HEALTH SCIENCES ALL FACULTY COUNCIL
General Faculty Meeting
Faculty Club – Atkinson Pavilion
5:30 – 7:30pm
Meeting Minutes – Tuesday, June 4, 2013

Present: Chair: T. Savides; D. Brenner; D. Bailey; R. Clark; D. Granet; R. Mehta; M. Savoia; D. Sears;

Unable to Attend: S. Brown; D. Conrad; B. Cosman; J. Hirsch; V. Hook; R. Mehta; C. Miller; S. Ramamoorthy; D. Rapaport; E. Reid; R. Espiritu; G. Hasegawa; H. Kimmons; T. McAfee; R. Smith; B. Smith

Guests: J. Alksne; M. Baker; D. Bouland; K. Bulow; K. Cadenhead; G. Casola; S. Cherqui; S. Chien; R. Clark; S Crowe; E. Dennis; B. Eliceiri; W. Dillman; J.Dimsdale; W. Ettouati; P. Ernst; E. Dennis; R. Fitzgerald; C. Giovanna; D. Granet; S. Hayden; F. Imam; P. Insel; J. Ix; G. Jacobsen; F. Jahansouz; S. Jassal; M. Karin; C. Kelly; A. Kuo; W. Ladd; R. Lee; L. Levi; R. Loomba; J. Mandel; A. Markou; L. McEvoy; L. Mell; R. Mittal; P. Montgrain; S. Mullaney; A.J. Mundt; V. Pretorius; A. Ries; M. Richman; M. Ryan; M. Ravinder; E. Seki; J. Simerjot; F. Torriani; M. Tsuang; M. Ulibarri; V. Vallon; J. Vinetz; P. Viviano; F. Torriani; D. Ward

Speakers: D. Brenner; P. Viviano; M. Savoia; Carolyn Kelly; Jess Mandel; Stephen Hayden; Joel Dimsdale

Recorder: A. Robles; D. Romano

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Call to Order and Approval of Minutes

- Dr. Thomas Savides called the meeting to order at 5:40 pm.
- Approval of the May 2013 minutes were deferred to the July meeting.

Chair Announcements

- Dr. Savides explained that the purpose of this meeting was to provide an update on the Clinical, Research and Health Sciences School of Medicine, and a brief overview of upcoming changes to the retirement program and other issues that affect the quality of life for the faculty.
Dr. Savides stated that this meeting was intended to be interactive and the faculty were highly encouraged to speak up, should they have any questions or concerns.

**David Brenner, MD; Vice Chancellor Health Sciences and Dean of School of Medicine**

- Dr. Brenner discussed the “State of Health Sciences” presentation.
  - Dr. Brenner first reviewed the “Financial Update” portion of the presentation to include: Health Sciences 10 Year Revenue Trend; FY 2012 UCSD Expenditures; FY 2013 Health Sciences Sources of Revenue; FY 2013 Professional Schools Sources of Funding. (Refer to slides for graphs)
  - Despite the cutbacks, Health Sciences is doing very well with a 4% decrease in maximum research direct costs; Indirect costs are down 1%, which reflects that some foundations were providing research support but still give IDC; Clinical income is increasing and State support is flat at 2%.
  - Tuition income has increased slightly and the State support of Clinical structure is now at zero. The UCSD Health Sciences makes up two-thirds of all expenditures and 5% is SIO by students. The Health Sciences including the School of Medicine (SOM) is 2/3 of the revenue; Clinical is predominantly at 3.4%; Research is at 1.4% and Academic tuition is about 2% from the State of California.
  - **Question:** Who’s generating the Revenue?
    - **Answer:** The School of Medicine (SOM) is generating 42% of revenue, The Medical Center generates 46%, minus the private practice, which is 10% and 2% is generated from the Skaggs School of Pharmacy, which in total generates 2.2 billion in revenue.
    - The Skaggs School of Pharmacy and Skaggs School of Pharmaceutical Sciences are similar, but not identical types of
funding. The larger type of funding belongs to Clinical, which includes gifts and endowment. Because all colleges count foundations as gifts, there is no distinction between gifts and grants. IDC is small, but significant recharges are contracts we do and other clinical-generated income.

- Skaggs School of Pharmacy and Skaggs School of Pharmaceutical Sciences are more geared to education and they both have less than 1300 faculty. Also, they train half as many students, due to less faculty, so it is very different, however, very successful in Research. Because of the decreased faculty, it is more dependent upon the State support, and the endowment is large to Skaggs contribution.

- Dr. Brenner reviewed the “Capital Update – Research” portion of the presentation and discussed the following new projects:

  - **Bio-Medical Research Facility II (BRF II):** The justification for this project is basic science research growth and consolidation of off-campus wet and dry research leases. This facility will be 190,000 gross square feet; Cost $180,000,000; Occupation date: Fall 2013 – Winter 2014; Funding: Indirect Cost Recovery; Debt Service; No current naming philanthropy; IDC$/ASF required - $166/ASF per year. Funding by the Garamendi Funding. John Garamendi made each law that gave UCSD IDC off the top to fund new research buildings including: Cancer Center, Leichtag to Pharmacy building 4th floor, and the 4th Sanford building.

  - **The Bio-Medical Research Facility II Programmed Space:** This building is the most expensive building thus far. An RFA has been put out by the Space Committee. The building will contain the following:
    - Biomedical informatics and genomic information sciences
- Inflammation and repair in GI tract and Liver
- Glycobiology research and training center
- Cardiac research program
- Studies in immunity, infection, and inflammation
- Neurosciences: The Center for Neural Repair studying anatomical, electrophysiological and functional plasticity in the intact and injured adult central nervous system.
- Pediatrics programs

**Altman Clinical Translation Research Institute:**
Justification to expand clinical and translational research growth; of off-campus wet research leases. The building will be 345,000 gross square feet; Cost $249,00,000; Occupation date – 2016; Funding: Philanthropy; Indirect Cost; Recovery; Debt Service; IDC$/ASF TBD (wet/dry lab configuration TBD). This will be the largest lab building that was ever built with plenty of assignable square footage. An RFA was sent out for this project, but it has still not been filled. Also, there will be a bridge to connect the Sulpizio and the Altman building.

**Altman Clinical Translational Research Institute Programmed Space:**
- Pediatrics diabetes research center (PDRC)
- Clinical and Translational Science Award (CTSA) emphasizing interdisciplinary collaboration among scientists and innovative approaches that resolve difficult medical challenges.
- Muscle Physiology Laboratory studying muscle development, fiber structures, muscular architecture,
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<th><strong>Center for Novel Therapeutics:</strong> Justification to collaborate between research and private (incubator space). The building will be 110,000 gross square feet; Budget of $110,000,000; Occupation date of 2016 (RFA for occupants); Funding through Private Funding Development – UCSD rents up to 49%; Programmed Space for Cancer/CRO/Clinical Trials. We do not know if this will happen yet and it has been proposed to the Chancellor. The CNT will be similar to the Accelerator Corporation, which is located in Seattle, Washington and the company identifies, evaluates and manages ground-breaking emerging life sciences opportunities. If people respond to the RFA we will proceed. Dr. Brenner stated that Mission Bay is doing something like this for UCSF.</th>
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<td>Dr. Savides thanked Dr. Brenner for his presentation and introduced Paul Viviano.</td>
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<th><strong>Paul Viviano, UC San Diego Health System Update, Chief Executive Officer, UC San Diego Health System</strong></th>
<th>Mr. Viviano reminded the faculty that he joined UCSD a year ago during a time of transformational change.</th>
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<td>Mr. Viviano stated that at a time of tremendous growth, UCSD is attempting to increase its clinical volume to really compete as an academic health system. Health Sciences wide investments are helping with that goal considerably.</td>
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<td>He reminded the audience that the last time the strategic plan was revised was 2007 and that it was very successful at that time. There were two core elements to the 2007 plan:</td>
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<td>The first core element was to invest in quality and safety improvement; which has paid off, as we are currently listed in top 100 and top 50 programs nationally.</td>
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The second core element was investment in leadership and resources.

In 2007, the focus was on clinical service lines: cardiovascular, cancer care, women and infants and surgery. We have accomplished all of these goals; hence the need for new plan.

Mr. Viviano stated that the effort to develop a new strategic plan was started with a new Mission and Vision which are both outlined below:

- **Mission:** To deliver outstanding patient care through commitment to the community, groundbreaking research and inspired teaching.
- **Vision:** To create a healthier world — one life at a time — through new science, new medicine and new cures.

Mr. Viviano had reminded the audience about the uncertainty that we face with regard to health care reform, and that this uncertainty brings considerable risk to the institution. While many changes remain unknown, the following changes are expected at the very least:

Health Care Reform:

- Expansion of coverage for uninsured (Covered California). About 2.6 million Californians will be eligible to purchase subsidized health insurance on the first day of 2014; An additional 2.4 million will be newly eligible for full coverage through Medi-Cal; 400,000 San Diegans are expected to qualify for coverage on day one, and there is currently a shortage of doctors to meet that demand.
- Other changes include: Accountable care Organizations (ACOs); Risk-Based Reimbursement.
The changes in Medicare / Medi-Cal Reimbursement are described below:

- Medi-Cal is going to be expanded. Employees are taking people out of existing healthcare plans and putting them into exchanges.

- Low income programs will be expanded and 400,000 residents, who currently have no insurance will be on the exchange. UCSD has been caring for them already, but it will be an increase in reimbursement. This may make us eligible for a bonus, as an institution, and may affect physician compensation.

- Sequestration (April 1, 2013):
  - The sequestration will result in 2% payment cuts for Medicare providers.
  - There are also expected reductions in research funded by NIH and funds supporting Graduate Medical Education.

- Competitive San Diego Market:
  - Integrated delivery health care systems with strong primary care access.
  - San Diego market is largely comprised of small employers.
  - The UCLA Center for Health Policy Research, based on a 2009 statewide health survey, estimates that 18.7% of San Diego County residents, which is about 515,000 people, are uninsured.
  - A Statewide study estimates that nearly 43% of uninsured Californians will qualify for Medi-Cal in 2014. That could mean 43% of San Diego uninsured, or about 220,000 people, will join the Medi-Cal rolls, as a result of health care reform. An
additional 123,000 could be eligible to purchase care on the new insurance exchange at subsidized rates.

- This presentation will focus on the Strategy component of our change initiative to adapt our organization to industry challenges.
- We chose the name “Project Helix” because just like the base pairs in the double helix, there are many factors that must come together in a systematic and meaningful way to positively change our organization.
- The new strategic plan started in January 2013 and 75 faculty members are participating in its ongoing development. We are currently at the end of phase three.

- The Strategic Planning Process has:
  - Five distinct phases for completing the strategic plan, each of which builds upon the work completed in the previous phase.
  - Each phase also has a concrete timeline.
  - Deliverables are also defined for each phase so that each participant knows what to expect throughout the process.
  - The process is ultimately linked to the budget and annual management planning for implementation.
  - Focusing on the assessment of new services.

  **Questions include:** What are we adding in Hillcrest? ; What are we moving up to La Jolla? ; We also want to improve patient lives and the lives of our faculty.

- The Jacobs Medical Center will be 50% complete by August 2013. We are looking to outpatient needs to drive development moving forward. We want to keep our actions transparent, so as to be measured by value, quality and cost,
There are plans in the works for a 100,000 square foot Out-Patient Pavilion, with services for Urology, Hematology, Ambulatory and Outpatient Imaging. We are actively trying to increase profitability.

The Impetus for the Outpatient Pavilion:

- Augments Health System La Jolla Master Plan.
- JMC provides world-class inpatient facilities and builds capacity to meet health care industry challenges.
- UC San Diego needs companion outpatient facilities to maximize patient convenience and grow market share.
- Outpatient pavilion provides opportunity for disease-specific centers consolidating all facilities, ancillary, professional and support services, needed to treat a condition.
- Patient ease, access and continuity are Paramount.
- It will be on the East side of Perlman, adjacent to the Moores Cancer Center and the Shiley, but we are limited by our budget of $100 million.

Question from Audience:
- Will there be parking?
  - Answer: The plan is to build a 1,400 space parking structure on the lot outside of Shiley. The first estimate ran at $32,000 per space. Our current estimate brings us down to $29,000 and there are plans for a light rail train from old town to campus.

Question from Dr. Savides:
- What happened to the bridge going over the freeway from medical center campus to main campus?
  - Answer from David Brenner: It will happen in 2018. Both a foot and driving bridge from Gilman to
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<th>Maria C. Savoia, MD; Dean of Medical Education</th>
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<td>• Dr. Maria Savoia introduced herself as the Dean of Medical Education.</td>
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<td>• Dr. Maria Savoia stated that medical education starts with outreach and includes admissions, student aid, graduate medical education, continuing medical education, Alumni Affairs and the body donation program.</td>
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<td>• Despite fiscal challenges, Dr. Savoia commented that we have had a great year and this would be the second year in the new medical education building.</td>
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<td>• It was stated that the San Diego Union Tribune did an article on our Interprofessional Education Conference, which was comprised of 450 nurses, pharmacy students and medical students, who all worked in teams, and it was very successful.</td>
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<td>• Dr. Savoia commented that she works with a great team of Associate and Assistant Deans and they include: Carolyn Kelly, MD, Associate Dean of Admissions &amp; Student Affairs; Jess Mandel, MD, Associate Dean of Medical Education; and Steve Hayden, MD, Associate Dean of Graduate Medical Education. All of these individuals were in attendance and presented on their areas.</td>
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<th>Carolyn Kelly, MD, Associate Dean of Admissions &amp; Student Affairs</th>
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<td>• There were a total of 6700 applications (up 22% from 5500 in 2011) to the medical school this year.</td>
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<td>• We admit just 4% of applicants for the 125 positions available in entering class</td>
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<td>• Programs and pathways</td>
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<td>o Bachelor-MD program (conditional acceptance) ~12</td>
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<tr>
<td>o Medical Scientist Training Program (MD-PhD) ~8-10</td>
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Please be reminded how critical faculty involvement is in medical school admissions. Per the LCME standard:

- The final responsibility for accepting students to a medical school must rest with a formally constituted medical school admission committee.
- Faculty select students for interviews
- Faculty conduct interviews
- Faculty select students for admission

We have a new interview process, “Multiple Mini Interviews”, affectionately known as the “speed dating interview”, that has been piloted for the last two years.

- It has been RAC approved for all “MD program” interviews for 2013-2014
- MMI utilizes interviewer/raters to assess applicant responses to standardized questions/scenarios
- Typically 8 stations for each applicant
- Scenarios seek to examine personal attributes of applicant (e.g. empathy, communication skills, critical thinking, ethical decision making)
- Metrics and experiences assessed through application materials
- Applicants seem to think it is fair.

Advantages of MMI are:

- Interviewers blinded to application and metrics
- Standardized scenarios consistent and fair
- Raters compare different applicant responses to same scenarios
- 8 opinions rather than 2 on each candidate
Extensive research demonstrating correlations with MMI performance and clinical performance

Rapid feedback to interviewer group on candidate performance

Disadvantages of MMI are:

- Loss of “personal connection” with applicant
- Potential loss of “recruitment time”

Both of these can be dealt with by modifications to MMI and remainder of the interview day

Recruitment:

- Students identify positive features as:
  - Supportive environment for students from Student Affairs and UGME offices (GQ data well above national average)
  - Curriculum
  - Student Run Free Clinic Project
  - Research opportunities and support for research

We have had some challenges to recruitment, namely:

- Tuition gap c/w private schools narrowing
- Scholarship funds at well endowed schools eliminate gap
- Stiff competition for students from backgrounds underrepresented in medicine (African American, Hispanic, Native American)

We have a new structure in Student Affairs related to the Academic Communities. We have six academic Communities each led by a faculty member (Drs. Kama Guluma, Sunny Smith, Marianne McKennett, Charlie Goldberg, Lori Wan, and Joe Ciacci). The idea behind the Academic Communities was to better connect the students to one another, to connect with faculty, and to connect with the community at large. The Faculty are tasked with:
- Mentoring and advising
- Clinical skills and professional development

- POM, Primary Care clerkship, Principles to Practice small groups drawn from communities
- Service learning opportunities, e.g. Health fairs for underserved populations (MANA, Stand Down); Eric Paredes Save a Life (cardiac screening high school athletes); Olivewood Gardens-nutrition classes; San Diego Youth Services; Reality Changers (high school tutoring/mentoring)

- One of the challenges we have in Student Affairs is dealing with the Clinical learning environment.

  - We are above the national average in student "mistreatment" (the percentage of students who feel as though they are being treated inappropriately).
  - Public humiliation/bullying and racial/ethnic insensitivity are the two most problematic areas

- But we are making efforts to improve this:

  - Multiple reporting pathways for students.
  - Prompt notification of faculty/division chiefs/department chairs when there are problems.
  - Documentation of all reported events/resolutions.
  - MS3-MS4 monthly sessions with ACDs to discuss issues arising in clinical learning environment. We’re trying to empower students to deal with problems directly, because there is also an issue of misperception in communication that is not intentional mistreatment.

  The Faculty plays important roles in both Admissions and Student Affairs. If you are interested in getting involved, please contact me (ckelly@ucsd.edu).

**Jess Mandel, MD; Associate Dean of Medical Education**

- Dr. Jess Mandel, Professor of Medicine and Associate Dean for Undergraduate Medical Education provided an overview of
At a 2007 faculty retreat faculty decided to relook at the medical school curriculum. The new curriculum was launched in September of 2010 and we now have step 1 data and other data supporting the success of the program.

The Goals of the Integrated Scientific Curriculum are:

- Improve scientific engagement and literacy by all students across all four years.
- Make explicit connections between best science and best clinical practice with improved coordination/integration of educational activities and use of best practices of adult learning.
- Improve the learning environment, linkage of formal and informal curricula, and more explicit focus on professional development.

The emphasis has gone from a discipline-based curriculum to organ and system based blocks.

It is still a little too early to determine if the program has been a complete success, but the Step I information and other outcomes data we have so far indicates a very, very positive outcome. It should be noted that the improvements were across all disciplines and not in some areas at the expense of others.

Students also performed better in the subjects typically considered the hardest to teach: professional ethics, cultural competence and psychosocial evaluation.
| There is a high rate of student satisfaction with the new curriculum versus the previous curriculum. |
| Successes reflect outstanding efforts by dozens of faculty and staff, and logistical requirements of new curriculum are substantial. |
| We will continue to make iterative improvement in the curriculum and track outcomes data closely. |

**Stephen Hayden, MD; Associate Dean of Graduate Medical Education**

| We currently have over 800 trainees in graduate medical education. |
| The ACGME's vision of the Clinical Learning Environment is setting the bar incredibly high and despite our best efforts, we are not quite there yet. |
| We are responsible for a total of 885 trainees to include the following: |
| o 727 in accredited (A) programs (521 Residents; 199 fellows; 7 chiefs) |
| o 125 in non-accredited (NA) programs |
| o 25 pharmacists in training |
| o 8 Non MD clinical trainees |
| We have seen a 31% growth of trainees, since 2004-2005. We are adding trainees and programs. We have 76 ACGME accredited programs; 23 core first board; 49 are second board; 51 are non-accredited and highly specialized. We have 127 total training programs. We continue to receive requests for new programs. |
| The ACGME expects the 6 focus areas for CLER visits to function like a finely tuned Swiss watch and include: patient safety, duty hours, healthcare quality and disparities; supervision; transitions of care; and professionalism. The |
ACGME will talk to faculty, residents, staff, and program directors during site visits to assess how well we do in all these areas.

- **The ACGME Cares about:**
  - Reporting of adverse events; near misses.
  - Education on patient safety; culture of safety.
  - Residents’ gain experience in patient safety investigations and follow-up (i.e., RCA).
  - Monitoring of resident and faculty engagement in patient safety.
  - Training in disclosure of patient safety events.

- **Patient Safety and QI Priorities are:**
  - Can residents, faculty and staff articulate institutional/departmental safety goals?
  - How are safety and QI efforts communicated to residents, faculty and staff?
  - Residents are aware of and committed to reducing health care disparities.

- **Resident Supervision:**
  - Is supervision appropriate to resident skill level?
  - Can residents identify their supervising physicians and know when to ask for help?
  - Are established protocols consistently followed?
  - Are supervising physicians responsive and available, even in the middle of the night?

- **Transitions of Care:**
  - The expectation is for a formal system to be used institution wide; and that the system, minimizes the number of transitions and monitors the quality of information transmitted.
  - Are there guidelines for acceptable methods?
- **Duty Hours and Fatigue Management.** The Program must:
  - Actively monitor resident duty hours.
  - Educate all *faculty and residents* to recognize the signs of fatigue and sleep deprivation.
  - Online core module “SAFER.”

- **Alertness Management/Patient Safety:**
  - Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities.
  - “Strategic napping”, particularly after 16 hours of continuous duty and between 10 p.m. and 8 a.m., is strongly encouraged for patient safety.
  - Need a bank of unassigned call rooms to accommodate this.

- **Professionalism:**
  - CLE teams should be patient centered and interdisciplinary.
  - Physician (resident and faculty) as team leaders.
  - Mutual respect, maintain professionalism in all interactions.
  - The standard is that breaches in professionalism and disruptive behavior is dealt with immediately and anyone can raise concerns without fear of retribution.

- **CLER Visits**
  - All of these components are evaluated by the ACGME during CLER visits.
  - The visits are largely unannounced (10-14 days notice).
  - There is a team of site visitors.
  - They meet with “C” suite, senior management and then in groups with residents, faculty, PDs.
  - Participants are required to answer standardized questions with an ARS (Audience Response System).
  - The team then walks the wards, ED, OR, adjacent clinics.
  - These site visits occur every 18 months.
- The Clinical Competence Committee (CCC) will act as an early warning system to gather information on residents and apply them to milestones to mark their progress.
  - Every program must have a CCC.
  - CCC makes “consensus” decisions, they do not vote.
  - CCC acts as an “early warning system” and focus on remediation.
  - CCC must include core faculty; these Core faculty must observe residents in the clinical setting.
  - The CCC may include assessment specialists and Non-MD educators.
  - CCC members may need protected time because the assessments can take 1 hr per resident; shorter over time.
  - The CCC can evaluate residents in a number of ways.

- Independent of CCC (which evaluates individual residents), each program must have a Program Evaluation Committee (PEC; evaluates program). The PEC does an Annual Program Evaluation (APE).

- In Summary:
  - Residents and Faculty at UCSD must become integrated in patient safety and QI.
  - ACGME is convinced that residents are “imprinted” by their learning environment.
  - Assess the CLE with site visits; 6 focus areas.
  - Role of faculty is evolving in the vision of CLE.
  - Faculty will participate in CCCs, PECs, and APEs.

**Maria C. Savoia, MD; Dean of Medical Education**

- Dr. Maria Savoia briefly presented on Continuing Medical Education as included in the 2012 Annual Report.

- Dr. Maria Savoia reminded the audience that: “The mission of UCSD SOM CME is to provide needs-based and outcomes driven education for physicians and health care providers to improve knowledge, competence and performance and enable
In 2012, the CME office was comprised of the following:

- Accredited 144 conferences, mini-residencies, and home study programs.
- Accredited 98 grand rounds/case conference series.
- Offered 2612.50 CME credits (exclusive of grand rounds).
- Educated 22,374 participants (12,452 physicians, 9922 non-physicians)
- Provided meeting planning services for 29 programs that generated $383,000 in fees.
- Returned $320,000 in course profits that was transferred to departments.
- But still ended up in the red because of rent for off campus office space and ASSA Administrative fees.

UCSD is also:

- CME provider for the AAMC, accrediting 20 AAMC events for 594 participants.
- Working with Medscape Education.
- Participating in the UCCME Consortium, with on-line E-learning activities.
- Currently the CME Provider for Rady Children’s Hospital.

The Future Directions of the CME office are to:

- Establish financial stability.
- Resolve space issues.
- Make programmatic enhancements.
- Positioning re: MOC

In conclusion, Dr. Savoia mentioned that Terry Davidson, MD, the Associate Dean for CME passed away in February 2013. Dr. Davidson did a wonderful job and Dr. Savoia wanted to publically thank him for all he did.
Joel Dimsdale, MD; Emeritus Professor, Psychiatry

- Dr. Dimsdale commented on the high quality of the evening’s program then switched to his presentation on Faculty retirement.

- Dr. Dimsdale indicated that he has been involved in the faculty retirement program for many years and has traveled between UCSD and UCOP extensively so as to prepare him to be an appropriate messenger for the program.

- He reminded the audience that in order for the pension system to function well, there needs to be a balance between the number of faculty paying into the system; 17.5% of payroll must be invested in the system and there needs to be a 7.5% return on investments annually.

- Unfortunately, for the last 20 years, not enough has been invested into the pension system, and the deficit is growing. To be more specific, the dollar value of the deficit will double every decade if the current system remains unmodified.

- For more than 20 years, we have not been contributing adequately to this system. In 2013, we had $40 billion in assets, but $50 billion dollars in liabilities. Now that faculty are contributing to the system, we have the opportunity to address the deficit.

- At this point, the question is how to pay off the debt. Should it be paid quickly or slowly? The comparison to a 15 year mortgage or 30 year mortgage was made. As such, two classes of faculty retirees have been formed and divided into faculty that were hired before 2013 (the old tier) and after July 1, 2013, (new tier).

- The main difference is retirement age. If a new tier faculty member retires before the age of 65, the benefits are not as good as they would be for an equivalent retiree under the old
tier program. For example, under the old system, a 30 year employee can retire at age 60 and receive 75% of their compensation. Under the new plan, a 30 year employee can retire and receive only 54% of their compensation.

- Starting in July 2013, the faculty employees will contribute 6.5% and the university will contribute 12% to the plan. Increases are expected every year so as to balance the deficit.

- Contributions are assessed to the employee and the funding source, i.e., grants, hospitals and the department. The contributions are assessed to covered compensation, not the rank or step.

- There are also potential ongoing discussions concerning a composite benefit rate. The implications of this rate are uncertain for Health Sciences faculty and need to be tracked closely.

- All faculty should be reminded that the pension system impacts grant funding. The impact will be budgeted into fringe benefit rates, a direct cost. Clinical and grant income pay both employer and employee contribution benefits so salaries may take a big hit.

- There will also be changes to the health care plan. Under the old tier, health care eligibility begins at 56 with 10 years of service. You max at age 65 with 20 years of service. If your age plus years of service to the UC = 50 as of June 2013, you are grandfathered into the old system but there are no guarantees that these benefits will remain in the future. In any event, the UC contribution to health insurance coverage will be decreasing slowly over the next couple of years.

- The potential changes to the plan include cutting health insurance benefits to half-time employees; increasing co-
payments, or decreasing the spousal or family subsidy for insurance costs.

- Retirees in the new tier under the age of 55 will receive no healthcare coverage. From ages 55-64 coverage percentages are progressive. Under the new tier, you only receive the full benefits if you retire after age 65 with 20 years of service.

- There is also a Medicare component to retirement benefits. Part A is free because you have been contributing to it all along. Part B covers 80% of outpatient and lab fees. Part B will be billed at $105/per person based on a progressive tax based on your income. That is, Part B charges could triple, depending on your income. See the following link for further information: [http://senate.universityofcalifornia.edu/committees/ucfw/UnderstandinghealthcarecostsforUCretireesonMedicarefinalMay2013.pdf](http://senate.universityofcalifornia.edu/committees/ucfw/UnderstandinghealthcarecostsforUCretireesonMedicarefinalMay2013.pdf).

- Final thoughts in this regard are to look at the spreadsheet carefully before retirement.

**Final Remarks by Dr. Savides**

- Dr. Savides thanked everyone for coming and encouraged people to ask David Brenner and the other Deans additional questions.

- Dr. Savides stated that Dr. Leslie Martin would be taking over as the Health Sciences Faculty Council Chair in September of 2013.

- The August 2013 meeting has been cancelled for Summer Break.

**OLD BUSINESS:**

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<td><strong>Adjournment</strong></td>
<td>o The meeting was adjourned at 7:23 p.m.</td>
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| **NEXT MEETING**         | o Tuesday, July 2\(^{nd}\), 2013, 5:00 to 6:30 pm  
Dean's Large Conference Room BSB 1320 | The August 2013 HSFC Meeting has been Cancelled. |