Primary Focus Points for the Year:
• Gift and Endowment Assessment Proposal
• Indirect Cost Waiver Task Force Recommendations
• UCSF Space Planning
• UCSF Climate Survey Results
• Workspace Planning for Clinical Sciences Building and UC Hall
• Academic Senate Involvement in the Selection of President Napolitano
• Bridges Curriculum
• International Student and Research Visa Policies
• Overview of Funds Flow Model Changes
• Three-year Medical Degree
• Leadership Stewardship Reviews
• UCSF Fresno

Issues for Next Year (2014-2015)
• Redesign of the Undergraduate Medical Education Curriculum
• Gift and Endowment Assessment Implementation
• Operational Excellence - Pre-Award and Human Resources
• UCSF Space Governance Committee
• UCSF Climate Survey Changes
• Selection of New Dean
• Student Dismissal Regulations
• Leadership Stewardship Reviews
• International Student and Researcher Policies

2013-2014 Members
Ellen Weber, Chair
Marcelle Cedars, Vice Chair
Susannah Cornes
Cynthia Curry
Teresa De Marco
Judith Ford
Ruth Goldstein
Celia Kaplan
Tim Kelly
Dana Rohde
Phil Rosenthal (CAC Liaison)
Joseph Sullivan (Post-Chair)
Lydia Zablotska

Ex-Officio Members
Bobby Baron, Associate Dean, Graduate Medical Education
Renee Binder, Associate Dean, Academic Affairs
Sam Hawgood, Dean
Catherine Lucey, Vice Dean, Education
Jack Resneck Jr., Chair, Committee on Curriculum and Educational Policy

Number of Meetings: 9
Senate Analyst: Artemio Cardenas
This year, the School of Medicine Faculty Council took up the following issues related to the San Francisco Division:

**Gift and Endowment Assessment Proposal**

In November, the Faculty Council learned of a new proposal from campus leadership to increase the amount assessed to the spending of donor gifts and endowments from 1% to 6%. Upon learning about the proposal, Council members acknowledged the need to increase the assessment, but recommended that the increase not be retroactively charged on all prior gifts given to the university. The concern was that faculty would have to go back to donors and explaining to them that UCSF will be reducing the effective amount of the gift to pay for administrative fees.

Over the course of the year, the Faculty Council offered support to the other Academic Senate committees reviewing the issues. In April, a set of recommendations were drafted by the Academic Planning and Budget Committee. The five recommendations included

1. ease the tax in progressively;
2. tax smaller gifts less;
3. take funds being cut from any faculty-related programs and invest it back into faculty;
4. reject a tax on gifts related to student support; and,
5. grandfather existing gifts and endowments and tax only new gifts.

In June, Executive Vice Chancellor and Provost Jeff Bluestone and Dean Hawgood informed the Senate that the administration agreed make the following changes to the proposal: To phase in the assessment, at 2% each year; to exempt all student support; and to grandfather existing gifts, with the exception of endowments.

**Indirect Cost Waiver Task Force Recommendations**

In September, Professor Matt Springer, an Academic Senate representative serving on the campus Indirect Cost Waiver Task Force, was invited by the Council to report on the charge of the Task Force, the recent work of the group and the next steps for the development of a waiver policy. He informed the group that last year, Associate Vice Chancellor of Research Susanne Hildebrand-Zanki charged a Task Force with the responsibility of developing guidelines for an indirect cost waiver. The reason why new guidelines were needed was because not only does a policy not currently exist, but the campus has been losing money on grants from sources that do not pay the necessary indirect costs. While previously accepted, the practice of issuing waivers to all members of UCSF who receive grants from under-paying sources had become unsustainable as costs have increased and revenue sources have become scarce.

Over the summer, the Indirect Cost Waiver Task Force reviewed all the information related to the issue and a recommendation report was developed. In September, Dr. Springer informed the Council that he would have liked to share the recommendations, but it was still early in the process of the proposal development. He informed the Council that he could share the task force’s underlying principles used in the development of the recommendation, and then when the recommendations are released later in the year, he could come back and report.

In March, Dr. Springer came back to the Faculty Council to follow up the discussion in September. His presentation reviewed the following points from the recommendations report (Attachment 1):

- Current Financial State of the University
  - The campus is experience an environment with rising costs and decreasing revenues. Campus leadership projects that if mitigation efforts are not taken now, the campus will eventually go into run negative budget balances.
Currently, UCSF does not recoup all of the costs expended to support the research enterprise. With increasing costs to core administration and infrastructure, new ways to generate revenue must be reviewed.

- Proposed Removal of the Indirect Cost Waiver
  - Previously the Office of the President determined the policies for the collection and distribution of indirect costs. With recent changes to this system, the campuses are now responsible for developing their own policies. With the change, new opportunities to recoup cost have arisen.
  - Recommendations from the Task Force included:
    - Customization: Modify UCOP Facilities and Administrative Policy and Language for UCSF
    - Guidelines: Create an Indirect Cost Waiver Implementation Guideline to accompany the policy
    - Do not require a waiver request: This would be for government sponsors and non-profit sponsors with published F&A policies
    - Criteria: Create a set of criteria that will be used consistently to assess whether a waiver request should be granted
    - Authority/Accountability: Align authority to approve waivers with the responsibility to cover shortfalls
    - Alignment with Gifts: Implement an infrastructure charge for non-government awards and align the assessment on gifts and infrastructure change
    - Exemptions: Exempt career development awards and fellowships from the minimum rate
    - Encourage Inclusion: Relevant facilities and administrative costs as direct costs to non-federal sponsors in cases where indirect costs are allowed
    - Process: Seek extensive input form the faculty and department chairs on the taskforce’s recommendations
    - Assess: Assess the policy and implementation of the guidelines after year one

- The two major changes that were proposed by the Council included:
  - The recommendations that will result in a large reduction in the number of proposal requiring a waiver.
  - The recommendations call for the establishment of an infrastructure charge equivalent to the assessment on gifts for most non-profit awards.

- The University currently requires that all grants provide a certain level of indirect cost recovery. However, these waivers are generally granted to faculty seeking grants that pay no indirect costs at all. The proposal the Task Force is considering is a requirement that all grants provide at least a 10 percent indirect cost recovery. In the cases that the foundation or non-profit will not pay the 10 percent, then the money will have to be provided from a different source.

In response to the presentation, the Faculty Council members provided the following feedback for Dr. Springer to bring back to the Task Force:

- Disparate Resources among Departments: Council members were concerned that “poorer” departments would not have the necessary funds to compensate for grants
- Overall Net Value of the Proposal: Members commented that they wonder whether the total sum of revenue projected to be collected is actually worth all the time and effort?
- Allocating Funds in Other Ways: Members seemed to agree that if the university is going to go forward with the new policy, then a portion of the revenue should be set aside for grants which would be administered by a committee. This recommendation would give all faculty an opportunity to apply and raise the necessary funds to make up the 10%.

**UCSF Space Planning Committee Report**

In April, Dr. Bruce Wintroub, Co-Chair of the UCSF Space Committee, reported to the Council on the following space policy items:
• **Laurel Heights:** The University is in the process of determining the future of the Laurel Heights Campus. Leadership has analyzed the property and deemed that it would be more cost effective to possibly sell or lease the campus.

• **UCSF’s New Space Policy:** Last year the UCSF Space Committee recommended that all space owned by the schools should be assessed at a certain minimum value. The goal of the policy was to free-up unused space and make sure all space was used efficiently. After piloting the new policy, the group learned that for wet-lab space the cost per square foot of $90 was useful and could be raised to higher numbers in the future. The group also learned that all data for dry lab and administrative space was not accurate and that all work evaluating dry lab and administrative space would have to be postponed.

• **Future of Mt. Zion:** Members were informed that university leadership envisions using the space at Mt. Zion for more outpatient and primary care services.

**Review of UCSF’s Climate Survey Results**
In May, Vice Chancellor of Diversity and Outreach Renee Navarro provided a presentation (Attachment 2) to the Council on the recently released UCSF Climate Survey results. Council members asked several question regarding specific results to the School of Medicine and on gender equality issues. Vice Chancellor Navarro informed the group that UCSF has been provided with a complete dataset and that more analysis is possible. Faculty interested in viewing the results report can visit this website: http://www.ucsf.edu/news/2014/03/112601/ucsf-climate-survey-qa

**Workspace Planning for Clinical Sciences and UC Hall**
In April, Dr. Matija Peterlin, member of the Clinical Sciences Building (CSB) and UC Hall Workspace Planning Committee, provided the Council members with a report on the retrofit and redesign status of the CSB and UC Hall buildings. He reported that after several meetings of the committee, the current plan being discussed includes workspace that will include both private offices and activity-based workspace. This plan represents a general compromise that addressed the concerns of faculty and administration. He also informed members that half of UC Hall will become residential housing for students.

**School of Medicine Business**

This year, the Faculty Council took up the following issues related to the School of Medicine:

**Academic Senate’s Involvement in the Selection of UC President Napolitano**
In November Dr. Sandra Weiss, the UCSF representative that served on the UC Academic Advisory Committee, reported to the Council on the Academic Senate’s involvement in the selection of UC President Napolitano. She informed the group that faculty where involved throughout the process in reviewing and narrowing down the group of highly qualified applicants.

**Admissions Committee Annual Report**
In May, Associate Dean of Admissions David Wofsy provided the annual Admissions Committee report to the Faculty Council. He informed the group that the school had completed the process for the 2014 class and that notification letters had gone out to all candidates. This year the school received 7400 applications for 149 seats. Of note, the newly admitted group is over 50% female and 33% of admits are from underrepresented minority groups. This is one of the most diverse group of admits the school has had in recent years.

Associate Dean Wofsy noted that the main concern of the admissions this year was the diminishing ability to offer competitive financial support compared to other institutions. It has become apparent that competitor schools have increased their resources for financial support and are offering the top students with more competitive packages. While the data shows that UCSF is not yet losing the majority of
prospective students to other schools solely based on financial aid awards, the increase of resources at other schools will eventually have impact on the school and UCSF might not be as competitive.

Finally, Associate Dean Wofsy informed the Council that the School of Medicine’s secondary application will be changing as a result to state and federal regulatory changes. The two new optional questions that will be added include asking the prospective applicant what their sexual orientation is and whether they have served in the military. Members of the admissions are concerned that since these are the only two questions on the application, it might make applicants feel unnecessarily uncomfortable.

**Bridges Curriculum Reports**

Over the course of the year, the Faculty Council received quarterly reports from Bridges Curriculum representatives, former Vice Dean for Education and Chair of the Bridges Leadership Design and Integration (BLDing) Committee David Irby; Bridges Curriculum Committee member Anna Chang; and Associate Dean for Curriculum Susan Masters.

In January, Dr. David Irby and Dr. Anna Chang presented to the Council on the work of the Bridges Curriculum Committee and the development of the UCSF Bridges Curriculum Charter (Attachment 3). Details were provided on the purpose of the charter, the rationale for the school to change its curriculum, and a review of the emerging competencies needed for physicians to improve the health of patients, populations and delivery systems.

In April, Dr. David Irby and Dr. Susan Masters provided their second report (Attachment 4). The informed the Council that two major events had occurred since the last meeting: The first was meeting held in March between all of the 10 select Medical Schools that are part of the American Medical Association’s accelerating change consortium. Dr. Masters and members of the curriculum steering committee attended consortium and noted that the event provided a great opportunity to learn what the other medical schools are working on and to share best practices. The second event, also held in March, a retreat was convened that included students, faculty, staff and stakeholders. The focus of the retreat was on how to make the clinical experience more effective and powerful. The event served its purpose in engaging people around the discussion of what should be reformed and how, as well as in determining a consensus around a vision on how the relevant committees should move forward.

After the retreat an ad hoc committee was formed and tasked to develop a framework for a new curriculum using the vision developed at the March retreat. Working quickly, the ad hoc group developed the framework and held a presentation in early April. If approved by all groups within the school, a new curriculum could be rolled out in late 2015 or early 2016. The timing of the roll out will depend on whether the final curriculum will include drastic changes. The proposal will continue to work through the vetting process.

In June, Dr. Masters provided the final report for the academic year (Attachment 5) and informed the Council that a Bridges Curriculum skeleton plan had recently been approved and that the school was moving forward with filling out the details. Highlights of the plan included the immediate integration into clinical teams, an early start in August, immersion in inquiry across the curriculum, and the realignment of the Board exams after the second phase of the curriculum that features clerk ships that integrate foundational sciences and inquiry. Council members expressed that they were pleased with the work to date, and they look forward to future reports.

**Committee on Curriculum and Education Policy Annual Report**

In June, Vice Dean Catherine Lucey provided a report on the work of the Committee on Curriculum and Educational Policy over the past year. She informed the Council that the CCEP enjoyed its first academic year with updated bylaws featuring greater participation from colleagues in Graduate Medical Education.
including the associate deans of GME and two residents. According to her handout, issues reviewed and actions taken over the course of the year included:

- **Educational Data:** The annual synthesis of student perception and performance data revealed many strengths and high levels of satisfaction. The areas of concern such as preparedness to work within systems, preventive medicine, and population-based medicine are all areas that the Bridges Curriculum endeavors to address.

- **LCME Accreditation:** CCEP oversaw the three areas of compliance with need for monitoring including the additional systems put in place to ensure that required clinical experiences are logged and monitored, more reporting from the system tracking compliance with the distribution of learning objectives to all faculty, and additional reports on the management of curricular gaps and redundancies in the current curriculum which the Bridges Curriculum is a comprehensive response.

- **Clinical Informatics and Medical Education:** CCEP heard from Carolyn Jasik, a representative of the Good Documentation Group at Parnassus, on some challenges and opportunities in medical education and informatics at UCSF. The committee has a continued interest in ensuring constructive and helpful roles for student in the electronic Health Records so that the experience for students will be equivalent to those at other sites like the VA, Kaiser, and SFGH.

- **Faculty Diversity:** In July, CCEP is scheduled to hear from Vice Chancellor from Diversity and Outreach Dr. Renee Navarro and the head of the PROF-PATH program to support disparities.

- **Endorsement of Ambulatory Care Task Force Report:** CCEP endorsed the findings of the Ambulatory Care Task Force, a group appointed by the Integrated Curriculum Steering Committee (ICSC) to consider a gap identified in the curriculum: insufficient depth of student in ambulatory care.

- **Assessment Policy Update:** The committee approved an update to the Clinical Core Assessment and Grading Policy including the LIC interim assessments. The update integrates the LIC interim assessment into the screening and promotions process in place for all medical students.

- **Sub-committee Charge Revisions:** CCEP revised the subcommittee changes for the 2014 – 2015 academic year to accommodate needs for the emerging bridges curriculum.

- **Bridges Curriculum Skeleton Approval:** The committee approved a curricular skeleton. The Bridges Curriculum Design groups may now build out the specifics of the Bridges Curriculum.

- **Bridges Curriculum Implementation Plan Approval:** CCEP endorse the two-year implementation plan and charged the Associate Dean for Curriculum to propose a feasible rollout that uses a September start in 2015-2016 and implements the August start in 2016 – 2017. The committee remains committed to ensuring the highest quality for the existing curriculum throughout its final iteration and phase-out.

**Dean’s State of the School Report**

In April, Dean and Interim Chancellor Sam Hawgood convened a separate meeting with members of the Faculty Council to provide his annual State of the School report. Issues reviewed included:

- **Development of a Health System:** In response to recent changes in the national and local health care market and policy, Dean Hawgood informed the Council that UCSF will be developing a new health system model. The focus of the new system is to expand provider partnerships, increase transparency and to reduce costs. He also informed the group that there is a big effort to collaborate with the other UC Medical Centers and Medical Schools to find establish new efficiencies and leverage the power of the UC system.

- **Proposal to Increase the Gift and Endowment Assessment:** Dean Hawgood acknowledged the many concerns raised by faculty regarding the proposal to increase the assessment. He said that his main focus is to support the faculty and ensure the sustainability and excellence of UCSF. The hope is that the revenue from the gift and endowment assessment increase would help to compensated for the essential core resources that serve the faculty in many ways. He reiterated that the goal of the campus leadership is to support faculty as best as possible. He gave the example that there have been funding increases for the Bridge Program.
Improving Communication with the Senate: Dean Hawgood feels that campus leadership has not performed well in communicating with the Academic Senate and faculty regarding the recently-implemented and proposed administrative changes. He hopes to improve communications going forward by commuting early and often with faculty regarding proposed changes and the justification for those changes.

International Student and Researcher Visas
In November, Vice Chair Cedars informed the Council that due to changes in federal immigration policies, some financially sponsored foreign-nationals participating in research at UCSF would not be able to continue.

In March, Brian Groves, the Director for the International Scholars Office, attended to review the university and federal international student policies. In response to Vice Chair Cedars concerns, he informed the Council that international volunteer scholars can be hosted by UCSF under specific classifications. For example, students who are being sponsored financially either by their host country or university, are considered Visiting Scholars, an academic appointment outlined in Academic Personnel Policy 430 (http://www.ucop.edu/academic-personnel/_files/apm/apm-430.pdf). Council members asked specific questions regarding volunteers, high school students, undergraduate students from other countries. Vice Dean of Education Catherine Lucey added that she has been working on clarifying the different groups in current policies and that she is willing to come to a future Council meeting and discuss more information. Director Groves also offered to attend another meeting to discuss more with Council members.

Overview of Funds Flow Model Changes
In November, UCSF Medical Center’s Chief Medical Officer, Josh Adler, presented to the Council on the Medical Center’s plans to reform the model used to allocate resources across the School of Medicine and the Medical Center. He informed the Council that the need for change is necessary to compensate for recent health care reforms, dwindling financial resources and increased competition. Furthermore, the current model is complex and lacks necessary financial transparency.

To address the issue, Dean Hawgood and Medical Center CEO Mark Laret commissioned a group to review the current funds flow process and to propose alternatives that might be a better fit the school. The group researched models used around the country, both from academic and non-academic settings. After review, the model that the group decided best fit UCSF was the RVU (Relative Value Unit) system. In this model, all money from patient care flows into one entity deemed “the health system.” and all costs are then burdened by the “health system.” The hope is to implement this new system by July 2014. An oversight committee has recently been assembled to ensure a smooth transition process. Over the course of the next few months, this committee will review all of the unique circumstances some departments and units may face.

Council members noted that under the new model faculty will be given disincentive to engage in teaching, as their funding will depend on the number of patients served. Associate Fan Bobby Baron suggested that a certain set of funds be allocated by the health system to compensate for the disincentive to teach. Council members also asked about the composition of the committee that proposed the new funds flow model, and whether this group included educators or researchers? Dr. Adler informed the Council that the recommendation committee consisted of relevant department chairs that are tasked with representing the interests of all faculty members.

Three-Year Medical Degree
In November, the Council discussed the idea of implementing a three-year medical degree curriculum at UCSF. To provide more information on the issue, Vice Dean Catherine Lucey was asked to review the implications of an accelerated degree program. In January, Vice Dean Lucey informed the Council that because of the interest within the school regarding the three-year medical degree, a forum was created online for members of the school to comment. A few journal articles and other resources were also
provided to inform the debate ([http://open-proposals.ucsf.edu/bridges/challenge/proposal/11818](http://open-proposals.ucsf.edu/bridges/challenge/proposal/11818)). A summary of responses was shared with the group (Attachment 6).

**UCSF Fresno Presentation**
In April, Council member Cyndy Curry provided the Faculty Council with a report on the status of the UCSF Fresno location. Member Curry reviewed the following topics:

- Economic Challenges of the Fresno Metro Region:
  - Low levels of educational attainment
  - High unemployment
  - High rates of poverty
- Environmental Issues Facing the Population
- Overview of Fresno’s Medical Facilities
- Overview of the UCSF Medical Facilities
  - 250 Residents
  - Growth in the Fellowship Program
  - 35% of those who served on the Fresno area stay
  - Faculty Census
    - 4 Ladder Rank Faculty
    - 14 Clinical X Faculty
    - 18 Total Academic Senate Faculty
  - Strengths of the Fresno location is the rich clinical environment
  - Weaknesses is the little time and incentive for research

**Screening Committee and Academic Standards Report**
In April, Associate Dean of Student Affairs Maxine Papadakis provided the annual report for the Screening Committees and the Academic Standards Committee.

- **Screening Committees:** She reviewed the process by which the screening committees become aware of a student’s academic issues and the process that the committees follow to ensure students receive the necessary support to succeed. Support services for students include faculty mentors and supplemental academic and mental health support. Medical students also have mentors that act as advisors for students. These services have proven to be very effective in most cases.
- **Academic Standards Committee:** When the Screening Committees have exhausted all options to help students, the committees may refer the student’s case to the Academic Standards Committee (ASC). In this case, the ASC reviews the case independently from the Screening Committees and makes a recommendation to Vice Dean Catherine Lucey on whether the student should be allowed to continue or be dismissed.

**Stewardship Reviews**
Early in the year, members of the Faculty Council noted concerns with the fact that department vice chairs and division chiefs lacked an adequate evaluation process. To address this issue, members invited Vice Provost of Academic Affairs Brian Alldredge to review the university’s stewardship review process for chairs and to discuss how it could be replicated for other department leaders. After review, Vice Provost Alldredge share the specific survey that Academic Affairs uses for the chair reviews.

In June, following up on the request of the Faculty Council at the May meeting, a communication to the Dean was drafted and distributed to the Faculty Council for review. The aim of the communication was to inform the Dean of faculty concerns with the lack of faculty evaluation of Division Chiefs, Associated Chairs and Vice Chairs. Council members and other faculty feel all individuals holding leadership positions supervising faculty should undergo some kind of process for evaluation and feedback. After discussion, the Council resolved that the draft should be revised to recommend to the Dean that an evaluation be done by the Academic Affairs Office of the School of Medicine. The communication was
sent to the Dean and, in response, the Council was informed that the Dean would look further into the matter.

### Going Forward

Ongoing issues under review or actions, which the Faculty Council will continue into 2014-2015:

- Redesign of the Undergraduate Medical Education Curriculum
- Gift and Endowment Assessment Implementation
- Operational Excellence - Pre-Award and Human Resources
- UCSF Space Governance Committee
- UCSF Climate Survey Changes
- Selection of New Dean
- Student Dismissal Regulations
- Leadership Stewardship Reviews
- International Student and Researcher Policies

### Appendices

- **Appendix 1**: Indirect Cost Waiver Task Force Recommendations Report
- **Appendix 2**: Climate Survey Slide Deck Presentation
- **Appendix 3**: January Bridges Curriculum Update
- **Appendix 4**: April Bridges Curriculum Update
- **Appendix 5**: June Bridges Curriculum Update
- **Appendix 6**: Three-year Medical Degree Response

Senate Staff:
Artemio Cardenas, Senate Analyst
Artemio.Cardenas@ucsf.edu; 415/476-4245
UCSF Facilities and Administration Policy and Waiver Implementation

Recommendations from the UCSF IDC Taskforce

For Discussion
Background

- UCOP will delegate authority to grant finance and administration (also known as Indirect Costs, or IDC’s) and F&A waivers to the campuses

- UCSF has to develop its own policies and procedures related to F&A waivers

- UCSF Indirect Cost Waiver Policy Taskforce created to form recommendations

- Recommendations and Report created in Summer of 2013

Desired Goals of Today

- Share Recommendations and rationale

- Provide answers to FAQs

- Get your input and take it back to the taskforce before final policy finalization
Situation: Rationale

Overall

• UCSF is a business operating in competitive, market-driven areas

• 10-year operating projections show near term deficits and recovery in latter years

• UCSF is positioned to manage through challenges, yet requires constant vigilance

Research Revenue

• Long-term Federal research funding uncertainties, including sequestration

• Private research funding is not expected to outpace Federal funding in the near term

• Opportunity to grow new strategic programs while protecting critical existing programs will require choices, scenario planning and for each project to contribute to UCSF
Enterprise-wide strategic priorities drive UCSF’s business and financial planning efforts
In the near term, expenses will outpace revenues; but, recovery is possible with careful management.
During this same time period, undesignated campus core fund balances are projected to fall to minimum acceptable levels.
## UCSF Indirect Cost Rates for FY 13-14

<table>
<thead>
<tr>
<th>Sponsor Type</th>
<th>On-Campus</th>
<th>Off-Campus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Research</td>
<td>57.0%</td>
<td>26%</td>
</tr>
<tr>
<td>Federal Instruction</td>
<td>44.0%</td>
<td>26%</td>
</tr>
<tr>
<td>Other Federal Sponsored Activity</td>
<td>34.0%</td>
<td>26%</td>
</tr>
<tr>
<td>State</td>
<td>variable between 0 and 26%</td>
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</tr>
<tr>
<td>Industry Sponsored Research</td>
<td>57.0%</td>
<td>57.0%</td>
</tr>
<tr>
<td>Industry Clinical Trials</td>
<td>33.0%</td>
<td>33.0%</td>
</tr>
<tr>
<td>Foundations</td>
<td>variable between 0 and 44%</td>
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</table>
UCSF Indirect Costs: Some Details

FACT:
• In FY 11-12, the cost of supporting research at UCSF was $343 million
• UCSF only received $191.4M to cover those costs
• UCSF is losing approximately $75M/year (amount of indirect costs not covered by non-federal awards)
• Of that, $3M comes from awards with < 10% IDC
UCSF Indirect Costs: Steady Decline

Effective IDC on Total Directs
Trend from 2009-2013

From 2009 to 2013 drop of 3% = $17.6M

Office of Research
UCSF Indirect Costs: Some Details

Distribution by Rank and $$ of Current Active Awards with Less than 10% IDC

Total: $8.3M forgone IDC for 318 awards

- Prof: $5.5M
- Assoc. Prof: $2.3M
- Asst. Prof: $350K
- Fellows: $15K; Other: $200K

Source: Office of Research
UCSF Indirect Costs: Some Details

Distribution by Rank and FTE of Current Active Awards with Less than 10% IDC

- Professor, 121, 61%
- Assoc Professor, 29, 15%
- Asst Professor, 37, 19%
- Postdoc/Fellow, 8, 4%
- Other, 3, 1%

Source: Office of Research
## Comparative Practices

### Waiver Practices at Peer Institutions: Public and Private

<table>
<thead>
<tr>
<th>Entity</th>
<th>Waivers</th>
<th>Inst. Pool</th>
<th>Who Approves</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>U Michigan</td>
<td>Yes</td>
<td>No</td>
<td>VP Research</td>
<td>?</td>
</tr>
<tr>
<td>U Virginia</td>
<td>Yes</td>
<td>No</td>
<td>Dept. Chair, Dean or Associate dean, Associate Vice Provost for Research before University Comptroller makes final decision</td>
<td>?</td>
</tr>
<tr>
<td>U Wisconsin</td>
<td>Yes</td>
<td>No</td>
<td>Dir. of Research and Sponsored Programs</td>
<td>infrequent</td>
</tr>
<tr>
<td>Harvard</td>
<td>Yes</td>
<td>Yes</td>
<td>Dean of each individual school</td>
<td>?</td>
</tr>
<tr>
<td>Stanford</td>
<td>Yes w. min.infrastructure charge</td>
<td>No</td>
<td>Vice Provost, Dean of Research, Dean, Dept. Chair</td>
<td>Rarely</td>
</tr>
<tr>
<td>Hopkins</td>
<td>Yes, but considered cost sharing with offset funding required</td>
<td>No</td>
<td>Research administration and business offices at each school</td>
<td>Negligible</td>
</tr>
<tr>
<td>MIT</td>
<td>No</td>
<td>Yes</td>
<td>N/A</td>
<td>None</td>
</tr>
<tr>
<td>Columbia</td>
<td>Yes, but departments are charged 17.5% assessment on all awards</td>
<td>No</td>
<td>Vice Dean for Administration</td>
<td>?</td>
</tr>
</tbody>
</table>

*Source: UCOP Taskforce on Indirect Costs Waivers*
**UCSF IDC Waiver Taskforce**

**Charge**

- Develop a UCSF-specific Waiver Policy, implementation guidelines and procedures
- Develop methods for determining the level and source of institutional support for all large grants, ensuring alignment of policies for grants and gifts.

**Membership**

**Co Chairs:**
Susanne Hildebrand Zanki, Office of Research
Eric Vermilion, Finance

**Office of Research:**  John Radkowski, Erik Lium  
**Finance and Administrative Services:**  Nilo Mia  
**Academic Senate:**  Sharmila Majumdar, Matt Springer  
**School of Dentistry:**  Peter Rechmann, Deborah Greenspan, Stuart Gansky  
**School of Medicine:**  Jane Czech, June Chan, Paul Volberding  
**School of Nursing:**  Kathryn Lee, Kit Chesla, Patrick Fox  
**School of Pharmacy:**  Jim Wells, Stuart Heard  
**University Development and Alumni Relations:**  Jennifer Arnett, Suzy Beemer
Guiding Principles: IDC Taskforce Recommendations

1. **Mission-Critical**: Work for which waivers are sought should support the mission of UCSF

2. **Equity**: Waiver guidelines should ensure equitable treatment of the faculty

3. **Infrastructure support**: That is included in the direct budget will be credited toward the requirement for F&A support

4. **Accountability**: Authority to approve waivers should be aligned with the responsibility to cover shortfalls

5. **Transparency**: The waiver process should be transparent
Two Major Changes

1. The recommendations will result in a large reduction in the number of proposals requiring a waiver

<table>
<thead>
<tr>
<th>Waiver Required</th>
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<th>Recommended</th>
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<tr>
<td>Government agreements</td>
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<tr>
<td>Not for Profit with IDC policy</td>
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<tr>
<td>Not for Profit without IDC policy</td>
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2. The recommendations call for the establishment of an infrastructure charge equivalent to the assessment on gifts for most not-for-profit awards

This is a requirement to come up with the difference between what is paid by the sponsor and the infrastructure rate. At a rate of 10%, the additional revenue will be approximately $3 million/year.

<table>
<thead>
<tr>
<th>Infrastructure Charge Required</th>
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<tbody>
<tr>
<td>Government sponsors</td>
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<tr>
<td>Not for Profit sponsors</td>
<td>x</td>
</tr>
<tr>
<td>Not for Profit Career development awards</td>
<td>X up to federal rate for equivalent awards</td>
</tr>
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</table>
Specific Taskforce Recommendations

1. **Customization:** Modify UCOP Facilities and Administrative (Indirect Cost) Policy language for UCSF

2. **Guidelines:** Create an Indirect Cost Waiver Implementation Guideline to accompany the policy; spelling out intent and procedure for obtaining an IDC waiver

3. **Do not require a waiver request** for government sponsors or non-profit sponsors with a published F&A policy

4. **Criteria:** Create a set of criteria that will be used consistently to assess whether a waiver request should be granted,

5. **Authority/Accountability:** Align authority to approve waivers with the responsibility to cover shortfalls

6. **Alignment with Gifts:** Implement an infrastructure charge for non-government awards and align the assessment on gifts and the infrastructure charge

7. **Exemptions:** Exempt career development awards and fellowships from the minimum rate.

8. **Encourage the inclusion** of relevant facilities and administrative costs as direct costs to non-federal sponsors in cases where indirect costs are not allowed

9. **Process:** Seek extensive input from the faculty and department chairs on the taskforce’s recommendations

10. **Assess** the policy and implementation of the guidelines after 1 year
Recommendations

Recommendation 1: Customize
Modify the UCOP Facilities and Administrative (Indirect Cost) Policy language for UCSF

Details:

• Incorporate UCOP policy requirements but provide UCSF-specific context: include infrastructure charge as a vehicle to offset impact of no or very low F&A (indirect charge) resources

• Do not include specific rates in the formal policy, as they are subject to change and would require a policy revision every time there is a rate change

• Specific rates should be incorporated into the implementation guideline and procedures
Recommendation 2: Guidelines
Create an Indirect Cost Waiver Implementation Guideline to accompany the policy; spelling out intent and procedure for obtaining an IDC waiver.

• Provide clear guidance that explains the intent of the policy (*refer to Guiding Principles*)

• Provide criteria for judging whether a waiver is *appropriate* (*see Recommendation 4*)

• Outline the decision process for obtaining a waiver (*see Recommendations 5-7*)

• Include applicable rates in the guidelines
Recommendations

Recommendation 3: Guidelines
Do not require a waiver request for government sponsors or non-profit sponsors with a published F&A policy

- Allow investigators to apply for funding from government and non-profit sponsors with current published F&A rates without institutional approval
  - For government awards the expectation is that Government Business Contracts staff will negotiate the best possible rate
  - For state government awards our effort to create a master agreement between the state and UC systemwide is intended to preempt individual instances of negotiation for state-paid indirect costs

- Awards from non-profit sponsors with F&A policies, as well as awards from sponsors requiring a waiver, are subject to any applicable infrastructure charge; government contracts are exempt.
Recommendations

Recommendation 4: Consistent Criteria
Create a set of criteria that will be used consistently to assess whether a waiver request should be granted, as below:

- **High Risk:** award would be jeopardized without a waiver and would have a substantial negative effect on the faculty member's overall research program

- **Value/Mission:** the research is of mission-critical value to UCSF

- **Limited Options:** alternative funding sources, such as startup funds, pro fees, or gift funds, are unavailable to the PI (e.g., no FTE support)

- **Career Development:** the proposal is beneficial to the career development of new or junior faculty members

- **Innovation:** the proposal supports proposes research in new directions which might not be sufficiently developed to attract typical peer-reviewed awards

- **Financial and Administrative Considerations:**
  - to the extent reasonable, allowable F&A costs have been included in the direct cost budget
  - administrative burden of managing the award at UCSF is reasonable
  - total cost to UCSF is reasonable for the benefit the award potentially provides
Recommendations

**Recommendation 5: Authority/Accountability**
Align authority to approve waivers with the responsibility to cover shortfalls

- Empower Control Points (Schools and Depts) to target average F&A yield

- Control Points should be able to develop their own strategy to do this, including creating incentives for increasing F&A funds and to make appropriate decisions regarding allowance of low F&A awards

**Rationale:**
The Control Point is in the most appropriate position to make decisions on specific projects because:

- Is familiar with area-specific projects and funding mechanisms
- Is already accountable for achieving space based indirect recovery cost goals
- Is able to engage with faculty as partners in this process
Recommendation 6: Infrastructure Charge/ Gift Assessment Alignment
Implement an infrastructure charge for non-government awards and align the assessment on gifts and infrastructure charge

• To ensure that all awards provide necessary infrastructure support, each non-government sponsored project should generate infrastructure resources.

• To avoid discrepancies between the infrastructure charge and assessment on gifts, the infrastructure charge should be equal to and move with the assessment on gifts. Awards for purposes that are not subject to the assessment on gifts are also exempt from the infrastructure charge.

• In cases where the sponsor’s policy provides less than the 10% of IDC, the combination of sponsor-funded IDC rate and infrastructure charge should be capped at 10% of total direct costs. This charge could be offset by the provision of infrastructure resources via the direct budget.

• Infrastructure charges can come from appropriate fund sources available to the investigator, the department, the school, or the EVCP, in that order.
Recommendations

Recommendation 6 (Cont.): Infrastructure Charge/ Gift Assessment Alignment

Implement an infrastructure charge for non-government awards and align gift assessment and infrastructure charge

- A request for funding would have to be well justified using the waiver criteria and would need to include a justification why funding cannot be provided by the lower Control Points. (E.g. a request to the EVCP would need to be supported by the PI, the Department Chair, and the Dean with an explanation of why they cannot support all or part of the infrastructure charge.)

- To ensure that departments have fungible resources to cover an infrastructure fee, the funds flow model will have to ensure that departments have access to fund sources that can be used to cover the infrastructure charge

  - Additionally, UCSF could create a pool that could be used for this purpose. This pool should be replenished with indirect cost recovery dollars that exceed the expected recovery for the year. *This creates an incentive for faculty to press for higher indirects where they can, in order to be able to accept awards with lower indirects.*

  - Gift funds that are considered appropriate to offset the assessment on gifts should also be considered appropriate to use for the infrastructure charge
Recommendations

Recommendation 7: Exceptions
Create an exception for career development awards and fellowships from the minimum infrastructure rate

- Indirect cost rate for training and career development awards should be pegged to the federal rate for F, K, and T type awards
- For career awards from sponsors who pay less than the federal rate, the infrastructure charge would be assessed up to the federal rate
Recommendation 8: Encourage the inclusion of relevant facilities and administrative costs as direct costs to non-federal sponsors in cases where indirect costs are not allowed

- Investigators are strongly encouraged to budget administrative costs to the extent allowed by the sponsor that is reasonable for the size of the budget, especially for budgets that are uncapped.

- The departmental or school resources freed up could then be used to cover all or a portion of the infrastructure charge.

- A list of potential items that could be direct-charged is available to PIs and research administrators.
Recommendations

Recommendation 9: Process
Seek extensive input from the faculty and department chairs on the taskforce’s recommendations

To ensure that all who are potentially impacted by this policy have the opportunity to provide input, the committee members support the EVCP’s approach, as outlined in the charge letter: “Most importantly, the recommendations of this committee will be vetted broadly with the department chairs and faculty to ensure that we have a unified approach to the challenges.”

This is the purpose of our taskforce meetings with faculty and leadership forums

Recommendation 10: Process
Assess the policy and implementation of the guidelines after 1 year

• The policy and its implementation should be assessed to ensure that the policy is working as anticipated and make changes as necessary

• Provide information back to the faculty on the financial impact of the policy at regular intervals
Estimated Timeline: IDC Policy

**UCOP IDC Waiver Recommendations**
- **July 2012**
  - UC wide task force report with recommendations developed

**UCSF IDC Taskforce Discussion & Recommendations**
- **January - Sept. 2013**
  - EVCP charged cross UCSF group to revisit UCOP recommendations and develop UCSF specific recommendations.
  - Taskforce met regularly to develop report with recommendations in September

**UCSF IDC Recommendation Sharing and Input**
- **Dec. 2013 - Spring 2014**
  - (Present) IDC taskforce members attending School and other leadership forums to share taskforce recommendations
  - Goal is to obtain input and questions.

**UCSF IDC Policy Modification**
- **Spring/Summer 2014 Ongoing**
  - Based on input, taskforce or another forum may or may not be reconvened to modify policy as appropriate
  - Once input is obtained and discussed, policy will be posted on website

**What We Need from You:**
- **Your Input and Questions**
- **Sharing of this with others to get their input and questions**
PURPOSE OF CHARTER
This document provides an overview of what we aspire to create in the Bridges Curriculum: a view of the future physician, important concepts to sustain and incorporate, and guiding principles for curriculum development.

VISION OF 21ST CENTURY PHYSICIAN
The UCSF Bridges Curriculum will prepare the 21st century physician to work collaboratively in promoting health and reducing suffering while continually improving our health care system. Our students will contribute to improving healthcare outcomes today while being educated to work within complex systems to improve health care tomorrow.

RATIONALE FOR CHANGE
Despite years of dramatic advances in biomedical science and over a decade of attention to the problems of quality and safety issues, progress towards achieving the IOM goals for high quality health care has been slow. Medical education is part of the problem. If medical education is to fulfill its social contract and work to ensure that all members of our society have access to care that is safe, timely, effective, efficient, cost conscious and patient centered, it is time for a major change.

ENDURING AND EMERGING COMPETENCIES NEEDED TO IMPROVE THE HEALTH OF PATIENTS, POPULATIONS AND DELIVERY SYSTEMS

Adapted from Lucey CR. Medical Education: Part of the Problem and Part of the Solution. JAMA Intern Med. 2013: July 25, E1-5.
GUIDING PRINCIPLES FOR CURRICULUM DEVELOPMENT

The UCSF Bridges Curriculum will enhance the acquisition of enduring knowledge and skills while integrating the emerging knowledge and skills that are critical to becoming a 21st century physician. The following foundational principles will guide the work of the curriculum steering committees:

**IMPROVING HEALTH BY FOCUSING ON PATIENTS AND LEARNERS**

1. **Grounding in Science and Patient Centered Care**: Students will learn, practice and continuously apply critical thinking and problem solving skills for patients and populations using foundational concepts derived from the biomedical, social, behavioral and systems sciences. Students will also learn to recognize the limits of existing knowledge, and be encouraged to participate in the discovery of new knowledge and its translation to clinical practice.

2. **Immersion in Authentic Workplace Learning**: Students will develop 21st century physician clinical, scientific and systems skills by participating in authentic, developmentally appropriate and longitudinally arranged workplace learning experiences from the beginning of medical school.

3. **Integration into Interprofessional Collaborative Care**: Students will learn, practice and demonstrate effective team-based and interprofessional collaborative practice skills across all settings.

4. **Formation of Professional Identity**: Students will embrace the identity of the 21st century physician and continuously identify and develop their own unique skills, contributions and leadership; while being supported by advising and mentoring.

5. **Advancement based on Competency Based Progression**: Students will demonstrate mastery of Entrustable Professional Activities (EPAs) through a competency-based progression, based on milestones for knowledge, clinical and systems skills, and professional attributes.

**IMPROVING HEALTH BY FOCUSING ON SYSTEMS, INSTRUCTIONAL STRATEGIES AND DEVELOPMENT**

6. **Engagement with Health Care Delivery Systems**: Students will be prepared to add value to and learn from clinical microsystems while minimizing faculty/staff burden during workplace learning experiences.

7. **Flexibility for Individualized Tracks**: Learners will have opportunities to pursue individualized and specialized tracks of study both through the admissions process (PRIME, JMP, MSTP) and following the start of training (Pathways to Discovery). In selected cases, students with prior training and demonstrated competencies will have the opportunity to combine a shortened course of study coupled to early entry into internship.

8. **Reliance on Technology and Sound Pedagogical Principles**: Students and faculty will employ technology to advance learning, assessment and curriculum management while also using research from the learning sciences to select, implement and study instructional and assessment strategies.

9. **Development of Faculty, Residents, Fellows and Staff**: Faculty members, residents, fellows and clinical partner staff members will be empowered to create and continuously improve learning environments and activities that improve patient care and support our students.
Committee: BLDInG

BLDInG Committee Meeting: 4/14/2014

Discussion Points and Decisions

I. **Post Retreat Update**, Dr. Anna Chang:
   a. Need for central messaging from Bridges and a new vision statement: *The UCSF 21st century physician will have individual expertise grounded in inquiry and improvement, and collaborative expertise with teams and systems.*
   b. Members of BLDInG are asked to use this vision statement to inform and engage stakeholders.

II. **Bridges Institute Steering Committee (BISC) Initial Report**, Discussion by Dr. Brad Sharpe:
   a. The motto of BISC is to “leave no faculty or staff member behind” in their design of faculty/staff development within Bridges.
   b. 4 working Groups (Needs assessment, delivery system, blue print, content)
   c. They’ve designed a Blueprint template to show how this might be implemented and showed some sample Modules that might be disseminated.
   d. Recognizing that there are multiple levels of involvement and expertise required, different modules will be designed for each level.
   e. Questions to BLDInG:
      i. Does everyone need to be proficient in QI/PS? AAMC says yes. However, this is really a matter of definition of who is the faculty (full time, voluntary; JMP; Fresno; other health systems faculty) and do they all need everything? **Decision:** The answer is no.
      ii. Kaiser has a person in charge of CME and MOC credit (Carol Havens) who organizes maintenance of certification opportunities….can this be duplicated here?
   f. Development work will initially focus on where there are the biggest gaps.

III. **AMA Update**, Dr Susan Masters:
   a. 10 other schools in AMA consortium- this was an opportunity to share what everyone is doing.
   b. UCSF viewed as a leader in group of schools; technology, use of big data for education and EPAs were focus of discussion.

IV. **FSSC Ad Hoc Group Update**, Drs. Susan Masters and Catherine Lucey:
   a. After retreat ad hoc group was created to develop the initial curriculum framework/skeleton/structure.
   b. The ad hoc group created a curriculum framework proposal, which was approved by FSSC on 4/9.
   c. Key ideas:
      i. Foundational sciences are designed through a lens of inquiry
      ii. Clinical sciences through a lens of systems-based inquiry
      iii. Every student must be able to ask a good question, interpret data (consume), collaborate (cooperate), and champion (develop habits of the mind).
   d. This skeleton/framework is being shown to curriculum committees and stakeholder groups throughout the month of April.
The UCSF Bridges Curriculum: Physician as Leader and Scientist

- **Vision:** UCSF will graduate a diverse set of physicians, each prepared to be leaders in a variety of fields, committed to advancing health and transforming healthcare to reduce the burden of suffering and disease.

- **Mission:** Every graduate must be able to embrace inquiry, investigation, discovery/improvement and interdisciplinary teamwork as core elements of their chosen professional work and focus.

- **Strategy:** We will inspire students to master these competencies and to make meaningful contributions to the diverse communities in which they learn.

**The Sciences WE use to Question, Investigate & Improve these Systems**

- Population Science
- Biomedical Science
- Social and Behavioral Science
- Clinical Science

**A Population of Physicians; Each Expert in a Unique Area of Discovery/Improvement**

- Population/Community
- Pedagogy
- Systems Engineering
- Biomedical
- Social/Behavioral
- Clinical/Translational

**High Quality, Patient Centered Health Care**

**Each with core competency to contribute in other of inquiry**

- Expertise: Discovery/Improvement Leaders
- Proficiency: Collaborators
- UCSF Core Competency: Practitioners / Champions
# The Ten Other Schools in AMA Consortium

<table>
<thead>
<tr>
<th>School</th>
<th>Focus</th>
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<tbody>
<tr>
<td>Brody, East Carolina</td>
<td>Focus on patient safety curriculum as the core; strong IPE; Teachers of Quality Academy to help with faculty development</td>
</tr>
<tr>
<td>Brown</td>
<td>MD-MS degree in primary health and population health; new clerkship to integrate care of individual and population health, focus on admissions</td>
</tr>
<tr>
<td>Indiana</td>
<td>Creating a virtual health care system based on their home-grown electronic medical record (EMR)</td>
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<tr>
<td>Mayo</td>
<td>Science of health care delivery as the curriculum core</td>
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<tr>
<td>Michigan</td>
<td>Two-year foundational trunk followed by flexible professional development branches; leadership &amp; change management curriculum, scholarly concentration</td>
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<tr>
<td>NYU</td>
<td>Creating an integrated care coordination and analysis curriculum as a flexible 3-year curriculum; strong ePortfolio and dashboarding</td>
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<tr>
<td>Oregon</td>
<td>Learner-centered, competency-based curriculum based on milestones; strong ePortfolio; possible fast track</td>
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<tr>
<td>Penn State</td>
<td>Triad of basic science, clinical and health care delivery faculty to lead all courses; systems focus</td>
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<tr>
<td>UC Davis</td>
<td>Three-year Accelerated Competency-Based Education in Primary Care in partnership with Kaiser</td>
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<tr>
<td>Vanderbilt</td>
<td>Workplace learning at one site; strong ePortfolio and dashboarding fed by data from home-grown EMR</td>
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http://www.ama-assn.org/sub/accelerating-change/grant-projects.shtml
The Bridges Curriculum skeleton was unanimously approved by the Bridges Leadership Design and Integration Group (BLDInG) and by the Committee on Curriculum and Educational Policy (CCEP). The CCEP also unanimously approved a two-year implementation plan with some elements of the Bridges curriculum implemented in the ’15-’16 academic year and full implementation in ’16-17.

**Bridges Curriculum Skeleton Key Points**

- Early August start with a block for orientation and preparation for an inquiry-focused foundational science curriculum and workplace learning
- Shift of the USMLE Step 1 exam to Winter of the 3rd year
- Sixteen-month Foundations 1 phase that includes an eight-week summer
- Year-long Foundations 2 phase that contains respites (e.g., Intersessions)
- Third-year milestone assessment
- Inquiry Immersion blocks in each year
- Advanced Studies phase with a required inquiry “deep dive”

**Bridges Curriculum Design & Implementation**

The curriculum will be completely planned by Spring 2015. Implementation will occur over two years (’15-’16 and ’16-’17). In ’15-’16, every medical student will experience some element of the Bridges curriculum as the major innovations for the Bridges Curriculum will be present in some form in the curriculum. Examples of major innovations include:

- Advanced foundational science in the Clinical Studies (3rd & 4th years)
- Early learners improving the work while learning the work in clinical settings
- Entrustable Professional Activity (EPA)-based assessment
- Increased continuity with clinical sites
- Inquiry immersion blocks
- Innovative content delivery
- Integration of emerging and enduring foundational sciences

**Next Steps**

Efforts by multiple committees and task forces are focused in the following areas:

- Next level of detail of the scaffolds for Foundations 1 and Foundations 2
- Rapid prototyping for early learner workplace learning
- Design of the Inquiry Curriculum and deep dive
- Innovation in content delivery methods
- Faculty development needs and resources
- Aligning communications for applicants with the Bridges Curriculum vision
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<th>Year 2</th>
<th>Year 3</th>
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SK 6/12/14

Simple

- Orientation, ground school for workplace learning & inquiry immersion
- Foundations 1: Foundational sciences, inquiry, clinical and workplace learning, professional development weeks
- Inquiry/Summer
- Foundations 1: Foundational sciences, inquiry, clinical and workplace learning, professional development weeks
- Foundations 2: Core clerkships, interessions, assessments
- Flex: Inquiry Immersion/Clinical Work
- Winter Break
- Inquiry Immersion
- MILESTONE ASSESSMENT
- Winter Break
- Inquiry Immersion
- MILESTONE ASSESSMENT
- NBE Step 1 & Step 2 CK Prep
- Winter Break
- Inquiry Immersion
- Coda/Competency
- Winter Break
- Advanced Studies: subinternships in preparation for residency application
- Graduation!!!

Organization:

- Foundational sciences, inquiry, clinical and workplace learning, professional development weeks
- Inquiries
- Foundations 1: Foundational sciences, inquiry, clinical and workplace learning, professional development weeks
- Foundations 2: Core clerkships, interessions, assessments
- Winter Break
- Inquiry Immersion
- MILESTONE ASSESSMENT
- NBE Step 1 & Step 2 CK Prep
- Winter Break
- Inquiry Immersion
- Coda/Competency
- Winter Break
- Advanced Studies: subinternships in preparation for residency application
- Graduation!!!
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Legend:
- Foundational Science
- Inquiry
- Clinical & Workplace Learning Level 1
- Clinical & Workplace Learning Level 2
- Clinical & Workplace Learning Level 3
- Clinical & Workplace Learning Level 4
- Flex: Inquiry Immersion, advanced clinical work
- Residency Interviews
- Legacy Presentations
- Graduation!!!
- Clerkships, intersessions, advanced clinical work
- Specific threads
- Specialty-specific threads
- Advanded Studies: subinterventions in preparation for residency application
Bridges Challenge
Your IDEAS building Bridges!

Takeaways

**Challenge: What should be UCSF’s response to the call for a three year medical school?**

An Open Proposal call for comments on the Bridges challenge question "What Should Be UCSF's Response To The Call For A Three-Year Medical School?" was posed to the UCSF Community in November – December 2013. Nineteen UCSF faculty, staff, and learners commented on the proposal.

We have summarized the results into three key findings:

1. Themes for which there was consensus among respondents regardless of whether they agreed with whether UCSF should have a three-year medical school
   a. The three year option should be reserved for the few who enter with a clear career path and those who interested and capable of navigating key benchmarks and demonstrating competences.
   b. The three year option must provide:
      i. Robust, valid, and flexible assessments that closely tracks learner development. This also includes creating a flexible curriculum path.
      ii. Robust advising system available for learners with extensive faculty development around advising and mentoring.
      iii. Ability for students to "opt out" of three years.
   c. Program has to ensure that learners' health and wellness is safeguarded.
   d. Clear understanding of the cost of producing and hosting a three year program, where individual pathways are necessary.
   e. Understanding of the impact of a three year curriculum on elective and research opportunities.

2. Themes from those who either supported or did not support the notion of a three-year medical school and reasons why
   - Respondents who did not agree with a three-year medical school, cited the following reasons for their opinion:
     - Concern that clinical experience will be short changed: clinical experience depends on patients seen and there is variability in when certain patient experiences might occur
     - Will not save cost to student
     - Medical school goals should focus on the physician that needs to be developed and not fast tracking
     - Topics such as social and behavioral science and interprofessional education would be eliminated
     - Students need time to reflect and digest experiences as experienced and a shortened experience would not allow for that
     - Students would become less involved in the community and do fewer extracurricular activities. This risks giving students less experiential learning, while also leading to less of a UCSF impact in the surrounding community (UCSF's name wouldn't be heard in as many corners of the community).
   - Respondents who agreed with a three-year medical school, cited the following reasons for their opinion:
     - Timing is right to make this change in medical education. Other schools are offering similar programs.
     - More likely to work for those entering non-competitive specialties and who are willing to stay at home institution for residency
     - Government push to reduce burden of medical education cost

3. Respondents suggested these things should be considered in developing a three-year medical school
   - Learn from six-year programs
   - Revisit pre-med requirements and reduce those
   - Allow option for students to test out of pre-clinical courses
   - Decide first what is core curriculum all students need to experience
   - Do away with division between pre-clinical and clinical year
   - Leverage online/asynchronous learning to make three year medical school happen
   - Develop measures to mitigate the potential negative impact on medical school cohort camaraderie
   - Eliminated summer between 1st and 2nd year and move to year round curriculum (2)
   - Build 2nd year preceptorships into summer experience
   - Build early clinical experiences into curriculum
   - Determine how timing of USMLE would fit in to three year curriculum
   - Reduce length of certain core clinical rotations
- Create transitional MSIV-Internship year
- Build in to curriculum 4th year experiences which we know UCSF students find useful
- Visit alternative ways of funding medical education
- Involve residency program directors in developing three-year medical school
What should be UCSF's response to the call for a three year medical school?

Created by Kevin Souza[1] on November 8, 2013 - 5:10pm.
Last revised by Web Producer on February 3, 2014 - 2:57pm.

**Challenge Status:** Closed[2]

Medical education nationwide has a new focus on learning outcomes and the competencies of a graduating medical student. This approach opens the option for medical schools to move away from a time-based, required four years for medical education.

With a shortened degree option, some medical students might go into residencies after three years while others might choose to take a “deep dive” into projects or specialties, but not in the constrained format of medical education today. The New England Journal of Medicine recently posted a point/counterpoint on the issue of the three year medical school curriculum. See Point: *A 3-Year M.D. — Accelerating Careers, Diminishing Debt*[3] and Counterpoint: *The Three-Year Medical School - Change or Shortchange*[4]

As we work to design the Bridges Curriculum for the 21st Century
physician, we turn to our community to ask your thoughts on the three year curriculum debate. Should UCSF work to design a curriculum in which students could complete all required rotations (including subinternships) in three years? If so, what would be our main goals of that curriculum: the opportunity for students to complete their education earlier or to take deeper dives into more individualized content? What would have to be in place so that we are confident that our graduates are still expert? How might you envision compressing the existing curriculum to make this happen? We welcome your thoughts on these and any other questions about shortening training in medical school.

Challenge closed as of December 12, 2013. Thank you for your ideas!

Takeaways

We have summarized the results into three key findings:

1. Themes for which there was consensus among respondents regardless of whether they agreed with whether UCSF should have a three-year medical school
2. Themes from those who either supported or did not support the notion of a three-year medical school and reasons why
3. Suggestions respondents suggested should be considered in developing a three-year medical school

See details[5]
Adding on to all of the excellent comments below, there are clearly many advantages and disadvantages of a 3 year curriculum. Other medical schools have experimented with this change, and many residency programs offer a residency analog of a 3 year medical school curriculum called “fast tracking” in which residents can forgo some years of their residency so as to enter into a fellowship early. Just like “fast tracking” is an option for a minority of motivated residents in certain residency programs, a 3 year medical school could be an option for a minority of motivated medical students at UCSF.

If UCSF were to create such a “fast track” for medical school, there would need to be several safe guards in place so as to ensure that the graduates UCSF produces are both medically and professionally ready to become physicians as well as to ensure their mental well being with such an accelerated schedule. In regards to proving medical and professional readiness to become a physician, a series of core competencies that others have alluded to could serve this goal. Mental well being would be much harder to document with a core competency. Ideally, there would be a robust advising system established for those students choosing to pursue a fast track, and there would be multiple opportunities for students to “opt out” of the “fast track” and revert to a more traditional curriculum in case of medical student burnout, lack of medical student preparedness and/or second thoughts re: future career paths.

I have very much enjoyed the back and forth of this debate, and see great arguments on both sides. One unorthodox idea along these lines is why does medical school need to be set to a year requirement? Whether that requirement be 3-years or 4-years? If, as Dr. Irby and Dr. Laponis pointed out so well, if there are transparent, well delineated competencies, a very motivated student should be able to travel through the curriculum at a speed that is befitting of their goals, aspirations, temperament, and abilities.

I think a 3-year or shortened medical school is more feasible now than ever. As many have pointed out, Duke has essentially been doing this for many years. Ohio State operates a "self-directed" track in which students do the majority of their learning on their own. As online learning tools improve, and on-line learning gains more acceptance, the ability to direct one's own learning, and to progress at variable speeds will be far greater.

On the other hand, while I think this is an interesting question, I can already poke many holes in my own arguments, many of which have been addressed in others comments. Being a medical resident, I know very little about the organizational side of medical education, and I can see how something like this could pose some impressive logistical obstacles. Scheduling exams, clinical rotations, and graduation ceremonies would be quite the challenge. Additionally, I am proud of the steps that the ACGME have taken to ensure duty hour restrictions in an attempt to improve resident wellness, health, and patient safety. Allowing medical students to barrel through the curriculum "at their own risk," could present many wellness issues. And lastly, something I don't recall seeing mentioned, the camaraderie of the medical school experience would take quite a blow
if everyone was taking the curriculum on individually. Having completed medical school recently myself, I look back on my time fondly, mostly for the experiences shared with others, tackling obstacles as a united class.

There were certainly times in medical school when I felt the curriculum could have made better use of my time, or thing could have been more condensed. But would I have lost some of the structure? Or would I have lost the supportive and caring enviroment in which I was able to learn? Or perhaps I would have lost the camaraderie, the piece I will remember with the most nostalgia? A three-year curriculum has potential cost benefits, and benefits of time efficiency, but what would we be giving up?

Submitted by Julie Lindow on December 2, 2013 - 11:16am.

From a coordinator perspective, I think logistically a 3-year curriculum may not be the best use of resources because creating individualized schedules and tracking individualized assessments to allow students to graduate in 3 years will require significantly more faculty and coordinator time, and thus increase the cost per year/per student of medical school.

Also, I think that non-clinicians often forget what Dr. Nussbaum said, "The preclinical curriculum is a carefully crafted program - clinical experience is much harder to control, since it depends to a great extent on which patients happen to come in when a student is on each rotation. I recognize that there are important competencies that can be learned from ANY patient but there are also some very special experiences that come only with certain, special patients, and
it is really hard to predict and program for these. Cutting clinical time even more makes it less and less likely that a student will encounter these highly formative experiences."

I think we need to balance the kind of physician we want to develop, with the MD program duration, with costs, and our resources (faculty and staff time, and clinical opportunities/number of patients), rather than let any one of these drive the new curriculum.

Submitted by Robert Nussbaum[8] on November 29, 2013 - 4:00pm.

Interesting conversation. I recognize the economic pressures and why a 3-year curriculum would be valuable but I would hate to see clinical experience shortchanged. The preclinical curriculum is a carefully crafted program - clinical experience is much harder to control, since it depends to a great extent on which patients happen to come in when a student is on each rotation. I recognize that there are important competencies that can be learned from ANY patient but there are also some very special experiences that come only with certain, special patients, and it is really hard to predict and program for these. Cutting clinical time even more makes it less and less likely that a student will encounter these highly formative experiences.


We should embrace this concept. Recently at a meeting with Rep Pelosi's staff, we learned that they would very much like to see some way of reducing the burden of cost of medical education. This certainly would address that, as well as get our students to achieve their goals at an earlier age. We have much success to review from
the 6 year programs and knowledge to gain from that experience.


Overall, I am in favor of the idea of an individualized pathway in medical education. Lengthier pathways (i.e., 5+ years) are already in place somewhat, as students will often extend their UME years by taking a year of research, a year to do a masters degree, etc. I remember several members of my medical school class at UCSF "splitting" their MS2 year into two years to enable more time to focus on the difficult academics. (Not sure if that is still an option here . . .?).

Extension of medical school is, of course, easier than shortening it. As reiterated in the comments below, regular, thorough assessments and close tracking of students needs to occur for this to work and ensure we are producing learners prepared for intern year, academically, psychologically and professionally. I also agree with Nina that this is much more likely to work for those entering less competitive specialties and planning to stay at their home institutions.

Ways to compress the curriculum as it stands now, could involve eliminating the summer between 1st and 2nd years, decreasing the length of various core rotations (for example, I know some medical schools only have a 3 week pediatrics rotation) and eliminating fourth year electives. The question is what curriculum changes do you apply universally to all medical students and what to simply the "fast-trackers"? The more curriculum pathways, the more money, admin time and faculty involvement needed, which could be
problematic.

I do find the idea exciting, though!


Very interesting discussion! I think individualized pathways make sense, presuming robust assessment strategies are in place--including assessments related to maturity and professionalism. Even though there is currently a lot of compartmentalization between undergraduate studies, a student’s next endeavors if they don't go straight to medical school, UME, and GME, I think it is also important to re-examine the full educational continuum. Is it crucial for all future doctors to take a year of organic chemistry? Could that time be better spent pursuing a research (or other interest) with a scholarly approach to learn evidence-based medicine and critical appraisal skills? It would be wonderful to build a transitional MS-IV-internship year that maximizes educational opportunities and minimizes noneducational scut work and "extraneous load." Are there alternative ways to fund medical education so that debt burden doesn’t influence career trajectories as much?


I support the flexibility of 3- or 5-year options for students, depending on their interests and their demonstrated expertise. There are opportunities to build early clinical experiences into the curriculum, allowing some students to identify and pursue early differentiation into a subfield. There is an additional opportunity for a didactic, and potentially interprofessional, summer quarter. Some
of the costs of education are fixed costs - should the physical therapy students be the sole occupants of fixed cost university classrooms during the summer? Although many medical students participate in educational experiences during the summer quarter, the UME curriculum schedule could be altered from the current undergraduate model to a graduate level, year-round educational model.

Submitted by Christopher Fee on November 26, 2013 - 12:19am.

How is moving to a 3 year curriculum any more justified than a 4 year curriculum when the ultimate goal is to prepare learners for the next phase of their training (residency, research, industry, etc) through the achievement of well-thought out, validated, benchmarks/milestones? If this is true, could it not be the case that some learners would meet these goals before 3 years have elapsed (the "new" time-based curriculum in a sense). Should medical students be allowed to test out of pre-clinical courses if they have had the exposure elsewhere (undergrad coursework, for example)? The logistics here are mind-boggling of course since much of the current coursework is sequential in nature such that simply testing out of a given subject wouldn't necessarily translate into a more rapid transit through the curriculum (since a given course might only be offered once per year, etc). Asynchronous learning options would potentially be a pivotal part of this.

Submitted by Dylan Alegria on November 25, 2013 - 12:33pm.

I am not convinced by the argument for a purely 3 year curriculum. As has been mentioned in prior comments, the critical advancement that must be acheived before this takes hold is a robust, valid and
flexible assessment process. The current state of assessment is not up to the task as subjective assessments are not completed with adequate care and objective assessments are limited to medical knowledge domains.

I strongly advocate a flexibly timed curriculum, that allows learners to progress at their own rate and develop skills that they value. The logistical challenges of this approach are monumental and would require a deep embrace of competency and objective based education (as opposed to simple mapping of objectives to pre-existing material).

The current siloing of the pre-clinical and clinical curricula is a major driver of the length of medical school. The content that medical students learn in lecture halls could easily be incorporated into the clinic (and might reduce student temptation to volunteer for scutwork that does not impact their learning but may bolster evaluations).

Submitted by Michael Coppolino\textsuperscript{[13]} on November 21, 2013 - 5:13pm.

I am certainly no expert in the field and would simply add that I do like the consistency of competency and outcome based assessments as opposed to a simple time based graduation policy. I do not like the idea of the cost of education being a major factor in determining duration of training. I support a minimum duration regardless of competencies gained. This would be necessary not just for the sanity of those making schedules but also to ensure adequate exposure to role models and life experiences regardless of medical competencies.
gained. Similarly, perhaps a maximum duration where further training is unlikely to be of benefit and can therefore be terminated.


I think increasing flexibility by shortening to a 3-year program could be a great option for students selecting a career in one of the core clerkship disciplines, but would be challenging for those interested in a specialty not otherwise represented. As discussed in the NEJM papers, this would only be realistic for students continuing at the same institution for residency (or at a different institution also offering a 3-year program).

If the larger goal in creating the 3-year curriculum is to shorten the total time before beginning practice (and reduced number of years accruing debt), particularly in fields that have very long training processes (i.e. 6-7 year residencies with 1-2 year fellowships to follow), will the 3-year option actually have the desired impact? Would the directors of those training programs at our institution welcome these students into a coveted position without time to do research or additional study? I worry that the program would only shorten the process for students choosing a more general discipline, which would have a lower impact on the larger goal.

I think it would be critical to involve UCSF residency program directors in the discussion to ensure they will support excellent students in this pathway. They are key stakeholders who will influence the success (or failure) of the short track.

My other comments/questions are more logistical--
A seamless process for converting to a 4-year program if a student’s goals or readiness change would be critical. Logistically, it sounds quite challenging to create a personalized compressed program that remains flexible enough to accommodate dynamic change. At what timepoints would the change be possible? Would the converted student rejoin the 4-year curriculum "off-cycle"? If they have a more compressed "pre-clinical" curriculum, would faculty have to teach adapted courses twice a year? This may be acceptable to core SOM education faculty, but what about all of the additional apprenticeship experience faculty? How would the timing of USMLE Step 1 and 2 fit in with a 3-year model?


If there are clear, robust and transparent assessment strategies, it makes sense that medical school should be competency based and not time-based. With such an approach, a 3 year curriculum could make sense for a motivated and competent medical student with clear goals for their learning/career. Given this transition, however, there should be preparation for extending medical school for those that do not reach competency and adequate faculty development in assessment to ensure competency is assessed appropriately.

Submitted by David Irby[16] on November 18, 2013 - 6:13pm.

Adding a three year option only works if there are robust assessment measures, clear milestones, strong career advising and motivated students. This option is consistent with our Carnegie recommendation to standardize on learning outcomes and individualize the learning process.
Outcomes from three year programs are identical to that of four year programs. Thus, the fourth year should offer other opportunities that might entice our students to continue through the four years (such as the Pathways to Discovery Program, joint masters degree programs, and other elective opportunities). Currently, 40% of our students take longer than four years so I don't anticipate that the three year option will be a large pathway. But, it will be an important pathway because it demonstrates our commitment to personalized education and flexible programs.


I anticipate many thoughtful comments. I would like to highlight that I have found that UCSF functions well with options available for learners. So mindful of challenges already pointed out, I would support that an individual with quality advising could opt to forego the fourth year. I actually think this will be a small number of our students. However, I think this is an important opportunity for residencies to be innovative as to how they might transition a third year student to internship. Plans for this will give serious consideration to the concept of "continuum" in medical education.


Duke does this in a way - they have a 3 year curriculum but then require a 4th year of research or additional course work in lawy, business, public health, etc. They compress the preclinical coursework and clinical experience into 3 years by eliminating most of the summer time for electives/experiential exploration.
In fact, a three-year training program will be more attractive to students pondering a career in medicine, so the demand for medical training will rise. When demand for something rises, but supply remains fixed, the cost goes up, not down. There might be a temporary period where the three-year MD is less costly, but over the long run prices will equilibrate according to supply and demand.

One might say that stewards of public institutions will commit to keeping per-year tuition low, and so the actual cost of a three-year program at public institutions will remain low compared to the four-year program. But this, too, misses the larger picture. We have a lot of private institutions of education in this country, which is another way of saying that market forces rather than the decisions by public administrators are what largely determine the average price of education.

To see why this is the case, it may be helpful to partially sketch out the mechanism of price equilibration in our mixed public-private system. As a result of price controls at public institutions, the capacity of medical school classes at public schools will grow more slowly than the capacity of classes at private institutions that do not face the same revenue constraints. Over the long term, the number of such spots will decline in comparison to the number of spots at private schools, and there will be increased competition for the relatively small number of spots available at public schools where tuition is controlled. Ultimately, the overall debt burden will increase as more students attend expensive private institutions.

The outcome might be different if there were very few private institutions and if higher education were provided largely by the
state, as it is in many other countries. But in our country we have a very large private market in education. As a consequence, the state is largely unable to set prices, except by acting through the channels of supply and demand.

How to control the cost of education is a discussion for another day, given that this forum is about the three-year MD. To be clear, I think the question of a three-year MD is an interesting one that deserves discussion. But the NEJM authors might have acknowledged that the price of education is largely a function of market forces, and that the three-year MD, if designed as an equivalent to the four-year program in terms of rigor, is likely to raise the cost of education, not lower it. In order for the three-year degree to truly provide cost savings, it would ultimately have to be a less valuable/less desirable product than the four-year degree, or there would have to be a much larger market restructuring involving increases in the supply of UME and GME training positions.

Submitted by Ivan Mendez on November 14, 2013 - 11:34am.

This is a thought-provoking proposal. I think one way to achieving a three-year medical school is to have second-year preceptorships completed during the summer. The student would go on a daily basis for a period of 2-3 weeks in the summer, to a clinical setting.

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Submitted by Ryan Laponis\[^{15}\] on November 19, 2013 - 8:12pm.

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Going to 3 years means giving up an opportunity to explore other interests during the summer between 1st and 2nd year as well as time for electives. I can see the economic motives for this. It is still not clear to me if you are still going to want 4 years but will have a full year to do a "deeper dive", the way Duke does it, or will you allow people to graduate in 3 years and go right into residencies? I worry that the students will not be adequately prepared for residencies without some time to practice as 4th year students and gain maturity and knowledge.


I agree with the sentiment that the additional clinical training time that comes with the fourth year has a lot to add. UCSF students, more so than other schools nationally, believe that their fourth or final year was important in enhancing their clinical education. This means we are doing something right with the that final year that we will want to retain even if we move to a three year curriculum. It maybe that we would need to understand better which clinical experiences our students have found useful and ensure that we build opportunities for those into a three year plan at the relinquishment of something else....

Submitted by Erron Titus on November 14, 2013 - 8:22pm.

The authors of the NEJM article in favor of a three-year MD assert that the shortened program will lead to a reduction in student debt burden. I believe this assertion is incorrect.
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