College of Medicine
General Faculty Meeting

June 13, 2013
HG611
COM General Faculty Meeting
June 13, 2013

- Faculty Council Update
  - John D’Orazio, M.D., Ph.D.
    2012–13 Chair, College of Medicine Faculty Council

- Proposed Change to CoM Rules of the Faculty
  - C. Darrell Jennings, M.D.
    Senior Associate Dean for Medical Education

- State of the College
  - Frederick C. de Beer, M.D.
    Dean, College of Medicine
    Vice President for Clinical Academic Affairs
Faculty Council 2012–2013

Basic sciences:

- Lee Blonder, Behavioral Science 2011-2014
- Subbarao Bondada, Microbiology, Immunology and Molecular Genetics 2011-2013
- Brian Jackson, Ex-officio (Past Chair) Physiology
- Davy Jones, Graduate Center for Toxicology 2012-2015
- Daniel Noonan, Molecular and Cellular Biochemistry 2011-2014
- Hollie Swanson, Molecular and Biomedical Pharmacology 2012-2015

Clinical sciences:

- Alison Bailey, Internal Medicine 2012-2013
- Franca Cambi, Neurology 2010-2013
- John D’Orazio, Pediatrics 2011-2014
- Paul Kearney, Surgery 2011-2014
- Peter Nelson, Pathology and Laboratory Medicine 2011-2014
- Joseph Valentino, Otolaryngology—Head and Neck Surgery 2012-2015
Issues discussed recently:

- College of Medicine Strategic Plan
- Wethington Award Program
- Markey Cancer Center reporting structure change
- College of Medicine’s role in UK Undergraduate education
- Kentucky Neuroscience Institute
- College-wide Assessment of Educational Productivity
- Professional Code of Conduct
- Medical school course and faculty evaluation form changes
- Creation of Department of Urology
- AR 5:4 Enrollment of GME Residents and House Staff
- Massive Open Online Courses (MOOC) Proposal
- New University-wide “value-based” financial model
- Integrated Biomedical Sciences (Ph.D. graduate program) curriculum
- Master’s in Science program, College of Medicine
- Clinical Faculty Compensation and Productivity Plan
- Medical School Curriculum Revision
- Faculty evaluation appeal process
The minutes from the monthly Faculty Council meetings are available at:

https://med.uky.edu/faculty-council
Proposed Change to CoM Rules of the Faculty

C. Darrell Jennings, M.D.
Senior Associate Dean for Medical Education
ED–25–A

At a medical education program, students in clinical learning situations involving patient care must be appropriately supervised at all times. While students learn through graded responsibility as their skills progress, supervision at all times must ensure patient and student safety.

Annotation

The accountability of physicians and non-physicians who supervise medical students in clinical learning settings will be clearly described in the program’s policies and procedures. The level of responsibility delegated to the student by the supervisor will be appropriate for the student’s level of training, and the activities supervised will be within the scope of practice of the supervising health professional.

Rationale

This new standard and annotation address patient and student safety and the clinical supervision of medical students by health professionals in clinical learning settings.
4.0 Educational Policy Rule Concerning Supervision of Clinical Activities of Medical Students

4.1 In order to ensure an appropriate learning environment for optimum patient and student safety, a College of Medicine faculty member must directly supervise or appropriately delegate supervision of all student clinical activities involving patients. Faculty supervision must include the designation of the clinical setting, level of student involvement, and planned activities that are appropriate for the student’s level of training and experience. The faculty member may delegate the direct supervision of the student's activity to an appropriate resident, advanced practice provider, and/or other health care provider. In doing so, the faculty member must ensure that student activities fall within the designated supervising provider’s scope of practice. Further, the supervising faculty member must ensure that the supervisor is appropriately trained and credentialed to supervise the student's clinical activities. The necessity of faculty oversight, direction, and supervision, direct or delegated, applies to all patient encounters by medical students, regardless of training level.

4.2 This requirement must be incorporated into the planning and operation of all medical student activities. All courses that include patient interactions must delineate supervision guidelines in compliance with this requirement in the course syllabus. The course or clerkship director will assume primary responsibility for compliance with this requirement. Compliance with this faculty rule will be monitored by the Dean’s office. Failure to comply with this requirement will result in suspension of student activities until compliance is ensured.
State of the College

Frederick C. de Beer, M.D.
Dean, College of Medicine
Vice President for Clinical Academic Affairs
136 Students in Class
Kentucky (91)  Out of State (45)
As of June 12, 2013

<table>
<thead>
<tr>
<th>Gender</th>
<th>Race/Ethnicity</th>
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<tbody>
<tr>
<td>Male</td>
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<td>Female</td>
<td>Hispanic 4</td>
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<th>Residency</th>
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<tr>
<td>RA</td>
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<tr>
<td>R</td>
<td>BS/MD 2</td>
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<tr>
<td>U</td>
<td>RPLP 11</td>
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<td>International</td>
<td>MD/PHD 3</td>
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### Entering Class of 2013: By the Numbers

*N=136*

<table>
<thead>
<tr>
<th>MCAT Averages</th>
<th>GPA Averages</th>
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<tbody>
<tr>
<td>Verbal Reasoning 10.31</td>
<td>Science GPA 3.61</td>
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<tr>
<td>Physical Sciences 10.54</td>
<td>Non-science GPA 3.74</td>
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<tr>
<td>Writing Sample “P”</td>
<td>Cumulative GPA 3.67</td>
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<tr>
<td>Biological Sciences 10.94</td>
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<tr>
<td><strong>Total</strong> 31.8</td>
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</table>
Students With 34+ MCAT
41
Students in the RPLP program
11
Students in the MD/PhD program
3
Students from BS/MD program
2
**Non-Kentucky Undergraduate Schools Attended:**

- Amherst
- Case Western
- Dartmouth
- Davidson
- Emory
- Hanover College
- Loyola–Chicago
- Northwestern
- Notre Dame
- Ohio State
- Penn State

- Princeton
- Purdue
- Stanford
- University of Michigan
- UNC Chapel Hill
- US Air Force Academy
- Vanderbilt
- Wake Forest
- Washington & Lee
- William and Mary
- Yale
Strategy: Quality of Care

Our Vision: To be a national leader
Our Objective: Meet or exceed our enterprise goals
Our Path:

• The Patient
• Alignment
• Empowering the clinical care providers to drive change
• Transparency
• Culture
<table>
<thead>
<tr>
<th>Mortality Domain</th>
<th>2012 Rank</th>
<th>Current Rank</th>
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<tbody>
<tr>
<td>Mortality aggregate (28 service lines)</td>
<td>26/101</td>
<td>11/100</td>
</tr>
<tr>
<td>Cardiology</td>
<td>60/101</td>
<td>60/100</td>
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<tr>
<td>Cardiothoracic Surgery</td>
<td>32/97</td>
<td>68/91</td>
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<tr>
<td>Gastroenterology</td>
<td>31/101</td>
<td>7/100</td>
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<tr>
<td>Medical Oncology</td>
<td>15/101</td>
<td>10/100</td>
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<tr>
<td>Medicine General</td>
<td>25/101</td>
<td>18/100</td>
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<tr>
<td>Neurology</td>
<td>16/101</td>
<td>15/100</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>10/98</td>
<td>23/96</td>
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<tr>
<td>Surgery General</td>
<td>58/101</td>
<td>27/100</td>
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<th>Effectiveness Domain</th>
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<tr>
<td>30-Day Readmission Rate (all cause)</td>
<td>6/101</td>
<td>17/100</td>
</tr>
<tr>
<td>AMI Composite</td>
<td>29/100</td>
<td>25/80</td>
</tr>
<tr>
<td>HF Composite</td>
<td>71/100</td>
<td>1/80</td>
</tr>
<tr>
<td>PN Composite</td>
<td>46/100</td>
<td>9/80</td>
</tr>
<tr>
<td>SCIP-IP Composite</td>
<td>85/100</td>
<td>36/80</td>
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<tr>
<td>SCIP-OP Composite</td>
<td>89/98</td>
<td>62/76</td>
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<tr>
<td>ED-1b</td>
<td>--</td>
<td>42/78</td>
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<tr>
<td>ED-OP-18b</td>
<td>--</td>
<td>36/76</td>
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<td>IMM-1a</td>
<td>59/81</td>
<td>59/81</td>
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<td>IMM-21</td>
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<th>Safety Domain</th>
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<tbody>
<tr>
<td>PSI 03 Pressure Ulcer</td>
<td>85/101</td>
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<tr>
<td>PSI 06 Iatrogenic Pneumothorax</td>
<td>85/101</td>
<td>43/100</td>
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<td>PSI 07 Central Line-Associated Bloodstream infection</td>
<td>88/101</td>
<td>52/100</td>
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<tr>
<td>PSI 09 Postoperative Hemorrhage and Hematoma</td>
<td>91/101</td>
<td>62/100</td>
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<tr>
<td>PSI 11 Postoperative Respiratory Failure</td>
<td>69/101</td>
<td>64/100</td>
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<tr>
<td>PSI 12 Iatrogenic PE or DVT</td>
<td>27/101</td>
<td>18/100</td>
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Core Measure Performance Trends
as measured by UHC Perfection Scores
## UK HealthCare Patient Centeredness Journey

### HCAHPS Enterprise by Discharge Date

<table>
<thead>
<tr>
<th>FY10 Q2 n=178</th>
<th>FY10 Q3 n=191</th>
<th>FY10 Q4 n=170</th>
<th>FY11 Q1 n=156</th>
<th>FY11 Q2 n=178</th>
<th>FY11 Q3 n=189</th>
<th>FY11 Q4 n=166</th>
<th>FY12 Q1 n=198</th>
<th>FY12 Q2 n=452</th>
<th>FY12 Q3 n=479</th>
<th>FY12 Q4 n=1185</th>
<th>FY13 Q3 n=1235</th>
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<tr>
<td><strong>Domain/Question</strong></td>
<td><strong>Percentile</strong></td>
<td><strong>Percentile</strong></td>
<td><strong>Percentile</strong></td>
<td><strong>Percentile</strong></td>
<td><strong>Percentile</strong></td>
<td><strong>Percentile</strong></td>
<td><strong>Percentile</strong></td>
<td><strong>Percentile</strong></td>
<td><strong>Percentile</strong></td>
<td><strong>Percentile</strong></td>
<td><strong>Percentile</strong></td>
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<tr>
<td>9-10 Definitely yes</td>
<td>12</td>
<td>24</td>
<td>6</td>
<td>6</td>
<td>38</td>
<td>25</td>
<td>49</td>
<td>26</td>
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<tr>
<td>10-15 Help tolerating soon as you wanted</td>
<td>26</td>
<td>66</td>
<td>69</td>
<td>31</td>
<td>40</td>
<td>25</td>
<td>73</td>
<td>45</td>
<td>71</td>
<td>72</td>
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<tr>
<td>16-20 COMM W/ NURSES Nurses treat with courtesy/respect</td>
<td>46</td>
<td>21</td>
<td>35</td>
<td>25</td>
<td>70</td>
<td>71</td>
<td>48</td>
<td>56</td>
<td>23</td>
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<td>21-25 Nurses listen carefully to you</td>
<td>68</td>
<td>33</td>
<td>41</td>
<td>36</td>
<td>36</td>
<td>32</td>
<td>83</td>
<td>51</td>
<td>83</td>
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<td>26-30 Nurses explain in way you understand</td>
<td>47</td>
<td>26</td>
<td>33</td>
<td>40</td>
<td>80</td>
<td>78</td>
<td>41</td>
<td>47</td>
<td>20</td>
<td>86</td>
<td>66</td>
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<tr>
<td>31-35 RESPONSE OF HOSP STAFF Call button help soon as wanted it</td>
<td>45</td>
<td>55</td>
<td>51</td>
<td>44</td>
<td>36</td>
<td>64</td>
<td>71</td>
<td>70</td>
<td>73</td>
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<tr>
<td>36-40 COMM W/ DOCTORS Help to toileting soon as you wanted</td>
<td>53</td>
<td>37</td>
<td>28</td>
<td>60</td>
<td>56</td>
<td>42</td>
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<td>41-45 HOSPITAL ENVIRONMENT Doctors treat with courtesy/respect</td>
<td>25</td>
<td>10</td>
<td>17</td>
<td>4</td>
<td>50</td>
<td>70</td>
<td>31</td>
<td>29</td>
<td>24</td>
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<td>46-50 Doctor listen carefully to you</td>
<td>27</td>
<td>46</td>
<td>49</td>
<td>27</td>
<td>76</td>
<td>12</td>
<td>71</td>
<td>20</td>
<td>9</td>
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<td>51-55 Doctors explain in way you understand</td>
<td>43</td>
<td>42</td>
<td>38</td>
<td>44</td>
<td>62</td>
<td>63</td>
<td>71</td>
<td>19</td>
<td>48</td>
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<td>56-60 HOSPITAL ENVIRONMENT Area around room quiet at night</td>
<td>39</td>
<td>15</td>
<td>21</td>
<td>1</td>
<td>10</td>
<td>20</td>
<td>36</td>
<td>42</td>
<td>68</td>
<td>61</td>
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<td>61-65 Room and bathroom kept clean</td>
<td>30</td>
<td>22</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>13</td>
<td>31</td>
<td>28</td>
<td>40</td>
<td>64</td>
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<td>66-70 Hospital environment</td>
<td>53</td>
<td>49</td>
<td>46</td>
<td>28</td>
<td>23</td>
<td>54</td>
<td>69</td>
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<td>64</td>
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<td>19</td>
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<td>76-80 Pain well controlled</td>
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<td>34</td>
<td>16</td>
<td>51</td>
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<td>54</td>
<td>10</td>
<td>10</td>
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<td>81-85 Staff do everything help with pain</td>
<td>28</td>
<td>8</td>
<td>35</td>
<td>39</td>
<td>62</td>
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<td>18</td>
<td>70</td>
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<td>86-90 COMM W/ MDL Tell you what new medicine was for</td>
<td>40</td>
<td>17</td>
<td>74</td>
<td>3</td>
<td>37</td>
<td>75</td>
<td>23</td>
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<td>91-95 Staff describe medicine side effect</td>
<td>59</td>
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<td>72</td>
<td>3</td>
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<td>96-100 DISCHARGE</td>
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<td>86</td>
<td>34</td>
<td>41</td>
<td>72</td>
<td>52</td>
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<tr>
<td>101-110 Staff talk about help when you left</td>
<td>76</td>
<td>95</td>
<td>56</td>
<td>17</td>
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<td>59</td>
<td>63</td>
<td>21</td>
<td>43</td>
<td>87</td>
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<tr>
<td>111-120 Info re symptoms/prob to look for</td>
<td>36</td>
<td>92</td>
<td>93</td>
<td>38</td>
<td>67</td>
<td>74</td>
<td>93</td>
<td>50</td>
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<td>121-130 Info re symptoms/prob to look for</td>
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<td>93</td>
<td>50</td>
<td>55</td>
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<tr>
<td>131-140 Care Transitions</td>
<td>76</td>
<td>95</td>
<td>93</td>
<td>38</td>
<td>67</td>
<td>74</td>
<td>93</td>
<td>50</td>
<td>55</td>
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<td>141-150 Care Transitions</td>
<td>36</td>
<td>92</td>
<td>93</td>
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<td>93</td>
<td>50</td>
<td>55</td>
<td>50</td>
<td>57</td>
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<tr>
<td>151-160 Staff took pref into account</td>
<td>86</td>
<td>81</td>
<td>84</td>
<td>79</td>
<td>79</td>
<td>76</td>
<td>70</td>
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ICD–10

The U.S. is converting from ICD–9–CM to ICD–10–CM due to:

- ICD–9–CM is 29 years old
- ICD–9–CM codes not keeping up with technology and exhausting some sections
- ICD–10 provides a greater level of specificity and clinical detail
- New procedures and diagnoses can be easily incorporated and updated to be consistent with current clinical practice

The compliance date was originally set for October 1, 2013, but has been moved to October 1, 2014.
ICD–10 Overview

Current State ICD–9
- Diagnosis
  - 13,000 codes
  - 3–5 digits
- Procedure
  - 3,000 codes
  - 3–4 digits

Future State ICD–10
- Diagnosis
  - 69,000 codes
  - 3–7 alphanumeric digits
- Procedure
  - 72,000 codes
  - 7 alphanumeric digits
ICD-10 Challenge

New with ICD-10:
Provider will have to document:
• right/left
• initial / subsequent encounter
• displaced / non-displaced
• transverse vs. oblique
• delayed healing
• and more...

Orthopedics has 20K+ new codes in ICD-10
Project Structure

ICD-10 Executive Steering Committee

Physician Advisory Group
Physician Documentation Group

ICD-10 Working Group

WORK STREAMS
Patient Access/Patient Financial Services
Health Info Mgmt/Clinical Doc Program
KMSF Bus Ops
Decision Support¹
Information Tech/Testing Strategy

SUB-GROUPS
Training
Payer Readiness
Coder Development Strategy
Major Strategic Initiatives

• Standardization of Coding Policies and Work Flows
  - Standardization of professional coding across the enterprise will help UKHC respond to the increased complexity associated with ICD–10 and allow providers to focus on documentation.

• Implementation of Electronic Health Record
  - In order to utilize Computer Assisted Coding (CAC) to its fullest capacity and gain its benefits, 100% of records need to be available electronically.
  - Not all clinics will be live on AEHR by October 1, 2014. Standardized documentation, coding and charging can only be achieved through full implementation of the EHR.
News from Other Academic Medical Centers

- University of Michigan Medical Center credit rating downgraded (11/27/12)

- Wake Forest/Baptist Medical Center credit rating downgraded (3/20/13)

- Temple University Medical Center credit rating downgraded (5/28/13)
News from Other Academic Medical Centers

• NY State Comptroller reports SUNY Downstate Medical Center faces insolvency; lost $3 M/week through 2012 (1/17/13)

• Vanderbilt University Medical Center faces $30 M shortfall; stops paying for faculty vacation (4/3/13)

• LSU Medical School – Shreveport faces $42 M shortfall; only enough funds to operate for 7 of next 12 months (5/14/13)
  - LSU Medical Center is privatizing and will no longer support the medical school (5/27/13)
Fund balance may be supplemented by additional EIR as necessary

Note: beginning clinical fund balances to be loaded
Endowments include spendable balance in the endowment fund
College of Medicine
Financial Summary

- The College will need to improve financial performance over the next 12–18 months to:

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<tr>
<td>Reduce current funding deficits</td>
<td>($16.4 million)</td>
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<tr>
<td>Manage future reductions</td>
<td>($6.0 million +)</td>
</tr>
<tr>
<td>Provide funds to invest in clinical and research programs</td>
<td>(minimum $2–3 million)</td>
</tr>
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</table>

- The College should improve operations by $25 million
Securing the Future

- Faculty
- Staff
- Kentucky
What we will not do

• Nothing

• Tinker

• Across the board salary reductions—one caveat
What we will do

• Invest
  – Academic
  – Clinical

• Grow
Become more efficient

- Increase productivity
- Reduce costs
Actions underway:

- Negotiate with state for increased PSP in lieu of Primary Care per diem payments lost
- Transition to provider-based clinics where appropriate
- Increase new patient visits
- Implement Integrated Business Units/shared services
- Intense focus on physician billing (documentation, charge capture and reconciliation, benchmarked analyses)
What is Project revUP?

• Identification of 30+ Enterprise projects aimed at
  – Increasing revenues
  – Increasing efficiencies
  – Reducing costs

• Project characteristics:
  – Professional and technical revenues (some have both)
  – Back-billing opportunities
  – Most linked to the Integrated Billing Units

• Ensure project sustainability
  – Status reports
  – Ongoing monitoring
One year from now

- Financially stronger
- More efficient
- Academically stronger
- Will have made significant strides to secure our future