Main theme appeared to be the difficulty (financially, educationally, and practically) of giving care in the outpatient clinics.

Example by Dr. Bikle – Income to faculty from a clinic visit
Chest - $313 reimbursed, but minus admin overhead, etc, the net was $10.33
Similar for cardiology. Net was even lower. $2.50

Presenters: Glenn Chertow, Elena Gates, John Engstrom
Questions the Presenters were asked to Address:
• The value of the time spent in clinical care to you as part of your academic career
• Degree to which clinical care is appropriately rewarded for time spent.
• Degree to which the current clinical structure provides worthwhile teaching environment
• Suggestions for fostering creativity and innovation in patient care; how should UCSF distinguish itself from patient care in community.

1. All agreed that the value of time in clinical care was essential:
• For basic scientists a link to patients, training and teaching
• For clinician investigators, essential component of research efforts, synergy
• For clinician educators, classroom, essential
• “The reason we are here”

2. Reward – generally agreed not sufficient.
• Generally based on derived income
• Depended on type of specialty: surgeons>procedural specialists>non-porecural specialists> generalists
• Not valued for promotion
• Taxes too high and reimbursement low
• The clinical income being used to underwrite other parts of the mission (? Mission Bay)
• Pointed out later by Wade Smith that the NIH essentially supplements clinic care – couldn’t do it without a grant
• Reward depends on whether you are teaching.

3. Teaching environment – not sufficient
• Students hurt the most – have to pack clinics, little time to teach
• No place to put students to have a real experience with a patient
• Clinical initiatives aimed at bringing in revenue rather than good clinical cases for teaching; the revenue is not used to help us teach.
• Areas within our control that could be fixed: infrastructure: see CAC survey, telephone office staff, difficulties patients and providers have accessing the system, end-runs to circumvent the system. (less in our control are reimbursement strategies, audits, documentation requirements).

#4 Fostering Creativity and improving our image in clinical care:
• Change perception in the community that we are not an ivory tower
• Focus some efforts on relevant diseases of 21st century, (aging, degenerative chronic illness, obesity) not only on high technology, high reward conditions.
• Work with dept chairs to retain highest quality clinical faculty
• Community outreach, transportation and parking, telephone and computer enhancements
• Branding as a superior place for care
• Think about the clinical care as part of “translational research”; value clinicians for patients they bring in. Create a clinical program that is active in the academic mission rather than building programs to generate taxes to support the mission.

Question for administration: What is your perception of how best to balance the needs of the Medical Center to provide top notch medical care while enabling the faculty develop their academic careers.

Mark Laret
Hospital’s mission is not to generate money but cannot support any mission without money. Cuts across all departments. Hard for practices to support themselves and yet pay the taxes to the school. Problem is the schools don’t have any discretionary funds.

Four causes for this question:
• Expectations may be unrealistic – expected division to produce scholarly and provide patient care. Is It realistic for any one faculty member to do this?
• Reimbursement models don’t work. E.g epilepsy surgery makes money, outpt care doesn’t; arthritis similar
• Not designed around efficiency, continuity of care, or pt centered care, or safety.
• Relied on residents as service providers – probably far more than is appropriate.

Three things we need to do:
 Institutional emphasis on providing great patient care. Unless we own it and say it is as important as education and research, we won’t get there.
 Need new structures to organize ourselves to take care of patients: hiring only clinician/teachers; improve operations of ambulatory care so work more efficiently.
 Need new financial models- $50 million to departments to pay for residents, backstop, et. Source is patient care. But this model isn’t cutting it. Correct for some of the reimbursement

Why we need to own clinical care:
 Right thing to do.
 Operations research in health care is exploding. Solve problems in how to deliver care; teach residents
 Obligation to expose our students and residents to a truly patient-centered experience.
 Patient care is the financial foundation of the hospital and allows us to do other things.

Providing top notch patient care should not be at expense of academic mission but do it in a way to support the academic mission.

Ernie Ring
• Reasons we came into academic medicine - Work with innovative and smart people; not afraid to try new things.
• Evolution of academic health centers from two services: private and clinic; these merged, housestaff as focus of care. Now change in work hours, documentation rules – now attending is at the center with no change in the reimbursement structure and less housestaff support.
• Admin aware that ambulatory care do not make financial sense for many faculty.
• KSA report mentioned
**Audience comments:**
- Clinical care should be on a par with scholarship
- Many barriers to giving care.
- Faculty being asked to do too much on too many fronts.
- Departmentalization, constantly running into barriers to care. Need better integration
- NP’s – paid well but have more stringent hours – felt unfair to faculty in some situations.

Larry Pitts – faculty being asked to do too much on too many fronts. Place is highly departmental – causing problems. Administration is somehow going to have to do something that spills across boundaries. Need a better system. Improve the ability of the clinician to give that care with less work. Every time you want to get something done, will meet a barrier. The part of the clinical system is in your lap. (Also is $50 million spent correctly – different than previously).

Jack Rodnick – suggested a faculty development program for clinicians, mini IHI. How to lead your health care team, operational advances, etc.

**Recommendations (from EW)**
- This meeting, coupled with the KSA findings for the ACC task force suggest this is an opportune time for the CAC to get involved in the issue of ambulatory care.
- CAC may wish to ask leaders of the ACC task force to come to the ACC to share their thoughts and recommendations, and to determine where CAC may augment or support these recommendations.
- CAC may additionally wish to create a series of its own recommendations to take to administration regarding some or all of the following: funding, overhead, infrastructure, support for the clinical mission, and direction for clinical programs.