**Introduction to the Planners’ Toolkit**

The role of the planner in academic medicine is rich and varied. Projects may encompass strategic, programmatic, space, capital, and operational planning (to name a few), and can span the clinical, research, academic, and community missions of our institutions. Depending on the size, scope, and organization of the institution, roles may be highly specialized or very broad.

With this in mind, the Association of American Medical Colleges Group on Institutional Planning has developed this Planners’ Toolkit, which is intended to provide an overview of planning in academic medicine. Whether you are new to a planning role, a seasoned veteran with new roles and responsibilities, or an occasional participant, it is our hope that the toolkit can be used as an introduction to the field, as well as to some of the key issues and activities it encompasses. It includes a series of short introductory articles by some of our most experienced members on:

- Planning in Academic Medicine
- Organizational Structures and Planning
- Strategic Planning in Academic Medicine
- Master Planning
- Space Planning: Clinical, Research, Education
- Space Management/General Facilities Information
- Data and Benchmarking (forthcoming)
- Why We Love Working in Academic Medicine
- Appendix A – About the Group on Institutional Planning (GIP) and the AAMC
- Appendix B – Master Planning

We hope the toolkit will become a living document that will continue to expand as our members contribute new topics from their various areas of expertise. We welcome your comments and thoughts on how we can continue to make this a useful resource. The toolkit will be distributed to current GIP members, and to all newcomers to the Group. It will also be accessible on the GIP website.
How to Use the Toolkit

Most of us at some point have assumed duties that included institutional planning for a school of medicine or an academic medical center. Because there are no educational programs to prepare one for becoming an institutional planner, few of us have a clear picture of what is involved in becoming an institutional planner.

Recognizing the “deer in the headlights” look, some of our more experienced members offered to prepare a toolkit to explain some of the basics associated with tasks we frequently are asked to do. For additional assistance, they have also listed their contact information so that you can call them in your darkest hour. I thank our contributors for their work; condensing processes that sometimes take years into a few simple steps.

We all hope this toolkit helps our members in their efforts to be more successful in serving the advancement of our institutions--the value of good luck cannot be overestimated.

Bob Marriott, Chair
Group on Institutional Planning
March 2010
Planning in Academic Medicine

Context:

Planning is classically described as a staff resource, helping line executives perform their responsibilities to set direction and establish an agenda for change. This classic definition fails to capture the variety of ways in which planning is carried out in modern organizations, or the variety of staff and management roles a “planner” may be asked to perform. This paper is intended to illuminate the full scope of the planning role in an academic medicine setting. The focus is on those whose primary responsibility is planning, but the observations have relevance to the planning segment of any manager’s portfolio.

Academic medicine refers to the array of organizations that contribute to the education of physicians and biomedical scientists, and also contribute new knowledge through their research programs. Patient care is a third element of mission for many of these organizations.

Academic medicine includes medical schools and teaching hospitals, but it also includes many other types of organizations as well; and the number and variety of organizational forms is expanding rapidly. Planning in academic medicine may also occur in an academic medical center, or within a consortium of teaching hospitals, an HMO or IPA, a faculty practice plan, a university-affiliated research institute, and others. This document is intended to capture the common elements of planning in all these settings.

Most academic medicine organizations have characteristics that can make planning especially challenging. They are part of a web of complex organizational relationships. For example, a medical school’s organizational network may include its parent university, the university’s other health and science schools, affiliated patient care organizations, affiliated research institutes, affiliated physician practice organizations, and so on. The relationships among these organizations are often poorly defined and highly codependent.

The internal organization of an academic medicine organization is no less complex. Most are flat organizations where each executive has a broad span of control. To extend the example of the medical school, it is not unusual for a dean to have 20 or more associate deans and department heads reporting to him or her. Despite this flat organizational form, medical schools can also be very hierarchical. The chain of command from dean to associate dean to department head to division chief to tenured professor, and down through the many faculty and trainee ranks can be rigid.

Governance of academic medicine organizations is multilayered. There is normally a complex array of standing and ad hoc faculty committees charged with policy and oversight of academic issues. In addition, there are layers of governance provided by the parent university, including the central administration, trustees, overseers, visiting committees, and the like. Organizations that are part of state systems receive oversight from their legislatures as well.

Academic medicine organizations are also part of local and global communities. They are primarily not-for-profit service organizations, and their teaching, research, and patient care missions bring them into the public arena in many ways. Their external constituencies include patients, students’ parents, alumni, the cities and neighborhoods in which they are located, donors, funding agencies including the government, the worldwide scientific community, etc. Academic medicine organizations operate in an industry that is highly regulated, high tech, capital intense, knowledge intense, and constantly changing.
Role and Scope

These characteristics mean that planning can be both extremely difficult as well as extremely important in these organizations. Planning is made difficult by the rapidly changing external environment, the many constituencies, the limited control of the chief executive, and the extensive consensual decision-making processes. But the rapid pace of change and high-stakes investments required for new programs also make planning critical.

Like academic medicine itself, planning in these organizations must be multifaceted. Planning involves research and data-gathering about both the internal and external environments. It involves analysis and synthesis—searching for insights into problems and opportunities. Planning involves process facilitation—helping individuals and groups through processes of discovery as they hone in on where they want to go and how to get there. And, of course, planning involves evaluation of both the process and results.

Planners in academic medicine use these processes in a wide variety of settings and topical areas. Some planning is strategic, dealing with issues of mission and long-range goals at the highest levels. Other planning is targeted at individual departments or programs. Planners must be able to shift focus constantly between the forest and the trees, between the immediate and the long range.

Because of the capital-intensive nature of these organizations, planners often are responsible for space planning and capital projects. And because these organizations are knowledge intense, planners often have a key role in planning for faculty recruitments. Marketing, especially for patient services, is frequently a responsibility of planners. There is often considerable overlap between the responsibilities of planners and those of public affairs, government and community relations, development, and the budget office. Planners may have line responsibility for any of these functions, or others. In addition, the decentralized, entrepreneurial nature of academic medicine means that line managers within large programs and departments often have a substantial planning component in their jobs.

Core Competencies for Planners

Planners are first and foremost masters of process. Planners must skillfully employ a variety of techniques to shepherd participants through the steps of visioning, environmental assessment, development of goals, objectives and strategies, and tactical planning for implementation. The skills involved are both substantive and political.

Planners must be generalists with the ability to master new subject areas quickly. In one instance, the planner may be called on to facilitate planning for managed care networks, and in the next, be called on to plan for a transgenic animal program. The potential topical areas are nearly limitless, and the planner must be comfortable working with technical material that may be unfamiliar.

The roles that planners are called on to play are even more varied than the many different organizations that make up academic medicine. The senior planning position in a large organization, such as an academic medical center, would include all of the elements listed below. Senior planners in smaller organizations, or specialists within a planning group, may have responsibilities requiring some of these abilities, but not all of them.

The menu of skills and abilities required of planners in academic medicine include the following:

- Facilitation of discovery and decision making by individuals and groups;
- Communication skills: oral, text, visuals, formal, informal;
• Mediation and negotiation skills;
• Research, data-gathering, data analysis, qualitative analysis, modeling, projecting, playing “what if”—often with the aide of computer technologies and databases;
• Proficiency in evaluating resource requirements, including dollars, people, space, and capital;
• Ability to lead a facility planning project for concept through occupancy so that it achieves programmatic objectives on budget and on schedule;
• Ability to interpret legislative and regulatory initiatives affecting health care, education, and research, and to participate in framing the organization’s response;
• Sensitivity to issues of government and community relations and an ability to factor such constituencies into planning and implementation;
• Ability to flag issues requiring a change in institutional policy and participate in crafting and obtaining approval of such policies;
• Ability to define and integrate issues, identify problems, and synthesize solution elements into a cohesive action plan;
• Act as a change agent;
• Skills in playing the “conductor” role: organizing and coordinating the work of committees and other types of task groups;
• Skills in running meetings, retreats, workshops, public forums, etc.;
• Be self-directed, have ability to manage multiple projects simultaneously, flexibility to adapt to changing priorities;
• Ability to deal with both ambiguity and conflict;
• Ability to take responsibility when authority isn’t always clear;
• Objectivity and neutrality, ability to bridge parochial interests;
• Skill in rapidly assimilating new technical material and in obtaining advice from technical consultants;
• Ability to manage the work of others, including many who are not direct reports, such as consultants and team members from other units;
• Keen sense of how to get things done in a complex organization.

Organizational Structures and Planning

It has been stated that, “If you’ve seen one academic health center, you have seen one academic health center.” Our organizational structures are as diverse as our physical plants. (See the AAMC publication “Organizational Models for Medical School-Clinical Enterprise Relationships,” Academic Medicine: February 2001, Volume 76, Issue 2, pp. 113-124). The AAMC maintains an organizational characteristics database that provides information on the structure of, and relationships between, the primary components of each school’s academic medical center. Despite variations in structure, the responsibilities and fundamentals of governance, including planning, are very similar.

The term strategic planning has taken on many contemporary names, usually with a marketing twist to suggest improved processes with better-defined outcomes. Regardless of approach, the principles of developing a successful strategic plan have not changed much over the years. Successful planning still depends on goal and objective setting, but perhaps most important, it depends on individuals in leadership positions who can rise above the day-to-day, time-consuming issues and express a coherent vision for what they want as a legacy. Planning not only supports the organizational process of developing and maintaining a strategic plan, but it also requires a mental process of considering what future activities are necessary to survive, thrive, and excel.

Planning provides a process for garnering creative insights and building consensus that may or may not be achieved otherwise. The value of the planning process as an educational tool for individuals at partner institutions cannot be underestimated -- particularly in organizations with numerous “silos.” The planning process should minimize current cultural and individual discomfort zones, while increasing corporate appreciation in interdisciplinary activities. As a planner, this should be one of your most important focuses—the barriers, both formal and informal, that stifle creative thinking.

Depending on your organizational structure, there may be many “planning” offices within your enterprise. Good planning requires active engagement of all encompassed units, and good leadership recognizes that planning must be a fundamental responsibility of every leader in the institution. Leaders who only support planning cosmetically, are unengaged, or relegate the mental processes of strategic planning to an administrative office, are not likely to create successful and sustainable organizations.

The planning function can be housed within a large academic department, a particular hospital or clinic service, the medical school, an academic health center (AHC) or health system, or parent institution’s governing body. Regardless of where responsibility lies, a planning approach should be simultaneously focused on the internal organization, while being, acutely aware of the local and broader external environment, and be able to transcend current structures and individuals. Individuals (and decisions and plans) at various levels may be parts of different offices, schools, departments, levels, etc.

The table below describes the more common organizational entities found within academic medical centers. At each organizational level (row), plans are formulated for that level and below, but usually in the context of plans at higher levels. In some cases, the linkage between the plans is explicit, in others, it is not. It is recommended that planning efforts fully involve the faculty and staff within the scope of the organization level, and suggested that the leaders or constituencies in the rightmost column be involved to some extent.
<table>
<thead>
<tr>
<th>Organization Level</th>
<th>Key Planning Leader(s)</th>
<th>Typical Scope</th>
<th>Key “External” Planning Relationships</th>
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<tbody>
<tr>
<td>Program</td>
<td>Program director</td>
<td>Single program</td>
<td>Chair(s) or center director(s)</td>
</tr>
<tr>
<td>Department center, institute</td>
<td>Chair/director, faculty</td>
<td>Programs and scope, recruitment, space</td>
<td>Dean’s office; hospital, practice plan (for clinical departments)</td>
</tr>
<tr>
<td>Practice plan</td>
<td>CEO, dean, clinical chairs</td>
<td>Clinical services and sites, faculty, facilities, equipment</td>
<td>Patients, hospital, payors, community clinicians</td>
</tr>
<tr>
<td>School/college</td>
<td>Dean, chairs</td>
<td>Mission-area programs, faculty, students, facilities</td>
<td>University, practice plan, hospital</td>
</tr>
<tr>
<td>Hospital (owned or contracted)</td>
<td>Hospital and university CEO, trustees</td>
<td>Services and sites, level of care, teaching facilities, shared equipment</td>
<td>Medical school, practice plan, community, physicians clinical partners, community</td>
</tr>
<tr>
<td>University unit (e.g., AHCs)</td>
<td>Provost, vice chancellor, deans</td>
<td>All AHC colleges and clinical practices, facilities</td>
<td>Community, all stakeholders</td>
</tr>
<tr>
<td>University (public or private)</td>
<td>Chancellor/President, Provost, Trustees/Regents State Officials (e.g., governor, legislators)</td>
<td>All programs, faculty, and facilities</td>
<td>Community, all stakeholders</td>
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**David H. Browdy**  
Associate Dean, Strategic Planning and Management  
Northwestern University Feinberg School of Medicine  
420 East Superior, 12th floor  
Chicago, IL 60611-3008  
Phone: 312-503-0584  
dbrowdy@northwestern.edu

**Thomas B. Higerd, Ph.D.**  
Associate Provost  
Medical University of South Carolina  
College of Medicine  
179 Ashley Ave.  
Colcock Hall  
Charleston, SC 29425  
Phone: 843-792-4333  
higerdtb@musc.edu
Strategic Planning in Academic Medicine

“Strategic planning” is a term that is often misunderstood and incorrectly applied to a wide variety of planning activities. To create an effective strategic plan, it is important to clearly understand the essential elements of strategic planning and the management of a strategic planning process.

Strategic plans, and strategic planning, distinguish themselves from other planning activities by virtue of their focus on articulating specific future goals or desired outcomes and developing plans of action designed to achieve those goals. While a strategic plan is the formal documentation of a strategy, strategic planning is the specific process used to create the strategic plan. Both are essential and equally important.

At its core, strategic planning is a leadership function that benefits anyone in a leadership position. However, to be effective, strategy cannot stand alone or apart from operations. If strategy defines the desired future states and the means to that end, “operations” defines, allocates, and manages the necessary resources.

The essential elements of an effective strategic plan include:

Leadership
If the impetus for strategic planning comes from the top and the organization’s leader is prepared to visibly and consistently commit the organization to a strategic process, a strategic plan is likely to succeed.

Process Design and Management
To produce a plan that will be effective in guiding an organization’s strategic investments, the planning process must be well designed, effectively managed, and include:

- Environmental assessment – a systematic evaluation of the organization and the environment in which it functions.
- Vision, mission, goals – clear and succinct statements of the organization’s purpose and desired future states.
- Success measures – key measures that collectively define “success” for each goal.
- Strategies, tactics, and priorities – key new activities needed to achieve success prioritized to guide implementation over time.
- Resource estimates and forecasts – the estimated capital, one-time and ongoing resources required for implementing each strategy.

Through stakeholder interviews, constituent surveys, and broadly inclusive planning teams, the strategic planning process provides an opportunity to engage the community in developing the plan while creating a sense of ownership and advocacy in the process.

Organizational Integration
To be effective, strategy cannot stand alone or apart from operations. The design and management of an effective strategic planning process must achieve organizational integration through linking, coordinating and assignment.

- Linking to annual forecasts and budgets – Strategic plans involve change, and change often requires the investment of resources. To succeed, the strategic planning process must include the means by
which its resource estimates and priorities become part of the institution’s long-range resource forecasts and annual budgets.

- **Coordinating** with related organization(s) – Few organizational units stand entirely on their own. To succeed, the strategic planning process must anticipate and involve participants from other affected units and must communicate regularly across the organization.

- **Assignment** of ownership and accountability – The organization’s management must, in the end, embrace assignment of ownership and accountability. To succeed, the strategic plan and the organization’s leadership must clearly assign and communicate organizational and individual responsibility for the successful execution and implementation of each goal and strategy.

**David O’Brien, M.H.A.**
Director, Office of Institutional Planning
Stanford University School of Medicine
Building 110, Room 2
555 Middlefield Road
Menlo Park, CA 94306
Phone: 650-868-8064
dob@stanford.edu
Master Planning

Introduction

Facilities and space planning go hand-in-hand in defining a university’s long- and short-range capital development and enhancement needs. Master planning strives to guide campus development along predetermined leadership goals that give long-range physical form to the institution’s mission and vision and provide effective use of human, environmental, and financial resources. Space planning processes address realignment of space and spacial relationships (adjacencies), as well as the physical alignment of resources for current and future growth of the clinical, research, and education missions.

Many academic planners have some level of responsibility for space ranging from the actual assignment of space to projections of future requirements to how and where new facilities will be developed. Planners typically employ standards and benchmarks within this process, but it is often just as important to understand the internal political dynamics, programmatic priorities, and what drives the decision-making process. An overview of these responsibilities is provided below and separated into three general categories: master planning, space planning, and space management.

Master Planning

INTRODUCTION: The master plan is a physical expression of an institution’s long-range mission and goals for growth; typically, it is one part of a larger institutional strategic plan that delineates the following: 1) facility’s mission, 2) planning horizon, 3) study area or scope, and 4) facility’s planning goals. The master plan is a set of physical development plans for a site containing more than one building. Master plans analyze and document overall multiple building designs, their interrelationships, and site requirements.

The master plan should reflect thorough planning by: establishing a comprehensive and coordinated approach to physical development at the site, fit within the context of the larger organizational entity; ensuring regulated growth and land use, permit flexibility of use; and providing for future expansion to meet long-range program goals without disrupting the efficiency of the plan or adversely affecting the environment.

PROCESS AND STRUCTURE:

The process should address the following component:

> Land area
> Academic, research, clinical or other programs
> Relevant support services
> Leadership approval stages and tiers
> Extent of participants – executive leadership, management, user stakeholders, facilities, expert consultants
> Schedule
> Organizational structure

Typically, the size of any of these elements will define the complexity of this process and its duration. The master plan will typically incorporate needs analysis, site analysis, and planning, and ultimately the development of the plan.
Creating a structure to guide the process is critical. One should establish a steering committee and appropriate subcommittees; the steering committee is responsible for driving the process, identifying key priorities, guiding principles, and communicating the mission of the master plan with all stakeholders. This committee is comprised of people who are able to represent the key constituencies, and can lead and resolve the decision making process.

The roots of the structure are comprised of the key constituents, while the top of the structure will include executive administration and the board. A consultant leader (master plan architect) will report to this core team and is responsible for managing the experts required. Lawyers, financial advisors, and real estate experts may have direct access to the core team.

The organization chart for this structure depends on the breadth and scope of work to be accomplished; typically, the work will be subdivided into committees or groups with a recognized leader to manage and resolve the work assigned.

See: Appendix B – Master Facilities Planning

Sean Ossont
Associate Vice President, Strategic Planning
University of Rochester School of Medicine and Dentistry
601 Elmwood Avenue, Box 706
Rochester, NY 14642
United States of America
Phone: 585-275-5658
sean_ossont@urmc.rochester.edu

Mary I. Ockenden
Associate Vice President, Space Planning
University of Rochester School of Medicine and Dentistry
601 Elmwood Avenue, Box 706
Rochester, NY 14642
Phone: 585-275-7832
mary_ockenden@urmc.rochester.edu
Space Planning: Clinical, Research, Education

BACKGROUND

Responsibility for planning the creation of physical space to support an organization’s programs varies among institutions. The scope may include all, or only segments, of the following elements: clinical space (inpatient, outpatient, and support services), research space (wet, dry, human subject, and clinical trials), educational (lecture halls, libraries, computer labs, simulation labs, etc.), along with typical administrative space requirements.

Thoughtful planning is necessary to ensure an appropriate environment for the function. It is essential to understand the relationship of a space request to the institution’s strategic plan, campus master plan, and vision of the organization to ensure a successful outcome. Anticipating not only the requirements of the current request, but how it relates to the anticipated growth or contraction of the organization’s programs, may drive the final space solution.

Most institutions have planning and design professionals on staff (architects, engineers, etc.) or have access to them as consultants to help develop, design, and construct these spaces. Working with these professionals as initial discussions and concepts are being developed, will help establish a clear program and design direction in order to avoid future complications and project delays.

PLANNING PROCESS

The initial steps in the development process are critical to the success of the project. First, a needs assessment is produced, which at a minimum should describe the problem to be solved, existing physical conditions, and the stakeholders involved in the project. Once the needs assessment is produced and approved by the appropriate leadership, stakeholder representatives are identified and recruited along with key support teams (IT, physical plant, etc.) to develop the project. This group works with the planner and design professionals to create a plan that will describe the project scope, baseline assumptions, programmatic and adjacency requirements, site, timeline, and estimated cost. Guiding principles should be developed to help keep participants focused and help reduce scope creep.

This plan defines the gross order of cost magnitude of a project, along with the project priorities (what is “in” or “out” of the project). The smooth implementation and overall success of a project will be directly related to the level of definition and consensus that can be developed at this stage. After the plan is approved, the project will proceed through the formal programming, design, and construction phases, with ongoing refinement of the budget estimate. Please refer to the representation of the typical components of a planning process and key terminology on the next page.
Each mission area of the institution has unique attributes that should be considered during this process. Some items of consideration are identified below:

**Clinical:**

- The major program components should be identified, including patient demographics, patient volumes, and support service requirements. Determining program adjacency requirements will assist in establishing space and location options.
- A market analysis including provider supply and patient demand for services will help determine feasibility, size, and location of the new program.
- Documenting patient access and the flow of patients through the site will help determine the appropriate location and size of the program.

**Research:**

- The type of research (wet, dry, animal, human subject, or clinical) will impact the choice of location and level of security required to operate the program.
- The potential use of animals, along with certain types of chemicals or select agents, may restrict physical placement of the program and overall size of the space.
- Determine the need for access to research core facilities, e.g. imaging, histology, proteomics—location and frequency of use, cost, other requirements.
- Scientific equipment should be identified early in the process to clarify mechanical and electrical requirements, along with vibration standards, height, and weight restrictions.

**Education:**

- The instructional curriculum must be considered with regard to specific space needs and requirements (small groups, lecture halls, class laboratories, computer labs, etc.).
- Use of electronic learning resources must be considered to determine IT/AV needs, networking (wired/wireless) requirements, and support, etc.
- Specific types of instructional spaces and special needs should be identified early on because they will affect space design and infrastructure requirements. This would include gross anatomy labs, simulation labs, standardized patient areas, traditional and electronic library needs, and others.
- Requirements for support areas such as conference facilities, student study areas, informal interaction space, food service, vending, changing rooms, etc., should be identified early on.

Planners new to this area must be aware that the terms used to describe space and budgets are not interchangeable. Square footage is calculated with different methodologies, depending on the purpose, which can create confusion. Always be cognizant of whether you are discussing gross versus net versus assignable versus leasable square footage. Costs are also calculated using different methods, and definitions will differ by institution. While the term “construction cost” has a common definition, what is included within the “total project cost” will vary and may include financing costs, legal fees, and internal cross-charges along with other typical expenses such as design and engineering fees and furniture.

Cost estimates are also developed sequentially as the project progresses. Therefore, it is important to keep critical parties informed of any changes to avoid the project being derailed due to financial concerns. Keep the appropriate parties informed of the evolution of the project budget and the causes of any significant escalations as development progresses.
Clinical

**Lynette S. Sebohm**
Assistant Vice President, Planning
Office of the Senior Vice President for Health Sciences
University of Utah Health Sciences Center
175 North Medical Drive, East
5th Floor Moran
Salt Lake City, UT 84132
Phone: 801-587-3488
[Lynette.sebohm@hsc.utah.edu](mailto:Lynette.sebohm@hsc.utah.edu)

Research

**Donna K. Gissen**
Assistant Vice President of Health Affairs, Facilities Planning and Management
University of Louisville Health Sciences Center
Abell Administration Center
323 East Chestnut Street
Louisville, KY 40292
Phone: 502-852-5184
[Donna.gissen@louisville.edu](mailto:Donna.gissen@louisville.edu)

Education

**Horace I. Bomar**
Director, Facilities Management and Planning
University of Michigan Medical School
1150 West Medical Center Drive
1590 MSRB II
Ann Arbor, MI 48109-5670
Phone: 734-647-2788
[hofo@umich.edu](mailto:hofo@umich.edu)
Space Management/General Facilities Information

Space management is generally regarded as the application of a set of guidelines, policies, or rules used to guide decision making as it applies to adding or reassigning existing inventory. For the purpose of this discussion, the acquisition of new space by construction is excluded. To arrive at these guidelines and policies, it is important to assign a valuation to space, treating it as any other commodity. One way to look at valuing space is to assign it a value based on its “highest and best use.” This means looking at the space in terms of quality, location, physical attributes, and potential for serving a programmatic need. For example, space with sophisticated technology infrastructure is best reserved for clinical or research programs, while basic office space is usually not worth the cost of converting to higher technology uses.

Space Requests

When projecting or responding to space demands, the first step is to confirm the request on the demand side of the equation. A typical mechanism is an online request form that asks basic questions regarding the need by category (typically, clinical, academic, teaching, or subsets of these), number of people, and type of work space needed. The requests are vetted by the appropriate person or committee for further consideration. The next step is the further development of the request. The Program Planning Guide listed below identifies the typical information needed to complete the evaluation. Various formats can be used; it is important to obtain as much information as possible to make a comprehensive review and recommendation.

The intent is to match the request (from department, institute, core resource, or individual, to name a few), with the goals and objectives of the institution. It is also important to confirm the institutional commitment to the requesting program. The second step is to review the options available to meet that demand.

Space management options consist of 1) renovation of existing space, 2) lease or purchase, and 3) assignment of vacant space.

Renovation of existing space requires the application of criteria for determining the most appropriate solution. Renovating space is preferred from a cost perspective if the original use of the space is not changed. For example, refurbishing an office space for a new office function, or renovating outdated laboratory space for a new laboratory function. It is typically not cost effective to renovate office space into lab space, or lab space into office space, unless a ROI can be established for the renovation.

Most institutions employ lease and purchase options to help manage space needs. The lease or purchase scenarios are driven by several factors. Among them are 1) long-term vs. short-term objectives; 2) available capital; 3) the need for revenue streams (i.e., rental income from a purchased building); and potential cost savings based on tax status, lease terms, and the cost of borrowing. One advantage of leasing office or other light duty space is the flexibility of lease terms. It typically enables departments to expand or contract over a period of 2-5 years without incurring large capital costs. It also allows departments to adjust locations for various operations. For example, as space on the main campus gets scarcer, non-clinical administrative programs may be shifted to off-campus lease space to allow for expanding programs requiring direct proximity to clinical services.
Some Pros and Cons of Leasing

<table>
<thead>
<tr>
<th>Pros</th>
<th>Cons</th>
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<tbody>
<tr>
<td>Potential to borrow capital from landlord</td>
<td>May lose tax advantages</td>
</tr>
<tr>
<td>Capital freed up for program costs</td>
<td>Long-term commitment to future rate increases</td>
</tr>
<tr>
<td>More flexible location options</td>
<td>Long-range budgeting difficult</td>
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Tracking Space Usage

The most effective tracking systems are user friendly, and either Web based or those using geographic interface databases that are easily downloadable. Common systems allow either the user or the space manager to update records periodically and after renovations. These systems can also track some operating costs such as rent and basic utilities if tied into a plant operations office. Tracking productivity is a separate issue. Some institutions use research dollars or indirect cost recovery to track productivity by investigator, department, or institute. Award and publication data may also be used to track productivity, but there is some controversy as to the efficacy and fairness of that data.

Politics of Space

Space management issues in an academic medical center, as in any large complex organization, are subject to politicizing when forming and enforcing policies. In addition to being a vital resource for accomplishing the multiple missions of the institution, space is also an expression of status, hierarchy, and ego. The most reasonable course to take when dealing with those conditions is to rely on objective data and invoke a fairness doctrine through a defined space policy. Most department leaders do not want to be viewed as possessing unproductive space. Most department leaders are responsive to the notion that a fair-minded organization is beneficial to them as well.

Program Planning Guide Outline

This document is to be used for the submission of departmental proposals to accomplish any combination of increasing assigned space, relocating functions, or renovating space.

1. Description of program
   a. Describe the current program in terms of its clinical, research, academic, or combined missions. Explain its relationship to other relevant health sciences programs. Describe the functional components of the program. For example, a program may consist of investigators, clinical coordinators, academic administrators, and support staff.
   b. List the number of FTEs associated with the program.
   c. Describe the current location in terms of the number and type of rooms currently assigned.

2. Problem statement
   a. Describe the factors or conditions leading to the conclusion that a space or renovation request is necessary. Some typical factors include space obsolescence; additional grant funding requiring space to hire more faculty/staff; additional equipment; expansion of clinical programs; and requirements for new adjacencies with other programs, to name a few.
   b. Explain the impact if the request for space/renovation is denied.
c. Describe alternatives you have considered that would not result in a space assignment/renovation request.

3. Proposed solution
   a. Describe solutions based on your existing knowledge of potential reassignment/renovation options.

4. Request sign-off by appropriate director/department chair/authority

5. Space planning and management review
   a. Review proposal for compliance with health sciences initiatives in strategic, business, and master planning.
   b. Review proposed solution.
   c. Revise or prepare new recommendation.

6. Dean’s office (or equivalent) approval to proceed with planning

7. Space planning and management
   a. Develop detailed description of project.
   b. Need for consultants.
   c. Preliminary estimates.
   d. Detailed plans (if applicable).

Steve Panish
Assistant Vice President
University of Utah School of Medicine
175 North Medical Drive East
John A. Moran Eye Center
Salt Lake City, UT 84132-2101
Phone: 801-585-2643
steve.panish@hsc.utah.edu
Why We Love Working in Academic Medicine
(Submitted by the Group on Institutional Planning Steering Committee, 2009-2010)

#12. Because your boss tells us with a straight face, “I’d rather do an autopsy than your job.”

#11. You appreciate that the parking manager keeps you off the top of the most hated list.

#10. Because it’s nice to work on issues where no emotion or politics cloud the strictly analytical decision-making process.

#9. You have a chance to find and deal with abandoned medical records, leftover chemicals, and unlabelled objects in cold rooms.

#8. You have an opportunity to work with laid-back, easy-going people without a care in the world.

#7. Because this work makes a future as a Wal-Mart greeter look better and better.

#6. Because it gives you a chance to see how threats and intimidation are still a part of everyday life.

#5. Because you will reach a state of mind in which air traffic controller in D.C. Center may not be challenging enough to hold your interest.

#4. Because you may reach a point at which the dean will express appreciation by telling you that your job is impossible.

#3. Because proper performance of your job will give you a chance to apply your hostage negotiation training.

#2. Because when someone says, “I don’t know how you do it,” you can honestly answer, “Neither do I.”

And number one………

You have a chance to work with hundreds of people who can prescribe medication.
Appendix A – About the Group on Institutional Planning and the AAMC

About the GIP
The AAMC’s Group on Institutional Planning (GIP) is committed to advancing the practice of planning in academic medicine and to be the foremost professional resource for planners in advancing academic medicine. GIP members work in medical schools, teaching hospitals, academic health science centers, and related organizations in the different areas of planning: strategic, academic, clinical services and marketing, facilities, space, information systems, and resource allocation, among others. GIP members’ responsibilities span the entire process of planning. This multi-faceted discipline includes research and data gathering about external and internal environments, analysis and synthesis in searching for insights into problems and opportunities, process facilitation, and evaluation of both process and results. The primary purposes of the GIP are to:

• Enhance the planning skills and knowledge base of its members;
• Establish an active network of communication among its members to disseminate creative ideas and learning experiences;
• Serve as a planning resource to AAMC member institutions;
• Encourage members to contribute to the fundamental body of knowledge about planning theory and applications.

About the AAMC
The AAMC represents all 132 accredited U.S. and 17 accredited Canadian medical schools; approximately 400 major teaching hospitals and health systems, including 68 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 125,000 faculty members, 75,000 medical students, and 106,000 resident physicians.

Through its many programs and services, the AAMC strengthens the world's most advanced medical care by supporting the entire spectrum of education, research, and patient care activities conducted by our member institutions. The AAMC and our members are dedicated to the communities we serve and steadfast in our desire to earn and keep the public's trust for the role we play in improving the nation's health.

The AAMC is guided by nine strategic priorities
1. Serve as the voice and advocate for academic medicine on medical education, research, and health care
2. Lead innovation along the continuum of medical education to meet the health needs of the public.
3. Facilitate development of a health system that meets the needs of all for access, safety, and quality of care.
4. Strengthen the national commitment to discovery that promotes health and enhances the treatment of disease and disability.
5. Lead efforts to increase diversity in medicine.
6. Be a valued and reliable resource for data, information, and services.
7. Help our members identify, implement, and sustain organizational performance improvement.
8. Provide outstanding leadership and professional development to meet the most critical needs of our members.
9. Nurture a culture at the AAMC that promotes excellence in service to our members and the public good.

For more information about the GIP and the AAMC, please contact:

**Heather Sacks**  
Director, Planning & Administrative Affairs  
GIP Executive Secretary  
[hsacks@aamc.org](mailto:hsacks@aamc.org)  
202-862-6220.
Appendix B – Supplement to Master Facilities Planning Summary

Master Planning Considerations:

- Land use
- Program distribution
- Building size and locations
- Vehicular circulation
- Pedestrian circulation
- Parking
- Support services
- Utility size and locations
- Landscaping
- Environmental impact
- Phasing
- Future expansion

General Master Plan Requirements

Master plans should address each of the following areas and provide viable solutions for any deficiencies or conflicts that may be identified:

- **Program requirements** – Establish planning premises and master plan goals and objectives. Define the specific concepts and standards for future development including institutional standards for design and construction.
- **Region and location** – Describe the regional setting in terms of existing and future land use patterns, transportation systems, utility services, population, economy, and cultural assets. Also indicate current land use and zoning of adjacent areas.
- **Boundary and topographic data** – Include existing and proposed surveys as appropriate.
- **Proposed site utilization** – Show the areas allocated to each function and proposed general use.
- **Improvements** – Show existing and proposed structures and other improvements, such as roads, parking areas, heliports, refuse handling areas, etc.
- **Circulation** – Indicate internal road network, access points, parking facilities, pedestrian and bicycle movement systems, public transportation, and service access flow. Evaluate traffic impacts of proposed development and propose transportation management strategies to minimize impacts. Material flow should also be delineated (e.g., deliveries and trash disposition) as appropriate.
- **Landscaping** – Indicate general concepts for open space and green areas, and the location and extent of existing and proposed landscaping.
- **Fire, life safety, and accessibility** – Proposed building site location should consider fire protection and safety. Factors for consideration include, but are not limited to, combustibility, occupancy and attendant hazards, proximity of fire fighting resources, ease of access, climate, and topography. Special consideration should be given to the safety and accessibility of facilities for occupants as well as visitors.
- **Utilities** – Show all utilities including solid and hazardous waste handling and disposal plans. Indicate proposed utility upgrades and new utilities necessary to support proposed development. It is preferable that utilities be located underground where practicable. Also, where possible, utility distribution systems should be located to facilitate ease of access and future land use. Utility capacity in excess of five years should be evaluated on a life-cycle cost basis.
Existing resources – Determine the major natural and artificial elements that affect potential development, such as the physical features of the site, climate, environmental features, utilities, historic/archaeological features, natural amenities and visual quality, constraints, and opportunities.

Development plan – Illustrate the proposed development of the site over the next 20 years, including the disposition of existing buildings, the infrastructure, new construction, and other improvements.

Energy conservation – Establish energy conservation strategies and policies as they relate to siting and design of buildings, transportation practices, and renewable energy resources.

Site development standards – Present specific site element recommendations such as building density, bulk guidelines, and setbacks.

Implementation – Illustrate phasing strategies for implementing the master plan over the next 20 years.

External consideration – State, local, and municipal requirements, including:
- Zoning
- Neighborhood – community input (focus groups)
- Environmental Impacts – plan impact on the environment, geography, geology, natural resources, historic properties
- Impact on municipal services.

Interrelationship – Describe the relationship of the master plan to other institutional campuses and/or programs including other on-site and off-site real estate.

Master Planning Process and Structure

Needs analysis
- Space planning – global space projections by type using rational metrics based on the institutional growth financial plan deducting existing space by type to calculate surplus or deficit of space type.
- Condition assessment – evaluate the condition and functionality of existing space targeted by the long-range plan, consider changes in care models and technology.
- Evaluate and project needs for support including building services, infrastructure, parking, and circulation.

Site analysis and planning
- Analyze existing site and facilities.
- Establish basis of study, including topography, boundaries, land use, circulation, and utilities corridors.
- Identify assets, including views, orientation, access, and open space.
- Identify problems, including circulation, existing facilities, circulation conflicts, municipal regulations, environmental, and community.
- Determine opportunities based on needs and long-range plan implications.
- Identify building sites or existing facilities to meet expansion requirements.

Develop the plan
- Identify general planning concepts and alternatives to meet the requirements of the institution.
- Select a general direction for plan development.
- Develop detail planning solutions to meet the requirements of the long-range plan.
- Provide an outline of priorities and needs.
- Develop a sequencing for implementation.
- Identify each capital project, including quantity of program provided, size and scope of work requirement, and cost.
Master Planning Experts and Resources

- Master planner
- Architect
- Civil engineer
- Building services engineers (mechanical, electrical, plumbing, fire protection)
- Landscape architect
- Real Estate attorney
- Tax attorney
- Real estate advisors
- Financial advisors

Submittals

Normally, master plans are developed under contract and involve three stages or more, as described below:

- **Preliminary:** This is the initial stage and generally contains single-line sketches and several alternatives. Also includes preliminary environmental documentation. The approval of this stage by the government review office entails selection of the preferred alternative and, therefore, requires sufficient documentation to support selection.

- **Intermediate:** Generally submitted at the midpoint of planning development to the government review office and includes work on all disciplines included in the final master plan.

- **Final master plan reports:** A final master plan report is prepared upon completion of all component plans. The report can be submitted under separate cover or combined with other data (estimates, charts, etc.) under one cover. Also include the agency’s environmental determination, consisting of a determination of categorical exclusion, or a finding of no significant impact resulting from an environmental assessment, or the executive summary of an environmental impact statement. Master plans normally require, at minimum, the preparation of an environmental assessment.

Master Plan Report Content

1.0 Executive summary

2.0 Introduction
   - 2.1. Background and purpose
   - 2.2. Mission and goals
   - 2.3. Strategic plan
   - 2.4. Institutional needs (medical/teaching/research)
   - 2.5. Participants

3.0 Master plan
   - 3.1. Existing facilities
     - 3.1.1. Development objectives
     - 3.1.2. Program
     - 3.1.3. Existing conditions, including site and facilities
     - 3.1.4. Standards for development
   - 3.2. Existing site
3.2.1. Site conditions
3.2.2. Property
3.2.3. Road network
3.2.4. Neighborhood adjacencies

3.3. Master plan concept
3.3.1. Planning and design concept
3.3.2. Final plan
  3.3.2.1. Site
  3.3.2.2. Buildings
  3.3.2.3. Use
  3.3.2.4. Access
  3.3.2.5. Circulation
  3.3.2.6. Open space
  3.3.2.7. Connections
3.3.3. Phasing
3.3.4. Project descriptions
3.3.5. Environment
3.3.6. Municipal approvals

4.0 Appendix