point. If we assume there are 80 van loads of equipment in the patient service move and we can load four vans concurrently, it would mean we would be able to complete transferring the 80 van loads of equipment ideally within four or five working days. However, many other factors must be considered, one of which is the probability of being able to load four or more vans concurrently at the existing hospital.

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This statistic is one that must be determined quite early so as to establish what supplementary hoisting provision must be made at the existing facility. If we are only able to load two vans concurrently at the existing hospital, it would mean that the 80 van loads would ideally take approximately nine working days, plus whatever contingency amount would be required to make that move. Thus, it becomes critical to early establish the statistics surrounding the move of equipment from the existing hospital.

As part of this study, Mr. Richards is working with Mr. Schroeder on a grided inventory procedure, followed by an application of this grid to the existing and new facility. Next, an inventory of the existing building will be prepared, after which the moving specs will be written. The fundamental product of this early work will be to quantify the needs of the hoisting and moving contractors and agencies. (Keep in mind all figures must be modified by a contingency allowance.)

Concurrently, the Patient Move Committee will be working on the patient move assignment and the patient service move priority list. The patient service move priority list will categorize the various functional equipment units of the hospital by basic priority from the least to the greatest patient need and along with it, identify its point of origin, its consignment target and the number of vans required to move that equipment unit. In all likelihood it will be essential to group in the vans those pieces of equipment that have similar consignment targets although it should not be forgotten that these new groupings may not resemble existing groupings. This may require considerable assembly time from various originating points in the existing hospital.

As a help to identify the means of classifying elements of the patient service move by priority, we discussed various phrases that might be used as yardsticks. These included in order of rough desirability the following:

- Dependency of each priority action upon other actions
- Disability level of patients
- Equipment characteristics
- Ambulation characteristics of patient
- Age of patient (except for the very young and the very old patient)
- Department of patient

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Much of our time during the meeting was taken in conceptualising the various elements of the move so as to more easily reduce them to measurable activities. For instance, although the van concept described above may appear to be a simple concept, it took considerable discussion to work it into identifiable form.

Again, it was pointed out how important is the time of year relative to the patient move. The doctors spoke of the fact that certain days of the week and month are more medically active than others. For instance, pay days and full moon days see an increase in activity at the hospital. Late winter appears to be a high homicide time, primarily due to cabin fever. These elements although somewhat abstract are important to consider.

Another element brought up by the doctors was the fact that a most significant influence on the move would be the availability of nursing help as compared to availability of doctors. The reason is that the doctor is generally on call at all times, whereas the nurse works on a regularly scheduled assignment, which means that the presence of the nursing body is a regularly scheduled presence rather than on-call presence. Thus, the move must be made at a point when an adequate volume of nursing help is usually available.

As a result of the discussions, it finally was decided that the patient move still is a six to eight hour move and must be carried out continuously from the time it starts until the time it is completed. The patient contact move is one that may be slightly longer but also must be kept to a minimum since it deals essentially with those services in direct contact with the patient. The patient service move might be considered to start as long as 48 to 72 hours previous to the patient move and could possibly extend as much as 48 to 96 hours after the patient move. Thus, the total time involved from the abort point where we must carry through to the patient move is right now a span of 3 to 5 continuous days followed by 2 to 4 continuous days to complete moving all essential and critical patient support services. The administrative service move which precedes and is concurrent with the patient service move could start considerably ahead of this and might begin as many as three weeks ahead of the patient move.

To close out the meeting, we reviewed the current status of the pre-move items. Most of this work is considerably behind our originally projected dates, primarily because of budget constraints that have been placed upon delivery of the elements. Presently it is expected that governmental approvals on medical equipment, furnishings, carpeting, blinds and accessories will be requested by July 1, 1975 (working day 128). We probably will have

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to allow at least two weeks for this approval to be given so that these items can be expected to be put out for proposals on or about July 11, 1975 (working day 136). Interior and exterior signing is still being reviewed at the budget level by the architects. Mobile case work proposals are expected to be received shortly and the contract should be awarded by July 1, 1975 (working day 128). This is about 18 working days behind our original schedule. Landscaping materials will be ordered later due again to budget constraints. The scheduled delivery system (SDS) has been deferred for the time being and this matter will not be pursued further until a later date if at all. Moving specs have not been prepared since these will require an inventory grid to be prepared for identification of the move scope of work. This item is being carried out by Mr. Schroeder and Mr. Richards now.

Overall, it is expected that the current status of pre-move items will permit a full blown activity relative to the pre-move period to start at the beginning of 1976. This then places the start of the administrative services move in mid or late February 1976 and gives a target for the patient move itself of somewhere between mid-March and early April. Presently it appears this range of dates is reasonable and acceptable to most responsible parties concerned.

I shall be in touch with Mr. Richards regarding our next session. However, prior to that it is hoped that a considerable amount of the work discussed in our conference today can be planned and completed.

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RJS
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To: Mr. Peter Levy
Mr. Chuck Richards - Gen. Hosp.

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July 9, 1975

Subject: Monitoring Report #3

Hennepin County Medical Center Move-In (HCMC)

Minneapolis, Minnesota

Project: 75:29

Date of Monitoring: June 26, 1975 (working day 125)

Actions taken:

- Discussed move-in principles with Mr. Tom Mattison and Mr. Chuck Richards

General Summary

The purpose of this meeting was to review work and plans to date and project them for the future on the Hennepin County Medical Center move-in (HCMC move-in). The major thrust of the conference was to set future direction, particularly in management, responsibility, and authority patterns for the entire move-in procedure. Now that construction of Center Hospital and General Hospital is entering the final phase, it will become increasingly important to define move-in procedures in detail. Mr. Richards suggested we will have to carefully chart the actual patient move and also the major blocks of equipment and furniture moves. It should not be necessary to diagram the detailed, individual furniture element moves from the old hospital to the new since these details will probably be reflected in translations to charts, tables and other graphic forms from the master network. This matter is one that should be reviewed in detail at our next planning session.

Mr. Richards and I discussed classifications of the actual patient move and it appears presently the priorities for classification are:

1st priority	Patient location in existing hospital
2nd priority	The disability level of the patient within category 1 above

It is possible that there will be 12 to 15 generic locations that can be identified as the origin of patient moves in the existing hospital. Thus, we may use these relatively few locations to plan the entire short duration patient moves.

There has been some thought that our consideration and focus should shift from a weekend patient move to a mid-week patient move. This, to take advantage of the increased staff, particularly nursing assistance available during regularly scheduled hours. This matter will be reviewed in detail by the patient move committee.

It is presently critical that we begin isolating and defining the specific tasks that should be in work to accomplish the total move-in. Therefore, a major share of Mr. Richards and my conversation today revolved around this matter. Elements in work or to be done for each of the five major functional categories described on page 5 of Monitoring Report #1 dated April 9, 1975 are listed below:

1) Equipment management and control

A. Grid

Mr. Schroeder has assigned, or soon will, a young man from his office to do the actual drawings of the existing and new hospital facility along with the overlaying grid. Presently it is considered that a 5' x 5' grid will be adequate to identify the origin and consignment elements of a piece of equipment. Probably the horizontal grid will be numbered and the vertical grid lettered. It was further decided that a maximum of five letters or digits would be needed to identify all of the location grids.

B. Inventory

An inventory of existing furniture and equipment will be made in August using college students implementing a system already devised. Presently it appears that as the inventory is made a move tag and a permanent inventory tag will be attached to the furniture. The move tag should designate the point of entry at the new

B. Inventory (continued)

building, either north or south block and the consignment target, both level and grid. The permanent tag will merely contain the name of the organization and the inventory number. I suggested to Mr. Richards that we might want to place on the move tag the phase during which the piece of equipment probably will be shifted. These phases are:

PM Patient move

PCM Patient contact move

PSM Patient service move

AM Administrative move

This will be reviewed by Mr. Richards.

11/5/75 Arch has list of modifications needed.

C. A laundry list defining the existing building equipment modifications necessary will be prepared.

D. A service disconnect - transport, reconnect characteristic description for equipment will be prepared to assist in letting the move contract.

E. A laundry list will be prepared of the modifications necessary to existing equipment.

2) Training and Orientation

A. Mr. Richards plans to ask department heads to prepare an orientation manual for their own department describing its role in the new building. They also are to be asked to prepare a brief of this manual for the total hospital facility so that others can be made aware of each department's needs and functions.

B. A description of the new systems to be used, such as the demand delivery system will be prepared.

C. Employee locker room assignments will be given early consideration.

D. It would be wise also to consider publishing of regular articles either as independent newsletters or within the present in-house newsletter to describe the move and to disseminate and provide information to all employees about this very important activity.

3) Physical Traffic Control

A. The closing of streets necessary to make the patient move should be discussed at an early date with the Police Department and the appropriate public authorities.

B. A security plan for the old and new buildings during the various moves should be prepared.

C. It is important to early define special moving equipment requirements.

4) Governmental authority liaison

A. This was a point deferred for discussion until later when a better understanding of the liaison problems is available.

5) Communications and public relations

A. A briefing of the County Public Information Department will be given in the very near future. This should be aimed at encouraging them to issue and publish authentic information of an interesting nature about the whole move.

B. It would be wise to consider preparing conference and presentation graphics of the various flip charts used in the analysis and evaluation of the move-in elements. This material could be used wherever it is necessary to communicate with others regarding the move-in.

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Closing out our discussion for the day, we reviewed the various reporting relationships back to Mr. Richards who is in charge of this move for the General Hospital. The management structure for the move-in is still under consideration and Mr. Richards will work toward defining the structure more specifically over the next few weeks.

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RJS
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To: Mr. Chuck Richards
Mr. Peter Levy

RALPH J. STEPHENSON, P.E.
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November 12, 1975

Subject: **Monitoring Report #4**

Hennepin County Medical Center Move-In (HCMC)

Minneapolis, Minnesota

Project: **75:29**

Dates of Monitoring: **November 4 and 5, 1975 (working days 216 and 217)**

Actions taken:

- **Reviewed move-in with parties concerned**
- **As part of Center Monitoring, prepared completion, punchout and acceptance plan of work for Center Hospital**

General Summary

The purpose of this meeting was to review the current status of work and plans for the Hennepin County Medical Center move-in. As space becomes available in the entire HCMC complex, it will be increasingly important to bring plans for the move-in into sharp focus. Presently it appears that a tentative target for patient move has been established sometime in late April or early May. For purposes of our discussions during this session, we assumed a patient move-in on Wednesday, May 5, 1976 (working day 344). If this is the current patient move-in target, it should be recognized that from November 5, 1975 (working day 217) to the May 5, 1976 date (working day 344) there are only 127 working days.

The patient move committee is very active and according to Mr. Richards, still very enthusiastic. They are now coping with the more difficult detailed elements of the move and are beginning to assemble logistics of the program so that numbers can be attached to the requirements.

The points covered in our monitoring are reviewed below at random.

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- Present thinking tends to favor keeping the patient and his bed, along with his belongings together to the greatest extent possible. This is to minimize separation of possessions which might be difficult to reconcile during the confusion of the move.

- There has been some difficulty in obtaining approval of purchase on new equipment and furnishings. Therefore, the intent presently is to use as much of the existing equipment and furnishings as possible. This factor has tended to encourage movement of patients along with their beds and belongings.

- The shift to mid-week move thinking has been basically motivated by the need for as much staff in numbers and diversity as possible. It is felt that during the week these goals can be achieved more easily than during a week end move since on Wednesday most of the staff is on duty.

- Efforts have already been initiated to tie the move closely into the city traffic pattern. The Traffic Department has been working with the hospital to minimize disruption and set a good circulatory system.

- Mr. Richards said that experience indicates a need for a patient consent form. This will consist of two elements - a consent to move and a consent to be photographed. Wherever the consent to be photographed is not obtained, special provisions will be made to insure that desired privacy is respected.

- The vehicles to be used in the move will be buses for ambulatory patients, vans for patients who are not necessarily in bed but will be moved with their beds, and mobile intensive care units for patients who are confined to their beds. It was emphasized there probably will have to be a doctor and an emergency kit for each vehicle.

- A careful review has been made of reducing the hospital population to the greatest extent possible for the move. This, of course, is in the interest of patient safety and comfort. A one day survey of patient type, location and characteristics, along with a study of patient population at various times of the year has been made. It seems that at certain times of the year the patient population has been reduced down to as low as 230.

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Therefore, in considering the number of patients that must be moved, it is possible that the population could be reduced down to near this level for the actual patient move. This matter will be studied in more depth during the coming weeks.

- Another influence upon the time of year at which the move is made deals with the point when interns and residents complete their tours of duty. The intern term is over the last week in June. The resident's term is over a week later. This has been an influence in establishing the current target patient move date.

- Task force chairmen have been identified and meetings will soon be held with these men and women to review the work they are to do. The initial task force groups include dietary, laboratory, dialysis, outpatient and emergency room.

- Provision of supplementary vertical hoisting capacity will be essential for moving patients and equipment at the existing building. Presently it appears that there may be a need for two outside equipment hoists. This matter is being studied in depth as the logistics of the move are analyzed.

  Presently it is considered desirable to maintain as little intermediate mobilization space as possible to keep the moves direct and one step in nature.

- It has been decided a move tag format will be used to direct equipment, material and other elements from their existing locations to their positions in the new hospital. The tag format has been set and tags are presently being printed.

- Casework storage may turn out to be somewhat of a problem although presently the space available at the basement beneath Chicago Avenue is under study as a storage area. More work will be done on this over the coming weeks.

- A detailed study has been made of equipment modifications and their disconnect, transport, reconnect characteristics. This very important part of the move is under continuous study, and the most economical way of modifying transporting and connecting equipment will be generated by the hospital move staff over the coming weeks.

- Preparation of the orientation manual has not yet been initiated. However, Mr. Richards is meeting this week to define responsibility patterns.

- A description of the systems that will be put into use in the new hospital is presently in work. This is a very important matter since many of these systems are unique and new to the present hospital operation.

- A public relations program is being initiated and a series of articles in various publications is planned.

- No work has yet started on security plans. I recommend this matter be given early consideration.

- Reduced size graphic plans of all areas for the new hospital are being prepared.

  Since the move tag defines the name of the space, proper identification of where these spaces are will be critical.

- Relative to the point above, the signing program must be carefully thought out so that all those involved in making the physical move can find the various locations easily, quickly and by the most effective route.

- A training program for employees will be conducted concurrently and as a part of the orientation procedure. This most likely will be done when most construction is complete.

  Presently we are considering that construction may go through as many as four phases. The first is when the space is completed adequate to receive stored equipment and furnishings. The second phase is when it is complete and ready for equipment hookup. The third is when it is ready for display in orientation use and the fourth when it is operational. Thus, the training program which requires the space to at least be available for display is thought to be more appropriate later in the construction process.

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- There was some miscellaneous discussion about backup for all personnel involved in the move. Presently Mr. Richards feels comfortable with this.

- The abort point has not been finally set.

- It will be important to establish the number of vehicles actually to be required for the move. Presently there does not seem to be a problem with obtaining adequate moving capacity. However, since it is a technical problem to be solved, and one dealing with patient and equipment logistics, it would be wise to early establish some preliminary vehicle number and type targets.

- There is still a need to improve communications about the move and efforts are being made to involve and inform all parties who are to play an active and policy role in the move. This is an ongoing problem and will become more and more critical as deadlines for decisions appear.

  I suggest we continually maintain a sense of urgency about the move since as pointed out earlier, there are only 127 working days remaining until the move is to be made. This is not a great deal of time and there are sizable amounts of work yet to be done.

- There is a high potential for some early move-in by MMC, particularly to Center Hospital areas. These moves should be reviewed relative to the present projected completion dates in Center Hospital and a thorough evaluation made as to whether the support services for such moves will be available. Mr. Richards, Mr. Anderson and others are fully aware of the implications of this move.

- As construction nears a completion point, it will be essential to continually maintain realistic planning targets for completion of each space throughout the entire complex. A preliminary list of these has been prepared for the Center Hospital portion and is shown on sheets 1, 2 and 3, Issue P1 dated November 4, 1975.

RALPH J. STEPHENSON, P. E.
CONSULTING ENGINEER

The sheets consist of identification of the completion, punchout, correction, final inspection and owner acceptance of all spaces within the Center Hospital complex. I recommend the same procedure be followed for the remainder of the Hennepin County Medical Center so that clearcut targets are set as goals. It should be recognised that these may change but it is far easier to cope with change to identifiable goals than change to goals that have not been established.

- Mr. Richards and I made a review of the special items shown in the preliminary move-in network P1 dated April 3, 1975. A brief resume of the items on that network is as follows:

  - The medical equipment funding was reduced considerably and purchasing is now preparing a new set of specifications.

  - Furnishings for Center Hospital have been let. A delivery will be set in the near future. Furnishings for the General Hospital have not been released as yet.

  - A carpet contract has been let and delivery will be set in the near future.

  - A blinds contract has been let and delivery is to be set.

  - The interior signing package is still in budget and analysis. This will be an increasingly critical item and should be given a high priority of attention.

  - Exterior signing has been contracted for and is now in fabrication.

  - Mobile case work is in manufacture with part of the shipment ready for delivery.

  - Landscape will be done as funds allow.

  - The scheduled delivery system has not been awarded as yet. Further consideration will be given at a later date.

  - Moving specs are now in preparation by the accounting staff. This will be released shortly.

RALPH J. STEPHENSON, P.E.
CONSULTING ENGINEER

The above has not been a studied effort to tie today's discussion to previous monitering evaluations. However, the random points covered are all important and should be given serious consideration through the move planning period. Of critical importance is to insure that all of the bases in this move process have been touched and it would be wise to consider preparing a detailed checklist in the near future identifying <u>every</u> action and <u>every</u> element that must be accomplished up through the patient move.

I shall be in touch with Mr. Richards sometime during the next two months to determine the need, if present, for another move-in review meeting.

Ralph J. Stephenson, P.E.

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To: Mr. Chuck Richards
Mr. Peter Levy