Call to Order – Meeting called to order by Dean Cairns at 4:30 pm

Welcome and Announcements - Charles B. Cairns, MD, Assistant Vice President, Clinical Research and Trials, UAHS and Interim Dean, College of Medicine

Dr. Cairns thanked the faculty for a wonderful past year since he first led the general faculty meeting in November 2014. He said the partnership with Banner has brought COM-T into the national spotlight. There were 200 new faculty positions approved over the past few months, and there are many new facilities being developed, and more investments in current programs. COM-T is one of the highest applied to medical schools in the country. He thanked faculty for stepping up to help with the admissions process for this high volume of applicants. There has been extraordinary collaboration between Tucson and Phoenix to help improve Graduate Medical Education programs. Research numbers are going up, and Dean Cairns thanked the faculty for their good work. Finally, we are going to have integrated academic faculty have split employment between Banner and the University. He wants to make sure those who have transitioned to Banner have the support they need to ensure it goes smoothly. Dean Cairns finished by introducing Mark Barkenbush to give an update on the Banner projects.

Banner Construction Update: Mark Barkenbush, Senior Project Executive, Development and Construction, Banner University Medical Center – Academic Division

Mr. Barkenbush showed the user group structure that has been helping make decisions on the Banner development and construction projects. He showed the original plans and cost estimates for the renovations, and explained they are no longer demolishing floors three to eight of the 201 building in favor of using that money for other areas. The new hospital will be larger, and the new renovation scope is greater as well. He broke down how much each projected renovation will cost, and explained where compromises have been made to save costs, such as leaving some departments in their current spaces and not using emergency back-up power. The new target budget is $400M. Some construction will begin in the near future. Official groundbreaking will not occur until spring.

He moved on to show a conceptual rendition of the North Campus layout, and said they are working to establish user groups for this project. He presented the original costs and plans for this project, with the original cost expected to be around $40-50 million. Now, they have identified clinics they ideally wish to move to the North Campus, and he presented the relocations and new services planned under this renovation. The current cost estimate is $134M, with a target budget of $85M, leaving $15M for a neighborhood Health Center at La Reserve. They are looking at all the providers they would like to move to develop the best combination to achieve this. He shared the opportunities to save costs on this project. Occupancy of the North Campus will begin at the end of 2017, with the first patients in the beginning of 2018. Construction of the Main Campus will finish a year after that, with occupancy beginning at the start of 2019.
He opened the floor up for questions: Will there be a place for out-of-town patients to stay when receiving treatment here in Tucson?—there is currently no plan for this. Where is La Reserve?—up in Oro Valley area.

Committees and Brief Reports - Dean Cairns announced the committees and their leaders.
- Committee of Ten – Ken Knox, MD
- CME Committee – Gail Pritchard, PhD, Randa Kutob, MD, MPH
- Dean's Research Council - Anne Cress, PhD
- GMEC Committee-South Campus – Eugene Trowers, MD
- MD/PhD Committee – Ken Ramos, MD, PhD

Presentations/Discussion:
UA Vitae Update – Anne Wright, PhD, Senior Associate Dean for Faculty Affairs
UA Vitae is the online system for faculty evaluations, and it will go live in January. It will facilitate reporting on behalf of the departments, and it allows faculty to pull everything together in a more comprehensive format. They created three faculty committees (basic science, clinical service, and clinical teaching) to address issues about the adaptation of what has worked for the University to the College of Medicine. There has been a lot of effort over the past few months to work with departments and faculty to help with training to make use of the system go smoothly. She addressed some issues, that they are working with ArizonaMed to get teaching efforts and roles into UA Vitae, and the grants and awards section is currently disabled to make corrections. These should be finalized in the next few months, and faculty should review their UA Vitae in January to make sure the information is accurate. She provided resources for faculty, including a website and administrative super users.

She opened it up to questions: Is it prepopulated or do users have to enter manually?—it is prepopulated to mid-July, and users will have to make updates for anything after that, and they will also need to check the prepopulated information to make sure it is correct. Does it update automatically going forward?—No, users will have to update themselves.

Proposed changes to promotion guidelines and COM Bylaws – Anne Wright, PhD, Senior Associate Dean for Faculty Affairs
The first proposed change for the P&T guidelines is to restrict the use of the title “Clinical Instructor” for Chief Residents and Fellows. They want to remove the number of teaching hours for Clinical Instructors from the guidelines, and they proposed to amend the appendices to reflect that “Excellent” and “Outstanding” can also refer to associate and full professors, which was the original intent of the P&T guidelines. The new “Faculty Physician” title is for people who are on the Banner medical staff who do not contribute to the educational or research missions, and they will revise the bylaws to indicate that this is a non-voting title. There are two other bylaws changes regarding the composition of committees as it does not make sense to have the basic science/clinical science regulations for all committees. She opened it up for discussion and questions: Someone expressed the concern over the use of the word “faculty” in the Faculty Physician title and wondered why they did not use another word. Dean Cairns explained there is currently nowhere in the current guidelines where this role would fit, so we have to evolve what the term faculty means. Dr. Wright added that these people are required to have a faculty title, so coming up with a new title rather than diluting the existing ones was the best course of action. Someone said they believe that this role should be expanded to involve the educational mission, and Dr. Wright said if these people wish to be involved in education, they can easily switch to one of the existing tracks that included that role. One of the department chairs said he appreciates the new title.
because it helps give department chairs more control over who joins their staff that the previous ones did not have. Another department chair said she supports this because it better helps meet the needs of the community and institution and it allows there to be a broader array of professionals with differing expectations. Someone summarized this discussion by stating that it seems the issues people have are with the description of the role rather than the title. Dean Cairns suggested by rewording the description of this track’s contributions.

Someone asked what the reasoning behind taking the time commitment off the promotion definitions—basically, it is arbitrary and hard for people to make a commitment because some of these factors are out of their control. There will be two weeks of online voting on these changes.

**Conflict of Interest policy revision – Kevin Moynahan, MD, Deputy Dean, Education**

There has been a Conflict of Interest policy in place since 2011. The policy eventually was given a B rating, and the then-dean asked for a committee to look at the policy and see what needs to be updated. The updated policy has been sent out. There is improved reporting that can be done on UA Vitae to make the process more seamless. It is meant to create transparency for faculty innovation in industry. He opened up to questions: Does it apply to students and trainees?—yes, it does apply to students and residents, but he is not sure going forward if this will be binding for residents who are Banner employed. Faculty employed by Banner are bound to this policy because they have a faculty title. Someone said they give talks without compensation to allow for networking, and this new policy would prohibit that. Someone followed up that even though there is no compensation, it is still not allowed by the AAMC.

Dean Cairns said this is an important topic for discussion, but they need to move on to give enough time for the committee updates.

**Faculty Forward Committee Update**

- **Research – Monica Kraft, MD & Carol Gregorio, PhD**
  
  Dr. Kraft began by showing a list of the members on the Research Committee. They started in July, with the most recent meeting on November 12th. She said there are four main areas they found to be especially important. The first is fundamental infrastructure, which includes equipment and research support for investigators, Bridge funding and Grant Development funding, assistance with faculty development and philanthropy, pre-award proposal management, and funding plans for graduate students. The next area is space, specifically the quality of space and how to intersect AHSC space with the Banner construction. The third is Responsibility Centered Management, including discussion about incentivizing research and discussion about indirect cos allocation mechanisms. Finally, the fourth area is faculty and career development resources and how to best coordinate these resources and determine the gaps.

- **Education – Joe Miller, MD, MPH & Todd Vanderah, PhD**
  
  They began by pointing out two things that came out of the Faculty Forward survey: there was low satisfaction regarding the focus on the medical school mission and medical school governance. They identified other issues as well, such as how state and tuition dollars can best support the education mission and the need for an education committee composed of faculty and staff. Dr. Vanderah broke down the number of faculty teaching by their degree, finding more MDs teach than PhDs. He also broke down the teaching hours by department, as well as the suggested hours for preparation in teaching based on responses from faculty on how long it takes to prepare for a one hour lecture. He provided the responses to the survey on the curricular changes moving from 24 months to 18 months.
Dr. Miller presented the issues identified from the Graduate Medical Education Faculty Survey. The main concern was the need for some mechanism for GME base budgeting. The second most common theme in the survey was individual compensation. Faculty are most concerned with providing a better educational environment for the graduate medical students. He thanked everyone for their participation in the survey.

- **Faculty Affairs – Alex Chiu, MD & Sam Keim, MD**
  
  The committee found three main areas of focus and formed three subcommittees to address these focuses. The first was academic tracks and titles. This focused on track expectations, including more consistent protected time within each track. It also discussed the distribution of faculty on tracks, with the recommendation that each department should have a target distribution of faculty on each track. The committee also discussed the “faculty physician” track.

  The second subcommittee was the Faculty Retention and Remuneration Subcommittee which recommended the implementation of an Academic Incentive Program in a new Compensation Plan, a new leadership training, and a new Faculty Recognition Program. The committee also recommended improving new faculty on-boarding and mentoring, as well as conducting exit interviews with departing faculty to find out their reasons for leaving. They recommended improved communication regarding acute issues with clinical operations, implementation of an Operations Committee (which is being led by Dr. Kraft) and Retention/Change Champions, and increasing opportunities for faculty engagement. The White Paper will be drafted shortly and sent to Dr. Cairns. The Outreach/In-reach Committee was not mentioned in the presentation, but Dr. Keim said it will be included in the White Paper.

*Adjournment* - Dean Cairns adjourned the meeting.
BUMCT HOSPITAL EXPANSION AND RENOVATION
User Group Structure
# Project Costs Originally Presented

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
<th>Size (sf)</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make Ready</td>
<td>Site work, building demolition, site demolition, utility changes, underground detention, and temporary structures.</td>
<td>n/a</td>
<td>$18 - 22 million</td>
</tr>
<tr>
<td>DCMC Lobby</td>
<td>Expanded lobby with connections to parking deck and configuration to serve as entry to clinics.</td>
<td>17,150</td>
<td>$6-7 million</td>
</tr>
<tr>
<td>New Hospital</td>
<td>New 11 (2 floors shelled, not included in the budget) story hospital building with bridge connectors, 240 beds, 22 OR's, and 25 imaging rooms.</td>
<td>607,787</td>
<td>$300 - 340 million</td>
</tr>
<tr>
<td>Renovation</td>
<td>Renovation of DCMC for OB and connectors plus NEP/201 for admin, conference, HIMS, IT, observation, lab and clinics.</td>
<td>155,538</td>
<td>$30 - 40 million</td>
</tr>
<tr>
<td>Demo</td>
<td>Demolish floors 3-8 of the 201 building.</td>
<td>139,576</td>
<td>$20 - 22 million</td>
</tr>
</tbody>
</table>

$374 - $431 million
Current Scope and Size

- Size of new hospital is greater than originally projected, 670,000 sf vs. 607,800 sf due to:
  - adjustment to tower based on ICU footprint
  - more imaging modalities
  - added new area for Trauma based on building configuration
  - additional space to support academic medicine (reading rooms, call rooms, lockers, conference rooms)
  - understated size in space program for the following:
    - surgery suite
    - CSPD
    - Materials
    - ED expansion

- Scope of renovation is greater (numerous different areas throughout)
- Decision has been made to not demo floors 3 – 8 of the 201 Building
Current Estimated Project Cost

- $435.8M current project cost estimate
- Scope already excluded to get to $435.8M (NOTE, all can be accomplished as future projects):
  - 10th & 11th shell floors ($8.7M)
  - Shell 4 OR’s & 15 prep/recovery bays ($1.3M)
  - No emergency power back-up for UA chilled water production ($5M)
  - Leave some departments in current location ($3.5M)
  - Eliminate DCMC lobby expansion ($7M)
  - Reduce renovation scope to 75,000 sf ($3.5M)
  - Aggressive equipment budget assumptions for re-use
  - Targeted 10% construction cost savings opportunities as design evolves
- $400.0M target
NORTH CAMPUS EXPANSION
User Group Structure

- Monitor the “Big Picture”
- Approve service program, business plan and overall design
- Project oversight (scope, schedule, budget)
- Create the project vision
- Approve building stacking
- Appoint/charter teams
- Ensure teams are staffed and participating
- Resolve issues or refer to steering committee
- Review/refine building stacking
- Review/develop functional service plan

User Groups:

- Clinics
  - Cardiology
  - Thoracic
  - Vascular
- Radiation Oncology
- Imaging
- Ambulatory Surgery
  - Endo
  - CSPD
- Building Support Functions
  - Retail Pharmacy
  - Laboratory
  - EVS/Materials/Facilities

User Group Roles
- Review service program
- Review Health Center templates
- Provide input during facility design
- Solicit design feedback from other user stakeholders
- Develop operational plans for new facility
# Project Costs Originally Presented

<table>
<thead>
<tr>
<th>Ambulatory Strategy Projects</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Component</strong></td>
<td><strong>Description</strong></td>
<td><strong>Size (sf)</strong></td>
<td><strong>Cost</strong></td>
</tr>
<tr>
<td>North Campus</td>
<td>50,000 - 80,000 sf health center for specialists plus a 15,000 sf for Radiation Oncology treatment</td>
<td>105,000</td>
<td>$40 - 50 million</td>
</tr>
<tr>
<td>Health Center NW</td>
<td>Neighborhood Health Center with 2 clinic pods, lab, imaging, etc. for 14-14 MD's.</td>
<td>23,000</td>
<td>$14 - 15 million</td>
</tr>
<tr>
<td>Health Center South</td>
<td>Neighborhood Health Center with 2 clinic pods, lab, imaging, etc. for 14-14 MD's.</td>
<td>23,000</td>
<td>$14 - 15 million</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$68 - 80 million</td>
</tr>
</tbody>
</table>
North Campus Starting Assumptions

Clinics:
- All BUMCT Adult Clinics move to North Campus with the exception of Peds and OB/GYN
- Alvernon Orthopedics & Ophthalmology, La Cholla Neurology and Casas Adobes Dermatology move to North Campus
- Urology relocated from Cancer Center
- BUMCT Psychiatrics Clinics move to South Campus

Services / Ancillaries:

Relocations:
- University Medical Imaging (Campbell Ave)
- BUMCT Radiation Oncology

New Services:
- Ambulatory Surgery
- Laboratory
- Endoscopy

Other Support Space:
- Procedure Rooms
- Cardiac Stress Testing
- EKG
- Pulmonary Function
- Other
Conceptual Site Plan
Estimated Project Cost

• Current project estimate = $134M
• Target project budget = $85M (leaves $15 M for a neighborhood Health Center at La Reserve)
## Project Cost Reduction Opportunities

- **Off-site clinics remain off-site - $8.3M**
  - Average 49.2 Providers per day in clinic if highlighted providers stay in current location = 6+ clinic modules @ 8 providers/module = 2 exam rooms/MD.

<table>
<thead>
<tr>
<th>Clinic</th>
<th>#</th>
<th>CFTE</th>
<th>Avg Weekly Sessions</th>
<th>Total Weekly Sessions</th>
<th>Avg Sessions Day</th>
<th>Avg Providers per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiovascular / Thoracic / Vascular</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Med Cardiology</td>
<td>29</td>
<td>22.6</td>
<td>3</td>
<td>88</td>
<td>18</td>
<td>8.8 *</td>
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<tr>
<td>Surg CT</td>
<td>4</td>
<td>3.4</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Surg Vascular</td>
<td>4</td>
<td>3.0</td>
<td>5</td>
<td>20</td>
<td>4</td>
<td>2.0</td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
<td>29.0</td>
<td>3</td>
<td>113</td>
<td>22</td>
<td>11.2</td>
</tr>
<tr>
<td><strong>Head &amp; Neck</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Other ENT</td>
<td>6</td>
<td>3.5</td>
<td>4</td>
<td>24</td>
<td>5</td>
<td>2.4</td>
</tr>
<tr>
<td>Surg Neurosurgery</td>
<td>4</td>
<td>3.2</td>
<td>4</td>
<td>15</td>
<td>3</td>
<td>1.5</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>6.7</td>
<td>4</td>
<td>39</td>
<td>8</td>
<td>3.9</td>
</tr>
<tr>
<td><strong>Musculoskeletal</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Orthopedics</td>
<td>11</td>
<td>8.2</td>
<td>4</td>
<td>44</td>
<td>9</td>
<td>4.4 Alvernon</td>
</tr>
<tr>
<td>Surg Podiatry</td>
<td>2</td>
<td>1.0</td>
<td>4</td>
<td>8</td>
<td>2</td>
<td>0.8</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>9.2</td>
<td>4</td>
<td>52</td>
<td>10</td>
<td>5.2</td>
</tr>
<tr>
<td><strong>Other Surgery</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Anes- Pain</td>
<td>2</td>
<td>1.1</td>
<td>4</td>
<td>8</td>
<td>2</td>
<td>0.8 South</td>
</tr>
<tr>
<td>Surg General Surgery</td>
<td>2</td>
<td>0.2</td>
<td>3</td>
<td>6</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Other Ophthalmology</td>
<td>10</td>
<td>6.9</td>
<td>4</td>
<td>40</td>
<td>8</td>
<td>4.0 Alvernon</td>
</tr>
<tr>
<td>Surg Transplant</td>
<td>2</td>
<td>1.2</td>
<td>5</td>
<td>10</td>
<td>2</td>
<td>1.0</td>
</tr>
<tr>
<td>Surg Trauma</td>
<td>9</td>
<td>6.7</td>
<td>3</td>
<td>23</td>
<td>5</td>
<td>2.3 Remain?</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>16.1</td>
<td>3</td>
<td>87</td>
<td>17</td>
<td>8.7</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>190</td>
<td>132</td>
<td>4</td>
<td>741</td>
<td>148</td>
<td>74</td>
</tr>
</tbody>
</table>

*Includes Residents
Project Cost Reduction Opportunities

- All of imaging remains at UMI - $8.15M
- Shell 3 OR’s plus pre/post op in the ASC - $500k
- Defer surface parking lot - $450k
- Further reduction in site work (storm water) - $TBD
- Further reductions in building costs - $TBD
- Reduce project contingencies

Projected, reduced project cost $104.5M
## Project Schedule Update

### BUMCT

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</thead>
<tbody>
<tr>
<td>Design/Permit</td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>Obtain PAD Zoning</td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>Construct New Facility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activate/Open New Facility</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Construct DCMC Entrance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renovate Portions of DCMC/NEP/201</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>U of A Vacate Modulars (5/1/2018)</td>
<td></td>
<td></td>
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</table>

### North Campus

<table>
<thead>
<tr>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Planning/Programming</td>
<td>Q1</td>
<td>Q2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Design/Permit North Campus Building</td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>Construct North Campus Building</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activate/Open New Facility</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Relocate Existing Linear Accelerators</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>TBD</td>
</tr>
</tbody>
</table>

Note: 
- Blue color indicates tasks completed.
- Purple color indicates tasks scheduled for future years.
Committee of Ten
Report to General Faculty, November 18, 2015

In July, the committee voted to elect Dr Ken Knox, MD Chair of the Committee of Ten. Dr Knox assumed these responsibilities from Dr. Art Sanders. Over the past year the committee met with leaders of UAHS and the newly formed Academic Medical Council (Drs Jason Yuan, Jason Krupp, Charles Cairns, and Alex Chiu. Topics included research productivity in the College of Medicine and faculty representation in the clinical enterprise.

In the last report, specific recommendations were made based on our analysis of the AAMC faculty forward survey and included:

1) Electing a peer review/appeals committee- the recommendation was based upon faculty stating they did not have recourse, citing intimidation on the survey

2) A faculty elected group to provide input and representation of the clinical faculty- The recommendation was based upon the premise that faculty feel they are disengaged and undervalued

3) A reassessing by the CoM of research faculty, linking expectations to protected time for research and solutions for barriers of research (for example, bridge funding).

Progress has been made with the formation of three faculty forward committees (reports to be posted). An effort to communicate expectations to faculty via promotion and tenure forums has also started. Our specific recommendations and timelines have been supplanted by these efforts.

One specific proposal addressing faculty representation in the clinical enterprise was presented to Drs Cairns, Krupp, and Chiu. This proposal (below) has received some traction with leadership but has not yet been formally endorsed.
Proposal to Academic Management Council
Banner University Medical Group Faculty Council
April 23, 2015

Purpose:

(1) To establish a role for member faculty in the Banner University Medical Group.
(2) To improve bilateral communication between member faculty and the Academic Management Council.
(3) To provide a formal mechanism for member faculty input thereby empowering faculty as part of the Banner University Medical Group.

Structure: Banner University Medical Group Faculty Council will be a representative group. Member faculty will elect 6 members to head the Council with staggered 3-year non-renewal terms. At least 1/3 of the elected Council Members must be from geographically distinct regions. The President of the Group Practice and at least one member of the Academic Management Council (AMC) will be ex-officio members of the Council.

Function:

1. The Council will work with Banner on optimizing communication between the AMC and member faculty. The Council will hold a minimum of bimonthly member meetings to discuss issues of importance to the Banner University Medical Group. The Council will also present member faculty concerns to the AMC.

2. The Council will advise the AMC with regard to member issues such as compensation, benefits and working conditions.

3. The Council will develop a set of Bylaws, Rules and Regulations for the member faculty with regard to expectations and clinical interactions.

4. The Council will ensure members have an independent review/appeal process to review disciplinary actions or member concerns.
Continuing Medical Education Committee Report to the General Faculty

November 2015

The Continuing Medical Education (CME) Committee is one of the permanent committees of the University of Arizona, College of Medicine (COM). The Continuing Medical Education Committee approves CME policy, provides oversight of CME activities, and assures the approved policies and activities meet accreditation standards for continuing medical education. The College of Medicine Office of CME (OCME) is the operating arm for CME activities. The current CME Committee members and COM support staff are:

- T. Gail Pritchard, PhD, (Chair) Assistant Professor, Medical Student Education (2/2014 – 6/2017) tpritcha@email.arizona.edu
- Betsy Dokken, PhD, Assistant Professor, Department of Medicine (6/2013 – 6/2016) bdokken@deptofmed.arizona.edu
- Raymond Runyan, PhD, Professor, Cellular & Molecular Medicine (6/2013 – 6/2016) rrunyan@email.arizona.edu
- Ole Thienhaus, MD, MBA, Department Head, Psychiatry (6/2013 – 6/2016) ojt@email.arizona.edu
- Richard Amini, MD, Assistant Professor, Department of Emergency Medicine (6/2014 – 6/2017) ramini@aenrc.arizona.edu
- Meredith Hay, PhD, Professor, Physiology (6/2015 – 6/2018) mhay@email.arizona.edu
- David Elliott, PhD, Assistant Professor, Cellular & Molecular Medicine (6/2015 – 6/2018) elliott@arizona.edu
- Isabel Oliva, MD, Associate Professor, Medical Imaging (6/2015 – 6/2018)
The College of Medicine is accredited by the Accreditation Council for Continuing Medical Education (ACCME) through March 2019 to sponsor educational activities for *AMA PRA Category 1 CME Credit™*. Every CME activity has to comply with criteria for development, funding, presentation and evaluation. Since the OCME serves our academic community, activities originate from faculty members of the College of Medicine (direct activities) and from outside organizations (joint providers). Activities include enduring materials (e.g., online educational programs); live events (e.g., conferences); and regularly scheduled series (e.g., grand rounds). Table 1 below lists the CME activities by type over the last three calendar years.
### SUMMARY OF CALENDAR YEARS 2013, 2014, and 2015

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enduring Direct</strong></td>
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<td>22</td>
<td>22</td>
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<tr>
<td><strong>Enduring Joint</strong></td>
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<td>28</td>
<td>23</td>
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<tr>
<td><strong>Total Enduring</strong></td>
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<tr>
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<td><strong>Live Joint</strong></td>
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<tr>
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<tr>
<td><strong>Regularly Scheduled Series (RSS) Direct</strong></td>
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<tr>
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<tr>
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<tr>
<td><strong>Total Activities</strong></td>
<td>148</td>
<td>141</td>
<td>135</td>
</tr>
</tbody>
</table>

In 2012, as part of its expansion into online CME, the College of Medicine purchased The Virtual Lecture Hall® (VLH), an interactive, evidence-based, online medical education website that offers CME courses on a wide variety of topics, many of which are required for licensure or renewal of licensure in several states. The list of VLH offerings includes courses on medical errors prevention, medical ethics, risk management, patient safety, professional responsibility, cultural competency, and pain management, among others. The VLH does not accept advertisements and is supported by fees from individual users and organizations in order to print CME certificates. The VLH does not offer CME courses supported by educational grants from pharmaceutical or device companies. Several of the courses offered by the VLH were developed with grant support from the National Institute of Health (NIH), resulting in numerous research publications and several clinical/educational tools for physicians, such as “The Physicians’ Competence in Substance Abuse Test” (P-CSAT) which is now in the public domain (Harris & Sun, 2012). The VLH currently offers 23 courses with a total of over 85 CME credit hours. Since 1998, physicians have earned over 160,000 CME credits on the VLH website (www.vlh.com).
2014-2015 Accomplishments

- The Committee assisted with the University of Arizona College of Medicine’s successful 4 year Re-accreditation as a provider of Continuing Medical Education! The report was very positive in regards to our work in the College as well as our outreach/collaborations at the state and national levels.

- The CMEC endorsed:
  - collaboration with Dr. Dan Derksen in the College of Public Health on an Arizona Department of Health Services-sponsored initiative to disseminate new Arizona opioid prescribing guidelines. We just released an online course, Safe and Effective Opioid Prescribing While Managing Acute and Chronic Pain which is being offered to Arizona DEA prescribers.
  - partnership with Dr. Moreno in the Office of Diversity and Inclusion to create another online course, Using CLAS standards and Cultural Competence to Mitigate Health Disparities: An Introduction. This course was created by Dr. John Bormanis (Department of Family & Community Medicine) and was released in conjunction with a presentation by Dr. Bormanis at Dr. Sally Reel’s Third Annual Inter-professional Rural Health Professions Conference.
  - creation of the course, Diagnosis and Management of Hospital-Acquired, Ventilator-Associated, and Healthcare-Associated Pneumonia, created by Dr. Al Mohajer in the Department of Medicine.

- Dr. Ole Thienhaus (CMEC member and Head, Department of Psychiatry) authored the online, case-based course, Suicide Risk Assessment for Primary Care and Emergent Settings.

- Dr. Aiden Abidov, (Past Chair, CMEC) and CMEC members discussed and assisted the OCME in the decision to purchase an online application system and grand rounds attendance tracking system.
Dean’s Research Council Annual Report
November 2015
Chair: Anne E. Cress, PhD
Co-Chair:

**Elected Members**
- E. Fiona Bailey, PhD
- Ankit Desai, MD
- Kurt Denninghoff, MD
- Judith Gordon, PhD
- Emmanuel Katsanis, MD
- Ghassan “Gus” Mouneimne, PhD
- Terence O’Keeffe, MD
- Sai Parthasarathy, MD
- Amol Patwardhan, MD, PhD
- Gregory Rogers, PhD
- Patrick Ronaldson, PhD
- Magdalene So, PhD
- Marlys Witte, MD

**Ad hoc**
- William Dantzler, MD, PhD

**Ex officio**
- Angela Souza, MAdmin
- Anne E. Cress, PhD

The Dean’s Research Council is a standing committee which advises the Dean of the College of Medicine on matters pertaining to the research programs of the College of Medicine (e.g. space, faculty career development awards, core facility funding, faculty start-up funds, conflict of interest, legislation, animal welfare/animal rights, indirect cost recovery policy, technology transfer, interdisciplinary programs, and future strategies). The council develops research policy for the College of Medicine that is disseminated to the research community via the research office.

The Dean’s Research Council will resume activities when charged by the Dean.

2015 Accomplishments:
New faculty members were elected to serve on the Dean’s Research Council. The newly elected members are:
- E. Fiona Bailey, PhD
- Ankit Desai, MD
- Ghassan “Gus” Mouneimne, PhD
- Amol Patwardhan, MD, PhD
GME Committee (GMEC)

1. Overview: The UACOM-SC GMEC is currently into its 9th year of operations. The committee, composed of program directors, program coordinators, peer-selected residents from each program, quality officer from the primary teaching hospital and administrators, meets monthly. The committee’s charge is to monitor and advise the sponsoring institution on all aspects of graduate medical education; establish policies and procedures regarding the quality of education; provide oversight of ACGME-accredited programs’ annual evaluation and improvement activities and monitor the work environment for the residents in all its programs. The monthly meeting addresses the business of the GMEC as per ACGME requirements.

The committee holds an additional monthly “Task Force” meeting, which focuses on addressing specific issues requiring more detailed attention in order to enhance quality of care provided to our patients. Examples of our endeavors this past year included Mission Statement revision, Revision of SC new resident orientation to focus on standardized training in Transitions of Care, Increasing the integrity of evaluations.

2. Programs: There are 6 ACGME accredited residency program at UACOM-SC, all of which have enrolled residents. These programs include: Internal Medicine, Psychiatry, Ophthalmology, Emergency Medicine, Family Medicine and Neurology. In academic year 2014-15, there were 111 enrolled residents. All 6 programs participated in the NRMP (and Ophthalmology) MATCH and filled all offered positions successfully. None of our programs required participation in the new NRMP SOAP System (formerly post MATCH Scramble). Our Medical Toxicology program is a 2 year fellowship, accredited for a total of two fellows in the program and continues to fill in the NRMP Fellowship MATCH. They currently have 2 fellows enrolled.

3. Hospital Committees: The GMEC continues to work with both the hospital and residency programs in ensuring resident participation on hospital committees. Annually, a list of hospital committees is distributed to each residency program administration with a request that residents be appointed to the committees. Attached, please find a list of resident assignment to hospital committees.

During AY 15, the UAMC Resident Quality Council (RQC) continued to meet under the leadership of Dr. Andy Theodorou and Dr. David Sheinbein. They focused on educating and addressing Quality of Care issues pertinent to residents and patient care. The Council targeted professionalism in consultations and improving feedback to residents and faculty providers.
4. **Faculty Development**: Through FY 15, the GME Office continues to support each program to attend a national ACGME or specialty specific meeting. Attendance at these meetings not only increases GME knowledge base, but also enhances networking with the GME community at large. Upon return from national meetings, each PD and/or PC presents a brief report to members of the GMEC. Other opportunities for faculty development include: the annual University of Arizona COM at SC GMEC sponsored retreat, in which all of our programs as well as members of the UACOM T GMEC participate. Each program is also encouraged to develop a program specific faculty development program to train faculty educators in learner assessment and teaching modalities. The Office of Medical Student Education has also offered a number of faculty development instruction opportunities to each program – including videos of seminars, workshop guides, learning theory, and teaching strategies and tools, including direct observation of medical student/resident teaching. We also support program coordinators to attend the New Innovations workshop, in an effort to maximize their understanding and usage of our residency management system. This investment allows us to develop a few super users who are available to offer guidance to their program coordinator colleagues.

5. **Financial Support**: In accordance with ACGME requirements, the sponsoring institution continues to provide financial support for each residency program. This includes educational, administrative and technological support. PD funding continues in accordance with ACGME requirements. In 2013-14, a Residency Program Coordinator job series matrix was also developed consistent with ACGME requirements and distributed to departments.

6. **Resident Forum**: Quarterly, the DIO and GME Administrator continue to host a dinner meeting for resident representatives from each program. The meeting aim is to promote communication and cohesion among the residency programs and discuss issues pertinent to the resident work environment and education across disciplines. On occasion, hospital or sponsor leadership is invited to entertain a Q&A forum with the residents. 

**Resident Program Meetings** are scheduled biannually. During these meetings, the DIO and GME Administrator meet with each program’s cohort of residents to address institution and program specific issues/concerns. The issues raised are shared anonymously with the PD/PC and we work together to identify potential solutions as appropriate. The second meeting is to allow for follow-up and feedback regarding resolution of issues previously raised.

7. **Education regarding Fatigue and Well Being**: Each program is required to present the SAFER or LIFE program to their residents and faculty annually and document their participation. This is confirmed via the Annual Program Evaluation.

**Housetaff Counselor**: Dr. Larry Onate continues as the housestaff counselor for the University of Arizona College of Medicine. He not only provides services to residents and their families, but also offers didactic presentations for programs in multiple areas including Substance Abuse, Stress management, Physician Well-Being. He is introduced to the new interns/residents at orientation raising awareness of his availability. Annually,
he presents to the GMEC statistics of types of problems he has addressed in the previous year. He has noted a decrease in residents’ sense of Wellness across disciplines, which he will be presenting to the program directors at a GMEC Task Force meeting in the first quarter of 2016.

8. **Annual GME Retreat**: The annual retreat was held on May 8, 2015 at Hacienda del Sol. In addition to the opportunity to dialogue with our Sponsors (or designee), the retreat focused on Healthcare Transformation and its impact on GME – both locally and nationally. The guest speaker, Dr. Dan Derksen, challenged programs to consider the evolution of the Healthcare system and preparing physicians to practice in 21st century. Afternoon workgroups focused on various aspects of our CLER Report, providing tangible recommendations for improvement and implementation.

9. **Annual Scholarly Day**: UACOM-SC hosted its 6th GME Scholarly Day in May 2015. There were 31 posters submitted for consideration and over 100 attendees. The poster submissions were from UACOM medical students and residents in both UACOM-SC and UA GME programs. Posters were submitted in the following categories: Clinical, Research and Quality Improvement. Each participating residency program offered a brief clinical update. The recipients of the Scholarly Day awards were Dr. Joie Evans/Dr. Megan Rayman, Dr. Sridhar Reddy, Dr. Julia DiPierdomenico, Dr. Morgan Lyttle, Dr. Paul Swenson, Dr. Seongsuk Yun, and medical student, Lucy Han. One new award category was the Nursing Recognition Award. The nurses felt compelled to recognize Dr. Miles Stone for his compassionate, excellent medical care of patients.

**Major changes**

1. We bid farewell to: Dr. Vic Weaver (FM PD) and we welcomed: Dr. Jason Curry (Psych APD) and Dr. Karyn Kolman (FM APD).
2. Insert statement we used for annual updates

**Comprehensive Program Reviews (CPR)**

1. The Comprehensive Program Review (CPR) replaces the Internal Review evaluation process. It is a GME administered comprehensive program review, involving faculty and residents in the overview of a residency program. An appointed GMEC panel interviews residents, teaching faculty and the program leadership of the designated residency program. The panel also reviews pertinent documents related to resident education and environment for learning. Areas receiving special attention include:
   a. Addressing any deficiencies from prior site visits
   b. Program administration
   c. Participating institutions and affiliation agreements current
   d. Facilities and support services
   e. Education and implementation of QA/QI projects
   f. Core teaching faculty – sufficient volume; scholarly activity
g. Clinical teaching; including patient volumes, resident supervision, number of procedures
h. Educational program including reviewing goals and objectives, didactics, the written curriculum that incorporates the competencies, evaluation tools for the Milestones, QA/QI activities, resident scholarly activity
i. Resident evaluation, including criteria for advancement/promotion, summative letters, and evaluation forms
j. Faculty and program evaluation including confidentiality of the process, annual review of the program
k. Working conditions including duty hours, fatigue, moonlighting
l. Quality of applicants and graduates
m. Review of all program policies (duty hours, effects of leaves of absence, moonlighting, QA/QI, resident selection, supervision)

2. Over the course of the past academic year, the GMEC conducted one CPR with the Psychiatry Program. A report from the CPR was presented to the GMEC, approved and forwarded to the department chair.

3. The GMEC has approved each program completing a CPR every 3 years unless there is an area of concern requiring an expedited CPR. A CPR scheduled has been developed.

ACGME Site Visits
1. All of our programs have been awarded Continued ACGME Accreditation and are in the NAS 10 year cycle. The ACGME has now implemented Self-Study evaluations that provide a program to perform an in-depth, longitudinal critical self evaluation and improvement plan.

Ongoing Accreditation Mandates
1. ACGME Resident Duty Hours—Effective 7/1/11, ACGME implemented new Duty Hour requirements which were further specified by each specialty. Each program has been required to update their Duty Hours, Moonlighting and Supervision policies to address these changes. The requirements include:
   a. Clearer specification regarding 80 hour work week
   b. Specification of continuous work based on PGY year – liberalizing the requirements as a resident moves into the senior years of training. Senior residents may extend duty period if their presence is critical to patient care or continuity of care.
   c. A resident may not be responsible for the care of new patients after 24 hrs of continuous duty
   d. Limitations on breaks between duty periods by PGY year which must be monitored by program
   e. PGY1’s may not work more than 16 hour shifts. No call.
   f. Specifications regarding days off duty
2. Limitations on night float – frequency and must include an educational component.
3. All moonlighting (both internal and external) must now count towards 80 hour work week
4. Home call – when called in, hours count towards duty hours
5. Institution must provide lodging or transportation for residents who are too tired to travel safely after a duty period.
6. Programs must track episodes of noncompliance with DH requirements.
   a. Quarterly, the GMEC reviews each program’s Duty Hours documentation and annually we review the individual program’s ACGME resident survey report. If there are areas of noncompliance, the program is requested to investigate and report back to the GMEC within 1 month.
7. Resident Supervision– Effective 7/1/11, ACGME adopted supervision requirements. The requirements included:
   a. Three levels of supervision defined – Direct, Indirect and Oversight
   b. Program must assure proper level of supervision available to residents
   c. Programs must develop standards to identify limits of each resident’s scope of authority and the circumstances in which they are permitted to act with conditional independence.
   d. Program must develop list of must call situations.
   e. Program must limit number of resident transitions and train residents to utilize handoff tools.
      i. GMEC has developed and implemented a standardized educational module on Transitions of Care. In June 2015, every resident received the training. Each program is required to utilize a standardized handoff tool. The CLER Subcommittee will be performing a survey to evaluate effectiveness and usage of the new system. GMEC continues with its monitoring system of random observation of a program’s handoff by a PD from a different program. Reports are submitted to GMEC.
   f. Each program was required to update their Supervision policy in compliance with the new ACGME requirement. Annually, the GMEC continues to review resident and faculty ACGME survey reports to identify any concerns regarding supervision. It is incumbent on each residency program and department to assure they have an adequate number of faculty to support the supervision needs of their particular residency in accordance with regulatory and educational needs.

ACGME Next GME Accreditation System (NAS)

1. All of our programs are now in the ACGME’s NAS (New Accreditation System). This new accreditation system is an outcome based evaluation system, replacing the competency based evaluation system. “The aims of the NAS are threefold: enhance the ability of the peer-review system to prepare physicians for practice in the 21st century, accelerate the ACGME’s movement toward accreditation based on educational outcomes and reduce the burden associated with the current structure and process-based approach.” Increased emphasis will be placed on the Sponsoring Institution for the quality and safety of the environment for learning and patient care. The process will include:
2. Annual data collection for submission to ACGME (including institutional data, milestones and EPAs, faculty and resident surveys and resident procedure logs)
a. All programs have developed Clinical Competence Committees to evaluate resident progress and have submitted Milestone evaluations on their residents.

   a. The program received the SV report and distributed to the Sponsors. The GMEC appointed a subcommittee composed of PDs, PC, residents and GME Leadership to address the citations. The subcommittee provides the GMEC with monthly recommendations for improvement. Attached are a list of subcommittee accomplishments for 2014-15.

4. Institutional Site Visits every 6 years

5. Program Site Visits every 10 years (Programs demonstrating high-quality outcomes will be freed to innovate and extend the periods between site visits).

Quality Assurance and Patient Safety

1. The 4th New Resident Orientation, June 2015, was the result of a joint effort between UA, UAHN (now BUMG), UAMC-SC (now BUMCS) and UAMC-UMC (now BUMCT). Replacing the historic institution specific, multiple orientations, all new residents and fellows from both clinical facilities (over 200) convened at the Marriott Hotel for a single orientation. After a welcome and introduction to the institution, multiple exercises were introduced which exposed the new residents/fellows to the importance of quality of care, patient safety, patient satisfaction and communication skills. All new residents were distributed at small group tables with cohorts from varying specialties in an effort to increase camaraderie.

2. Resident as Educators Orientation occurred on the afternoon of the New Resident Orientation. New residents/fellows were acquainted with multiple methods of assessing and educating learners.

3. During July orientation, the GMEC sponsors a hospital orientation at Banner UMC South. Following a general review of the six ACGME Competencies and Milestones by program directors, chief residents presented on standardization of Transitions of Care. Subsequently, residents met with peers from their programs and completed a workshop on proper Transitions of Care.

4. During the first six months of the academic year, the pharmacy director (or a staff member) met with individual residency programs and presented pharmacy specific information. This program has been well received and requested to continue throughout the year.

5. In compliance with the GMEC requirement, every program’s faculty and residents complete either the SAFER or LIFE modules.

6. GMEC applied and was awarded a MEC Patient Safety Grant to encourage proper reporting of patient safety and quality improvement related hospital events.

7. GMEC implemented an educational plan to educate all residents in Quality Assurance terminology and application to patient care.
Resident Survey

The annual ACGME Resident survey continues to focus on six major categories: Duty Hours, Faculty, Evaluation, Educational Content, Resources, Patient Safety / Teamwork. In the NAS, ACGME intends to focus on program trends of improvement vs. declining performance. All seven of our residency/fellowship programs participated in the survey. For programs with more than 4 residents/fellows, a minimum of 70% participation from the residents in each individual program is required to receive a program specific report. We consistently had 100% participation from each of our programs. Once results are returned, the DIO meets with the PD to identify those areas not in substantial compliance. Subsequently, the PD meets with residents and faculty of their program to discuss potential causes and interventions. This report is presented at the next GMEC meeting. Based on the 2014-2015 Institutional Aggregate Program data the following table represents how we rate compared to the national mean.

<table>
<thead>
<tr>
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<th>Institution Mean</th>
<th>National Mean</th>
<th>Significant areas of noncompliance noted and planned interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duty Hours</td>
<td>4.8</td>
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<tr>
<td>Faculty</td>
<td>4.3</td>
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</tr>
<tr>
<td>Evaluation</td>
<td>4.4</td>
<td>4.5</td>
<td>Program use evaluations to improve (75%) Satisfied with feedback after assignments (74%) Evaluations of faculty are confidential (75%) *Task Force topic of discussion and implementation of system to increase resident confidence in process.</td>
</tr>
<tr>
<td>Educational Content</td>
<td>4.5</td>
<td>4.3</td>
<td>Education not compromised by service (71%) *Programs working to educate residents re: definition of “service” as well as assess workload. Given data to show personal clinical effectiveness (58%) *Working with EPIC to develop data sets to provide to residents. Report completed and ready for implementation</td>
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<tr>
<td>Resources</td>
<td>4.4</td>
<td>4.3</td>
<td>None</td>
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<tr>
<td>Patient Safety</td>
<td>4.3</td>
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</table>
Facult Survey

2014-15, all programs participated in the faculty survey. The categories surveyed included: Faculty Supervision and teaching; Educational Content; Resources; Patient Safety; Teamwork. Survey results are reviewed with the program faculty as well as DIO and included in the GMEC meeting presentation. Based on the 2014-15 Institutional Aggregate Program data, the following table represents how we rate compared to the national mean.

<table>
<thead>
<tr>
<th>Category</th>
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<th>National Mean</th>
<th>Significant areas of noncompliance noted and planned interventions</th>
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<tr>
<td>Faculty Supervision and Teaching</td>
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<td>None</td>
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<tr>
<td>Educational Content</td>
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<td>4.7</td>
<td>Worked on scholarly project with a resident (73%)&lt;br&gt;&lt;em&gt;Programs are tasked with ensuring residents have faculty mentors for scholarly projects&lt;/em&gt;</td>
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<tr>
<td>Resources</td>
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<tr>
<td>Patient Safety</td>
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<tr>
<td>Teamwork</td>
<td>4.5</td>
<td>4.6</td>
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</table>
Graduate Exit Interview

June 2015, the DIO and GME Administrator met with the volunteer graduating senior residents for an exit interview. General feedback will be shared with GMEC and individualized feedback will be provided to each program to implement appropriate changes.

1. Overall residents felt prepared for future career goals – practice, fellowship.
2. Residents appreciated the collegiality, cohesiveness of the smaller community hospital setting
3. Residents acknowledged the efficiencies created by implementation of an EMR
4. Resident continue to identify insufficient subspecialty presence at SC as a challenge
5. Resident recommend increased advertisement of educational activities at SC

GME Graduation Survey

To date we have had 135 graduates from the UACOM - SC residency programs. A graduate survey was distributed to the graduates. The overall results are shared with GMEC and individual program results are shared with the programs to help them implement appropriate changes or improvements. Based on survey for graduates through 6/2014, 82% responded “Excellent or Very Good” that the program met their educational objectives.
<table>
<thead>
<tr>
<th>Year</th>
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<th>FM</th>
<th>IM</th>
<th>Neuro</th>
<th>Ophthy</th>
<th>Psych</th>
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<tr>
<td>09-10</td>
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<td>Total</td>
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<td>19</td>
<td>38</td>
<td>6</td>
<td>8</td>
<td>17</td>
<td>135</td>
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</table>
Resident Responsibilities
Residents agree to abide by the terms of their employment contract and to fulfill the educational requirements of their training program; to use their best effort to provide safe, effective professional and compassionate patient care under supervision from the teaching staff; and to perform assigned duties to the best of their ability. Residents agree to abide by all UACOM-SC policies and procedures, including the provisions of the most current edition of the GME Policy and Procedure manual, the residency training program, and the rules and regulations of any affiliated institution to which they may be assigned.

Respectfully submitted,

Victoria E. Murrain, DO
Assistant Dean for Graduate Medical Education
ACGME Designated Institutional Official (DIO)
<table>
<thead>
<tr>
<th>COMMITTEE</th>
<th>RESIDENT PARTICIPATION</th>
<th>Meetings</th>
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<tbody>
<tr>
<td>The University of Arizona College of Medicine at South Campus GMEC</td>
<td>Naomi Young, MD, Family Medicine, PGY2</td>
<td>4th Friday, noon</td>
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<tr>
<td></td>
<td>Katie Houmes, MD, Family Medicine, PGY1</td>
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<tr>
<td></td>
<td>Matt Atienza, MD, Psychiatry, PGY3</td>
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<tr>
<td></td>
<td>Juan Gonzalez, MD, Psychiatry, PGY2</td>
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<tr>
<td></td>
<td>Natasha Sharda, MD, Internal Medicine, PGY3</td>
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<td>Sridhar Reddy, MD, Internal Medicine, PGY2</td>
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<td>Yuvi Grewal, MD, Neurology, PGY4</td>
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<td>Ari Magill, MD, Neurology, PGY4</td>
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<td></td>
<td>Claudia Prospero Ponce, MD, Ophthalmology, PGY2</td>
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<td></td>
<td>Cameron Newell, MD, Emergency Medicine, PGY3</td>
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<td></td>
<td>Michael Ori, MD, Emergency Medicine, PGY3</td>
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<td></td>
<td>Anju Nair, MD, Internal Medicine, Chief, PGY4</td>
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<tr>
<td>South Campus Hospital Pharmacy &amp; Therapeutics</td>
<td>Krunal Patel, MD, Internal Medicine, PGY3</td>
<td>2nd Wednesday, noon</td>
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<tr>
<td></td>
<td>Jessica Bates, MD, Emergency Medicine, PGY1</td>
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<tr>
<td></td>
<td>Anthony Cappa, MD, Emergency Medicine, PGY2</td>
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<tr>
<td>Pima County Medical Society</td>
<td>Bea Piña, MD, Family Medicine, PGY3</td>
<td>Last Tuesday, 5pm</td>
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<tr>
<td></td>
<td>Ari Magill, MD, Neurology, PGY4</td>
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<tr>
<td>Psychiatry Resident Education</td>
<td>Psychiatry residents</td>
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<tr>
<td>South Campus HCAHPS Process Improvement</td>
<td></td>
<td>3rd Wednesday, 1-2pm</td>
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<tr>
<td>South Campus ICU Critical Care</td>
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<td>Not an active committee</td>
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<td>(Gordon Carr 8/13)</td>
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<tr>
<td>South Campus ICU Code</td>
<td>Seth Assar, MD, Internal Medicine, PGY3</td>
<td>Wednesdays</td>
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<td>Bi-monthly 3-4p</td>
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<tr>
<td>GME Resident Quarterly Dinner Forum</td>
<td>Anju Nair, MD, Internal medicine, PGY4</td>
<td>Quarterly</td>
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<td></td>
<td>Jennifer Huang, DO, Internal Medicine, PGY3</td>
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<td></td>
<td>Rishi Bhargava, MD, Internal Medicine, PGY2</td>
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<td>Joie Evans, DO, Family Medicine, PGY3</td>
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<td></td>
<td>Megan Rayman, MD, Family Medicine, PGY3</td>
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<td>Bea Pina, MD, Family Medicine, PGY3</td>
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<td></td>
<td>Fatimah Gilani, MD, Ophthalmology, PGY4 (Jan-Jun)</td>
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<td></td>
<td>Billy McSwain, MD, Ophthalmology, PGY4 (Jul-Dec)</td>
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<td>John Rosell, MD, Emergency Medicine, PGY3</td>
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<td>Jessica Garst Orozco, MD, Emergency Medicine, PGY3</td>
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<td>Yuvi Grewal, MD, Neurology, PGY4</td>
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<td>Ari Magill, MD, Neurology, PGY4</td>
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<td></td>
<td>Julia DiPierdomenico, DO, Psychiatry, PGY4</td>
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<td></td>
<td>Krystal Chavez, MD, Psychiatry, PGY4</td>
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<tr>
<td>Committee</td>
<td>Members</td>
<td>Frequency</td>
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<tr>
<td>Medicine Housestaff Committee</td>
<td>Prince Buzombo, MD, Internal Medicine, PGY2</td>
<td>1st Monday, noon</td>
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<tr>
<td></td>
<td>Elizabeth Ulliman, MD, Internal Medicine, PGY3</td>
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<td></td>
<td>Faraz Jaffer, MD, Internal Medicine, PGY1</td>
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<td></td>
<td>Anju Nair, MD, Internal Medicine, Chief</td>
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<tr>
<td>Medicine Competency Committee</td>
<td>Anju Nair, MD, Internal Medicine, Chief</td>
<td>Quarterly</td>
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<tr>
<td>ACP Representatives</td>
<td>Archana Nair, MD, Internal Medicine, PGY2</td>
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<td>Jennifer Huang, MD, Internal Medicine, PGY3</td>
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<tr>
<td>Neurology Resident Education</td>
<td>Yuvi Grewal, MD, Neurology, PGY4</td>
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<tr>
<td>Emergency Medicine GME Committee</td>
<td>Jessica Garst, MD Emergency Medicine, PGY 3</td>
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<td></td>
<td>John Rosell, MD Emergency Medicine, PGY3</td>
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<tr>
<td>Ophthalmology PEC</td>
<td>Billy McSwain, MD, Ophthalmology, PGY4</td>
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<tr>
<td>South Campus GME Environmental Committee</td>
<td>John Rosell, MD, Emergency Medicine, PGY3</td>
<td>Annually</td>
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<td></td>
<td>Jordan Singleton, MD, Emergency Medicine, PGY3</td>
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<td>Roksolyana Tourkevich, MD, Neurology, PGY3</td>
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<td>Gowri Radhakrishnan, MD, Internal Medicine, PGY3</td>
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<tr>
<td>South Campus Quality &amp; Safety Oversight Board</td>
<td>Victoria McCurry, MD, Family Medicine, PGY2</td>
<td>3rd Wednesday, 1pm</td>
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<td>Admin Board Room</td>
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<tr>
<td>South Campus Resident Quality Council</td>
<td>Anju Nair, MD, Internal Medicine, Chief</td>
<td>1st Monday, 12pm</td>
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<td></td>
<td>Aaron Fernandes, MD, Internal Medicine, PGY3</td>
<td>Conf room 3030</td>
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<td></td>
<td>Sarah Patel, MD, Internal Medicine, PGY2</td>
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<td></td>
<td>Norman Beatty, MD, Internal Medicine, PGY1</td>
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<td>Jordan Singleton, MD, Emergency Medicine, PGY3</td>
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<td>Robert McAtee, MD, Emergency Medicine, PGY2</td>
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<td>Grace Price, MD, Family Medicine, PGY1</td>
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<td>Victoria McCurry, MD, Family Medicine, PGY3</td>
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<td>Jessica Hensel, MD, Family Medicine, PGY3</td>
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<td>Lori Hill, MD, Family Medicine, PGY2</td>
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<td>Shadi Koleilat, MD, Neurology, PGY4</td>
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<td>David Nguyen, DO, Neurology, PGY3</td>
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<td>Seeanaiah Byreddy, MD, Neurology, PGY3</td>
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<td>William Stevenson, MD, Ophthalmology, PGY2</td>
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<td>Justin Otis, MD, Psychiatry, PGY1</td>
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<tr>
<td>Emergency Preparedness Committee Linda Eckhoff-Meade</td>
<td>Duncan Johnston, MD, Emergency Medicine, PGY2</td>
<td>1st Thursday 1:00pm</td>
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<td>Sean Murphy, MD, Emergency Medicine, PGY2</td>
<td>SC Room 1233 BHP</td>
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<tr>
<td>Family Medicine Policy &amp; Procedure</td>
<td>Lori Hill, MD, Family Medicine, PGY2</td>
<td>UC Room 2216</td>
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<td></td>
<td>Naomi Young, MD, Family Medicine, PGY2</td>
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<td></td>
<td>Ben Gonzalez, MD, Family Medicine, PGY3</td>
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<td>Cynthia Carrillo, MD, Family Medicine, PGY2</td>
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<tr>
<td>Family Medicine Curriculum Committee</td>
<td>Daphne Rosales, MD, Family Medicine, PGY2</td>
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<td>Paul Swenson, MD, Family Medicine, PGY3</td>
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<td>Joie Evans, DO, Family Medicine, PGY3</td>
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CLER Sub Committee 2014-15

Each Chief (or designee) will present a QI refresher including Patient Safety and QI terminology at the first M&M of the year

A one page slide will be presented at every M&M on the Hospital’s Strategic Initiatives

IHI Modules are required to be completed by every new resident/fellow

Educational program under development for resident reporting – Grant approved

Annual Program Evaluation template has been modified to include data collection for CLER

Spanish Language Distinction Track with dinner series is the planning stage

New resident orientation workshop was presented including SAIFIR and Transitions of Care
MD-PhD Committee

2015 Annual Report

Members: Jan Burt, PhD; Charles Hsu, MD, PhD; Rajesh Khanna, PhD; Christina Laukaitis, MD, PhD, Lonnie Lybarger PhD; Mohammad Reza Movahed, MD, PhD, Linda Restifo MD, PhD; Alex Sandweiss, Jill Tardiff, MD, PhD

The Committee met on July 11, 2015 to introduce new members and to discuss the vision and mission of the program. Plans were made for roll out of the recruitment season for 2016 class. An Augmented Admissions Committee was established to include standing members of the MD-PhD Committee, standing members of the College of Medicine Admissions Committee and faculty with previous experience working with physician scientist admissions. Two interview cycles were established to be held October 29 and December 4, 2015. A total of 104 applications were reviewed and invitations extended to 32 applicants.

Augmented committee members include: Heddwren Brooks, PhD; Jan Burt, PhD; James Costello, MD, PhD; Jeff Frelinger, PhD; Charles Hsu, MD, PhD; Rajesh Khanna, PhD; Lonnie Lybarger PhD; Tejal Parikh, MD; Tanisha Price Johnson, PhD; Ken Ramos, MD, PhD; Linda Restifo MD, PhD; Alex Sandweiss, Jil Tardiff, MD, PhD; Andrew Yeager, MD

A summary of major activities is presented below.

2014-2015 Recruitment Process

- The 2015 Class includes 117 medical students and 5 MD-PhD students; selected from 800 applications.
- The Medical College Admissions Test was updated to measure social behavior as well as knowledge. The last updated was completed in 1991. Both versions of the exam have been accepted for the 2015-2016 recruitment season.

MD/PhD Students

- The 2015 class has five students. These are: Mohammed Abdelrahim Megan Ahern, Alex Alvarez, Jeremiah Bearss, and Austen Thompson. Goals and expectations of the program were discussed with the students.
- Progress evaluations were completed for the six current students. The evaluations included the student’s primary mentor along with a standing MD-PhD committee member.

Dual Degree Proposals

- A dual degree template proposal was distributed among participating programs in order to formalize the dual degree status of the MD-PhD program with the Graduate College.

Continuity Clinic

- A Continuity Clinic is being created under the leadership of Dr. Tejal Parikh to help MD-PhD students polish their clinical skills.
- Dr. Tardiff will host a reentry immersion clinic for graduating PhD students reentering the clinical curriculum.
UA Vitae
Background: UA Vitae

• Online system for annual faculty reviews that will go live in COM-T in January

• Facilitates accurate reporting for accreditation, academic program reviews; legislative reports; budgeting, etc.

• Enables faculty to provide a more comprehensive picture of their scholarly, outreach & service activities
COM faculty committees’ solutions

- Clinical teaching
  - What percent of your clinical time involves teaching?
  - Typical number of students/residents/fellows

- Clinical service
  - RVUs
  - Inpatient and outpatient service (weeks, half days)
  - Call (in house/house call)
  - Clinical service administrative roles
  - Other non-RVU generating clinical service
Communication and training to date

- April and Winie have met with 15 department heads
- Discussed UA Vitae at 13 department faculty meetings
- Led 6 training sessions for super users/administrative assistants
  - Super users have administrative access to the system
  - Administrative assistants have “delegate” access for individual faculty members
- Hands on training for faculty will begin in January (has already occurred in some departments)
Ongoing efforts

- Working with ArizonaMed to get teaching effort/teaching roles into UA Vitae.
- Template for NIH Biosketch available under Vitas and Forms
- PubMed ID not included on citation. Vendor asked to add
- Grant and Awards Section currently disabled so that corrections can be made
- Secondary titles coming soon
- COM Conflict of Interest with Industry review and reporting
Next Steps

- Dec/January:
  - UA Vitae team finalize configuration for department review process
  - Training sessions for faculty

- January, 2016: Go Live!
  - Faculty to enter data in appropriate fields
  - Review prepopulated sections (Sponsored Projects, ArizonaMed, publications)
Resources

- Department super users, administrators
- April Douet Gordon (adouet@email.arizona.edu)
- Winie Blumenkron (blumenkw@medadmin.arizona.edu)
- Ahlam Saleh, Assistant Librarian, to support faculty and Super Users with entry of Scholarly Contributions on the Activity Input Form
  - http://libguides.library.arizona.edu/c.php?q=406096&p=2765863
  - http://uavitae.arizona.edu/colleges/com-tucson
UA Vitae Faculty Committees

Basic Sciences
- Qin Chen
- Diana Damell
- Tom Doetschman
- David Elliott
- Jeffrey Frelinger
- Herman Gordon
- Katalin Gothard
- Nancy Horton
- Patricia Hoyer
- Clark Lantz
- Timothy Secomb
- Donata Vercelli
- Anne Wertheimer
UA Vitae Faculty Committees

Clinical Service
- Aiden Abidov
- Ilana Addis
- Jennifer Becker
- Marc Berg
- Leslie Cohen
- Betsy Dokken
- Marlon Guerrero
- Krisha Howell
- Emmanuel Katsanis
- Narong Kulvatunyou
- Hong Lei
- Peter Lichtenthal
- Jeffery Lisse
- Maria Proytcheva
- Ziad Shehab
- Baldassarre Stea
- Anna Stepczynski
- Sasha Taleban
- Mihra Taljanovic
- Ole Thienhaus
- Jonathan Walker
- Natalie Whitfield
UA Vitae Faculty Committees

Clinical Teaching

- Marisa Borders
- Leslie Cohen
- Sean Elliott
- Albert Fiorello
- Kimberly Gerhart
- Paul Gordon
- Wayne Jacobsen
- Arun Josyula
- Joanna Katsanis

- Wayne Kubal
- Guadalupe Martinez
- Hilary McClafferty
- Laura Meinke
- Valentine Nfonsam
- Isabel Oliva
- Linda Restifo
- Jason Wild
- Mark Wright
- Andrew Yeager
Questions?
Proposed Changes to COM Promotion and Tenure Guidelines and Bylaws
Proposed changes

1. Redefine “Clinical Instructor” title to be used primarily for Chief Residents or Fellows.

2. Remove the number of teaching hours in the guidelines for Clinical Instructors, Clinical Assistant Professor.

3. Amend appendices to reflect that “Excellent” and “Outstanding” refer to associate and full professors, respectively.
Proposed changes (cont.)

• Create a new “Faculty Physician” track for physicians serving on Banner medical staff who don’t contribute to the educational or research missions

• Revise bylaws to indicate that this title is a non-academic non-voting title with clinical criteria only

• Two bylaws changes to allow flexibility in the composition of committees, such that the Continuing Medical Education Committee can consist of clinical faculty only
Next steps

• Online faculty vote, Nov 20-Dec. 5, 2015
• Approved changes to take effect January 1, 2016
Policy and Guidelines for Interactions between The University of Arizona College of Medicine and Commercial Interests ("Industry")

Purpose of Policy
The purpose of this policy is to establish guidelines for interactions with Industry representatives for medical staff, faculty, staff, students, and trainees of The University of Arizona College of Medicine. Interactions with Industry occur in a variety of contexts, including marketing of new pharmaceutical products, medical devices, and research equipment and supplies; training for newly purchased devices; the development of new devices; educational support of medical students and trainees; and continuing medical education. Faculty and trainees also participate in interactions with Industry off campus and in scholarly publications. Many aspects of these interactions are positive and important for promoting the educational, clinical and research missions of the College of Medicine. However, these interactions must be ethical and cannot create conflicts of interest that could endanger patient safety, data integrity, the integrity of our education and training programs, or the reputation of either the College of Medicine or its personnel.

Individuals must consciously and actively divorce clinical care decisions from any perceived or actual benefits expected from any commercial interest. It is unacceptable for patient care decisions to be influenced by the possibility of personal financial gain.

Management of conflict of interest in health sciences offers additional and unique challenges in comparison to other areas of research. This policy for the College of Medicine is intended to complement and not supersede or conflict with overall research integrity policies at the University of Arizona. In research involving human subjects, potential financial conflicts may affect, or appear to affect, judgment regarding clinical care decisions, selection of human subjects, use of protected health information, adverse event reporting, data collection, and ultimate dissemination of findings. However, many new ideas and development of those ideas stem from interactions between academic and Industry contemporaries. Consulting and commercialization of intellectual property derived from academic pursuits are major drivers of practice-changing procedures, drugs, and devices. Thus, these conflicts of interest are unavoidable but can be minimized with appropriate oversight and management.

Definitions
Conflict of interest (COI): That situation which exists when a faculty, staff, student or trainee of The University of Arizona College of Medicine may have a significant financial or other personal consideration that may compromise, or have the appearance of compromising, their professional judgment or integrity in clinical responsibilities, teaching, conducting or reporting research, or performing other College obligations.
**Commercial interests (Industry):** Any proprietary entity producing health care goods or services, with the exception of non-profit or government organizations and non-health care related companies.

**Statement of Policy**

It is the policy of The University of Arizona College of Medicine that interactions with Industry should be conducted so as to avoid or minimize conflicts of interest. When conflicts of interest do arise they must be addressed appropriately, as described herein.

**Scope of Policy**

This policy incorporates the following types of interactions with Industry:

I. Gifts from Industry
II. Meals from Industry
III. Industry-sponsored promotional speaking relationships
IV. Industry support of ACCME-accredited CME
V. Attendance at Industry-sponsored promotional events
VI. Industry-funded scholarships and awards
VII. Ghostwriting and honorary authorship
VIII. Consulting and advising relationships
IX. Access of pharmaceutical sales representatives
X. Access of medical device representatives
XI. Conflict of interest disclosure
XII. Conflict of interest in the medical school curriculum
XIII. COI policies and adjunct/courtesy faculty and affiliated hospitals/clinics
XIV. Enforcement and Sanctions

I. Gifts from Industry

a. Personal gifts from Industry may not be accepted anywhere at The University of Arizona College of Medicine or at any clinical facility operated by the College. In addition, University of Arizona College of Medicine faculty, staff and trainees may not accept gifts at any non-College-operated clinical facility such as other hospitals or outreach clinics. Non-faculty medical staff are strongly discouraged from accepting gifts at non-College-operated clinical facilities but are not proscribed by this policy from doing so.

i. No form of personal gift from Industry may be accepted under any circumstances. Individuals should be aware of other policies, such as the AMA Statement on Gifts to Physicians from Industry (http://www.ama-
ii. Individuals may not accept gifts or compensation for listening to a sales talk by an Industry representative.

iii. Individuals may not accept gifts or compensation for prescribing or changing a patient’s prescription.

iv. Individuals may accept product samples from commercial interests only for patient use, provided no financial gain, or appearance of financial gain, exists.

b. Individuals may not accept compensation, including the defraying of costs, for simply attending a CME or other activity or conference (that is, if the individual is not speaking or otherwise actively participating or presenting at the event). Travel reimbursement, for travel conducted according to UA Travel policies, is acceptable for individuals attending specific training activities for use of a new medical device when the travel is necessary for appropriate training on that device.

II. Meals

Meals or other types of food or drink directly funded by Industry may not be provided at University of Arizona College of Medicine activities or at associated clinics. Exceptions for general ‘educational support’ are allowed under circumstance where: 1) the company is not acknowledged for providing support; 2) company representatives are not in attendance; 3) no promotional materials for company products are distributed or made available at the event; and 4) the event or meeting is a regularly scheduled scholarly activity and not an ad hoc event scheduled due to availability of a company-sponsored meal or promotion of company products or ideas.

III. Industry-sponsored promotional speaking relationships

Faculty, staff, students and trainees are strongly discouraged from participating in “Speakers’ Bureaus”, as an appearance of undue influence on content by Industry damages the integrity and validity of the work of UA faculty members. Financial compensation to faculty from Biomedical Companies for talks potentially considered promotional must be approved by the Department and reported to the College of Medicine. Faculty must retain intellectual independence over the content of any educational material they present. Faculty are prohibited from being compensated for participation in speakers’ bureaus or any other “educational” or informational event sponsored by Industry at which Industry exerts influence or control over the content, tone, or views presented. Without an open exchange of information, such events have the appearance of company marketing and are inappropriate venues for faculty presentations.

IV. Industry support of ACCME-accredited CME

assn.org/ama/pub/physician-resources/medical-ethics/about-ethics-group/ethics-resource-center/educational-resources/guidelines-gifts-physicians.page?) and the Accreditation Council for Continuing Medical Education Standards for Commercial Support (www.accme.org), which apply by reference to faculty, staff and trainees under this Policy.

...
a. ACCME Standards for Commercial Support bind all such activities at the College of Medicine. They provide guidelines for evaluating all forms of Industry interaction, both on and off campus, and include both University of Arizona College of Medicine events, as well as other events. The Standards are found at www.accme.org.

b. All educational events offered by The University of Arizona College of Medicine must be compliant with ACCME Standards for Commercial Support whether or not CME credit is awarded. Industry funding is not accepted for support of CME activities unless:
   i. The Course would be prohibitively expensive or an essential part of training that would not be possible without the support of Industry.
   ii. Educational grants, compliant with the ACCME Standards may be received from Industry but must be placed in a general designated account, and administered by the Dean of the College of Medicine or his designated representative. They may not be administered by individual departments, divisions, or individual faculty. The Dean of the College of Medicine, the Director of Continuing Medical Education, or their designated representative(s) must maintain records of fund distribution in compliance with ACCME Standards.

c. Faculty and medical staff should carefully evaluate their own participation in meetings and conferences that are fully or partially supported by Industry because of the high potential for perceived or real conflict of interest.

d. This provision does not apply to faculty attending meetings of professional societies that may receive partial Industry support, or other meetings governed by ACCME Standards.

V. Attendance at Industry-sponsored promotional events

Individuals who actively participate in meetings and conferences supported in part or in whole by Industry (e.g., by giving a lecture, organizing the meeting) should follow these guidelines:

a. Financial support by Industry is fully disclosed prior to the activity and at the beginning of the presentation by the meeting supporter.

b. The meeting or lecture content is determined by the speaker and not the commercial supporter.

c. The lecturer is expected to provide an impartial and objective assessment of therapeutic options and to promote objective scientific and educational activities and discourse.

d. The College participant is not required by the commercial supporter to accept advice or services concerning speakers, content, etc., as a condition of the commercial supporter’s contribution of funds or services.

e. The lecturer makes clear that content reflects individual views and not the views of The University of Arizona College of Medicine.
f. The use of The University of Arizona College of Medicine name in a commercially supported event is limited to the identification of the individual by his or her title and affiliation.

VI. Industry-funded scholarships and awards

Industry support of students and trainees should be free of any actual or perceived conflict of interest, must be specifically for the purpose of education, and must comply with all of the following provisions:

a. The College of Medicine department, program, or division selects the student or trainee.

b. The funds are provided to the department, program, or division and not directly to the student or trainee.

c. The department, program or division has determined that the funded conference, program, or other educational activity has educational merit.

d. The recipient is not subject to any implicit or explicit expectation of providing something of benefit to the Industry sponsor in return for the support, i.e., a “quid pro quo.”

VII. Ghostwriting and honorary authorship

Individuals are prohibited from publishing articles under their own names that are written in whole or material part by Industry employees.

VIII. Consulting and advising relationships

Consulting and advising relationships with Industry are allowed under the following circumstances:

a. Relationships are disclosed to the department head and Dean of the College of Medicine.

b. Relationships are in compliance with all other sections of the College of Medicine conflict of interest policy.

c. Relationships are in compliance with University of Arizona Conflict of Interest disclosure and assessment requirements.

IX. Access of pharmaceutical sales representatives

Sales and marketing representatives of pharmaceutical companies are permitted in non-patient care areas by appointment only. Appointments may be made on a per visit basis or as a standing appointment for a specified period of time, at the discretion of the faculty member, his or her division or department, or designated hospital personnel issuing the invitation and with the approval of appropriate hospital or clinic management.
X. Access of medical device representatives

Medical device representatives are permitted in non-patient care areas by appointment only, for evaluation by College personnel of new purchases of equipment, devices, or related items. Medical device representatives are permitted in patient care areas under the following circumstances:

a. By appointment only, for in-service training of College personnel regarding research or clinical equipment or devices already purchased.

b. When requested by College personnel to assist or advise in the technical use of equipment during surgical cases or research studies.

XI. Conflict of interest disclosure

a. In scholarly publications, individuals must disclose their related financial interests in accordance with the International Committee of Medical Journal Editors (http://www.icmje.org).

b. Faculty with supervisory responsibilities for students, residents, trainees or staff should ensure that the faculty’s conflict or potential conflict of interest does not affect or appear to affect his or her supervision of the student, resident, trainee, or staff member. Faculty with a significant financial interest, as defined by the University of Arizona Conflict of Interest policy (http://orcr.arizona.edu/coi), must disclose these relationships to trainees including students, residents, and fellows, prior to any training or educational activities related to the commercial interest.

c. Individuals having a direct role making institutional decisions regarding equipment or drug procurement must disclose to the purchasing unit, prior to making any such decision, any financial interest they or their immediate family have in companies that might substantially benefit from the decision. Such financial interests could include equity ownership, compensated positions on advisory boards, a paid consultancy, or other forms of compensated relationship. They must also disclose any research or educational interest that might substantially benefit either the Department or the individual by making the decision. The purchasing unit will decide whether the individual must recuse him/herself from the purchasing decision. This must be done in accordance with UA policies on Purchasing and Contracting Services (PACS, http://pacs.arizona.edu/manual_page01#Conflict).

i. This provision excludes indirect ownership such as stock held through mutual funds.

ii. The term “immediate family” includes the individual’s spouse or domestic partner or dependent children.

d. For disclosure requirements related to educational activities, see the ACCME Standards for Commercial Support (www.accme.org).

e. Faculty, staff and trainees who are engaged in teaching, research, administration or business operations in the College of Medicine also must comply with The University of Arizona Conflict of Interest and Conflict of Commitment Policies.
(http://orcr.arizona.edu/coi). In addition to the annual reports required under that policy, faculty, staff and trainees must annually report all grants, contracts, speakers’ bureaus, consulting arrangements, gifts, or financial interests they may have with biomedical companies.

XII. **Conflict of interest in the medical school curriculum**

All students, residents, trainees, and staff shall receive training regarding potential conflicts of interest in interactions with Industry. Conflict of Interest education will be part of new faculty orientation. Faculty will receive yearly reminders with a link to the Conflict of Interest Policy. Education for College of Medicine graduate trainees will be coordinated through the GME Office; education for medical students will be coordinated through the Office of Medical Student Education.

XIII. **COI policies and adjunct/courtesy faculty and affiliated hospitals/clinics**

This policy applies to all faculty and staff members of The University of Arizona College of Medicine, including members practicing at affiliated hospitals and clinics. This policy is in addition to and does not supersede, the Conflict of Interest policies of The University of Arizona or Banner-University Medicine.

XIV. **Enforcement and sanctions**

a. Faculty and staff will complete disclosure reports during their annual evaluations. Department Heads are responsible for assuring that all faculty complete a yearly Conflict of Interest form. Failure to complete a disclosure form may result in disciplinary action by the Department and Dean’s office. The duty to disclose is ongoing and not limited to an annual disclosure form.

b. Students, trainees, staff and faculty are encouraged to report any violation of this Conflict of Interest Policy or concerns about educational conflicts to the Dean’s office through the College of Medicine’s Professionalism Conduct Comment form (http://medicine.arizona.edu/webform/professional-conduct-comment). Any concern about a possible Conflict of Interest Policy violation will be investigated by the Dean’s Office. Corrective action will be taken when necessary to assure compliance with the Policy.
Faculty Forward – Research Committee

Dr. Monica Kraft, Co-chair
Dr. Carol Gregorio, Co-chair

Dr. Jil Tardiff (MED)
Dr. Todd Vanderah (PHCL)
Dr. Charles Hsu (RADONC)
Dr. Nick Delamere (PSIO)
Dr. Faye Ghishan (PEDS)
Dr. Diego Martin (RAD)
Dr. Wayne Jacobsen (ANES)
Dr. Kurt Denninghoff (AEMRC)
Dr. Abraham Jacob (ORL)
Dr. Eugene Chang (ORL)

Dr. Jane Mohler (ACOA)
Dr. Karen Weihs (PSYCE)
Dr. Myra Muramoto (FCM)
Dr. Judith Gordon (FCM)
Dr. Betsy Dokken (MED)
Dr. Henk Granzier (CMM)
Dr. Felicia Goodrum (IMB)
Dr. Lalitha Madhavan (NEURO)
Dr. Sai Parthasarathy (MED)
Dr. Anne Cress (resource) (RES)
Dr. Francisco Moreno (resource) (MED)
Timeline

July 20th    Report at Faculty Forward Head’s meeting (2x/month)
July 23rd    First meeting with committee
August 3rd   Report at Faculty Forward Head’s meeting
August 26th  Second meeting with committee (Anne Cress/Tony De Francesco: Space)
October 2nd  Third meeting with committee (Mike Jonan: RCM)
October 29th Fourth meeting with committee
November 12th Fifth meeting with committee

Current: Preparing White Paper for November 25th Deadline
Four Broad Focus Areas

1. **Fundamental Infrastructure:**
   - Equipment/Research Support/Services for Investigators – both clinical and basic
   - Bridge Funding/Grant Development (seed) Funding
   - Assistance with Development/Philanthropy
   - Pre-award Proposal management
   - Funding plan for graduate students

2. **Space: Quality, Quantity, how AHSC intersects with Banner Construction**

3. **Responsibility Centered** Management (RCM)/Funds Flow
   - To include: discussion about incentivizing research
   - To include: discussion about indirect cost allocation mechanisms

4. **Faculty/Career Development Resources in the COM and AHSC** – how to best coordinate and determine gaps
**Faculty Forward Education Committee**

<table>
<thead>
<tr>
<th>Co-chair</th>
<th>Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joe Miller</td>
<td>Ophthalmology</td>
</tr>
<tr>
<td>Todd Vanderah</td>
<td>Pharmacology</td>
</tr>
<tr>
<td>Nafees Ahmad</td>
<td>Immunology</td>
</tr>
<tr>
<td>Achyut Bhattacharyya</td>
<td>Pathology</td>
</tr>
<tr>
<td>Heddwen Brooks</td>
<td>Physiology</td>
</tr>
<tr>
<td>Melissa Broyles</td>
<td>Integrative Medicine</td>
</tr>
<tr>
<td>Conrad Clemens</td>
<td>Pediatrics</td>
</tr>
<tr>
<td>David Elmer</td>
<td>COM</td>
</tr>
<tr>
<td>Albert Fiorello</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>Wayne Jacobsen</td>
<td>Anesthesiology</td>
</tr>
<tr>
<td>Ken Knox</td>
<td>Medicine</td>
</tr>
<tr>
<td>David Labiner</td>
<td>Neurology</td>
</tr>
<tr>
<td>Lu Martinez</td>
<td>Medicine</td>
</tr>
<tr>
<td>Kevin Moynahan</td>
<td>Medicine</td>
</tr>
<tr>
<td>Victoria Murrain</td>
<td>FCM</td>
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<tr>
<td>Valentine Nfonsam</td>
<td>Surgery</td>
</tr>
<tr>
<td>Tejal Parikh</td>
<td>FCM</td>
</tr>
<tr>
<td>Bill Rappaport</td>
<td>Surgery</td>
</tr>
<tr>
<td>Heather Reed</td>
<td>OB/GYN</td>
</tr>
<tr>
<td>Kathy Smith</td>
<td>Psychiatry</td>
</tr>
<tr>
<td>Marc Tischler</td>
<td>Chemistry/Biochemistry</td>
</tr>
<tr>
<td>Amy Waer</td>
<td>Surgery</td>
</tr>
<tr>
<td>Jim Warneke</td>
<td>Surgery</td>
</tr>
</tbody>
</table>
Faculty Forward Survey - Education

Focus on the Medical School Mission  44% Satisfied
Medical School Governance            21% Satisfied

Areas of Concern Identified by the faculty
- Physicians ability to teach in the first two years of medical school
- Hours distributed for the preparation of lecture, labs, Sm & Lg groups, etc. & determining how State/Tuition dollars best support the education mission
- Going from a 24 month to a 18 month basic science curriculum and re-introducing basic science in year 4
- Setting Goals and Benchmarks
- Need for an Education Committee Composed of Faculty and Staff to monitor and promote quality teaching
Faculty with Different Degrees that Participate in the First Two Years of the Medical School Curriculum - Excluding Societies

Yr 2014-2015 (excludes societies)

<table>
<thead>
<tr>
<th>Department</th>
<th>PhD</th>
<th>MD</th>
<th>MD/PhD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridge</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Foundations</td>
<td>19</td>
<td>25</td>
<td>3</td>
</tr>
<tr>
<td>Nervous System</td>
<td>4</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>10</td>
<td>20</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 PT</td>
</tr>
<tr>
<td>Cardiac-Renal-Pulmonary</td>
<td>11</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>Digestive Metabolism &amp; Hormones</td>
<td>12</td>
<td>37</td>
<td>2</td>
</tr>
<tr>
<td>Infection &amp; Immunology</td>
<td>4</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Life cycle</td>
<td>15</td>
<td>32</td>
<td>1</td>
</tr>
<tr>
<td>Advanced Topics</td>
<td>13</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>Clinical Reasoning (Fall2015)</td>
<td>16</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>107</td>
<td>195</td>
<td>15</td>
</tr>
<tr>
<td>%</td>
<td>34%</td>
<td>62%</td>
<td>4%</td>
</tr>
</tbody>
</table>
## Teaching Hours by depts. for FY 2014-2015 (includes societies)

<table>
<thead>
<tr>
<th>Basic Science Depts. (5 depts)</th>
<th>Clinical Depts. (13 depts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biochem (1,843 h)</td>
<td>Anesthesiology (10 h)</td>
</tr>
<tr>
<td>CMM (6,003 h)</td>
<td>Emergency Medicine (3,741 h)</td>
</tr>
<tr>
<td>Immunology (2,123 h)</td>
<td>FCM (7,069 h)</td>
</tr>
<tr>
<td>Pharmacology (4,507 h)</td>
<td>Medicine (3,617 h)</td>
</tr>
<tr>
<td>Physiology (1,059 h)</td>
<td>Neurology (654 h)</td>
</tr>
</tbody>
</table>

Total 15,535 h

<table>
<thead>
<tr>
<th>FCM (7,069 h)</th>
<th>Medicine (3,617 h)</th>
<th>Neurology (654 h)</th>
<th>OB/GYN (99 h)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology (339 h)</td>
<td>Orthopedic Surgery (61 h)</td>
<td>Pathology (2,138 h)</td>
<td>Psychiatry (252 h)</td>
</tr>
<tr>
<td>Pathology (2,138 h)</td>
<td>Pediatrics (1,400 h)</td>
<td>Psychiatry (252 h)</td>
<td>Radiology (109 h)</td>
</tr>
<tr>
<td>Pediatrics (1,400 h)</td>
<td>Psychiatry (252 h)</td>
<td>Surgery (2,192 h)</td>
<td></td>
</tr>
</tbody>
</table>

Total 21,681 h
# Suggested Hours for Preparation in Teaching

55 responses with 23 from MD, MD/PhD and 32 from PhD faculty.

All faculty should receive direct student contact hours in addition to the following time below for preparation:

<table>
<thead>
<tr>
<th>Session Type</th>
<th>Hours</th>
<th>Split</th>
<th>Type</th>
<th>Roll Over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Reasoning</td>
<td>15</td>
<td>Yes</td>
<td>TCAuthor</td>
<td>No</td>
</tr>
<tr>
<td>Update Clinical Reasoning</td>
<td>3</td>
<td>No</td>
<td>TCSessionEditor</td>
<td>Yes</td>
</tr>
<tr>
<td>Facilitators</td>
<td>3 to 4*</td>
<td>Yes</td>
<td>TCAuthor</td>
<td>No</td>
</tr>
<tr>
<td>ILM</td>
<td>6</td>
<td>Yes</td>
<td>TCAuthor</td>
<td>No</td>
</tr>
<tr>
<td>Update ILM</td>
<td>2</td>
<td>No</td>
<td>TCSessionEditor</td>
<td>Yes</td>
</tr>
<tr>
<td>Lab</td>
<td>10</td>
<td>Yes</td>
<td>TCAuthor</td>
<td>No</td>
</tr>
<tr>
<td>Update Lab</td>
<td>3</td>
<td>No</td>
<td>TCSessionEditor</td>
<td>Yes</td>
</tr>
<tr>
<td>LargeGrp</td>
<td>15</td>
<td>Yes</td>
<td>TCAuthor</td>
<td>No</td>
</tr>
<tr>
<td>LargeGrp</td>
<td>3</td>
<td>No</td>
<td>TCSessionEditor</td>
<td>Yes</td>
</tr>
<tr>
<td>Lecture</td>
<td>15</td>
<td>Yes</td>
<td>TCAuthor</td>
<td>No</td>
</tr>
<tr>
<td>Update Lecture</td>
<td>3</td>
<td>No</td>
<td>TCSessionEditor</td>
<td>Yes</td>
</tr>
<tr>
<td>Team Learning</td>
<td>12</td>
<td>Yes</td>
<td>TCAuthor</td>
<td>No</td>
</tr>
<tr>
<td>Update Team Learning</td>
<td>3</td>
<td>No</td>
<td>TCSessionEditor</td>
<td>Yes</td>
</tr>
</tbody>
</table>

* 2 to 3 hrs credit for student contact and evaluations and 1 hr for weekly facilitator meetings

Needed requirements - **quality** assurance and **novel teaching methods** for long term learning and memory.
1) Would you like to be involved with the COM-T curriculum reform that moves the COM-T program to 18 months of pre-clinical education?
   - Yes (57%)
   - No (43%)

Out of 149 responses

2) If yes, which of the following curriculum aspects would you like to be involved with (mark all that apply)
   - Basic sciences 38 (41%)
   - Clinical 53 (57%)
   - Specialty discipline exposure 50 (55%)
   - Health care delivery 26 (29%)

Out of 92 responses
Cont. Survey Results

3) Your degree(s) (Mark all that apply):
   MD  105 (71%)
   PhD 45 (31%)
   MBA  3 (2%)
   MPH 10 (7%)
   other  8 (5%)

   Out of 147 responses

4) Do you currently work with medical students?
   Yes  130 (87%)
   No  19 (13%)

   Out of 149 responses

5) During which years do you currently work with medical students (mark all that apply)?
   Year 1  66 (51%)
   Year 2  63 (49%)
   Year 3  89 (69%)
   Year 4  91 (71%)

   Out of 128 responses
Cont. Survey Results

Comments:
- A serious “translational science” component should be developed and interwoven throughout 4 years – and the clinical time shouldn’t just be more “rotations” and sub-internships.

- Elective time should be expanded and the distinction tracks (particularly RDT & global medicine) further developed.

- To compete with other medical schools, curriculum reform (including an 18 mo basic science "core") is essential.

- This transition is a good time to look at a more solidified and longitudinally integrated simulation curriculum to supplement basic science concepts and the clinical approach of the undifferentiated patient.

- Take a look at the new UCSF Bridges Curriculum. They're doing a 3 phase blended curriculum.

- How do we evaluate the efficacy of the new proposed curriculum?
Comments:

- The amount of basic sciences curriculum has already been cut significantly. The schools named have a very strong incoming class of students. Given that at least some population of our students - specially the ones selected for having diverse life experiences or preparation that do not always include a strong science background, may not be prepared for such a switch.

- I think moving to a preclinical time of 18 months is great. My medical school did 15 months of pre-clinical time (and the last 3 months was focused on H&Ps- doing and documenting.) I was able to retain and solidify pertinent information by seeing patients in my second year.

- I am very interested in working on this initiative. Many educational experience includes my current role as the Chair of the Student Progress Committee, having served as a Societies Mentor for 6.5 years, experience as a residency Program Director for over 5 years and most recently I've been appointed to the ACGME Review Committee in Family Medicine for a 6 year term.

- I am interested in how to best integrate knowledge of basic sciences with application to clinical medicine in infectious diseases, particularly with regard to HIV. As a clinical faculty I have students mainly 3rd and 4th yr work with me on the Hematology Leukemia / BMT Floor and Malignant Heam / Stem cell transplant clinic.
Cont. Survey Results

Comments:
- This survey is highly prejudiced toward changing to the 18 month experiment. It asks if we want to be involved; I said yes, but only because I oppose it. There was no option listed to consider other alternatives--it just assumes we lemmings want to get on the 18 month bandwagon.

- I am an experienced family medicine residency director with particular interest and experience in rural and underserved populations. I am very much in favor of innovative curricular changes in both medical school and residency training. I am in favor of shortening pre-clinical experiences and also adding some milestone-oriented additions in the 4th year. I am happy to participate and help.

- There is an immediate need to develop Vertical ultrasound curriculum

- Asking a clinical faculty who already feel overburdened with clinical responsibilities (which undermines research/teaching time) to increase participation in unfunded curriculum development activities seems dubious.

- They already have a poor foundation of knowledge when they begin clinical rotations. This would impoverish that further.

- I think students will really benefit from a required anesthesiology rotation.
Comments:

- Having MD and not DO as an option in this survey is a bit insulting

- I was closely involved with the curriculum reform efforts in 2004-2006. I have been involved in medical education and residency training since 1987. Depending on the time commitment, I may be interested in learning more about the anticipated changes.

- Would also like to see bringing an occasional clinically relevant exposure during the 18 months of pre-clinicals, ie. Have a surgeon come to anatomy sessions.

- I give the Dermatology lectures in foundations block and work with 4th years on Derm rotations

- Need to change the curriculum
  I'd like to make sure that the Clinical Reasoning course will continue in any revised curriculum.

- I was the ID Block Director at UACOM-Phoenix before moving to Tucson to become the ID fellowship program director. Students need better fund of knowledge before clinical time
GME Faculty Forward Survey

“Most Pressing Issue”

Open Ended Question
Categories of Response
I think that a one size fits all budget approach is not advisable. Some programs may need to allocate more money to a certain line item (ie travel) while others may need to spend more on another (ie recruitment). Also there should be support outside of individual program budgets for resources used by all or many programs (ASTEC lab, etc).

It is a travesty that Pediatrics has only a couple of institutionally-supported fellowships slots, when other departments have as many fellows as Pediatrics has faculty.

Clarification of the extent to which the hospitals' CMS funding underwrites residency costs (incl. associated faculty cost and ancillary expenses) and to what degree other funding streams are responsible.

uniform funding on a "per resident" basis.

Fellowship funding for programs OUTSIDE the Department of Internal Medicine

Pediatric Fellowships are underfunded.

Alignment of payor source with role of the trainee - i.e., the hospital should pay for positions for those who work in the hospital primarily.

Increased support of pediatric subspecialty fellowships.
<table>
<thead>
<tr>
<th>GME Base Budgeting, Cont</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is no funding mechanism or award for post doctoral fellows who are in clinical programs and do research - they have no funds to travel to meetings - fellowship is a critical time in internal medicine subspecialties to really form the foundation for a career that includes investigation - need support to encourage this.</td>
</tr>
<tr>
<td>more research funding for residents.</td>
</tr>
<tr>
<td>We also need more funding for fellowship positions - especially in GI and ID.</td>
</tr>
<tr>
<td>complete funding office / support staff for CME south campus.</td>
</tr>
<tr>
<td>we really need administrative support to help with all ACGME requirements for specialty/subspecialty training programs</td>
</tr>
<tr>
<td>Does resident travel support include subspecialty fellows, if not then this should included.</td>
</tr>
<tr>
<td>GME support of social functions like graduation ceremonies and new-resident welcome parties. Paid membership to the hospital gym for residents to support resident wellness.</td>
</tr>
<tr>
<td>Support for educational materials and presentation at conferences must be the highest priority</td>
</tr>
<tr>
<td>Recruitment funding. Without healthy recruitment good residency candidates will go elsewhere!</td>
</tr>
<tr>
<td>The GME office has already developed a method for a fair, simple and transparent system for GME funding that has the support of Dept. Chairs. It should be adopted.</td>
</tr>
</tbody>
</table>

Disassociate GME funds from departments and from Banner. Remove barriers to use of funds but hold residency programs accountable to their proposed budgets.

<table>
<thead>
<tr>
<th>Funding for resident recruitment/interviews, resident graduation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fellowship salary funding</td>
</tr>
</tbody>
</table>

It was very difficult to rank the above. ALL of these things really ought to be priorities. It is not clear to me what the mission of this institution is with regard to GME. Without an overarching mission, it is difficult to truly plan for the future, and to have a resources discussion. GME is important, and it is one of the identities of this institution - as poorly managed and funded as many of these programs have been over the years. If it is the goal of Banner and the University to increase the number of primary care physicians that practice in the state of Arizona, then a significant amount of resources should flow in that direction. If it is our goal to attract the best trainees, then funding for residents/trainees beyond what is currently provided will go a long way. Not all funding should be considered a per trainee expense. Recruitment, for example, is one of our greatest expenses each year and doesn't fit well in the current per trainee $ amount. We should also look at the ACGME requirements as the minimum when it comes to support and think outside the box to provide tools, time, and resources necessary to innovate. I will get off my soapbox now.

Uniformity in resident educational costs
I don't think a one size fits all budget is appropriate. It may be OK to budget a set amount per resident across all programs, but individual expenses (like travel) may be significantly variable between different programs. Some programs may have didactic expenses that others don't. There also should be some shared GME budget for common expenses like the ASTEC lab.

Providing adequate education to existing residents--enough primary care faculty, good specialty rotations, less time wasted at meaningless VA rotations. Equity between programs is helpful.

Institutional recognition of residents with things like funding for graduation ceremonies and related events, occasional social events, and awards for excellence and achievement space
## Faculty Compensation

### 6 comments

<table>
<thead>
<tr>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faculty educational expense.</td>
</tr>
<tr>
<td>Support for faculty engaged in clinical and didactic GME teaching.</td>
</tr>
<tr>
<td>Funding for faculty who teach residents; change the silo culture to a cooperative one.</td>
</tr>
<tr>
<td>Support for faculty time to supervise residents, do case conferences, mentoring</td>
</tr>
<tr>
<td>Support for 'volunteer' faculty that teach our residents in the community.</td>
</tr>
<tr>
<td>Payment for volunteer clinical faculty who teach residents.</td>
</tr>
</tbody>
</table>
Matching manpower needs in the state, not only within our hospitals system.

<table>
<thead>
<tr>
<th>Increased fellowship spots.</th>
</tr>
</thead>
<tbody>
<tr>
<td>See above. We need more specialty and fellow residency slots.</td>
</tr>
<tr>
<td>Consider fellowship status of residents who have completed all required training for RRC and fund from practice income of fellows.</td>
</tr>
<tr>
<td>I believe that there is no reason to have our residents rotating at TMC (there has been an overall believe of the residents that TMC does not meet any education value, not just the attendings, but the system is not designed for that). I believe that the current administration at the VA has no intension to provide our residents with education when rotating on electives there, We should transfer all residents having electives there to the main campus, so they can actually see patients and not just sit in a room not doing anything, in the end we have the social obligation to provide our residents with the best training possible and graduate better doctors to take of our citizens and at this point I do not believe these two institutions mentioned are of any help on teaching our residents (TMC wards or VA electives).</td>
</tr>
</tbody>
</table>

- increase the diversity of the residents coming to our programs, increase URM representation
# Resident Research Funding

3 comments

| Exposure and potentially ability to participate in research |  |
| Research funding. |  |
| Increased resident level grant opportunities |  |
GME Program Expansion

2 comments

Funding for programs/tracks that will make UA GME programs distinctive.

Funding for global health directors to develop curriculum, mentor residents, and develop partnerships competitive resident salary.
The above list is sufficient

I am concerned about the design of this survey. Specifically the two items that ask faculty to rank the need for primary care and specialty care residency slots. Faculty will likely respond to this survey and represent their own areas. Primary care providers will likely rank the need for primary care slots highly and sub-specialists will do the same for subspecialty training slots. I would suggest a relook at this survey design for these two items.
## Teaching Environment

### Improved Simulation Laboratory.

Funds may be needed for additional learning space. Residents and fellows need classrooms too for didactics. Not enough learning space at this college.

Funding for simulation (faculty support and time, lab use cost, consumables, etc) for resident education directly linked to practice, such as procedure competency (e.g. central line) and interprofessional training (e.g. crisis resource management, code blue training).

<table>
<thead>
<tr>
<th>Space for residents and fellows; protected time for educators</th>
<th>Resident education facilities such as simulation labs</th>
</tr>
</thead>
</table>

N=5
Resident Debt

(Last but not least= a single comment)

Cut cost of Medical Education to reduce need for career choices based on financial reasons alone.
FF Faculty Affairs
3 Subcommittees

• Academic Tracks & Titles
• Faculty Retention
• Outreach
Academic Tracks & Titles
Subcommittee

Track expectations

• Review current expectations for COM series
• Discussed lack of consistent practice re: CFTE link to each series for new hires
• Recommendation made:
  – Tenure-eligible should be \( \leq 0.8 \), rec: 0.6
  – Clinical Scholar should be \( \leq 0.9 \), rec: 0.8
  – Clinical Series should be 1.0 CFTE
Academic Tracks & Titles
Subcommittee

Distribution of faculty on tracks

• Each Department should create a target distribution of faculty on various tracks to meet strategic goals aligned with COM

• Distribution approved by Dean and used to assist in planning for new hires

• Current distribution in COM:
  – Tenure = 30%
  – Clinical Scholar = 47%
  – Educator Scholar = 2%
  – Clinical Series = 10%
  – Research Scholar/Research = 11%
New series for new non-academic faculty

- Goal: create a title appropriate for faculty with few to no teaching or research expectations who are not employed by UA but deliver patient care within the Banner University Medical Division
- Title: “Faculty Physician”
Faculty Physician Guideline

- Recommended by Head
- Final approval by Dean
- Non-ranked
- Associate Designated Campus Colleague (DCC)
- Non-voting member of volunteer faculty
- Must not qualify for unmodified or modified series
- Board certified or equivalent, unrestricted license
Faculty Retention & Remuneration Subcommittee

• Survey and discussion of academic incentive plans from
• Review of recent VOICE survey
• Informal interviews
• Discussions with Banner Leadership Program leaders
Faculty Retention & Remuneration Subcommittee

- Implement Academic Incentive Program in new Compensation Plan
- Implement new Leadership Training
- Implement new Faculty Recognition Program
- Improve new faculty on-boarding and mentoring
- Implement exit interviews to collect data
Faculty Retention & Remuneration Subcommittee

• Improved communication regarding acute issues with clinical operations
• Implement new Compensation Plan
• Implement an Operations Committee
• Implement Retention/Change Champions
• Increase opportunities for faculty engagement
Faculty Forward
Faculty Affairs Committee

- Draft of White Paper asap
- White Paper to Dean Cairns by Nov. 25