

Faculty Senate Meeting Minutes

September 13, 2011

- I. **Welcome:** The meeting was called to order at 4:35 PM by Senate President Ron Gill, Ph.D. Dr. Gill welcomed all Senators to the new academic year, and he encouraged Senators to notify him about important issues and priorities and to help him plan the 2011-2012 Senate agenda. Dr. Gill emphasized the importance of hearing regular updates from the Faculty Assembly and the SOM Curriculum Steering Committee. Dr. Gill also introduced Adam Goldstein, representing the *Aurora Sentinel*, and Erika Matich from UCH Media Relations.
- II. **Approval of the minutes:** The minutes of the June 14, 2011 meeting were approved.
- III. **Dean's Comments:**
 - a. The search for the new chair of Emergency Medicine is nearing a conclusion. Dean Krugman is having ongoing conversations with finalist Richard Zane, MD, of Brigham and Women's Hospital in Boston. Dean Krugman noted that he will be meeting with Dr. Zane later in the week in Boston.
 - b. The search for a chair of Surgery is also progressing well. The search committee forwarded three names to Dean Krugman; one of the candidates has withdrawn, leaving two current finalists, Drs. Richard Schulick and David Fullerton.
 - c. Dean Krugman reminded Senators that the University of Colorado Hospital and Poudre Valley Health System have signed a letter of intent to explore developing a joint operating agreement. A leadership team representing the School of Medicine and Denver Health is also meeting regularly, in an effort to explore new opportunities to promote quality in education and patient care, and to better manage the affiliation between the two institutions. Similar productive discussions are ongoing with National Jewish Health. There have not been any significant changes with respect to the timetable for relocation of the VA Medical Center to the Anschutz Medical Campus. Finally, the School of Medicine and University of Colorado Hospital are continuing to plan important new initiatives in patient safety and quality of care; the Dean will provide updates to the Senate on a regular basis.
 - d. The day following the Senate meeting, Children's Hospital Colorado was expected to announce publically that Dr. Timothy Crombleholme has been appointed as the Surgeon-in Chief at Children's Hospital Colorado and as Director of the Center for Children's Surgery at the School of Medicine.

IV. **Updates**

- a. Dr. Robert Evans, chair of the Professionalism First Faculty Review Committee, provided an update of the work of the committee and the reports received to date. Dr. Evans reviewed the history and purpose of the Professionalism First program. He also reviewed the process that has been established, including: a) the use of the third-party, offsite EthicsPoint reporting system, which ensures confidentiality or complete anonymity for the student or resident filing a report; b) the handling of reports, whether referring to exemplary behavior or lapses in professionalism; c) how reports are triaged (for example, reports of exemplary or unprofessional behaviors by residents or fellows are forwarded immediately to a separate, parallel GME committee); d) efforts that are being taken to ensure that the reports are not erroneous and are not duplicates; and e) the extensive efforts made thus far to publicize the Professionalism First campaign and the new reporting mechanism. Dr. Evans and discussants emphasized that the EthicsPoint reporting site is meant to complement, not replace, existing reporting mechanisms that are available to students, which include the regular course evaluations and feedback that can be provided at any time to course and block directors. Equally important, a primary purpose of the new reporting system is to ensure that faculty members receive feedback, when lapses in professionalism occur. In the first 12 weeks of the program, the committee has received 7 reports (2 from medical students and 5 from residents). Of these, 4 reports involved SOM faculty members; 2 were reports of exemplary behavior, 2 reports were about unprofessional behavior. There were 3 reports involving residents or fellows (1 report of exemplary behavior and 2 reports of unprofessional behavior). Dr. Evans pointed out that these small numbers may accurately reflect the true incidence of this conduct, as seen by medical students; alternatively, the small numbers may reflect continued lack of awareness of the Professionalism First reporting mechanism or lack of trust and confidence in the anonymity of the reporting process.
- b. Dr. Donald Eckhoff discussed the importance of strengthening connections between the School of Medicine physician faculty and the American Medical Association (AMA). He pointed out that, in recent years, the AMA has taken action in a number of areas that affect academic medicine and medical education, including professionalism, industry conflicts-of-interest, medical student abuse, provider and safety net reimbursement, and other areas of advocacy. Despite the size and political clout of the AMA, overall only 25% of practicing physicians are current members.

- c. Dr. Lowenstein presented an update of the of the SOM's revised Conflict of Interest Policy. In May, 2011 the Senate approved a revision to the policy that prohibits faculty members from participating on speakers' bureaus. "Speakers' Bureau Activities" are defined in the new policy as *compensation by any pharmaceutical company, medical device manufacturer or manufacturer of other health- or nutrition-related products, or their subsidiaries, for speaking engagements whether on a one-time or recurring basis.* Dr. Lowenstein also reviewed the exceptions to the policy, which are carefully written to permit only speaking engagements that are educational in purpose and content, not promotional. Faculty members seeking to engage in an industry-paid speaking engagement must submit an application, along with the contract from industry, to a faculty review committee. Talks are not approved if: a) the talk focuses on specific drugs or products; b) the speaker is required to use any slides or other instructional materials provided by industry; or c) the slides or other content are subject to oversight or approval by industry. Dr. Lowenstein presented several examples of talks that could not be approved by the committee, because the language of the contract ceded control over content to the company. Working with Rob Shikiar, counsel to UPI, the committee has developed substitute, "model" language to ensure that "the speaker reserves the right to modify any slides or presentation materials provided by [company], based on the speaker's independent scientific judgment without the company's prior approval."

In the first 12 weeks, the COI review committee has received 27 applications for speaking engagement approval. Of these, 17 (63%) have been approved. Information about the COI policy, detailed instructions and the link to the application may be found on the Office of Faculty Affairs web site at www.medschool.ucdenver.edu/faculty. Click on "Rules and Policies" for all the relevant information. Questions and applications for approval of speaking engagements can be sent to som.facultytalks@ucdenver.edu. Dr. Lowenstein ended by expressing appreciation to the members of the review committee (Drs. Ches Thompson, Ron Gill, Rob Low and Jeff Wagener) and to Mr. Rob Shikiar and Ms. Cheryl Welch; all have contributed hours and hours to reviewing applications and to developing principles and policies to ensure that the intent of the COI policy is realized.

Minutes of the Faculty Senate of the University of Colorado School of Medicine

October 11, 2011

- I. **Welcome:** The meeting was convened by President Ron Gill, Ph.D at 4:33 PM. Dr. Gill asked those present at the meeting who were guests and/or members of the media to introduce themselves. A staff member of the University of Colorado Hospital e-newsletter UCH Insider was present. Other guests included Dr. David Thompson, President of the Faculty Assembly and Dr. Carol Rumack, Associate Dean of Medical Education, each of whom presented at the meeting.
- II. **Approval of the Minutes:** The minutes of the September 13, 2011 meeting were unanimously approved. There were no comments or corrections.
- III. **Dean's Comments:**
 - a. As Dean Krugman was absent, Dr. Steven Lowenstein, Associate Dean for Faculty Affairs, presented information regarding current chair searches and updates on our affiliate institutions.
 - The search for the Chair of the Department of Emergency Medicine is close to an end; the leading candidate is Dr. Richard Zane, currently at Brigham and Women's Hospital. This search is expected to be finalized within a month or so.
 - The search for the Chair of the Department of Surgery is nearing completion. There were three leading candidates; the finalist is Dr. Richard Schulick, Professor of Surgery and Oncology at Johns Hopkins.
 - The search for the head of the School of Public Health is being conducted in the Provost's Office.
 - b. Dr. Lowenstein provided updates regarding Affiliation Agreements of the SOM.
 - There are ongoing discussions with National Jewish Hospital, though there is no current, active agreement with NJH.
 - There is ongoing negotiation between Poudre Valley Hospital and UCH. UCH is also in discussion with Memorial Hospital in Colorado Springs, this discussion includes a possible joint agreement between all three sites. Issues to be determined include leasing, management, partnership and oversight.
 - c. Dr. Lowenstein invited Dan Meyers, Director of the Communications Office of the School of Medicine, to speak about the CU Medical School online magazine *CU Medicine Today*. Mr. Meyers requested ideas for the next edition of the magazine. He reported that the magazine had a readership of 200 several years ago and now has on-line readership of 22,000, with 11,000 copies of the magazine being printed each edition. Stories could include features as well as profiles. Mr. Meyers can be reached at Dan.Meyers@ucdenver.edu.
 - d. President Gill asked about the future plans of NJH and if there was a ten year plan for NJH to move to the Anschutz Medical Campus. Dr. Lowenstein replied that discussions were ongoing, but that he had no details. Dan Meyers

added that this would be complicated, for example how UPI would fit in, but he had nothing new to add.

IV. **Discussion Items:**

- A. **GME Annual Report:** Dr. Carol Rumack, Associate Dean for Graduate Medical Education, presented her annual report, which she had recently presented to the Executive Committee of the School of Medicine. This report will also be presented to the hospitals. The full report was sent to Senators via email prior to the meeting, and Dr. Rumack presented a shortened version today. Dr. Rumack reviewed that as the Associate Dean for Medical Education she is the Designated Institutional Official (DIO) for Graduate Medical Education issues, including problems with duty hours and other issues. Her role is to ensure that the GME programs on campus are in compliance with GME rules and regulations. She reviewed that there were 969 residents and fellows in 2010 - 2011, and that the majority of these were residents (680). Her office has been planning for the new duty hour requirements (interns have 16 hour days). Problems with compliance are being addressed.

For 2011 – 2012, there are 142 GME approved programs, 81 of which are ACGME accredited and 61 are not accredited by ACGME. Total enrollment continues to climb, though Dr. Rumack discussed that once a program is over its cap for residents, they do not get reimbursed for additional residents. Overall, the percentage of minorities (5-6% in GME programs) is not as high as in the CU SOM. This is expected to improve with a pipeline from the SOM, which has a higher percentage of minority students.

Seventy percent of GME residents/fellows are in primary care (Internal Medicine, Family Medicine and Pediatrics). Thirty percent are in specialties. Results of exit surveys of housestaff and fellows show improved satisfaction with their programs, improved marks regarding professionalism of attending physicians in their department, and improved satisfaction in professionalism by their programs, by nurses, and by other staff. Treatment of housestaff by patients was rated as less professional than in previous years.

Debt for students is rising. The average medical student in the US has a debt of 149K. One-third of residents go into academics, one-third into private practice, and one-third continue their training. In some cases, individuals have completed another fellowship as the job market becomes tighter. Sixty-five percent of primary care graduates and greater than fifty percent of non-primary care graduates stay in Colorado. The latter represents an increase from previous years.

Dr. Rumack's office has been planning for the new duty hour requirements for over a year, and these requirements were implemented three months ago. The goal is to balance service and education, both of which are now truncated. In September 2010 there was a CU duty hour retreat. Discussions included an overall communication plan and rounding. It was suggested that residents not

come in early to pre-round on patients, though it was acknowledged that they like to check in on their patients. One program that has been successful is the use of resident liaisons or clerks. This was implemented at Children's Hospital Colorado five years ago; Denver Health and UCH started this program this year. Clerks perform tasks which can be time-consuming for residents, such as scheduling appointments post-discharge. It was discussed that residents need a standard sign-out that is official and accurate in order to improve "telephone" problems.

Dr. Rumack discussed the involvement of faculty through required on-line modules such as the module on sleep deprivation, and the need for monitoring and adjusting of resident and intern schedules. There are several instances of duty hour violations, and these are being addressed. A goal is to decrease the emphasis on service over education for trainees.

Dr. Rumack closed by stating that the results of the site visit in June 2011 will be available in December, and that overall the site visit went well. In 2010 – 2011, there were 21 ACGME program site visits. Nine await Residency Review Committee status, 9 are accredited on a five-year cycle, 1 on a four-year cycle, and 2 on a three-year cycle. In 2010 – 2011, two new ACGME programs were added, and two closed voluntarily; three non-ACGME programs were added and two closed voluntarily. Fourteen programs conducted internal reviews. The question was asked whether this duty hour change will require a lengthening of residency programs. Dr. Rumack replied perhaps, and that options include using the last part of the fourth year of medical school to begin training. She added that after Match Day, some Surgery programs are training incoming surgeons, and in Pediatrics some medical students are starting earlier.

- B. **Faculty Assembly Overview:** David Thompson, Ph.D., presented an overview of the Faculty Assembly. Dr. Gill introduced Dr. Thompson by stating that this group handles important issues, and needs more representation from the School of Medicine. Dr. Thompson is an Associate Professor in the School of Pharmacy and is the Chair of the Faculty Assembly (FA). This group meets in the 7th floor boardroom of the Academic Office Building 1 (AO1-7000) from 11:30 AM – 1:30 PM on the last Tuesday of every month. Lunch is provided. The number of voting members of the FA is based on school size, and includes representatives of the schools of Nursing (2), Dental Medicine (2), Medicine (11), Pharmacy (2), Public Health (1), the graduate school (1), Denison library (1), and retired faculty (1). Chairs of each school's faculty senate are also voting members. The SOM, therefore, has twelve voting member slots. Non-voting members are the Chancellor, the Deans from each school, and an elected representative from the student council. Representatives of the FA must be at the level of instructor with more than two years' experience, or any rank higher instructor. Terms are for four years, and the selection process is determined by each school.

Faculty Assembly meeting agendas include the report of Provost Nairn, which

is an update on issues at AMC and the downtown campus; invited presentations; and the Chair's report, which consists of updates of Dr. Thompson's meetings with the Chancellor, Lilly Marks, and the Faculty Council. He meets with each of these individuals once per month. During the Faculty Assembly meetings, schools are asked to provide reports, and Dr. Thompson added that it is desirable to have more faculty representation from the schools in order to provide information regarding the schools. The duties of the FA are to provide a conduit to the Chancellor and University administration, especially Provost Nairn, regarding issues of broad interest to AMC faculty and Schools. Examples of issues considered by the FA include internal and external relations, educational policy, faculty responsibilities and privileges, and academic ethics. Recent issues that have been considered by the FA include formation of the Day Care Center on the AMC campus, tuition waivers (still being discussed – 9 credits), and AMC budgetary priorities (still being discussed).

In addition, the Faculty Assembly represents the AMC campus to the University by participating in the CU Faculty Council and its committees, and addressing policy matters related to interprofessional education, research, and service. The FA reviews and provides a forum for discussion and makes recommendations regarding University policies that affect AMC faculty, such as conflict resolution, promotion, tenure and benefits. The FA also helped establish a part-time ombudsman. They also make recommendations regarding AMC budgetary policies and priorities.

The Faculty Council is the executive body of the faculty assembly and makes recommendations to the president for submission to the Board of Regents related to educational policy, internal and external operations. Committees of the Faculty Council have greater than or equal to two representatives from each of the four campuses: Boulder, Colorado Springs, Denver, AMC. Multiple members of the SOM have been active on committees of the Faculty Council. A recent issue that was brought before the Faculty Council dealt with severance pay for tenured faculty dismissed for cause. Comment was made that it is important for the SOM to have adequate representation on Faculty Assembly in order for the School to have a voice in important issues that are discussed and decisions that are made throughout the University.

There was then discussion regarding the plan for SOM to fill its complement of Faculty Assembly representatives. Dr. Thompson commented that if the SOM was not able to provide a total of 11 representatives, then we should request that the number of SOM representatives be reduced to a more manageable number, such as 5 members. He also suggested that the meeting time could be changed to accommodate SOM members. Dr. Lowenstein stated that this is the second time that Dr. Thompson has come to the SOM Faculty Senate to make a plea, and that it is necessary to have support from the Dean's office to get this done so that the SOM can be properly represented. The Faculty Officers will discuss this issue at their next meeting, establishing a selection process to fill the open positions. Anyone interested in serving on the Faculty

Assembly should let one of the Faculty Officers know. The Dean offered to include a request for nominations of representatives in his next weekly email.

- C. ***Update on Promotion and Tenure Blue Ribbon Task Force.*** Nancy Zahniser, Ph.D. presented this update. Dr. Zahniser reminded the Senate that she and Harley Rotbart (co-chairs of the BRTF) had attended the June 2011 Faculty Senate meeting, and they had presented the initial update of the work of the task force at that time. The BRTF committee consisted of eighteen faculty members from both clinical and basic science departments. The task force recommended retaining the current definitions and types of scholarship using the Boyer definition and expanding the examples within each type. In addition, the following recommendations were made by the BRTF:

Education: further emphasize mentoring and leadership contributions.

Research: distinguish intellectual and financial independence for promotion to associate professor; better recognize “team science” contributions.

Clinical: clarify excellence in clinical effort and productivity; expand examples of scholarship; expand Senior Instructor Series for clinicians who opt not to do, or to document, scholarship.

The BRTF presented its recommendations to the Executive Committee of the SOM (EC) in July, and concern was raised regarding whether scholarship should be required of everyone in a professional track, despite the fact that the BRTF had voted 17 – 1 to retain the criteria for scholarship. Three options have been discussed since then, which include:

(1) The first option, which was recommended by the BRTF, is that clinicians who do not engage in scholarship may remain in, or revert to, *Senior Instructor* rank, with the possibility of offering modifying titles for this rank (e.g., *Master Clinician*). The argument for this option is that scholarship is the core definition of a professor, that it distinguishes us from our colleagues who are not in academic medicine, and that this current system works. The argument against this option is that this diminishes the importance of the busy clinician and that this may hurt recruitment and retention. However, if this option were adopted, the title of Professor would then be available to our volunteer faculty, but not to our own full-time clinicians.

(2) The second option is to utilize a different naming scheme for faculty who do not engage in scholarship, e.g., Associate Professor of *Clinical Pediatrics*. The argument for this option is that this matches the job description. The argument against this option is that the title is ambiguous since our volunteer faculty currently hold titles such as Clinical Professor. Another argument against this option is that this would be a return to a two-track system.

(3) The third option is that the promotion requirements for Associate Professor be modified so that scholarship is not required for promotion, e.g., a faculty member would have to be excellent in one area, teaching, research, or clinical service; and meritorious in *two* areas, rather than three: Service, Teaching, or

Scholarship. The argument for this option is that this is a compromise and retains the requirement to participate in *one* additional core mission, and that clinician-teachers would be eligible for promotion to Associate Professor. The argument against this option is that scholarship will not be required for promotion to Associate Professor. These three options seem the most feasible and realistic.

This was then opened for discussion. Todd Larabee commented: We have a simple system now, and it would be difficult to change the system to accommodate a small number of individuals. The response was that the Chairs of Pediatrics and Medicine are concerned about a need to have more clinicians, and they see this as becoming a bigger problem.

There was then extensive discussion regarding the three options, including potential issues that would arise if the options are chosen, e.g., devaluing the achievements of those faculty who have done scholarly work, by promoting faculty who have not engaged in scholarly activity to the rank of Associate Professor. It was suggested that the current level of scholarship activity that is required for promotion to Associate Professor is not too high, and that if a faculty member did not want to engage in scholarship, they should not expect to be promoted through the academic system. It was also suggested that the requirement that Assistant Professors be promoted within 7 years be eliminated; Dr. Lowenstein commented that this issue has been discussed, and it was felt that allowing that option without a deadline would mean a faculty member may not get chair or mentor support.

There were also comments regarding the option to allow faculty to remain as, or revert to, Senior Instructor. There was concern raised about this option. As an example, this could result in a faculty member who had been here for 30 years having the rank of Sr. Instructor, while a volunteer faculty member who is also not required to engage in scholarship would have the title of Professor.

There was also discussion regarding the amount of work it will be to fix this problem, for a seemingly small number of faculty who aren't engaged in scholarship. It was asked if there is a group of junior faculty that do not engage in scholarship who are upset that they cannot become Associate Professors. There was also a comment that we need a clear definition of scholarly activity. The question was asked whether any of these issues applied to tenure, and there was confirmation that the requirement for scholarship will still apply to tenure. Dr. Lowenstein added that he presented this information, with these options, to faculty at Denver Health, and that the consensus there was that a modest requirement for scholarship be preserved. President Gill closed the discussion by stating that there was no proposal to vote on currently, but Senators were encouraged to discuss the options with their faculty, and that this would be discussed at the next meeting.

- D. ***Curriculum Steering Committee Report.*** Due to time constraints, Dr. Linas was not able to present the Curriculum Steering Committee Report, but

encouraged everyone to read through the report and send any comments or concerns to him via email.

The meeting was adjourned, the next meeting is November 8, 2011.

Respectfully submitted, Renata C. Gallagher, MD, PhD

Minutes of the Faculty Senate of the University of Colorado School of Medicine

November 8, 2011

- I. **Welcome:** The meeting was called to order by President Ron Gill, Ph.D at 4:30 PM. Dr. Gill asked any guests and/or members of the media to introduce themselves. There were no guests.
- II. **Approval of the Minutes:** The minutes of the October 11, 2011 meeting were approved without comments or corrections.
- III. **Dean's Comments:**
 - a. As Dean Krugman was absent, Dr. Doug Jones, Senior Associate Dean for Clinical Affairs, presented information regarding current chair searches and affiliate institutions.
 - Negotiations with Dr. Richard Zane, currently at Brigham and Women's Hospital, and candidate for Chair of the Department of Emergency Medicine, are still underway. Negotiations with Dr. Richard Schulick, Professor of Surgery and Oncology at Johns Hopkins, candidate for Chair of the Department of Surgery, are also continuing.
 - Patricia Gabow, MD, CEO at Denver Health, is stepping down. The composition of the search committee for her replacement is not yet clear. It will consist, at least, of Dean Krugman, Dori Biester, Ph.D., former President and CEO of Children's Hospital Colorado, and will be chaired by Bruce Alexander, Board member of Denver Health (DH). There are regular meetings between the Dean, Patty Gabow, and senior staff of DH in an effort to solidify the relationship between DH and the SOM, and to put things on paper prior to her departure.

There have been no recent meetings with National Jewish Hospital
 - b. Poudre Valley Update:
 - Dr. Jones stated that there is little additional to say. Bruce Schroffel, CEO of UCH, has stated that relationships between physicians at the two institutions should proceed at their own pace, similar to the situation between Cornell and Columbia at Columbia-Presbyterian. This is based on his experience with Stanford and UCSF where merger of the faculties was unsuccessful and acrimonious. Therefore, it should be up to the faculty at the two sites to decide on their clinical relationships. Dr. Jones pointed out that there will be no merger of UCH and Poudre Valley Hospital as both are owned by entities that cannot sell them, the state and the county, respectively. They can cooperate, but not merge. There is a question as to what board composition should be; this is in process, and is not final, but may be so by Feb. 2012. On the evening

of November 16th there will be a meeting of the medical staff of Poudre Valley, several of the SOM staff will attend, but this is not mandatory. Dr. Jones asked for questions.

Dr. Chesney Thompson, Past-President of the Faculty Senate, asked about Memorial Hospital. Dr. Jones replied that they have put out an RFP, essentially for a management agreement, and that a response has been prepared. HCA is very interested in acquiring Memorial Hospital. Someone asked if the agreement with Poudre will affect transfers between Poudre Valley Hospital and UCH. Dr. Jones said that he did not know and was not sure if this had been discussed. The SOM has not been involved in this discussion. The Board of Regents has given approval for the discussion between the two hospitals to proceed.

President Gill asked Dr. Jones what the benefit is to the merger with Poudre. Dr. Jones stated that Bruce Schroffel and the Board have been concerned about the ability of UCH to be a stand-alone institution; there are very few of these. Benefits include access to capital, and purchasing power. The only free standing hospitals in the region are Memorial Hospital, Denver Health, UCH, National Jewish, and Boulder Community Hospital. Partnerships with other organizations will make these stronger and more likely to survive. If UCH stays free-standing the concern is that they will be absorbed by another system.

c. Clinical Enterprise Update:

- Dr. Jones next provided an update regarding the Clinical Enterprise. He stated that if the SOM wants to function as an enterprise it needs a management structure. The SOM has traditionally been Department and division-centric; there is a need to bring people together to discuss matters of importance to clinical practice at the SOM as a whole. Policies and practices are not standard. Should there be common standards? If the SOM wants to do this it is necessary to have representatives to discuss this who are clinically active, and not, for example, Chairs, who have multiple responsibilities. The Dean has created a Clinical Leadership Council made up of Vice Chairs for Clinical Affairs and Quality in each Department and major clinical Centers. The co-Chairs are Doug Jones, Joan Bothner, and Steve Ringel. The SOM is a multimillion dollar clinical operation and needs a better coordinated operations management. Philanthropy and state funds are insufficient to meet the School's needs, making a successful clinical enterprise of great importance. Question: Who comprises this? Answer: Each clinical department, as well as the Cancer Center, the Barbara Davis Center, and the Center for Children's Surgery. Every clinical department is represented by senior capable people. The Dean has purchased 10% of their time, and they have agreed to set aside clinical duties for this important task.

d. Question:

- An unrelated question was asked about the current branding of the SOM. This was prompted by a call in to Colorado Public Radio and was regarding the use of both UC and CU. This was clarified by members of the office of Media Relations. Our campuses are UC Denver, UC Anschutz Medical Center, UC Boulder and UC Colorado Springs. Legally UC Denver has two campuses, Denver and Anschutz Medical Campus. We are also the University of Colorado School of Medicine. The use of CU likely is related to the Kansas schools, the University of Kansas became KU. The school logo is a big CU. The URL is expensive to change and will not be changing. It is safe for faculty members to use University of Colorado School of Medicine, without the Denver, or to use UC Anschutz Medical Campus. AMC is not to be used, due to the wishes of our donor, and signs are being changed on campus to reflect this. In short, our e-mail addresses are not changing again.

e. Thanks:

- President Gill took the floor in order to express sincere and deep thanks on behalf of the Faculty Senate to Dr. Celia Kaye, Senior Associate Dean for Medical Education, for her work, and that of her staff, which resulted in the Medical School's receiving full accreditation for five more years. They had been evaluated in 2009 and the group returned two years later to address several issues, The medical school is now accredited for the maximal possible period.

IV. Discussion Items:

- A. ***Blue Ribbon Task Force on Promotion and Tenure Options: Additional Perspectives:*** This was to be second on the list of discussion items, President Gill requested that it be moved forward so that Steve Lowenstein, who had to leave early, could bring the discussion of the Faculty Senate back to the BRTF committee. It was reviewed that this is the third time that the report of the BRTF has been brought to the Senate, and that there is some confusion as to where we are with the discussion. It came back to the Senate for the second time after the Executive Committee requested further deliberation. There is good support for the majority of the conclusions of the BRTF, the issue is the requirement for a role for scholarship for promotion. Last month Dr. Zahniser presented three possible options. It was suggested that all points of view were perhaps not given sufficient time. Dr. Jones and Dr. Sloan of Anesthesiology were asked to present their views. Dr. Lowenstein stated that it was felt that the Senate did not talk enough about the advantages of clinical titles and of separate tracks. The three recommendations for consideration presented by the BRTF were: continued appointment, or re-appointment, as Senior Instructor for those who are exclusively clinical; or using a title such as Associate Professor of Clinical Pediatrics, or a clinical track; or to change promotion criteria such that promotion to Associate Professor would be based

on excellence in clinical work, with the additional requirement that one be meritorious in two, rather than all three categories of clinical service, teaching and scholarship. Dr. Celia Kaye, in particular, felt that the advantages of the Clinical title were not discussed enough.

Dr. Jones began the discussion by stating that he and John Moorhead had been the chairs when this was changed years ago. He stated that Joel Levine had been the major force behind the current system. Dr. Levine persuaded the group to make a quantitative change in what scholarship is, using the criteria of Boyer, that is, not to define scholarship exclusively as the scholarship of discovery. At that time lots of MDs started in basic research, then switched to clinical work when they were not successful at this. The impression was that this was not a good idea, and that clinicians should focus on being clinicians from the beginning. It was felt that scholarship had been too narrowly defined, and that clinicians who were not the best at clinical work were being promoted. The system became a one-track system. But in Pediatrics 10 - 12 years ago it became clear that a qualitatively different person was needed, like the neonatologists at Poudre Valley. They were appointed as Senior Instructors, and this created a two-track system, one department based. Now there are several hundred of these individuals in Pediatrics, OB-Gyn, and at Denver Health in Pediatrics. They are superb teachers, and do not wish to fulfill the requirements for traditional faculty appointments. However, there are problems with the name, calling these superb clinicians Instructor and Senior Instructor does not honor them, so the suggestion was to take scholarship away from the requirement for faculty appointment and to make them professors. Alternatively, one could ask what does that say to the outside world? The impression is that a professor contributes to scholarship. Also, the bar that we push people toward, pull and push, is promotion, would the school be the one we want it to be in ten years? Other faculty members have said that is pretty easy to get promoted to Associate Professor here. Is this change what we want? Some people say we have a one-track system and that we should keep that; but we effectively have a two-track system with Senior Instructors in a second group, even if not strictly speaking a track. The Senior Instructor category is Department based, should this be brought to the University? Dr. Lowenstein commented that he does not think that permanent Senior Instructor status is really a track.

Question: Nurse Practitioners and Physician Assistants are Senior Instructors; is there an option for promotion for them? If they possess a terminal degree in their field, they are eligible for academic promotion. Dr. Lowenstein - This is an interesting issue, Senior Instructor could be used for the busy clinician (but volunteer faculty are clinical professors) if we leave our faculty as Senior Instructors then there is no distinction between PAs, NPs and physicians.

Comment: As a clinician-educator up for promotion I do not think that the requirement for scholarship is onerous. Let's keep it the way it is. Dr. Lowenstein, most of the feedback has been, it is not broken, don't fix it. The question is, is there a better way to honor and retain clinical faculty?

Comments: What about the option discussed previously of coming in at Assistant Professor and staying there for 15-20 years, and needing scholarship to advance to Associate Professor? Or what about having a combined title of Senior Instructor and Clinical Associate Professor, this would be like being a volunteer faculty member and a Senior Instructor?

Dr. Lowenstein: We do not strictly have a one track system, there is a research professor series. This is for individuals who are scientists, and who are not teachers. There are about 75 individuals in this series, this is a full track, from Instructors to Assistant, Associate, and full Professors. They are free of any teaching obligation. This was recommended by the basic science chairs 8-9 years ago. These individuals are all "at-will", they are exclusively funded by grants. Their teaching portfolio is not reviewed for promotion.

Comment: I am strongly opposed to removing scholarship as a criterion for promotion at a university. This denigrates both our previous promotions, and the University. Why are we discussing this? Are there people who want this, or are people worried about something? Dr. Tod Sloan, Dept of Anesthesiology - the Dept of Anesthesiology faculty were concerned that physicians will be Instructors, like our nurses. At a national level nurses are taking jobs from MDs in Anesthesia. Many clinicians are very busy, they cannot do scholarly work, but they do not want to be at the same level as the NPs in Anesthesia. We will have trouble retaining and recruiting faculty if we do this. For example, a faculty member at Denver Health may not meet criteria for promotion and leave. Anesthesia faculty members do not want to be forced to become Instructors.

Comment: Volunteer faculty can be professors, sister institutions have found a way for people doing clinical work and teaching to be promoted. If we apply the current criteria for clinical work, the faculty member will get a title, the Instructor title could be used for someone who does not teach.

Dr. Doug Jones - Steve Daniels and David Schwartz represent a lot of faculty. Both say that it is hard to recruit to the Senior Instructor level. It has been done in Pediatrics, but is harder now, and is not easy in Medicine. Comment: It will be a problem to have faculty in the school staying at the Assistant Professor level when they see volunteer faculty promoted.

Question: how are volunteer faculty promoted? Dr. Lowenstein: There are school-wide and department specific criteria. It is not an option to remove the titles for these faculty members; they are essential for the residency programs.

Comment: We had two tracks, we changed this in 1997, it is not 1997 anymore. In some departments already there is a dual track system. If there are stringent requirements for promotion, if it is clear individuals have to reach a certain bar, then all will be happy. We will have to re-work the by-laws. Dr. Lowenstein - We do need to ensure that the standard of clinical work is rigorous, we already have criteria for this. The options seem to be to use the

title Professor of Clinical Medicine, or to say that individuals can be meritorious in teaching or scholarship, rather than teaching and scholarship. At this point President Gill ended the discussion, saying that later this month the BRTF would meet again to consider this input, and further recommendations. The recommendations of the BRTF will go to the Rules and Governance Committee, the approval of the Senate is required before the Executive Committee votes.

B. ***Medical School Admissions Report.*** Robert Winn, MD, Associate Dean for Medical School Admissions, presented. Dr. Winn began his presentation by stating that he has good news. As the Dean of Admissions for 2 years he has struggled with diversity issues. When he began the Medical School had 4-8% underrepresented minorities (URM), in a short period of time the racial, ethnic and geographic diversity of the students have improved. Dr. Winn pointed out that the CU SOM is the only medical school in a 500 mile radius. No expansion is planned soon, though the medical school is in discussion with Colorado Springs about a campus there. Currently there are 160 – 200 students at CU SOM, and the school will remain at this number for the next several years. In the last several years AMCAS applications have risen, from 2,150 in 2001 to 4,550 last year. As of this morning, there were greater than 5,000 applications for next year. This is the first time the applicant pool has been this large in the history of the medical school. Is this due to the economy? Yes, country-wide admissions are up 2-6%, but our increase is greater than that. Secondary applications are up from 857 in 2001 to 3,400 in 2011. This is great, though there is more work to do. Why has this increased? We have a great program. We tell people this. We have increased the number of people in the office, there are now two additional staff members. This staff now covers 98% of the colleges and community colleges in Colorado. We have added regional and strategic national recruitment. Last year 612 applicants were interviewed, 304 were offered positions, 160 matriculated, the acceptance rate was 49%, which is good. Two years ago the interviewers were a small group of 67 and were primarily emeritus faculty. There were no basic scientists, and no active practicing physicians. There are now 215 interviewers, most of whom are actively practicing physicians. This puts a new face on the school, and the applicants now have access to faculty. 52% are practicing physicians, 22% are emeritus faculty, 6% are basic science faculty and there are student interviewers. Student interviewers are up to 18% from 11%. Students interviewing students is as good as faculty doing this, there is data for this. The snapshot of our students is that 70% are in-state, 30% are out-of-state, 49% are female, 51% are male, the median GPA is 3.74 and the median MCAT 32Q, there are 9 MSTP students and 151 MD students.

Dr. Winn stated that when he started he was concerned that we couldn't get students from Duke, Harvard, Stanford, the challenge is that if we are competitive we should allow them to come here. Why not recruit them? 29% of students came off the wait-list. We have an obligation in this state to take a 2nd or 3rd look at applicants from Colorado, 26% were re-applicants. The 25th percentile for GPA was 3.57, for MCAT 30, the 75th percentile was 3.90 and

MCAT 35. Regarding diversity: 50.1% is the current class diversity, as follows: 32.5% Underrepresented in Medicine (URM): 4 American Indian or Alaska Native, 9 Asian Vietnamese, 9 Black or African American, 13 Mexican, Mexican American, Chicano/Chicana, 17 Spanish/Hispanic/Latino/Latina; 8.8% Other Asian American: 8 Asian Chinese, 3 Asian Indian, 1 Asian Japanese, 1 Asian Korean, 1 Asian Other (Turkish); 8.8% Rural - As represented by the number of students enrolled in the Rural Track. Fourteen students are enrolled in the Rural Track of which 11 self-disclosed having grown up in a rural community. We have had a strong showing, we are up 85% in minority applicants. We have also increased our geographic diversity, applicants are from every region of the US. We are trying to recruit and we provide a great education.

President Gill asked, "How do you cover the state, what do you do?" Dr. Winn replied that the staff attend recruitment fairs, but they had only one year and two staff members to do this. They contacted every pre-med advisor in the state and asked if they could visit, 15 % said no. We covered 90% of all 4 year colleges. We went all over the state and visited schools in clusters. "Congratulations, this is a great accomplishment"

Dr. Winn – We had to provide education about our school. We have been confident in what we have. We are looking for excellence in different ponds. The school will look different.

C. Appointment of Faculty Assembly Representatives: President Ron Gill stated that last month the Faculty Senate had had a plea from the President of the Faculty Assembly (FA) to contribute members to this body from the School of Medicine. There are now three names of individuals to be nominated to the FA. To be voting members of the FA the Faculty Senate must provide their stamp of approval.

The following individuals have been nominated, Colleen Dingman, Assistant Professor, Anesthesiology; James Davidson, Assistant Professor, Radiology; Lee Shockley, Professor, Emergency Medicine. In addition Tod Sloan, Professor, Anesthesiology, and Hari Koul, Professor, Surgery, have been representatives in the past. A motion was made to approve all five. This was passed, with none opposed.

The meeting was concluded at 5:54 PM.

Respectfully submitted, Renata C. Gallagher, MD, PhD

Minutes of the Faculty Senate of the University of Colorado School of Medicine

December 13, 2011

- I. **Welcome:** The meeting was called to order by President Ron Gill, Ph.D at 4:32 PM. Dr. Gill asked any guests and/or members of the media to introduce themselves. There were no guests.
- II. **Approval of the Minutes:** Dr. Gill expressed his thanks for the detail presented in the minutes of the November 8, 2011 meeting. These were then approved without comments or corrections.
- III. **Dean's Comments:**
 - a. Dean Krugman provided an update regarding current chair searches and affiliate institutions.
 - Dr. Richard (Rick) Zane, currently at Brigham and Women's Hospital, is coming to be the Chair of the Department of Emergency Medicine. His start date is April 1, 2012. He will visit the school several times prior to April 1st, including in February for the new Chairs and Division Heads orientation. He will be head of a Department that is integrated with Denver Health. He will oversee the academic development of both sides of that one department.
 - A letter of offer is being drafted for Dr. Richard Schulick, Professor of Surgery and Oncology at Johns Hopkins, candidate for Chair of the Department of Surgery. He runs the Hepatobiliary Program there. The hope is that his appointment will be announced early next year.
 - Dean Krugman stated that this will be the last chair recruitment that he intends to have over the next several years. He wants to initiate a strategic planning process for how we need to organize the School of Medicine. He discussed this in his recent State of the School address. It is time to ask, if we were to start over as a medical school today and the goal were to be maximally successful at each of our four goals of research, education, clinical care and community service, how should we do this? How should we be organized to be as successful as we will need to be in the future? This will be needed over the next decades as we look at state and federal funding. We need to think about the one time resources we need in each area, and ask how do we get where we want to be without destroying what we have built up? Dean Krugman stated that he envisions the planning as having two phases, and a duration of 18 months. He has spoken to the 24 chairs and at least 7 center directors, and nearly all are excited about this. Issues with respect to clinical work will need to be addressed with the hospitals.

The school will need to look at the life-span of medical education and at inter-professional interactions, e.g. with the School of Nursing. Dean Krugman also discussed the need to work with Lilly Marks who is working to draft a broader master plan for the campus, as plans were not necessarily cohesive or integrated initially. The campus was designed before we knew Children's would be here, or that the VA would move here. We thought that we had lots of space. UCH, the VA, and Children's are all independent; none of these collaborated as they began to do their planning. We need to think of a broader master plan. There will be new opportunities for thoughtful discussion in lots of committees by thoughtful people in the next months.

- Questions and comments: Chesney Thompson, MD, Faculty Senate Past-President. Could you provide updates on the hospitals? Dean Krugman stated that he has been going down to Memorial Hospital to discuss the offer made by UCH, and that he was told that on points UCH is the favorite to win the bid. UCH has agreed to provide 120 million dollars over 40 years, or 3 million dollars per year for forty years, to provide a branch of the medical school there; this would be mainly third and fourth year students. The community is very interested in this. The task force is to make a recommendation to the City Council by the end of the month. However, their recommendation has to be approved by the people of Colorado Springs. That vote will not take place until 11/2012. Therefore, we could make our arrangements and the voters could just say no.
- Regarding Poudre Valley the joint operating agreement is going well, except that the Laramie County Health District has not yet given approval for Poudre to join. The Regents and the Board of UCH have approved the agreement.
- Question: Could you comment on DU? DU is doing a feasibility study regarding starting a medical school to help the primary care shortage in Colorado. Dean Krugman said that starting a medical school is not the way to do this. The feasibility study is underway and three qualified outside individuals, including the LCME Secretary for the AMA, Henry James, are doing this. This is not a concern at this time, though if in three years they have a class, there could be pressure on clinical sites.
- Question: What if HCA gets the Colorado Springs contract, would we consider having a branch of the medical school there? It is in the mission of the SOM to support research, education, and community service. This is not true of for profit hospitals. It is not just money; it is the culture and climate of an academic hospital. HCA may not support our academic mission. There were no other questions for the Dean.
- President Gill asked Steve Lowenstein if the Blue Ribbon Task Force on Promotion and Tenure had had any more recommendations after the feedback from the Faculty Senate. They are still willing to consider the three options put forward, using Senior Instructor for clinicians, creating a clinical track, or taking out scholarship as a criterion for promotion. The committee members are trying to arrive at a consensus,

but it is very difficult. All know the advantages and disadvantages of each option. Their recommendation will go to the Rules and Governance Committee; this will then come back to the Faculty Senate for approval, and will then go to the Executive Committee.

IV. Discussion Items:

- A. **Update on Profiles:** Ron Sokol, Professor, Gastroenterology Hepatology and Nutrition, Children's Hospital Colorado, Director and Principal Investigator, Colorado Clinical and Translational Sciences Institute (CCTSI). Dr. Sokol thanked the Senate for the opportunity to present information regarding Profiles, and to get input on this database that the CCTSI is in the process of installing. He explained that we are all faced with the challenges of initiating collaborations; other challenges on campus include finding a mentor, locating core lab services, and networking. There is no current system at UCD for finding collaborators either internally, or, more important, externally. As part of its mandate in the RFA for the NIH CTSA grant, the CCTSI must develop tools to connect researchers, trainees and core facilities for biomedical research. The CCTSI is now in year four of the grant, this project needs to be completed by year five. Various options were explored, and the Harvard "Profiles" tool was determined to be the best available, and the most economical to install. This will be installed by the CCTSI at UC Denver, and perhaps could be extended to the whole CU system in the future. It will link with the hospitals and other Affiliates. It will make UCD visible through the Internet, and speed the process of finding individuals with specific expertise.

Profiles Research Networking Software (RNS) is an NIH-funded, open source web-based tool to speed the process of finding researchers with specific areas of expertise for collaboration and professional networking. It imports and analyzes directory information from PeopleSoft, to create and maintain a complete searchable library of web-based electronic CVs. It includes directory information such as one's address and building location. This requires that the information in PeopleSoft be correct. Therefore, faculty will need to update their information in the PeopleSoft database. Profiles will include all faculty, and can include faculty of interest at Affiliates, such as Denver Health and National Jewish Hospital. There will be a chance to include others as well. Profiles also has a direct feed from PubMed to update a database of publication history. It has a program called disambiguation that tries to eliminate similar names, for example. Faculty can add publications, take out others, and can add chapters. The PubMed feed occurs once a week. The PeopleSoft feed occurs every three months. This will be expanded to include graduate students and post-doctoral fellows. Passive networks are automatically created based on MeSH terms from an investigator's publications, current or past co-authorship history, organizational relationships and geographic proximity. Profiles extends these networks by discovering new connections, such as identifying "similar people" who share related keywords.

Users can also manually maintain active networks by identifying advisor, mentor and collaborator relationships with colleagues – they can modify their

profile. Ours will be web-based and open to anyone in the world. Searches can be done via key words or MeSH terms. Dr. Sokol demonstrated a search related to stem cells on the Harvard Profiles site. One researcher's information was used to demonstrate how information is displayed, and how it can be modified, to include student projects, and honors, for example. This is not all that Profiles does, it creates a social network of co-authors. It is possible to visualize co-authors, the thickness of the line connecting them shows the number of papers together. You can view the most common co-author. For Department Chairs, this tells you who your faculty are publishing with. You can see similar people; you can click on Google maps and find someone in Denver. The information provided in a search is: - Profile page for each faculty member: positions, contact info, publications (Pubmed), key words/concepts, & co-authors. Faculty can add more and edit if they wish (not required); - Network pages - researchers in common areas or that publish together; - Connection pages – why two people or profiles are linked. Boulder uses a different tool, and other institutions use other tools.

We are one of the few institutions at our level who do not have this. It is Open Source from the Harvard CTSA, and many improvements are expected over time. The national CTSA consortium (NIH) endorses and supports its use – it is relatively inexpensive. Other CTSA programs using it now include, UCSF, U of Minnesota, and a dozen other Universities are installing it. This will allow CU to link with a national CTSA network of 60 top biomedical research Universities. For example, one could get a ranked list of investigators at 60 CTSA's with the key word of "stem cells." It is searchable from the outside. Profiles can feed in to Domino or FIDO. The Domino and Profiles folks meet regularly in order to prevent a duplication of effort. This is not competing with Domino. Profiles costs 60 K to install and 30 K per year to maintain. Installation is complete, and it will be beta tested next week and will be rolled out at the end of January. This will be available first at the SOM, then the whole Anschutz Medical Campus, then selected Schools at the UCD/Downtown campus, then perhaps Boulder, though they are using a different system, VIVO. This is a search engine that all those around the world can use to find us. Dr. Sokol will be presenting this talk in other forums in order to make faculty aware of this. Some people have privacy concerns, and Dr. Sokol explained that all of the information contained in Profiles is publically available, though it will be easier to find this information through Profiles. It is possible to turn someone off, but this will be the exception, if someone does not want to participate. The hope is that all will participate. Questions: Where is the portal for an outside student? The CCTSI will have a portal, and there will be an icon on the CU home page. Are there plans for interfacing with tech transfer? They could put a link to their website on this. This will not include patent information. Some of the upgrades do include clinicaltrials.gov and NIH Reporter. Does this troll for CVs online? This creates a CV, but you don't upload a CV. This can be linked to a more robust Department website.

- B. ***Predictors of Early Faculty Attrition at the SOM***, Brenda Bucklin, Professor, Anesthesiology, Assistant Dean, Clinical Core Curriculum. Dr. Bucklin began

her presentation by stating the work she was about to present was done as part of a fellowship program, and she thanked several faculty including Dean Krugman and Steve Lowenstein, who were instrumental in this project. The background for this work is that a fifth of the nation's physicians are over 65 years of age. Faculty members in academia are aging as well, and many physicians work part time. As 30 million previously uninsured individuals will have health insurance by 2014, the projection is that there will be a shortage of physicians of more than 90,000 in the next decade. Therefore, physician and faculty retention have received increasing attention in recent years. There is a financial and a human cost to faculty attrition. This affects both the school and departments.

A study at the University of Arizona found that it costs \$115,554 to replace a generalist, 286,503 to replace a specialist, and \$587,125 to replace a surgeon. In one year at the University of Arizona the costs were 7 million dollars for this. Talented clinicians are sought by the private sector. The start up costs for basic scientists are 500 K to 1 million dollars. When start-up expenses and incomplete recovery of indirect costs are included, 40 cents to every grant dollar generated may be added. Physician and faculty retention have garnered increased attention in recent years, in part because academic medical centers are grappling with the lost human and financial capital associated with turnover. As Dean Krugman presented in his State of the School Address, the absolute amount as well as the proportion of revenue from the Practice Plan has increased with time, and this puts greater pressure on clinicians.

The Specific Aims of this project were to: -Measure the 3-year attrition rates of new faculty members who were hired in 2005-06, -Identify attributes, attitudes, experiences, and other factors associated with early attrition. Methods: A cohort of new faculty hired during 2005-06 was identified. A 40-question electronic survey was distributed. Survey questions addressed: general demographics; academic attributes, attitudes, experiences; career satisfaction; faculty responsibilities; and support for teaching, clinical work, and research. 3-year departure rates were measured. ORs (CI 95) were calculated to identify predictors of attrition. Results: 37 of 100 MD or DO faculty left within a three year period; of 8 MD, PhDs hired, none left; of 31 PhDs hired, 10 left. This is a 34% overall attrition rate. When broken down by Rank, more Instructors (27%) and Assistant Professors (26%) left. 27% of Associate Professors left, though the total number of these is small. 17% of recruited Professors left. When MD and DO hires are broken down by Rank, half of Instructors left, 26% of Assistant Professors, 20% of Associate Professors, and 13% of Professors. For PhD hires 43% of Instructors left, 27% of Assistant Professors and 33% of Associate Professors (6 total) and 33% of Professors (3 total). 38% of those who left responded.

The strongest predictors of resignation in three years were: extensive involvement in clinical care (> 50% of time), lack of recognition and support for excellent clinical care, lack of interest by Chair in faculty development, lack of recognition and support for excellence in teaching, absence of an "academic

community” in the faculty member’s department, lack of feedback by Chair regarding academic progress. These results are similar to those of Steve Lowenstein. Limitations of this study are that this was conducted at a single institution, the sample size was small, there was inaccurate contact information for faculty who had left, and the overall participation rate was 55% - unable to evaluate magnitude or direction of any non-participation bias. Conclusions: More than 1/3 of faculty members left within three years of hiring, the cost to the institution is greater than 5 million dollars, greater awareness of early attrition rates and factors associated with attrition may help to identify threats to faculty retention, departments should regularly monitor risk factors for attrition to foster faculty success and retention.

Questions: What is published at other universities? 10% attrition per year, but this is different. This is early attrition; only 16% left for career advancement. Dr. Lowenstein commented that attrition is always 8-10% per year. Lots of people go to private practice. Did people who left do so for more money? 50% went to private practice or industry. Some did leave for inadequate salary. Dr Lowenstein commented that it would be important to look at debt, this was not done. Comment: Some fellows stay on for a year after fellowship, they plan to leave. There is no way to find this out. UCSD did try a faculty development program; this increased the rate of retention by 66%. Dr. Lowenstein commented that not all attrition is an institutional failure. Comment: Some may not understand what an academic career is all about. Question: Do you know what proportion that leave do so because of failure of the institution versus fit of the institution and the individual? This is “failure of the institutional promise,” and we do not know the answer.

Dean Krugman stated that it is important to know if departments are not consistently mentoring faculty, that feedback needs to go to the section heads and department heads. Comment: Look at the Department of Pediatrics. Do more leave? Dean Krugman: They have 550 faculty, so that’s 55 per year. Dr. Lowenstein: We need to monitor the attrition rate. Question: who do we give this information to? We only scrutinize this at a 5-7 year review. Dean Krugman: This could be collected over time and monitored over time. Comment: our system is top-down; industry works differently, and is bottom-up. Dean Krugman: We don’t do that here, though we do it when there are formal reviews. We have acted on problems but have not asked all faculty how their Chairs are doing. Question: Was there a difference between support from the department versus support from the hospital for recognition of clinical care and teaching? This is an important point; physicians did not feel appreciated by the hospital. Comment: Look at what kept people here for 10 or 20 or 40 years. Dean Krugman: This brings up, should we have a non-compete clause for PhD and research faculty?

- C. **Overview of Ombuds Office** Lisa Neale, Associate Ombuds presented an overview of this office, which is an independent, safe and confidential place to voice your concerns. The role of the Ombuds Office is to assist people with conflict. The office can help people with options and resources for conflict

resolution/management. Sometimes conflict cannot be avoided. The office does not tell anyone what to do, or manage conflict. People may have one thing they want to have happen, here they can think about their long-term goals. The office can provide conflict management and team building training. There have been increased requests for training, including for Crucial Conversations training, which is 16 hours. There are two Ombuds offices, one at the Downtown campus and one at AMC. There are four principles. First, information is confidential; the office does not disclose names or case information to anyone without permission. (Imminent threat of serious harm is the only exception). No conversations are taped or recorded; no files or notes are maintained. The office is neutral. The Ombuds office does not take sides, and sees faculty, students and staff. The office takes the side of fair process and access to resources. The Ombuds can let people know that there is an issue, and can mediate; all the Ombuds are certified mediators. The Ombuds cannot be called to testify, adjudicate, or participate in any legal action. Mediating parties make their own decisions; the Ombudsperson remains impartial. The Ombuds is informal. The office does not participate in lawsuits, or in discussions with supervisors. The Ombuds can coach ahead of time, and can get information that may be useful for specific issues.

The office operates outside of the formal review, appeal, or grievance process, does not maintain records for the University, does not accept notice of any kind on behalf of the University. Finally the Ombuds is independent. It is not part of any department, not HR, not Risk Management. The Ombuds can take information and does not report it. The office has no power can cannot take up a cause. Anyone can visit if they are an affiliate of UC Denver, e.g. students, staff, faculty, administrators. Only general statistics are given to the Provost's office once a year. The Ombuds can help by listening, coaching, facilitating, mediating. The Ombuds can help with Working conditions, Sexual harassment, Interpersonal conflict, Disciplinary actions, Discrimination issues, Conflict resolution/management training, Options for reporting issues. Free training opportunities are: Understanding & Applying Conflict Styles, Conflict Management for Supervisors, DiSC Personality Profiles (*small fee for booklets), Teams: Utilizing Conflict Constructively, Basic Mediation Skills in the Workplace, Applying Principled Negotiation to Workplace Conflicts, Bullying in the Workplace, Crucial Conversations. There is a lot of research on bullying in academia. Contact information for the office is: Anschutz -303.724.2950, e-mail is melissa.connell@ucdenver.edu, or lisa.neale@ucdenver.edu. Downtown Campus -303.556.4498, e-mail: mary.chavezrudolph@ucdenver.edu. Offices are: Anschutz Medical Campus – Building 500, Room 7005C. Downtown - CU Denver Building, Suite 107P. Dean Krugman thanked Lisa Neale for her presentation.

The meeting was concluded at 6:00 PM.

Respectfully submitted, Renata C. Gallagher, MD, PhD

Minutes of the Faculty Senate of the University of Colorado School of Medicine

January 10, 2012

- I. **Welcome:** The meeting was called to order by President Ron Gill, Ph.D at 4:31 PM. Dr. Gill asked any guests and/or members of the media to introduce themselves. There were no guests.
- II. **Approval of the Minutes:** The minutes of the December 13, 2011 meeting were discussed. Dean Krugman commented that they were, again, excellent. They were approved without further comments or corrections.

- III. **Dean's Comments:**

Prior to the Dean's comments President Gill took the floor. First, he reminded the faculty senators of the presentation from the chair of the Faculty Assembly (FA) to the Faculty Senate asking the Senate to muster representatives from the School of Medicine (SOM) to that body. The sticking point, particularly for clinical faculty, has been that the meeting time was difficult, 11:30 AM – 1:30 PM. The meeting time will be changed to 4 to 6 PM in the hope of getting more representation from the School of Medicine. The meeting is held monthly, on a Tuesday. Dr. Gill asked that senators please go to their Departments and Divisions to muster six individuals to bring the SOM representation in the FA to eleven. If not, our allocation of representatives will be cut; we have not been near our allotment of representatives in the FA for a long time.

Dr. Gill then stated that he wanted to let everyone know that his e-mail is always open and his phone is always "on the hook." He requested that Faculty Senators let him know about issues to discuss at the Faculty Senate. He wants to bring issues from the "bottom up" rather than the "top down". If there are issues the only way that they will get on the agenda of the Faculty Senate is by request. He asked that faculty please bring issues forward.

- a. Dean Krugman then provided an update regarding current chair searches and affiliate institutions.

- He stated that he expected Dr. Richard Schulick to have signed, or to be signing, his letter of offer. He will be the new Chair of the Department of Surgery effective May 1, 2012. He will be here for the new Chair, Section Head, and Division Head retreat on February 16th and 17th. He was the search committee's top choice. Dr. Schulick views this as a wonderful opportunity to contribute to the growth and development of this department.
- Dean Krugman reiterated that he does not plan to recruit another chair at this time, as his priority is the re-organization that he has discussed. He has invited four consulting firms to present how that might help us with our strategic planning for the SOM, they will be on campus on January 31st and February 8th and 9th. He stated that money was set aside from the sale of the Givens Institute this summer for this re-

organization. He will interact with all four firms, and will pick one to help us over 9 – 18 months.

- Dean Krugman then provided an update regarding the UCH bid for Memorial Hospital. He stated that at 1:30 PM the City Council of Colorado Springs had voted unanimously (9-0) that Memorial Hospital be leased to UCH, or the UC Health system - the joint venture that is not yet complete. They accepted the recommendation of the task force, which had also been unanimous. Regarding the joint venture, this will be voted on by the Poudre Valley Board on January 23rd, and on January 24th by the UCH Board. Dean Krugman expects that this will be complete soon. Regarding the Board of the joint venture there will be four members appointed by Poudre Valley, four appointed by the UCH Board, and another member to be selected from the President of the CU system, Bruce Benson; the highest ranking executive official on the Anschutz Medical Campus, Lilly Marks; and the Dean of the SOM, Dr. Krugman. Children's will be part of the Memorial Hospital lease, and there will be a sub-lease to operate pediatric services as a hospital within a hospital. This has to do with the fact the children's hospitals have different reimbursement issues. Dean Krugman cautioned that the above is all dependent on negotiations, and on the terms of offer. In addition, likely in June 2012, the people of Colorado Springs will have to vote to approve this lease. This is all proceeding well, but nothing is final until it's final.
- Dean Krugman stated that there had been a meeting today to discuss the proposed SOM branch campus in Colorado Springs. UC Colorado Springs has received a four million dollar gift to build a four story building on the east end of their campus. They have made the fourth floor available for administrative offices of the UC SOM branch campus. We will start this, but slowly, as the people of Colorado Springs could vote yes or no on this. On July 1st we expect the three million dollars per year for forty years to begin. Celia Kaye, MD, PhD, Senior Associate Dean for Education, and Brenda Bucklin, MD, Assistant Dean, Clinical Core Curriculum, will recruit core faculty from the local physicians in order to develop the core blocks there. Also, Centura Health Systems will put up 1.5 million dollars per year more to be a part of the branch campus. This will allow our students to be at all three hospitals there, and having them contribute to funding would aid accreditation. We would expect to accept students who would attend the branch campus for their clinical years for the graduating class of 2017; that is, they would start their third year in May 2015. In the meantime we will be recruiting students to do volunteer rotations. We will probably have to do informed consent, though our experience with off-site rotations is positive. This gives us one and a half years to create a two year long longitudinal curriculum for students in Colorado Springs. We want to ensure that they have the competencies they need. We will identify faculty and develop rotations. This is a huge opportunity.

- Dean Krugman then stated that in the last week the NIH salary cap dropped; that will cost us 2 million dollars as their cap is now \$20,000 less. This will be made up from the clinical revenues of the departments. He then said that in the last decade some have done more with more; we have done more with less here. We may be coming in to a decade where we have to do less with less. This will take cross-subsidization of the academic enterprise with the clinical enterprise.

Question, President Gill: Will students at the branch campus come from the 160, our current enrollment number, or will we take more students?

Dean Krugman: Initially 24 of the 160 students will do their clinical rotations in Colorado Springs. However, we do want to increase the class size and take more students from outside the state. We had 132 students, 90% were in-state; now we have 160 students, and 70% are in-state. We have 5,400 student applicants, we won't lose quality. However, we will stay at an enrollment of 160 until we know that we are accredited. We discussed last time that Lilly Marks is working on an overall master plan for the campus. The plan for this campus was started in 1997, prior to knowing that Children's and the VA would be here. We have three times the number of people and cars that we expected. We are limited in space for the medical students to a class size of 200.

Comment: At 160 students there is fierce competition for small group rooms in the Education buildings. Dean Krugman: That is because all of the schools have grown: Dental, Pharmacy, Nursing, and the School of Public Health.

There were no other questions or comments.

IV. Discussion Items:

- A. **Faculty Updates** – Steve Zweck-Bronner, Senior Associate University Council; and Steve Lowenstein, Associate Dean for Faculty Affairs discussed a. Non-compete agreements, and b. A proposed retirement incentive plan. Mr. Zweck-Bronner began by explaining that the goal is to modify the non-compete agreement to better fit clinical faculty. This will be used going forward with new recruits, not backward. The current agreement does not fit everyone's need; this will make it easier to recruit, as the non-compete agreement has been a barrier to recruitment. Regarding the new retirement plan, several years ago a plan was created to allow tenured faculty to retire and take two years of their salary over five years. The drawback was that his was an IRS plan, and was sheltered from taxes. As a result, faculty could not work at the university for five years; some faculty wanted to come back to work at some percentage, and could not. Now with changes in legislation, the school is working on a similar plan, but one that is not a tax shelter. The hope is that it will be offered this spring, throughout UCD, both at the Anschutz Medical Campus, and the Downtown campus. The goal is to create flexibility for

Departments and for the Deans. Steve Lowenstein (SL): The previous retirement incentive plan was hard to follow; there was a moving target of retirement plans. Also, it had been at the discretion of the Chancellor with respect to resources, so it was unclear if it would be available. Several people took advantage of it, and then it disappeared. The Deans and the Provost have asked for more options. This plan will still be at the discretion of the Chancellor. Steve Zweck-Bronner (SZ): This will be fine-tuned in the next week and available for disclosure in 6 weeks. We do want to avoid a financial crisis. The University of California did this and too many people took it. SL: The question will be: Does this have to be offered to everyone? The Department has to show that they can afford it; we don't want to jeopardize the school. This could be used for SOM faculty who can no longer cover their salaries on grants, but who did not want to give up their tenured position. A change in legislation allows us to modify the retirement plan so that they could do this, and still be able to work at the University part-time.

Question: Related to the non-compete agreement, there is a discrepancy between MDs and PhDs who are doing research. SZ: The MDs have a non-compete agreement, the PhDs do not. That is because the law says that non-compete agreements are illegal, except in limited circumstances, and that includes MDs. Comment: But this is included for MDs who are doing research, and it adds a lot of money to the start-up costs. SZ: The department puts a lot of money in start-up packages for PhDs. If they leave, this is difficult for the department. One way to address this is, if the department is putting in \$100,000, say this in the letter of offer, and negotiate on a case-by-case basis any payback if the faculty member leaves. If there are unique recruitment costs this can be put in the letter of offer. SL: This is already being done; payback is pro-rated if the faculty member leaves in their 2nd, 3rd or 4th year. Dean Krugman: We have had a non-compete agreement for 14 years; this is not to tie anyone here. It is a business principle. If you are trying to leave, the recruitment package of the other institution needs to include payback to the department here. SL: This cannot be punitive; it is just recovery of reasonable damages. Comment: But this is discriminatory toward MDs. PhDs can leave without the department recouping the cost. SL: The letter of offer allows this to be equalized.

Comment: This need to be crystal clear, that start-up funds can be gotten back. Dean Krugman: If there is going to be another medical school in the area we will need to protect ourselves; it makes it more difficult for a school to recruit away someone. Non-competes are controlled by state statutes, but the letter of offer is not subject to state statutes. In the future this may all go into the letter of offer. The non-compete addresses recouping the loss if a clinician moves across the street. SL: Geography is important here. The question is, what will you repay if you leave after one, two, or three years.

SZ: Steve Zweck-Bronner asked if anyone had questions related to the issue of not requesting photos for resident applicants. Question: Where does that issue come from? SZ: That's the law. You use photos to remember who

people are, but according to federal and state law it is illegal to require or encourage someone to submit a photo with an application. This has been used to discriminate in hiring. Comment: But resident applicants send photos through ERAS. SZ: It is the other group that we can't ask for photos, those that don't send them through ERAS.

Question from President Gill: Regarding the new retirement incentive, will it also be two years of salary? SZ: It is not an IRS plan; it may be up to two years of salary. The question will be, do we have enough money? President Gill: Where does the money come from? SZ: The department. Dean Krugman: Often the School is asked to be a bank. For small departments, we will bank them, with no interest. President Gill: It would be a shame if the department can't recruit because they are paying these funds out. Yes, we don't want everyone to take this and bankrupt the department. Question: Why can't you take a job across the country and retire? SZ: If you are greater than 55 years of age and your years of service plus your age add up to 70, you can retire. The goal is to provide as many tools as we can. SL: This is one of the few tools around to manage tenure. SZ: This is not a right; it is at someone's discretion. Question: Is this two years of their tenured salary? SZ: It is two years of their base salary. If this isn't enough they can work and draw salary. Comment: So tenure is worth two years of extra salary? Dean Krugman: Before, when a faculty member was offered two years of salary over five years, under IRS rules the faculty member could not come back to work. Some wanted to come back at 20 – 30%. SL: A faculty member should not be able to come back at 60 – 80 %. SZ: This could allow someone not ready to retire to have a nest egg. President Gill: What is the incentive for the department? SZ: This is for the situation in which the department can't come up with the salary of someone who can't pay their own salary through grants. But is this on base salary? The previous plan one was two years base plus supplement. Dean Krugman: This is an administrative tool that could be helpful for some. We may do this differently in the coming years. There was no further discussion.

The meeting was concluded at 5:25 PM.

Respectfully submitted, Renata C. Gallagher, MD, PhD.

Minutes of the Faculty Senate of the University of Colorado School of Medicine

February 14, 2012

- I. **Welcome:** The meeting was called to order by President Ron Gill, Ph.D at 4:30 PM. Dr. Gill asked any guests and/or members of the media to introduce themselves. There were no guests.
- II. **Approval of the Minutes:** The minutes of the January 10, 2012 meeting were approved without corrections.
- III. **Dean's Comments:**
 - a. Dean Krugman provided an update regarding current searches and affiliate institutions. He began by stating that there are no searches in the Dean's office at this time. He provided updates regarding other searches of interest on campus.
 - There is a current search for a Dean of the College of Nursing, Dean Krugman is on this search committee and this search is proceeding.
 - There is a search for a Dean of the School of Public Health. David Goff, MD, PhD, Professor and Chair of Epidemiology and Prevention at Wake Forest University School of Medicine, is coming in a week or two to meet with the Provost.
 - There is a current search for the head of the Bioethics and Humanities Program. Dori Biester, PhD, former President and CEO of Children's Hospital Colorado, has been the interim head since Mark Yarborough left. Their building will be completed in July, it is now appropriate to recruit for the head of this program.
 - There will be a search in Pediatrics for the head of the CHA/PA Physician Assistant program, after 30 years Anita Glicken is stepping down.
 - Regarding affiliate institutions, Dean Krugman stated that the papers for the affiliation with Poudre have been signed and are waiting for approval by the attorney general.
 - Regarding the affiliation with Memorial Hospital, the lease with the UC Health system - the name of the new health system, is being negotiated with the city attorney of Colorado Springs. This will take place 4 hours per week, until it is done. The people of Colorado Springs will vote on the affiliation in August or November 2011. Until then we will look for faculty and rotations sites for the potential clinical branch campus in Colorado Springs.
 - Dean Krugman stated that he is also on the search committee for Patty Gabow's replacement as CEO at Denver Health. There will be an open meeting that anyone in Denver can attend to say who should take her place. She leaves in September, 2012. Dean Krugman asked for any questions.
 - Question: What is the status of the VA move? Dean Krugman (DK): It is moving along. Spring 2015 is the planned move date. Question:

Where is the VA? DK: The east side of the campus. The construction will make getting in and out of the east side of campus more difficult. There will be 120 beds in the new hospital.

- Question: Will the head of Bioethics and Humanities be an MD? DK: It is a campus program, not a program of the School of Medicine, therefore the head does not report to the Dean of the SOM. The head could be someone from Nursing or from another school. However, the program must link to clinical programs and our hospitals, they would likely have to hire an MD to do that.

IV. Discussion Items:

A. **Campus Master Planning Process** – Neil Krauss, Director of Administration, Office of the Vice-President for Health Affairs and Executive Vice Chancellor for Anschutz Medical Campus. Dr. Gill began by stating that there has been a lack of communication about the Master Plan, and a concern about traffic patterns, for example. Mr. Krauss began by stating that he would review what is being done and why. The goal of the Master Plan is to articulate the 5 and 10-year programmatic goals of the campus, and create a physical facilities and infrastructure plan to meet those goals. A Master Plan is required by the Colorado Department of Higher Education every ten years. Our's was last updated in 1998, and was revised in 2002. We also need to do this. Ten years ago the stakeholders, CU, UCH, the city of Aurora, and the Fitzsimons Redevelopment Authority, stopped having regular planning meetings and each focused on the success of its mission. As each entity focused on its own mission it produced what it needed to produce. One consequence was traffic and congestion problems. The Master Plan will focus on three areas: 1) the University's 5- and 10- year Master Plan (third column of attachment); 2) Site-wide planning (second column of attachment) ; and 3) Micro or mini-master plans to address specific topics, such as way-finding. It is common to bring in national consultants, and with representation from schools and colleges across campus, we selected Perkins and Will, who coordinated the development of our first master plan. We are completing contract negotiations and will begin in March. For the site-wide component of the plan, we will focus on the issues that were identified this past summer in a series of meetings by all Campus stakeholders. The range of issues includes traffic, an integrated transportation plan, signage, and land-use. This process was termed Phase 1, and its resulting report identifies the key questions that need to be addressed in Phase 2. There are no solutions yet. For example, a loop road was planned around campus in the original Master Plan with pedestrian walkways. One question is: does the loop road still work, and if not, what is the alternative? We will be working with a local transportation and engineering group, Felsburg, Holt and Ulleving, as part of the Master Plan to help focus on these issues. The second column of the handout represents the main body of the Master Plan. As a University campus, we will review the programmatic and strategic focus for each mission of the campus. One important step is to review, affirm or alter the UPAC strategic plan for the five and ten-year period. Do the initial guidelines still hold? Our ultimate goal is to ensure that support

strategies for facility and space meet the UPAC plan needs. Another question regards amenities, and how we work with the city and developers to bring more retail support to campus? The first step in the development of the Master Plan will be data collection and analysis. Next, subcommittees will be formed to address research, education, clinical care issues representing all the schools and colleges. We will use the expertise of the Perkins and Will consultants to guide the vision for the campus. For example, what will Research 3 look like and where will it be located? Josh Meyer guided the development of RC1 and RC2, he will be brought here for RC3. We will work with Dean Krugman and Dr. Ridgway, Senior Associate Dean for Academic Affairs, to identify the needs of the faculty. We can develop a master plan to meet the Dept. of Higher Education needs, but this is cursory, we have real needs and need to find a long-term solution. Post data gathering we will meet with the key stakeholders to refine the vision, we will have four to five options. The group will decide on one scenario for the build out. This will require lots of faculty and staff involvement. The goal is to have a plan by the fall of 2012. Questions? What about the VA development? They are doing off-site work, and need to do closures on Wheeling, Montview and 17th. The FRA (Fitzsimons Redevelopment Authority) owns the roads, and the University has been working with the FRA to ensure the VA doesn't close Montview and 17th at the same time. Does the Master Plan include bicycle pathways? NK: Yes, it will address alternate modes of transportation. This includes light rail, and the sooner we get that the better. We do want to improve bike routes around campus. Question: What is going on with the footprints on the sidewalks? NK: This is part of a wellness program, the idea was that they are a circular path to walk the campus, but there is no map on the pathway. Dean Krugman: There is a map at the information desk in Building 500. There is a red route and a green route, this is a project of the LEEDs program, it was put together by the medical students. There is a one mile, and a one and a half mile, loop. Comment: It would be nice to have this in an e-mail. Dean Krugman: I can do that. Question: What about dining facilities? NK: This is a key question, where will the town center be? Originally this was planned to be on Montview, but this is not the practical Town Center. There is talk of having it at Colfax and Peoria. The city and developers have much to discuss, including financial packages. NK: A conference center and another hotel is being discussed along Colfax. Sites have been purchased by developers, but they have not yet been developed. Will we have a modern campus-wide fitness center? Dean Krugman: Yes this is northwest of here, at 19th and Montview. There will be a place for receptions, and it will have a restaurant. Question: Where can we find information on the facilities and membership? NK: Go to the website for the Colorado Health and Wellness Center, they are trying to gauge interest, and will then set a price. Comment: If you sign up for a study they will decrease your membership cost. Questions from several individuals: Will there be separate showers or locker rooms, not at the Center, will there be another alternative? Will there be lactation facilities? Can we contact you? Can you ask us about these issues? NK: Yes, these are good questions. My e-mail is Neil.Krauss@ucdenver.edu. My phone number is (303) 724-6363. Lilly Marks wanted a website with a feedback mechanism about the

development process. Part of the website will have a message to welcome comments.

NK: Also, a new interstate exit off southbound I-225 will soon open up. The new entrance will open in 2014. The existing Colfax exit is going away. You will get off at 17th Place, and go to Colfax, or 17th Place. The state believes that 17th Place is great for hospital traffic, but you cannot get to the hospital from 17th Place. We are designing signage with this information now.

Question, President Gill: Has the FRA made progress regarding attracting businesses and biotech to the golf course? NK: Eight to ninth months ago President Benson and Lilly Marks worked to restructure the board of the FRA, which was largely from the city of Aurora, and included few with experience in developing biotechnology businesses. Now there is a new group and a new direction. The current building has greater than 30 start-ups and is expanding by 30,000 square feet. The plan is to develop this to attract businesses.

President Gill: Do you hope to attract large companies to relocate? NK: One of the candidates for the FRA director position is with CH2M Hill, and he indicated that what you are seeing now is that most pharma is leaving the US and Europe for the Far East and India. We are more likely to see small and medium sized companies from California relocating. We will continue our current incubation work.

Dean Krugman: Regarding the sign of the biotechnology park, ten years ago 167 acres was a lot of space. In Cambridge and Research Triangle Park the space was much smaller. It is hard to fill. But with the growth that we have here we will need to expand, we may expand there.

NK: One idea is that any large parking structure that is proposed go to the FRA site and have a shuttle system.

President Gill: Early on you said that neighborhood folks are involved. Who are these? NK: The stakeholders are the city of Aurora, UCH, Children's, the VA, the FRA, and CU.

President Gill: Are there issues with our neighbors, as there were at 9th Avenue? NK: No.

Are there any other questions? NK: We will enlist your help as we look at the program for the schools and the departments.

Dean Krugman: We should not spread the campus further apart.

- B. **Overview of Contracting Process** - Robert Shikiar, Senior Staff Attorney, University Physicians, Incorporated. Mr. Shikiar began by stating that he wanted to make all informed and aware of changes and updates in the SOM/UPI process for contracting out services. This covers SOM faculty members performing professional services related to their healthcare practice. It does not cover, for example, teaching music on the weekend. The rules are that the faculty member needs to contract through UPI. In addition the income is to be billed and collected by UPI. He discussed the following about the contract process: 1) Why and 2) How? 1) Why: It is required by the member practice agreement signed by all faculty members and outside professional income goes through UPI for billing and collection. This is prudent. Colorado has a law called the government immunity act. This provides low liability caps for faculty members: 150 K per occurrence. This is very low by national standards. This is for state employees, it only covers work done as a faculty employee. Also, there is a self-insurance trust of the SOM. If there is a judgment against you there is coverage by the self-insurance trust. But this only applies if a faculty member is acting within the scope of university

employment. For example, Dr. X is sued. Dr. X wants to prove to the court that the 150 K cap applies because Dr. X was acting within the scope of his/her university employment. Dr. X also wants to make sure the University self-insurance trust comes in to play so that it will pay the judgment. To prove this Dr. X needs to show that Dr X was acting within the scope of University employment. There are two possibilities: 1) The contract specifically says that the service was performed by Dr. X acting as a University employee and is signed by University officials. 2) Dr. X performs the service for company Y and there is no mention of the University. In scenario 2, the faculty member would not be covered by the liability cap or by the University self-insurance trust or any supplemental policies because Dr. X was not acting within the scope of university employment. Therefore this requirement that professional service contracts be handled by UPI on behalf of the faculty member is in the faculty member's best interest. Also, Mr. Shikiar stated that he reviews contracts for legal reasons, and is looking out for the best interests of the University and the faculty member. For example, almost any contract has a broad non-compete clause, e.g. Merck, Pfizer. In these clauses the doctor would be prohibited from competing against the company for any service, world-wide, for the duration of the contract, plus an additional five years. Mr Shikiar stated that his role is to take this out and to limit the scope of the non-compete as much as possible, ie scope, geography, duration. This is to the faculty member's benefit. 2) How: The UPI template has all of the required language and specifications. This states that the faculty member performs the contract services in their capacity as a university faculty member so that the immunity cap and the trust apply. This also has other clauses required by law, such as the Stark Law. Use this template, it contains all of the required language. This is available in Word, so that the company can make requested changes. It is understood that others will want to use their own contract, but that contract will have to be edited to put in this required language. UPI cannot accept a pdf contract. UPI insists that faculty either use the UPI template or use the company template in a Word document that can be edited and red-lined to put in the required language. A pdf cannot be accepted because it is unchangeable. Faculty should use the UPI template, or provide a Word version of the company's contract to UPI. Another significant change in the last few years has to do with how signatures are obtained. In years past, contracts were signed by the Dean, the Department Chair, the Division Head, the faculty member, the Executive Director of UPI and the company. It was hard to get the contracts signed. They travelled all over campus, and it took 1-2 months to get them signed. This was inefficient. Now these only need one signature, that of Jane Schumaker, the Executive Director of UPI. To do this she needs to have the authority to sign on behalf of the SOM, the Dept, the Division and the Faculty member. This is done by sending the completed contract via e-mail to the Department Chair. The Dept Chair sends an e-mail back giving approval. Once UPI gets the Chair's approval Jane Schumaker signs for UPI on behalf of the School of Medicine. Then UPI seeks confirmation by e-mail from the Dean. So the contract is approved by e-mail, with only one physical signature. This has greatly reduced the time it takes to complete contracts. 1) Tell colleagues to follow the process established by

UPI 2) Tell them to use the template or provide a Word version of the contract to be edited. 3) There is a perception that getting a contract signed takes a long time. This is not correct, the time has been cut from months to 1-2 weeks. UPI encourages faculty to follow these established procedures. This is required and is in the faculty member's best interest. Next: Exempt honoraria. This is a payment that the faculty member collects directly. An exemption is created by the SOM for a one time modest payment for a one time activity. If there is greater than one event, it is not exempt. Modest is not defined; in general it is in the \$3,500 –\$ 4,000 range. If this fits then it is modest and exempt from the contracting process. The faculty member can do the event and collect the honorarium. Next - the conflict of interest (COI) policy with respect to Speaker's Bureaus. UPI is involved if this is a paid speaking engagement on behalf of industry, if so this falls under the SOM COI policy, and the faculty member must seek approval from the SOM COI committee. Information regarding this can be found on the Faculty Affairs website under Policies and Procedures, and Speakers Bureaus. The procedure is given there for submitting a request. In practice the committee on occasion approves these, if there is a legitimate educational benefit to that speaking engagement. This is not approved if the faculty member is being paid to promote a pharmaceutical product or device on behalf of industry. If the company insists on having ultimate control of the remarks, or materials, the committee will say this is promotional and this will be denied. If this is just marketing a product, it will be denied. Question: Regarding exempt honoraria, if I go to a community hospital to give Grand Rounds, and I do this again the next year, is that one or two engagements? RS: It depends on what the hospital had in mind at the beginning of the arrangement. The first time is exempt the second time is not, and should be done through a standard UPI contract. Sometimes the company knows they want a recurring event, but they send four separate contracts for four different months, this is really a recurring event. It is what is known to the faculty member at the time of the contract, if it is recurring, go through UPI. Question: Do you distinguish between companies and professional organizations, like the American Heart Association, the American Academy of Pediatrics? RS: The issue is the source of payment, if it is the same source and is greater than once, it is not exempt. If it is a new source the second time around, it is exempt. If it is the same payment source and a recurring event, then it is not exempt. Dean Krugman: The AAP has 10 – 50 chapters, if three ask you to give the same talk this is not a contract. If you don't know you are being re-invited it is not a contract. RS: Don't confuse exempt honoraria with the Speaker's Bureau policy. They are two separate policies. If you do something repeatedly it's not exempt, do a contract with UPI. When it's apparent that it is recurring, then go through UPI. Dean Krugman: There will always be something that comes up, just ask. RS: If this is exempt from the UPI contracting process, the faculty member should sign the W4 and get paid directly. If the contract goes through UPI, then UPI bills and 2.5 % goes to UPI for administration and 10% to the SOM academic enrichment fund. This is in the SOM rules and in the UPI Member Practice Agreement. Comment: This is new news to new and old faculty members. RS: Just this week, I had an opportunity to look up a

member practice agreement from 1984 and I was surprised to see that it required professional services contracting to be handled by UPI on behalf of the faculty member and for the contract income to be collected by UPI. So this process has been around for many years. That is why I am here tonight – to remind faculty of these long standing procedures and encourage them to remind their SOM colleagues. Question: If a university invites me this year it's exempt, if they invite me again is it still exempt? RS: If at the outset you know it will be recurrent, it is not exempt. Dean Krugman: Another question is, if it is exempt does the Department or Division require that you take a vacation day? That is, are you doing this on University time? We want faculty members to have national and international reputations, but some people spend days on these events while others cover for them. Question from President Gill regarding Speaker's Bureaus: There is a new strategy of having an intermediate company, is there any distinction between having a pharmaceutical company paying or an educational company paying? RS: That seems to be done on purpose to avoid policies such as ours. If we can see this we do not allow this. Question from President Gill, again regarding Speaker's Bureaus: Is there a distinction between the company making changes versus making no changes? RS: The committee has set as a precedent that if the company insists on final approval, whether they make changes or not, that is not permitted. The precedent is that remarks not be subject to final approval by the company.

There were no other questions or comments, the meeting was adjourned at 5:45 P.M.

Respectfully submitted, Renata C. Gallagher, MD, PhD.

Minutes of the Faculty Senate of the University of Colorado School of Medicine

March 13, 2012

I. **Welcome:** The meeting was called to order by President Ron Gill, Ph.D at 4:35 PM. Dr. Gill asked any guests and/or members of the media to introduce themselves. There were no guests.

II. **Approval of the Minutes:** The minutes of the February 14, 2012 meeting were approved without comments or corrections.

III. **Dean's Comments:**

a. Dean Krugman began his update regarding current searches and affiliate institutions by stating that there are no searches in the Dean's office at this time. There are other searches on campus:

- There is a search for a head of the School of Nursing, this is proceeding.
- The search for a Dean of the School of Public Health is in the negotiation phase. The Provost is in discussion with David Goff, MD, PhD, Professor and Chair of Epidemiology and Prevention at Wake Forest University School of Medicine.
- The search for a CEO of Denver Health is underway. There was a public comment process. The hope is that this will be completed by September 2012, which is when Patty Gabow leaves.
- There is a search for the head of the Bioethics Center. Five airport interviews have been conducted.
- Regarding affiliate institutions, April 30, 2012 will be the first meeting of the Board of the University of Colorado Health System. Members of the Board include Lily Marks and Dean Krugman. Bruce Schroffel is President and Chair of the Board.
- The Memorial Hospital negotiations are going along. There will be 1-2 months more of negotiations with the city attorney, then this will go to the city council and then to a vote of the people. The earliest vote would be in August; this would need a special election. There were no questions.

IV. **Discussion Items:**

A. **Update on Faculty Conflict of Interest Committee Procedures** – Steve Lowenstein, MD, MPH, Associate Dean for Faculty Affairs, and John Sohrweid, Radiation Oncology. Steve Lowenstein (SL) began by saying that this whole effort, the ban on gifts, et cetera, was triggered by comments by medical students, by law making, by public pressure, and by changing norms in academic medicine. The Conflict of Interest policy and the Speaker's Bureau policy are products of the Faculty Senate, and it is important to provide an update regarding how this is working. One year ago the Senate passed a resolution prohibiting Speaker's Bureau activities occurring on a one time or a recurring basis. Exceptions are made for educational talks, not for marketing. There are three tests when a contract is in review. It will be denied if it focuses

on one product, if it is promotional, or if the presentation is subject to company review. The procedure for this is to submit a request form and a contract. The Committee reviews this and applies the tests above. In nine months 44 applications have been reviewed. Some have been for CME activities, or for academic institutions; these did not require committee review. 17 applications were rejected. This is a 40% disapproval rate.

It is now important to get feedback on process problems, the issue is delay, ambiguity and cross-talk. The faculty member submits a request, and this goes to Cheryl Welch in Faculty Affairs and then to the committee of 5-6 faculty members. Then there are e-mail comments regarding the contract between Rob Shikiar (RS), UPI attorney, and the committee. This process is inefficient. The process is continued until the committee agrees that the issues cannot be fixed, or RS contacts the company and asks them to change to language of the contract. One suggestion is that the contract go to RS first. He knows the precedents set by the committee, that is the principles used by the faculty, and can suggest deletion of phrases or modifications, and work with the company and the faculty member. Then, if the contract is acceptable to UPI, it would go to the committee for review.

This is the proposal, but it is not what the Faculty Senate voted on one year ago. It is important to talk about this policy change, or any other aspect of this. This policy has been rated as a model program by AMSA. Question: If we take the COI committee out of it, what is the purpose of the committee, that is if it goes to RS first? SL: The UPI attorney is working for the committee. He can approve the contract, which the faculty cannot do. The committee is to be faithful to the original intent of the Faculty Senate that the faculty review this. The proposal is to let the attorney review the contracts first, and to let the faculty review this after that.

Comment: President Gill: This does leave a lot up to the UPI attorney. Should there be a mechanism to go from conflict between the UPI attorney and the faculty member to the faculty committee if there is an unresolved dispute? Dean Krugman: Does the SOM put an undue burden on the UPI attorney? Jane Schumaker (JS), UPI: It is a lot of time for him. He does a lot of contracts. SL: We asked him, he said so far it is okay. This is less time for him. JS: It may make sense to find out if the company will make a change or not. Comment: RS is educated now, what if someone else comes in, how will they fill this role? Hari Khou: Does the committee have a chair? SL: The past-president of the faculty senate is the chair of the COI committee. Ron Gill: There will be a faculty member assigned to each request. If RS can do this, this will save faculty time. Comment: Then why do you have a committee? SL: Rob's approach is based on the committee's work. Question: At what level does the UPI level approve this, can the committee change his mind? SL: Yes, we just did this, he had missed something. Having him talk attorney to attorney takes care of some issues in advance.

Question: Does the 40% disapproval reflect the company not being willing to

change? SL: Yes, this is the advantage of Rob Shikiar looking at the request early; there are some common clauses that can be discussed. Comment: This is a legal issue; we say that these are our rules, but it is the lawyer who makes the rules re this. SL: There are some conclusions from this. 1) The committee should meet regularly with Rob Shikiar, UPI attorney, so that he reflects the opinion of the faculty on the committee. 2) If there is an impasse between Rob Shikiar and the faculty member, this should go to the committee. 3) In the beginning of the process, the contract will be assigned to one faculty member on the committee to shepherd this along. Comment: The committee work is irrelevant then. SL: The committee could find something unacceptable; some things could come up that are not quite clear. Rob Shikiar is working for the school, but is not policy setting. Comment: The committee can still reject it even if it is legal. The role of the committee is to say if it acceptable. SL: Right now the legal standard is equivalent to the policy standard.

Comment: There are two tiers, the first is the initial approval, whether it is approved or denied. That is, don't have the attorney fix this if there is no scientific or educational merit. SL: The committee doesn't know this, they cannot review the slides or handouts, they can only review the obligations. The faculty members don't review the content of the talk, such as whether it is evidence based or not. Comment: But your criteria are that it has merit. SL: The criteria are that it must be educational and not promotional; we wouldn't know that it is or is not valid scientifically. The committee would never know that; it would only know if it is promotional or not. We will make these changes and get more feedback another time.

John Sohrweid then briefly discussed the procedure in the department of Radiation Oncology, which is similar, but in which the department chair reviews and approves any outside activity with a written contract. SL: The gap this fills is that it includes the Chair. So there is triaging at the department level. John Sohrweid: Yes, Dr. Gaspar reviews them all. President Gill: This is a model. SL: Yes, but Radiation Oncology is a small department, this is a model for achieving Chair review, but it may not be able to be adopted by every department. Currently there is no role for the Chair; this allows that to occur. Jane Schumaker, UPI: Rob Shikiar requires Chair approval. UPI signs no contracts without the Chair's signature, because it affects their budget.

- B. **Overview of SOM Finances and Resources** - Jane Schumaker, Senior Associate Dean for Administration and Finance, Executive Director, UPI, provided an overview of the SOM finances and resources from the perspective of UPI. There are three parts: How do we fund the school? What is funds flow? and The B/S/I compensation plan. The context depicts how nationally medical schools are funded. We are like a private medical school in terms of funding, except with no endowment or philanthropy. We have lots of dependence on faculty research and on clinical dollars. We have a small contribution from the state. The only hard dollars are state and tuition fees. There is pressure on faculty to cover salaries. State appropriations are inappropriate for cross-

subsidy: We can't use student tuition; we don't have enough students. Increasing tuition doesn't make up the gap. We also have an increasing burden on students of the debt they end up with. The state and institutional funds are the financial underpinning for academic entitlements, tenure, guaranteed appointments and tenure.

Jane Schumaker then reviewed the state funding process. The Joint Budget Committee and the Governor propose budgets. These are reconciled in the Long Bill, where there are many pressures, including TABOR and other considerations. This process starts in the winter and goes on until May. The budget then goes to the Colorado Committee on Higher Education and then to the Board of Regents. They allocate funds to the System budget and the three campuses of the CU system, Colorado Springs, Boulder and Denver, which includes the Downtown Campus and the Anschutz Medical Campus. UCD then allocates funds to the schools and programs. Some funds that are generated, including: tuition and fees, Clinical Revenue, UPI Revenue, Research, go directly to Schools and Programs. Other funds, including: State General Funds, Tobacco Funds, and other revenue go to the Central Services and Administration, and Indirect Cost Recovery. In the SOM some funds go directly to the schools, some go to the Deans' office and then to the Departments. UPI revenue goes to the Departments, Programs and Centers. Restricted funds go directly to the grantee.

Regarding research funding, the days of NIH doubling are over, and the ARRA stimulus funds have ended. The success rate of grants is eroding, and it takes longer to get funding. Fiscal year 2011 awards were 4% less than those in 2010, \$333.6 M vs. 344.4 M. NIH success rates by Institutes have decreased over the last 13 years. In 1999, the success rate at NCI was 32%, in 2012 it was 14%. Also the NIH salary cap was decreased so that higher paid faculty get less of their salary covered and the department and the Dean have to make up the difference. There is a change to the indirect cost rate, it will go from 54 – 55.5% over three years. Other revenue comes from affiliated hospital contracts. The SOM staff have many roles, including as medical directors, and these contracts are managed by UPI. SOM faculty members also are involved in Graduate Medical Education. Other sources of income include Gifts and Endowments, and Indirect Cost Recovery. Administrative reimbursement is capped at 26%. This is a challenge, as some administrative costs are not being recovered.

There is a complicated formula for indirect cost recovery (ICR). Allocation of ICR revenue to the SOM is based on a campus-wide distribution formula that is comprised of 2 distinct components (base and incentive). The base component of the formula, assuming positive revenue growth from the prior fiscal year, is equal to 20% of the total ICR revenue generated by SOM in prior fiscal year. The incentive component rewards the SOM for positive growth in total cost recovery revenue over the prior fiscal year. If total indirect cost recovery revenue grows by 5% or more, the SOM incentive is equal to 50% of the incremental revenue. Since 1999, 50% of all indirect cost revenue

distributed to SOM has been earmarked for debt service of the new research facilities on the Fitzsimons campus, approximately 10% of total ICR returned to SOM per formula. Ninety percent of formula dollars received are allocated to departments on a pro rata basis and are then allocated by the Department ICR formula/policy. Ten percent of formula dollars are allocated to the SOM Dean and are used for school wide infrastructure support.

The academic enrichment fund is an important source of revenue. It is a 10% "Dean's Tax" on all UPI professional fee income (net collections) – and averages 6-7% because of exemptions. It generates approximately \$27 million/year. Approximately \$253 million has been reinvested in SOM over the past decade and a half. This is invested by the Dean in academic program development or enrichment to enhance the missions of the School. Awards are considered one-time commitments but may be spent over multiple years. No "in-perpetuity" commitments are made.

Clinical revenue is endangered, almost as much as research. Commercial professional fees are under pressure, especially specialty services. Medicare/Medicaid reimbursement will decline, though it will stay at the same rate until 12/12. Expanded Medicaid eligibility has a Pediatric impact; it covers a large percentage of patients and is the poorest payer. Hospital reimbursement is under pressure. There are emerging reimbursement models – pay for performance, bundled payments. There is increased provider accountability for costs and outcomes. MD and hospital consolidation brings increased competition, and systems control referrals. Hospital reimbursement under pressure may impact academic support. Finally, in the next federal budget there are potential cuts to Medicare GME payment (FY14). The bottom line is that we do see an erosion of the clinical margin. The take-away message is that the school is supported by the work of its faculty, that teaching is underfunded, and that clinical and research activities fund this.

UPI is a separate, not-for-profit corporation. It serves the faculty of the SOM. It has an operating agreement with the CU Board of Regents. Its work supports the SOM faculty, especially in the assignment of clinical income, and in collections. All faculty are members. All faculty sign the member practice agreement. Membership is mandatory. All clinical income goes through UPI. UPI is delegated to do billing and contracting by the SOM. It is governed by a Board of Directors and consists of clinical chairs and elected faculty. UPI is an employer of about 500 employees, 350 support billing and collections. UPI employees might work within the department. UPI wants to get the best and retain the best employees. They do billing and collecting of professional fees generated by faculty, capturing fees through coding and charging. They do commercial and third party contracts and managed care credentialing. They review and sign contracts for faculty services/consulting, after department review and approval. UPI has its own health plan, the University of Colorado Health and Welfare Trust, so that employees use their own providers. UPI are part owners in TriWest, a holding company for Tricare. UPI does business development including retaining markets and expanding markets, and

acquiring physicians who would like to join us. UPI is an investor, and owns its own building, 1/3 of this is leased out as a revenue source. This has been used to endow SOM scholarships. UPI took in 400 million dollars last year, part contractual, part fee for service.

In the last portion of her presentation Jane Schumaker discussed the BSI or Base, Supplement, Incentive Compensation Plan. This was adopted by the Faculty Senate in 1995. Others have been interested in this as a model. The base is equivalent to 70% of previous year's mean salary for basic science faculty @ each rank. Base salaries are readjusted annually. The supplement includes merit, administrative activities, service, and is based on funds available, determined annually. Incentives are determined per UPI Bylaws. In FY 2010 – 2011, the Base salary accounted for 28% of expenditures, the supplement 62% and the Incentive 10%. Bylaws dictate incentives, while not guaranteed, can be paid from available department earnings with the following limitations: 10% mandatory reserve, 50% - 90% to be paid as faculty incentive. Incentives must be limited to an amount that, when combined with base salary would be considered "reasonable, fair market" compensation (IRS requirement). Plans must be reviewed/approved by a majority vote of department faculty every five years. All payments are issued via University payroll (UPI does not pay physicians). Departments should include relevant metrics and formula to align incentive pay with internal objectives (wRVU's, call points, collections, profitability, etc).

Jane Schumaker asked for any questions. The first was for the Dean: Do you anticipate salary freezes? Dean Krugman (DK): Every decade has 2-3 years of salary freezes. Ever since we passed B/S/I, we have been exempt from the salary setting process; we fund our own salaries. Most of our raises don't come from the general fund. Comment: So we are exempt by virtue of clinical activity, but we are bound by politics. DK: We pay more in state payroll tax than we get in the general fund, by \$8 million. If they hold salaries down then they don't stimulate the economy.

The meeting was adjourned at 6:04 P.M.

Respectfully submitted, Renata C. Gallagher, MD, PhD.

Minutes of the Faculty Senate of the University of Colorado School of Medicine

April 10, 2012

- I. **Welcome:** The meeting was called to order by President Ron Gill, Ph.D at 4:33 PM. Dr. Gill asked any guests and/or members of the media to introduce themselves. Dr. Bill Arend of the Department of Medicine introduced himself as a visitor and a member of the Retired Faculty Members Association. Dr. TJ Payne introduced himself as a new representative from the Department of Orthopedics.
- II. **Approval of the Minutes:** The minutes of the March 13, 2012 meeting were approved without comments or corrections.
- III. **Dean's Comments:**
 - a. Dean Krugman stated that there a few things to report regarding current searches and affiliate institutions:
 - The Dean of the School of Public Health has been selected and is David Goff, MD, PhD, currently Professor and Chair of Epidemiology and Prevention at Wake Forest University School of Medicine.
 - The search for a Dean of the School of Nursing is proceeding, three airport interviews have been conducted.
 - Two of three candidates for Director of the Bioethics Center have had interviews.
 - Dean Krugman said that he would be leaving the Faculty Senate meeting early to attend the first meeting of the University of Colorado Health System; this includes Poudre and the University of Colorado Hospital.
 - Regarding Memorial Hospital in Colorado Springs, Bruce Schroffel is there one day per week. Assuming that the negotiations with the city go through there will be an election in August where citizens will vote. If this is not approved it would stop our planning, including for the branch campus.
 - The committee has met to evaluate the six responses to the school's RFP to the consultant group to help us with our strategic planning process. The state procurement process will notify the winner, then over the next nine months we will plan for the future. The Dean stated that he is hopeful that this will be a very broad conversation about the future with respect to the clinical, research, education, and community service missions of the school.
 - There is also the campus master planning process, this involves UCH, the VA, the Fitzsimmons Redevelopment Authority (FRA), Children's, UCD, AMC, and the Aurora City Council, the last because of the roads. Lily Marks and Neil Krauss have four firms to help them. There are challenging but important issues with respect to transportation and other issues.

IV. Discussion Items:

A. **Update on Tenured Faculty Retirement Incentive** – Steve Lowenstein, MD, MPH, Associate Dean for Faculty Affairs. The buyout exists officially, but is not yet public. This should be available for 2012. It is for individuals with at least a 0.5 FTE. It is subject to funds available in 2012, and can be extended by the Chancellor. Those eligible for retirement are those who are 55 or older, and for whom the years of service plus their age is greater than 70. This is taxable income, so that those who take this can come back to work, but not at a salary that is greater than, or equal to, two times their base salary. This has different IRS requirements than the previous plan. The Dean will help insure that the department has funds. One question will be how to choose the faculty member if more than one wants to do this. President Gill: How will this be published? SL: Either by the Dean or the Chancellor, as soon as it exists faculty will be notified. Question: Faculty at which campus are eligible for this? SL: The downtown campus and the Anschutz Medical Campus, the guidelines will cover all. The school will have to work this out fairly for faculty.

B. **Update from 2011 Curriculum Retreat: Potential Modifications of Curriculum** – Stuart Linas, MD, Chair Curriculum Steering Committee. Dr. Linas began by reminding senators that the main group that the Curriculum Steering Committee (CSC) reports to is the Faculty Senate. Their retreat took place last Spring; one hundred individuals met for 8-9 days. Four key areas were identified for further discussion, there is no decision yet, these are at the task force stage. The committee welcomes input from all faculty and senators regarding these.

The four key areas are: Master Educator, Learning Communities, “First Course”, and Longitudinal Clerkships. Each area has a “champion”. Robin Michaels, PhD, Associate Professor, Cell and Developmental Biology, Assistant Dean, Essentials Core Medical Curriculum is the champion for the Master Educator. Many schools of medicine recognize that it is important to recognize faculty with skills as educators; CU has not had the resources to reward this. As basic scientists play an important role in medical school teaching, this will first be addressed for basic scientists. The task force will determine the definition and work effort of a true Master Educator. The questions for the task force include: Is a Master Educator more than a great teacher/content expert? Are they different than a Block Director? Should there be some scholarship in education, or a hybrid? What is the definition of scholarship in education, is it innovative teaching techniques, novel ways to assess students, publications in education, mentorship of junior faculty? There are different types of interests/expertise. Finally, where will these faculty be primarily housed, i.e., evaluated? The task force will address these questions.

Next are Learning Communities. The champion of this is Marsha Anderson, Associate Professor of Pediatrics. This is like the college system for undergraduates. Learning communities have been introduced in many medical schools throughout the US. These divide students into groups or “houses” and the houses are subdivided into smaller groups. Advantages are:

the curriculum can be delivered in small groups. This fosters building of interpersonal relationships with a group of individuals, increases interaction with a faculty mentor, allows opportunities for ongoing personal and career mentoring, allows opportunities for student interaction between classes (it will include 1st, 2nd, 3rd and 4th year students) within the structure of the house, and it allows opportunities to improve wellness and support to students. The task force is currently developing a proposal for the CSC to consider, including: goals; logistics and structure, developing a structure that is cost efficient; considering ways to integrate students in Phase III and IV; budget; timeline; and the curriculum that could be delivered within this structure. This does allow the opportunity to deliver some Longitudinal Curriculum within Learning Community groups.

Marsha Anderson is also the champion of the "First Course." This could be a home for the Longitudinal Curriculum. The Longitudinal Curriculum has several elements, these are: Foundations of Doctoring; Mentored Scholarly Activity; Problem Based Learning; Threads (Culturally Effective Medicine, Evidence Based Medicine, Humanism/Ethics/Professionalism, Medicine & Society); Interprofessional Education; Integrated Clinician's Course; Tracks (elective) - Global Health, LEADS, Research, Rural, Women's Health, CU-UNITE (urban underserved). Most of these elements have a defined home, Threads are woven throughout the curriculum, but there is currently no place to develop a consolidated knowledge base. An opportunity for the Longitudinal Curriculum home is to develop a "First Course" that would occur during the first 1-2 weeks of medical school to provide framework for what students will be learning in medical school. This could include vignettes - standard and complex; ethics; life-long learning; and would carry through the 3rd and 4th years. We could partner with Student Affairs to build Learning Communities. The task force is currently meeting to define recommendations for: length of course (likely 1 week); logistics - add an additional week to the current curriculum, this is hard with the yearly schedule; budget; content. This likely would include introduction to a few virtual "patients" who would be referred to throughout the Essentials Core; likely will include base curriculum on thread topics; what is health?; Health system structure in the US (Medicine and Society); Health disparities (Medicine and Society); culturally effective medicine; professionalism (life as a medical student); timeline: with a possible roll-out 2013 or 2014 depending on logistics. The goal for the longitudinal curriculum home is to have a recurring curricular slot where the longitudinal curriculum is presented. This could be accomplished by utilizing the 1-3 PM time slot weekly in weeks that PBL (Problem Based Learning) does not meet, use of this timeslot would provide reinforcement of Longitudinal Curriculum on a weekly basis (PBL or other longitudinal content), curriculum could be delivered in "learning community groups" if Learning Communities are developed.

Last are the Longitudinal Clerkships. Brenda Bucklin, Professor, Department of Anesthesia; Assistant Dean, Medical Education is the champion. This is a schematic of the current third year. It is a standard block system. A student

rotates through in a structured way. An integrated clerkship looks different. On Monday a third year student starts at one hospital, and in the AM may be in Internal Medicine, in the PM in the ER, and in the evening is scheduled for reflection in a group. On Tuesday morning the student is in the Family Medicine Clinic and in the PM has self-directed learning which may be an opportunity to see a patient from a different clinic having a procedure. This was championed at Harvard and has been found to offer better learning opportunities and more long-term exposure to individual patients. For example, a student might see a patient in the hospital, and when that patient leaves the hospital the student would follow them in clinic and have long-term exposure to their care. This promotes patient-centered attitudes and promotes empathy and more patient-centered decision making. A 2009 article: Longitudinal, Integrated Clerkship Education: Better for Learners and Patients, *Academic Medicine* 2009; 84:821 included the advantages as: better clinical learning opportunities, more longitudinal exposure to disease, promotes patient-centered attitudes, prevents erosion of idealism and empathy, greater understanding of ethical decision-making and how social context affects patients, and students are more likely to receive feedback and mentoring. The goal is to meet the core clinical education in the longitudinal curriculum. Students can participate in the comprehensive care of patients over time, have continuous learning relationships with clinicians, and meet the majority of core clinical competencies across multiple disciplines simultaneously. It is an integrated approach. This could first be piloted at Denver Health and then expanded.

The process for moving forward is that the champions present proposals (including budgetary needs) to the Curriculum Steering Committee (CSC) for an up or down vote-2/3rd vote of CSC required for approval. Input from any faculty member is encouraged. The CSC is to prioritize the order of enthusiasm of the four proposals; the Faculty Senate will review this and provide input. The CSC will present the recommendations to Dr. Celia Kaye, Senior Associate Dean for Education, to give final approval based on budget availability. Dr. Linas then asked for thoughts, questions, concerns.

There were many questions. The first was: how many medical schools are doing this? Dr. Linas replied that none have all four items in place. The 25 – 30 top medical schools have one or more. Fewer have the integrated curriculum. Comment: this works well for great students and great teachers, others could be stuck. Dr. Linas replied that we are working toward an individual student curriculum. This is a start in this direction. This curriculum is flexible and allows time for self-directed reading. Comment: But the students aren't reading now. Dr. Kaye: The self-directed time is time to follow their patients, they are still expected to be the knowledgeable person about their patient to the ward team. Students apply for this, it is very hard in the beginning. The students self-select this, and are selected. It is not for all students. Question: What does the 4th year look like? Response: The 4th year looks the same. Comment: this has a downside for different services. The ER doesn't fit this. ER physicians are shift workers, we don't see the

same patients, the students won't see the same physicians. Also, do they get enough exposure; is this too piecemeal? Dr. Bucklin: This has had positive student outcomes; South Dakota has had this for 20 years. Students exhibit better empathy, they have less erosion of empathy over time. They have a better idea of the social situation of the patient. In the block system they have 8, 6 and 4 week blocks, In the longitudinal clerkships that time is still built in. Surgeries take priority. If a chronic renal patient goes to surgery, they follow that patient. Or a student might go to Labor and Delivery when a patient is admitted. They have proportional shifts; we still have to deliver the equivalent amount of content. Comment: They might learn more about a patient or a disease, but they will learn less about a specialty.

Question: Do they get enough experience with DKA, trauma surgeries? What about intensive clinical experiences? Dr. Linas: When programs and students are surveyed they love it. The students are as well or better prepared. Comment: But part of learning is the intensity and the total immersion. There may be as many content hours, but they lose the total immersion. Some manual and visual skills can only be learned by contact with a mentor. They won't integrate this if you dilute it over time. You learn better with intensity; this seems Family Practice oriented. Dr. Bucklin: The research shows the opposite, students have longitudinal mentoring. They log cases and see the same number as those in the block rotations.

Comment: I am in Orthopedics, one student is with me every Friday; the students feel like they are working in five places in one week. Question: How does this work in the inpatient world? There's no team, as a medical student it was important to be part of the team. Dr. Bucklin: There is a 2 week initial start up inpatient rotation that is a team experience. The emphasis is moving away from inpatient to outpatient care. Some students will flourish. Dr. Kaye: The third year is a different time. The 4th year is still a block elective, students will hone skills of professionalism and discernment in the third year.

Comment: You lose the feeling of what it is like to be a surgeon. Dr. Linas: It is not for all students, it is for a small group in the right setting. President Gill: Based on the interaction I have had with the first year students, the majority are reluctant to pursue integrated sorts of things, they want immersion. Also, how taxing is this on the faculty? Dr. Linas: I agree it takes special faculty. It is not for all of us, because of time, rvus. Dr. Bucklin: We will do faculty development pieces. It is easier on the preceptors, they get to know the students. The student is their partner. The outcome is that the preceptors are more engaged. President Gill: Are those people available to serve that role? Will it work logistically? Comment: This is about the Master Educator, what is the impact on the curriculum, and how are they different? Dr. Linas: That is what we are asking the task force, this should be accurate and fair. President Gill: Regarding the Master Educator, this could be a particular person who is a content expert following through several blocks, or this could be one person teaching pharmacology; in the last case there is continuity, students know the style and the content flows.

Comment: Yes, there is one person who is only a teacher and is the block director for their field in Medicine and Dentistry, but are the basic sciences going to have the budget for this? Dr. Linas: There will be a budget and support for part of an FTE. President Gill: It is the school's responsibility to have these people. Dr. Lowenstein: If we invest in a Master Educator what happens to the other faculty? Dr. Kaye: We have no intent to replace faculty, they are high level experts in their field. A goal is to provide four years of continuity. We have an unfulfilled promise; we shortened the basic sciences in years 1 and 2. We need to bring it back in years 3 and 4. What is different about physicians as health-care workers? Physicians know the basic science and apply it. Comment: Why change? Dr. Kaye: We live in a larger educational world. The concept of integrated learning is being developed. It will work for some. Board scores go up, empathy and ethics stays high. Dr. Linas: We are trying to do what is best for groups of students. One way is to introduce an important new way to educate medical students, we will pilot it to see if it will work. Dr. Lowenstein: This is hard for the faculty. But Dr. Hirsch said that the purpose of education is not to re-make ourselves.

Dr. Linas: Thank you, I will keep you informed. President Gill: I am sure there is more lively discussion to come.

The meeting was adjourned at 5:55 P.M.

Respectfully submitted, Renata C. Gallagher, MD, PhD.

Minutes of the Faculty Senate of the University of Colorado School of Medicine

May 5, 2012

- I. **Welcome:** The meeting was called to order by President Ron Gill, Ph.D at 4:30 PM. Dr. Gill asked any guests or members of the media to introduce themselves. There were no guests
- II. **Approval of the Minutes:** The minutes of the April 10, 2012 meeting were approved without comments or corrections.
- III. **Discussion Items:** As the Dean was not present at the beginning of the Senate meeting the Dean's comments were deferred. The first discussion item was the ***Blue Ribbon Task Force Update on Clinical Series*** – Nancy Zahniser, PhD, Chair, Blue Ribbon Task Force on Promotion and Tenure Criteria. Dr. Zahniser began by reminding the Senators that she last presented in October of 2011. At that time the committee presented recommendations for updates to promotion and tenure for those primarily in research and education and clinical care, as well as for expanding examples of scholarship. There was great enthusiasm for the recommendations, except for those related to scholarship. Now the committee is back with the current, new recommendations; all members agree that they support this. This is the final recommendation. The members of the BRTF are: Steve Anderson (Pathology), David Barton (Microbiology), Stephen Cass (Otolaryngology), Joseph Cleveland (Surgery), Jim Hagman (Immunology, NJH), Randall Holmes (Microbiology), Madeleine Kane (Medicine), Jean Kutner (Medicine), Linda McCabe (Pediatrics), Thomas Meyer (VA), John Ogle (Pediatrics, DHM), Steven Ojemann (Neurosurgery), Nayana Patel (Radiology), Claude Selitrennikoff (CDB), Tod Sloan (Anesthesiology), Nancy Zahniser (Pharmacology), Faculty Affairs: Steven Lowenstein, Cheryl Welch. The names that are underlined are the members of the subcommittee for the new clinical series.

Dr. Zahniser provided an overview of the proposal; this is a new series in parallel with the Research Professor Series. There is still a tenure-eligible regular series. The new proposal for the clinical series is that the title be: Assistant Professor of Clinical Practice, Associate Professor of Clinical Practice, or Professor of Clinical Practice. There is a concern that this is a bit awkward with the Department name, there is a possibility of using Assistant Professor of Clinical – Department Name. This is for faculty who devote most of their time to direct patient care. They are required to teach; there is no requirement for scholarship, though it is encouraged. These faculty are not tenure-eligible since scholarship is required for tenure. These appointments can be limited, indeterminate, or at-will. Faculty will have an annual review. They could request to switch to a different series; the faculty member would have to initiate this. This would need Chair support and approval by the relevant review committees. The expectation would be that faculty would move from Assistant to Associate Professor by their seventh year, that they have the terminal degree in their field or the equivalent, excellence in clinical care, meritorious performance in teaching, and a local or regional

reputation for clinical excellence.

The criteria for promotion to Professor are: terminal degree appropriate to their field or equivalent, excellence in clinical care, with continued growth and ongoing achievement in area of expertise. They must have at least meritorious performance in teaching, and one of the following: excellence in teaching; leadership of projects that have assessed and improved the quality, value and efficiency of clinical care; national or international reputation for clinical excellence. That is, for promotion to Professor, they need a second area of excellence. The approval process is as follows - First, approval of revised Rules and Matrix by the BRTF (done in 4/12). Next, Cheryl Welch and Steve Lowenstein will set up a meeting of the SOM Rules Committee. If approved there, this then goes to the Executive Committee, the Faculty Senate, the Executive Faculty and the Regents.

One year ago the Dean said, no major changes, but that was not what was best; this is more far-reaching, but what they thought was appropriate. Question: Will someone be hired as one or the other? NZ: Yes. Question: Is there still a clinician-educator track? Steve Lowenstein (SL): If your career includes scholarship, you should be in the regular faculty series. Comment: But some could be intimidated by this track, which could push them to maintain scholarship, without this I worry about clinician-educators. NZ: This is why the faculty member needs a mentor. The mentor should be sure that the faculty member is in the correct track. SL: The risks of getting it wrong are less here, there is less risk of second-class citizenship. Comment: But one needs to be pushed to do scholarship. Question: What about those who do not want to do this? Comment: This will have to be monitored; it could disproportionately affect women. The chair may not support a well-rounded faculty member.

Question: The requirement for advancement from Associate Professor to Professor is excellence in just one additional area; why not two or three? NZ: The input of the chairs of the clinical departments was that they did not want any requirement for scholarship. Comment: That is stunning. NZ: Regarding time to promotion it would not be expected that someone would be promoted before 5 years, and an extension could be requested before 7 years. Comment: Doesn't this ignore that we are hiring new faculty at affiliate sites; these are major changes? SL: There is no final understanding about this, some will be volunteer faculty. NZ: This addresses faculty here primarily doing clinical care. They are contributing and would like to be recognized. Comment: Could you only be promoted to Associate Professor of Clinical Pediatrics or Associate in the regular track, rather than starting at Assistant Professor in this track? SL: That is a nice idea. This could mitigate the concern above of tracking too early. Comment: Not everyone should get to be a Professor, this requires something special. To have such flimsy requirements is degrading to the name. The only ones who should be professors are those who have performance to warrant this. NZ: Here it is a demonstration of being a leader or a resource. SL: You have to have one of three additional areas of excellence.

Comment: What is the Chairs' reticence about this? NZ: The Chairs have not seen this. SL: it is hard to have a national reputation as a requirement, if you excel here that is what we pay you to do. Comment: Then they shouldn't be professors; set the bar higher. NZ: We went around and around on this. We are giving credence to clinical care. This is where they excel. This may not go forward. Comment: But providing excellent clinical care in an academic medical center or an affiliate requires excellence in teaching. Comment: If you are an Associate Professor, clinical excellence is assumed. SL: It is not assumed. Comment: But that is our goal. Comment: I can see some scenarios in which the Chair would push people in to these tracks. NZ: What about the decision happening at the time of promotion to Associate Professor? SL: This could work. NZ: I have heard that some people want to do scholarship but that their Chairs do not want them to. Comment: What about taking out the Assistant Professor and Professor roles? Then you would not have someone being a Professor without scholarship. NZ: People will get a chance to vote.

SL: I have made notes. I want to correct one thing, in the Research Professor series all faculty are "at-will", that is a Regent law and a state law. Question: Could you define that better? SL: The majority of faculty have limited appointments, one year, two years or three years. They expect notice at some time. At-will appointments could be for any non-tenured faculty member; there are increasing numbers of these, they can have their appointment revoked at any time, except for some legal reason. The 3rd category is indeterminate; this is used by Chairs for faculty members on soft money. Their appointment is dependent on grants. The fourth category is tenure. Question: How is this title different from that of the community, private practice physicians? SL: That is true, we agree, there is confusion, overlap and ambiguity. NZ: We tried to come up with a title that identifies the faculty member's primary focus. Thanks for the discussion and feedback; these are important concerns. We made our best effort, we will come to the point at which we will say this is the proposal. It may be that people will not be supportive of this and we will need another task force. SL: All rules come here. We will summarize everything. We will need action on a much bigger package than this. President Gill: Thank you, this is a wonderful compromise on an issue with competing interests.

- IV. *Standards for Notice of Non-Reappointment Policy Update*** – Steve Lowenstein, Associate Dean. The Administrative Policy Draft 3/13/2012 on Standards for Notice of Non-reappointment for Faculty was attached to the Agenda for this meeting. Dr. Lowenstein began by explaining the history of this policy. There is a history of appearance, disappearance and reappearance of this policy. This is about non-reappointment, not dismissal. The latter must be done for cause. Non-renewal or non-reappointment is that the contract will not be renewed after the contract ends. The notice requirements have been around since the 1960's, and were codified in 1984 in the Faculty Handbook. Faculty members with less than one year of university service required 3 months notice, with 1 year of service required 6 months notice, and after two years of service faculty required 1 year notice. Since 1990 this has applied to all faculty members.

Then a case came up, and the faculty member won. Notice had been given to her in the middle of her contract period; she lost a period of notice. One needed to give notice prior to the expiration of the current contract. Then this disappeared. It was published in the Faculty Handbook until 2006, and in 2011 the requirement for notice was just deleted. It simply disappeared.

Today, notice is no longer required by the Regents. Now there is a prepared draft statement. The current draft states: 1 year or less of service, three months notice, 1-3 years of service, 6 months notice, more than 3 years of service, 12 months notice. This eliminates what was required by the Subryan decision; that is, this notice can be given at any time. This started with the Chairs, administrators were advising short notice periods, Chairs said no, we owe them one year. You need to be here for three years to get one year's notice. This is what we will do, with the appropriate vote from the governance group. Faculty members should have an expectation of a longer appointment. Longer notice would give Chairs incentive to put faculty at-will. Comment: Someone won a lawsuit before, why will this be acceptable? SL: That is because the court was interpreting the Regents' policy. That doesn't exist anymore, there is no Regent policy.

Question: The appointment starts in July, I give you notice in August, does the appointment expire in July, or the next July? SL: That is the change: after three years of service a faculty member will have one year from the time of their notice. Question: Why is there a trend of having more at-will faculty? SL: Some say all should be at-will, it is superior for management and budgeting. There is so much pressure on Chairs, they can't manage a 2-3 year obligation; they see this as an albatross. But this has only adverse consequences; it is important to preserve notice. But I do not have to go to the Dean, as they do. Ron Gill: If one is not promoted from Assistant to Associate Professor, is one given a year's notice? Yes. They could move to the clinical series. Question: In the correct series, if you do not advance from Assistant to Associate Professor and move to the new series do you get another seven years to advance? SL: This has to go under review. Comment: That should be clear.

V. The Dean provided his comments at this point:

Dean's Comments: The Dean began his comments by stating that the SOM has contracted with Navigent consulting firm. Six firms responded to the bidding process to assist us with the strategic process Navigent, came out on top. They are excited to be working with a school that is asking this question; that is, how do we reorganize to be maximally successful in all that we do, research, clinical care, teaching, and community service. There will be a meeting next week, and we will have a process by June. The Dean stated that he wants to have as many faculty involved as possible. This is our future, yours and mine. The state purchasing process is finished, and the Dean looks forward to getting this started. This will take off in the late summer, speed up again in the fall, and will be done in the winter.

Regarding current searches and affiliate institutions: There is a search for a Dean of the College of Nursing; there is an internal candidate and an external

candidate. There are expected to be two to three candidates for the head of the Center on Bioethics and the Humanities shortly. Clinical Sites: We are still negotiating with Colorado Springs; Bruce Schroffel hopes that this will be done in early June for the August vote. University of Colorado Health still needs an IRS letter; it cannot function as a health care organization until they have the IRS letter, but it is behaving like a health care system even without the letter. At lunch there was a key information meeting, and all agreed that Bioinformatics is crucial. I feel very positive about this; we can't not do this. We need 10 million dollars to get this started. The critical part is what you will talk about now.

C. Approval of New Division of Computational Biology and Personalized Medicine, David Schwartz, MD, Professor and Chair, Department of Medicine; Mark Johnston, PhD. Professor and Chair, Department of Biochemistry and Molecular Genetics.

Dr. Gill indicated that this would be presented by Dr. Schwartz, and that there would be comments and questions at the end. He hoped that the Senate would enthusiastically support this. David Schwartz (DS): This is a new program and center, and could be a real game changer. This started a year ago when Dean Krugman asked Mark Johnston how to support Biomedical Informatics, because a review of the CCTSI said that Bioinformatics needs a home. Mark Johnston led a great committee that met weekly for 4-5 months for 1-2 hours and that took their charge very seriously. The committee came up with something that the Dean had not imagined. This will change what we all can do. The group interviewed 20 individuals and looked at what others are doing in computational biology and personalized medicine. This is computational biology connected to health care, connected to the EMR, connected to computational biology connected to the EMR; this will change how we deliver health care. This is an opportunity for the whole campus.

How do we put this together so that it meets the needs of the campus and the CCTSI? It needed to be a center that spanned the campus, so it was put in the Vice Chancellor for Health Affairs Office. It is part of all health sciences. This also needs an academic home in a department, because it needed to be connected to clinical medicine. We will use the EMR to understand disease at a different level; we will re-conceptualize how we care for patients and train our physicians. The goal is to have 7-10 faculty in the Department of Medicine. They will also have secondary appointments. This could grow in time, and could be its own department in the school. This could span schools; we did it small so it could succeed. We wanted a Center to span all health sciences schools and span an operational component. This is the data warehouse for information commons. This is highly operational, it needs to function outside the academic environment and assimilate data across the campus.

Mark Johnston (MJ): Faculty need an academic home in order to develop their scholarship. We need to serve the campus; that is where the center comes from. All we do will be centered around biomedical informatics. Question: Why isn't this in the CCTSI? Dean Krugman: It is not a department; centers have space and

resources but can't appoint faculty. We want to give centers the flexibility to move in different directions; the Department needs to care for the faculty. All need to agree that if the Center goes in a different direction, the Department will keep that person. The CCTSI is a center, but Ron Sokol does not appoint faculty.

DS: The facility will be very close to the CCTSI, and may change the direction of the CCTSI. Question: Is there buy in from the Cancer Center? DS: Yes, they are two steps ahead of everyone. It is possible that the head will be a cancer oriented person. There are lots of activities and opportunities in cancer. MJ: The nascent Bioinformatics Core is funded by the Dean, the Cancer Center, and the CCTSI. President Gill: Why is this not in the School of Public Health? Are they on board? David Schwartz: There are two members of the CSPH on the deliberation committee. We talked about putting it in the CSPH, but then it wouldn't have a connection to clinical care. We need to interface to change care. Vanderbilt is way ahead of us; they base care on the kind of program. The Dean of the CSPH agreed with this.

MJ: Intellectually this should be in Biostatistics, but this needs to be linked with the clinical enterprise. Dean Krugman: I talked about this with the CSPH incoming Dean, Dean Goff. He is fine with this. The Center needs to be across all schools. Individuals in Pediatrics and Emergency Medicine, for example, will have homes in their academic program with secondary appointments in Medicine. President Gill: Is there an associated PhD program? David Schwartz: Larry Hunter directs the Computational Biosciences PhD program; this is funded through a T32. This was recently re-funded; Larry Hunter wants to participate in this program. That academic program is important to this whole program. Whether this will be in parallel with us or within us is not clear. President Gill: Can we vote on this? Do we approve, or not, an Interdisciplinary Center for Biomedical Informatics in the Department of Medicine? The motion was moved and seconded, the vote taken; the Center was approved unanimously.

President Gill: At the Faculty Assembly meeting folks doing a campus-wide visionary plan had disappointing and not positive discussion. For example, they want to have a new building on the other side of the Education buildings. They are not thinking carefully about faculty, staff, patients, transportation. There will be two more meetings in which folks can share information. Please go back and share the importance of going to these with your faculty. We don't want decisions made that we can't live with. Steve Lowenstein: This needs grass roots faculty input. Question: Will they come to us? Dean Krugman: The meetings are in May, they can report in June. There is tension around this. Open space on campus is important. The next research building is to be west of here, this will balkanize the campus more, or we could connect RC1 and RC2 with a building; there could be a big cafeteria. Ron and Steve are right, we need more input. We came here with just UCH and the SOM, now we have the VA, Children's and the FRA (Fitzsimmons Redevelopment Association). People cannot get here, we have 1.1 million outpatient visits per year, and we are projected to have 1.5 million visits per year in 5 years. People who want to come here need to get here. We need space for students, researchers and patients. We don't need one over-

arching concept, we need a functional campus. Comment: There is not enough input from the SOM.

President Gill: We need a President-elect candidate for the upcoming Faculty Senate elections, this person must come from a basic science department.

The meeting was adjourned at 5:55 P.M.

Respectfully submitted, Renata C. Gallagher, MD, PhD.