Minutes*

Faculty Consultative Committee
The Ides of March, 2001
1:30 – 2:30
186 HHH Center

Present: Joseph Massey (chair pro tem), Linda Brady, Susan Brorson, Dan Feeney, Joseph Massey, Charles Speaks

Regrets: Fred Morrison, Wilbert Ahern, Muriel Bebeau, Les Drewes, Richard Goldstein, Marti Hope Gonzales, David Hamilton, Marvin Marshak, V. Rama Murthy, Paula Rabinowitz, Gwen Rudney

Absent: Billie Wahlstrom

Guests: Senior Vice President Frank Cerra

Other: none

[In these minutes: The Academic Health Center]

Professor Massey convened the meeting at 1:40 and began by telling Dr. Cerra that the Faculty Consultative Committee wants to work with the Academic Health Center governance committees to help them meet their goals. He asked if Dr. Cerra works with the AHC governance structure in a way different from the way he works with the deans and the department heads.

Dr. Cerra said he did and that the AHC governance committees have been invaluable in helping him. He said that they have gotten deeply involved in a number of issues in a way that has been very helpful.

Dr. Cerra went on to note the amount of external research funding generated by the various schools of the AHC. The School of Public Health generates nearly $500,000 per FTE per year; faculty in the Medical School bring in about $250,000 to $280,000, and Nursing faculty bring in over $200,000 each. The tenured/tenure track clinical faculty in the Medical School bring about $280,000 in NIH funding and about $200,000 each in clinical revenue. About 11% of the compensation for these faculty comes from state dollars.

They have documented the teaching that occurs in the Medical School and looked at the state funding and reallocated that funding in proportion to the teaching performed. Much of the shortfall in the Medical School budget is because of a lack of funds to pay for teaching; the shortfall showed up in the clinical departments because those are the ones that generate the money for the school. The biggest problem in the Medical School has not been solved: how to get things rearranged so that those who

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practice medicine and do 80% of the research do not have to spend an additional 30% of their time generating revenue. The revenue is supposed to THE RESULT of seeing patients.

Questions that need to be addressed include how much the practice plan should generate, how full Fairview is, how much time faculty need to spend in practice to generate revenue. Should they recruit faculty whose ONLY responsibility is to generate revenue? Dr. Cerra said he opposed that because it violates the mission of the Medical School. The revenues of the practice plan must be set at a level that is reasonable. That question is on the agenda for the next 5 – 6 months. The amount that should be generated by practice plans varies across the AHC schools.

The practice plan is private, asked Professor Massey? The question of who owns the practice plan is a good one, Dr. Cerra said. The physician practice plan is a legal entity outside the University, owned and operated by the physicians of the Medical School. It is regulated by Regental Policy, from the Medical School Dean's Office. Physicians are paid two checks, one from the University and one from the practice plane. The laws and regulations that govern the practice of medicine make relationships between entities such as Fairview and the practice plan or FUMC and the physicians complicated.

How can the FCC help the AHC in the next few years achieve its goals, Professor Massey asked? The core of the University has been very supportive of the AHC, Dr. Cerra said, a valuable ally. He said he has been trying to provide information from the administrative side on what they are doing to try to cope with the situation in order that faculty can do what faculty need to do.

Dr. Cerra quickly reviewed a series of slides outlining the financial structure of the AHC and then turned to data on funding of health professional education. He focused on clinical training at external sites and made the point that the AHC is highly dependent on the community for help in delivering the education: about 45% of clinical site instruction is pro bono contributions from physicians. That is why, he said, he signs 700- 800 affiliation agreements each year. This clinical training on site is threatened by managed care: because clinics must generate revenue, they are less inclined to take students, and the AHC is finding it more and more difficult to find sites for student clinical training. He noted that HealthPartners has about 20% of the AHC students in its clinics—and that costs them about $18 – 20 million per year. The total cost of the clinical training program is about $300 million per year; the (federal) balanced budget amendment cut about $200 million that came to the AHC.

Is there still a link to the Mayo Clinic, Professor Massey asked? Dr. Cerra reviewed the history of the connection between the University and Mayo and said that while there are links, they are not where they should be. But there is a fundamental difference in philosophy between the two organizations, he pointed out; Mayo is a health system with a medical school attached to it while the University does research and operates a practice plan to serve that mission; it is not the primary mission of Mayo to do research. Mayo has an international scope: about 10% of its students stay in Minnesota. The University has an international presence; 75-80% of its students stay in the state. The Duluth Medical School mission is to develop rural health care providers; about 70% of the students become rural practitioners. In response to a question from Professor Speaks, Dr. Cerra said that by all the measures they can identify, the Duluth and Twin Cities students in the third and fourth years are about equal—or the Duluth students may rank slightly better.

Professor Massey asked about the size of the medical school classes at the three institutions. Dr. Cerra said Duluth has about 55 per class (who come to the Twin Cities for their 3rd and 4th year of

instruction); the Twin Cities has about 165 per class while Mayo has about 50. The tuition at the University (both sites) ranges from $14,500 to $18,000 per year, depending on the year; tuition at Mayo is $4,700, subsidized by their endowment and by the state.

As there is more and more pressure on the Medical School, it loses faculty, Professor Massey observed. When he loses a faculty member it is because of a better offer. The loss of faculty implies there is a decline in the quality of education—but Dr. Cerra has not said that has occurred. Dr. Cerra said he can find no data to suggest that it has. He related that he interviews almost everyone who leaves the AHC; the dominant answer is that people get tired of spending so much time in the clinics seeing patients and having no time to do research. Only about 10% of those who left were lost to competitive offers elsewhere (in some cases, because they wanted to get away from the managed care environment in the Twin Cities—which they then discover is everywhere).

The "brain drain" in the AHC stopped around 1998, Dr. Cerra said. He has analyzed the recruiting that has taken place in recent years; in the large majority of cases, the departments have been able to hire the person they wanted. Those who did not come large did not do so because they did not want to come to Minnesota. He said he believed the AHC has achieved stability and its reputation is coming back.

What happens if the Governor's recommendation is approved, Professor Speaks asked? The first year there will be $8 million in non-recurring funds for the Medical School; in the second year there will be $8 million only if the University agrees to spend the money on new programs—but it needs the money for the core programs of the Medical School.

So if there is no change from the Governor's recommendation, Professor Speaks followed up? There will be a big problem, Dr. Cerra said. First, the Medical School will not have the funds to recruit new faculty (its goal was 13 new faculty per year for the next six years) to expand the size of classes to respond to workforce shortages. Second, the Governor's recommendation leaves the Medical School with the same problem it has now.

Professor Speaks said one worry is that no one knows what messages are being sent to the legislature from faculty and staff. One hopes they are appealing for support for education and not pitting the University against other systems (MnSCU, the K-12 system) and that they are not pitting one college against another. The problem must be solved for all because all are affected.

Dr. Cerra said it is his sense that that is not happening and that legislators are being told that the Medical School has a problem that must be solved within the context of support for the entire University. He has told the Medical School "ambassadors" that they should focus on the Medical School issues so legislators understand them but they must also insist that the entire University needs the funds that have been requested.

The Committee now focused on a graph in Dr. Cerra's handout that depicted the increased number of Minnesotans over the age of 60 and the graduation rates of the AHC schools. The number of Minnesotans over age 60 will double in the next 10 years; that, he said, is a surrogate for chronic disease, for people who will need to see the medical establishment regularly. At the same time, graduation rates from the AHC schools are flat—and they are at capacity now. At present there are serious shortages in a number of health professions in the state: there are 300 openings in pharmacy, 3000 in nursing, 100 in

medical technology, 250 in dentistry, and 300 for physicians; the need is greatest in outstate Minnesota. So there is a big problem, Dr. Cerra concluded—and with an eight-year training regimen in medicine, these shortages will not be addressed overnight.

While people are taking more responsibility for their own health, Dr. Cerra said, modeling by Dr. Kralewski in the School of Public Health suggests that there will be 6 million additional clinic visits in the next ten years. Each visit typically leads to three prescriptions. So there needs to be more students in the pipeline who are trained in the usual way—and if they are trained in the same way, in 10 years there will not be enough of them.

Dr. Cerra turned his attention briefly to the report from the panel that evaluated the sale of the hospital to Fairview. Of the three panelists, one was chosen by the University and one by Fairview; those two then chose the third, Win Wallin. The panel conducted a lot of interviews and provided a report (copies of which were distributed to FCC). In summary, the report said the University was right to sell the hospital and it has been a success (it is now in the black and there are enough patients to teach and to do research with).

The report also strongly makes the case that the Medical School is underfunded and that the state must step up its support. Fairview cannot be expected to bear the entire cost of the Medical School shortfall. The report also called for refreshing the vision of the hospital. Dr. Cerra noted that the Medical School has had a shortfall for the last 10 years and has been cutting costs; each move, however, was offset by a decline in clinical revenues.

One must understand how much the clinical revenues were used for teaching and research, Professor Feeney said—and that support continues. The clinical programs do not use money, they generate it. When times were flush, much was charged against those revenues; when revenue declined, the dollars were not available to fund other programs but no one else could afford them.

In the 1980s and early 1990s, Dr. Cerra related, the proportion of state funds to the Medical School was smaller than in any other part of the University (there was nothing wrong with that; there were the other funds that could be used). But few understood that managed care premiums included no money to pay for education. While the clinical revenue was available to pay for programs, that was fine, but they cannot do so anymore; the clinical faculty cannot pay for health professional education any longer. They are trying to AVOID seeing the same thing happen in Veterinary Medicine (which is where the Medical School was about a dozen years ago in terms of clinical revenues). Dr. Feeney agreed; if the Veterinary school teaching hospital loses market share, the college will be in big trouble. The same possibility exists in the other AHC schools in varying degrees, Dr. Cerra added.

Professor Speaks urged that the graph of aging and graduation rates be changed to better reflect the actual numbers. Dr. Cerra agreed that it would make the point better.

Professor Massey thanked Dr. Cerra for the discussion and adjourned the meeting at 2:40.

-- Gary Engstrand