<table>
<thead>
<tr>
<th>Call to Order and Approval of Minutes</th>
<th>Chair Thomas Savides called the meeting to order at 5:05 pm.</th>
<th>The April 2013 minutes were approved.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair Announcements</td>
<td>Dr. Brenner is not available to attend today’s meeting.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr. Savides explained there has been some turnover in staff and that Angela Robles is temporarily staffing this meeting.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>REMINDER: The Tuesday, June 4, 2013, meeting is an all faculty meeting to be held at the Faculty Club in an effort to increase attendance. David Brenner will be in attendance and Paul Viviano will be giving an update on developments in the hospital/medical center side of Health Sciences. Mia Savoia and Jess Mandel will give an update on things happening with the Medical School. There will also be an update on the UC retirement plan.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>We are trying to increase attendance at these meetings, perhaps by combining meetings, so please send along suggestions if you have them.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr. Savides introduced Jennifer Ford as a member of Dr. Gary Firestein’s team who will be providing an update on the New Clinical Research Billing process.</td>
<td></td>
</tr>
<tr>
<td>Jennifer Ford, MBA Director, Office of Clinical Research Administration Guest Speaker</td>
<td>The New Clinical Research Billing (CRB) policy goes in to effect July 1, 2013.</td>
<td>![New CRB Process Overview - Faculty Ci](New CRB Process Overview - Faculty Ci)</td>
</tr>
<tr>
<td></td>
<td>Jennifer is from the Office of Clinical Research Administration, she directs the Officer of Clinical Trials Administration and the Office of Coverage Analysis. Today's presentation is on coverage analysis.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr. Firestein has talked to the Council about this in stages for</td>
<td></td>
</tr>
</tbody>
</table>
several years but today’s presentation is intended to give a high level overview but also provide some detail to give the full picture.

- **Background:**
  - In 2010 the Office of the President started their “Work smarter, work faster,” initiative where UCOP wanted campuses to come up with IT solutions in high audit risk areas.
  - Clinical research billing is an area of risk. The purpose of this initiative is to improve quality of the clinical research billing process and to avoid million dollar settlements to the government due to improper billing.
  - The problems are often due to academic medical centers having no uniform systems for checks and balances.
  - The most common problem is double billing: charging the research sponsor for services and also billing the insurance companies.
  - Another problem is not billing either the sponsor or the insurance company.
  - Double billing is a violation of the false claims act. There is civil and criminal liability for violating the false claims act.
  - Another goal is to improve time management for trials by decreasing man hours spent reviewing the bulk accounts.
  - The number one goal is to minimize and eliminate improper patient billing.

- The Office of Coverage Analysis Administration was written in to clinical research billing policy. There are three major roles:
  - 1. Harmonization of study documents. One office will look at the study, the budget, the contract and the protocol.
  - 2. The OCAA’s scope is broader than just clinical
trials it encompasses all clinical research. Namely, if you say yes to humans, coverage analysis will now be required. The PI is the most important person in the coverage analysis process as he/she determines what is research and what is conventional care to be billed to a third-party payor.

- 3. VELOS is the system of record for research and coverage analysis. VELOS communicates nightly to EPIC, where the procedures are being ordered.

- The policy will go into effect July 1, 2013 for all new and renewal studies submitted to the HRPP. These studies submitted to IRB must be reviewed and if necessary, a finalized Coverage Analysis (CA) will be completed before the informed consent is released by HRPP. This must be reviewed and approved by the PI. Our goal is to work within the same time window used by the IRB to ensure timely enrollment of patients.

- J Hirsch: Does it happen within the process? Answer: Yes, a question has been added to the IRB application and investigators check a box if treatment is billable.

- The MCC implemented the new CRB process, January 1, 2013.

- The purpose of having a centralized office is to assist PIs in determining what is required for the new CRB process:
  - First, we determine if coverage analysis is required. Does the service generate a charge – regardless of funding source, NIH, for-profit, etc.? Then yes, CA is required.
  - Studies that do not require a CA are retrospective studies; data studies; and subsets of blood processing studies.
  - Once it is determined that CA is required, the analysis begins and OCAA determines if a study can be billed in a certain manner.

- The CA is really merging the clinical research and the medical billing code worlds. Details were omitted for the sake of this presentation.
• The hope is that OCAA will have faculty using systems already in place so as avoid confusion. The IRB already has a new question (as of February 2013): does your procedure involve billable activities? If you answer yes, an email is generated and sent to OCAA for further analysis.
• Another goal is to work around existing Just In Time requests for NIH grants and Notice of Award timelines for all other awards.
• For PI Initiated or Sponsor Initiated trials, the goal is to work with the HRPP and other contracting offices.
• For New and Renewal Studies, CA will be completed in two steps:
  o A Preliminary two stage approach reviewing the Conventional Care (i.e. SOC) vs. the research grid and a copy of the protocol or research plan.
  o The Final CA Review will require finalized documents: award documents, budget, protocol and research plan and informed consent document.
• The hope is that before everything is finalized, inconsistencies have been diminished to avoid having to make multiple amendments with sponsors, causing further delays to start the study.
• The Final CA is then sent to the CTRI Velos team to create a calendar. The study team enrolls patients within 48 hours of a subject signing consent and checks off visits within 7 calendar days of treatment.
• The IT Solution – We have developed an automated IT solution between Velos (focus at protocol level) and EPIC (order serves at the patient level). Billers can view Velos to determine where charges should be sent either to the study or to the insurance company. There will be transparency.
• Question from Dr. Savides: The problem is not that we can’t generate charges, it seems some charges are being held so we’re not able to submit clinical bills in a timely fashion. Can you address this?
• Answer: Jennifer, For questions about the current MCC bill hold please contact RCP - Kevie Naugthon or Angela McMahill, they are
supposed to help us address the current bill hold with MCC. They complete the data extraction and pull the MR numbers because we don’t have a VELOS or our new CRB process that can perform this activity automatically. It has taken a lot of time to determine which bills belong where. RCP has tried very hard to communicate that problem to everyone and we recognize the impact of this process but they are trying to resolve the issue quickly.

- Dr. Savides: They are not doing Velos? Ford: Not if it is a retro study – just renewals and new ones so all studies will all be in Velos within a year from July 1, 2013. It was hard to sequester the data and information but they are doing better. We just do not want to keep bills that don’t belong to the study in Velos – we want to be sure studies are being properly billed.
- Dr. Ramamoorthy: Who has access to the billing? Answer: Velos is available to whoever the PI wants to have access. Study coordinators if you want, PIs, and department administrators? PIs (or whoever has access) can edit if needed and the study coordinator can pull charges out as appropriate.
- Question from Dr. Savides: How much time will be added to the IRB approval process? Answer: We don’t know exactly but our goal is hire more staff to ensure that there are no IRB delays or at least keep the delays to a minimal level. The goal is to NOT add to the wait or create further delays.

**Bess Marcus, Ph.D., Professor and Chair, Department of Family and Preventive Medicine, Guest Speaker**

- Dr. Savides introduced Dr. Marcus to present a new proposal for a Bachelors of Science in Public Health.
- Dr. Marcus: We proposed this to the undergrad council; it was approved in December of 2012 and it launches in the Fall of 2013.
- A lot to people know about Family Medicine’s clinical side but we have 6 other divisions: Behavioral medicine; Biostatistics and Bioinformatics; Epidemiology; Global Health; Health Policy and Preventive Medicine. We have 45 primary care and 45 public health faculty members. 12 of the public health faculty members have joined in the last 2 years.
- Public Health:
Focuses on the development and application of knowledge that helps prevent disease, protects the public from exposure to potential harm, and promotes health from a local to global level.

- Represents a growing and dynamic field with abundant career opportunities in the public and private sectors.
- This is a great opportunity for an undergraduate program because we need more primary care and public health doctors and the idea is that if we expose undergrad students to public health, the exposure will be beneficial in med school.

The Motivation for creating this program is as follows:

- Build connectivity between Health Sciences and Campus and bridge public health and medicine.
- Raise the standards of our JDP in Public Health by having a stronger, more well-prepared applicant pool.
- Offer courses that will help Pre-Med students be better prepared for the new MCAT which comes online in 2015.
- Create more opportunities for our growing faculty and doctoral students (TAs).
- Build the new generation of public health scientists.
- Facilitate research collaborations between interested students and faculty mentors.
- There is a behavior and social science section on the MCAT so a Public Health major will help undergrads.
- Doctoral students say that they don’t have teaching experience or Teaching Assistant experience. This program has funds for TAs and postdocs and graduate students need the teaching experience so this effort is really intended to help look out for the next generation.
- The Institute of Medicine (IOM) recommends the development and expansion of public health majors at 4 year institutions.
- Currently only a small minority of institutions provide such training.
- Starting a program like this **now** places UCSD at the forefront of this growing international and dynamic field.
- An undergraduate degree in public health prepares students to:
  - Engage in critical issues related to human rights and cultural understanding.
  - Prepare them for a variety of professional and graduate programs, such as public health, medical school, and law school.
- There are many career paths available. IOM recommends students know about public health.
- The American Public Health Association resolved in 2009 to endorse undergraduate public health education and Healthy People 2020 objectives include encouraging majors and minors at 4-year institutions and associate degrees and certificate programs in 2-year institutions undergrad matters.
- This program will provide training in these areas.
- We believe we will have an interest in double majors from Biology students and Economics majors. Several top tier universities already have these programs.
- The first classes will be start next Fall. We want to start with a small community and hope it will grow to about 300 majors.
- There will be three specializations: Epidemiology and Biostatistics; Social and Behavioral Sciences; Health Policy. Students may also customize a specialization (e.g. Pre-Med).
- Several upper division classes will also be available.
- Majors will be permitted to take electives in other departments and some of the relevant courses are already available.
- The program co-directors are Cheryl Anderson and Simon Marshall, both associate professors in Family and Preventive Medicine.
- **Question from Dr. Bailey:** The person power will all come from Family Medicine? Yes, 7 new courses will all be taught by our department. The 12 new Public Health faculty recruited will teach most of the undergraduate courses as well as being involved in
medical student and doctoral student education.

- **Question:** Will campus provide the funding to do this? The students pay tuition and fees and will something go to your department? **Answer:** Yes, campus will transfer over money for teaching and for TAs, we modeled our program after the SIO marine biology major. We are provided a TA for every 30 students in a class.

- **Question from Dr. Bailey:** If it’s really popular – where will you teach the classes? If you cap at 30 students per course and have to offer several sessions, do you have the space? **Answer:** That is being worked out. Lower division courses will be held in 200 person classrooms and the classes will be held mostly on campus – depending on the time of day, we may want to draw students across the street the Health Sciences campus.

- **Question/Comment from Dr. Friedman:** This is a great idea. Is there also a MPH and PhD program plan? **Answer:** We will start with developing a 1 year capstone Masters degree for students who have majored in Public Health. Over time we may develop an MPH or MSPH. We don’t want to interfere with the MPH offered at SDSU and we’re trying to tread lightly by creating a different program. We already have a joint PhD program with SDSU. At this time there is no plan to establish a separate PhD program.

- **Question from Dr. Granet:** Will the students be encouraged to do research? **Answer:** Yes, there is a 199 course option and we will encourage this.

- **Question from Dr. Bailey:** is this the first undergrad degree in public health in the system? **Answer:** No, Berkeley has one and we consulted with them. UCI has one too.

- **Question from Dr. Rapaport:** As this is the first undergrad major offered though the School of Medicine, it’s weird that we haven’t heard about this sooner. Who is in charge of the program? Do we have metrics by which to evaluate the program’s success? The faculty? Do the undergraduate departments have to contribute the FTEs for this program? Are you using SOM FTEs to teach undergraduates? **Answer:** Dr. Brenner has known about this for
two years and Dr. Savoia has also known. The campus will initially transfer money to us but over time we can convert this to FTE’s. Also, many of the courses will be taught by our Adjunct faculty.

- **Question from Dr. Rapaport:** Who evaluates the program? Who is in charge? **Answer:** The Undergraduate Council will evaluate the program.

- **Dr. Bailey:** If faculty with SOM FTEs teach undergrads, the Undergraduate Council will probably evaluate it because the degree is not offered through health sciences. **Answer:** Both sides had a lot of angst over doing this. Campus chairs were skeptical but now are on board. It is uncharted territory but the Chancellor’s strategic plan it.

- **Question from Dr. Mehta:** Are we planning an online version? **Answer:** Yes, once we get the program up and rolling.

- **Question from Dr. Savides:** This wasn’t on our radar but how did this all happen? What’s the process? **Answer:** This was all done locally with the undergrad council, we presented there and then to the academic senate.

- **Comment from Dr. Bailey:** About the process, are we in route to a formal academic senate approval? Is this the body that would vote before it goes up the street? David Rapaport had not seen it. When’s that coming? **Answer:** I think undergraduate council votes. Dr. Bailey: If it is a new major does the academic senate need to approve it? I should probably check on this? **Answer:** The major is already approved and students are able to enroll in courses for Fall, 2013.

- **Comment from Dr. Rapaport:** There is a huge proliferation of these global health programs and it seems like no one is talking to each other and there’s no coordination. Are there going to be five different programs that overlap? Does the CEP know what’s going on? They are all well designed but there’s no coordination. There is potential for it all to blow up. **Answer:** On the undergrad side – there was a global health minor, out of anthropology. As it developed more, they have now proposed a major. We are not involved in the global health minor. If the major is approved
students in that major will take our epidemiology course to fulfill their major. These will be distinct and non-competitive majors.

- **Comment:** The Global Health minor will be in Anthropology; the Public Health undergraduate major will be in Family Medicine; and the graduate degree in Global Public Health is coming from the department of Medicine. We need a school of public health.
- **Question from Jan Hirsh:** Can we make a recommendation to combine these programs at some point?
- **Comment from Dr. Rapaport:** Since we’re supposed to endorse the program, shall we make a motion in favor of supporting this program? The motion was seconded by D. Bailey.
- **Comment:** Can we check with Guy Master in the Academic Senate as to what’s going on? How should it go forward? Are there any other majors to worry about?
- **Comment from Dr. Savides:** The point is well taken that we need to have them on our radar. CEP then Faculty Council, then Academic Senate. It is surprising this got this far without anyone knowing.
- **Question:** Are there other School of Medicine Departments that are doing undergraduate teaching? Answer from Dr. Savides: Not that I know of; this program sets a precedent.
- **Comment from Dr. Hill:** We are weird in that half of our faculty are MDs and PhDs involved in non-clinical stuff and work on joint PhD programs. All my residents get MPHs. There has been a strong connection with public health – which almost describes the divisions in this dept.
- **Comment:** Neurosciences – there was no undergraduate neurosciences undergraduate major. Response: Neurosciences has never tried to run an undergraduate major. Comment from Dr. Bailey – I didn’t know you could have an undergraduate major in SOM. Response: Which is why there’s no process.
- **Comment from Dr. Friedman:** This is great because we’ll get more students that would have otherwise gone to UCLA or Berkley.
- **Comment from Dr. Savides:** Regarding faculty payment, it seems that the faculty will be paid from campus funds for the course.
| Comment from Dr. Ramamoorthy: Bess talked to all the chairs, so all the chairs know the procedure is weird. |
| Question: Can undergrads enroll in med school classes? |
| Comment from Dr. Mehta: CREST gets no FTE support. The problem is that when students pay fees, they can't be transferred to different depts. It is not that people aren't willing but the transfer of money doesn't happen easily. So, it affects the FTEs for the masters program – you can get the CREST masters but it is a supplemental degree. |
| Comment from Dr. Rapaport: If this is billed as a path to get in to medical school, it's going to be huge. There is going to be a lot of students. I'm not sure that's a good justification for offering an undergrad major. Is being a public health major going to make them primary care physicians? |
| Comment from Dr. Brown: Preventative Med will have to cap it by the number of people that can teach it. |
| Comment from Dr. Freidman: Are the floodgates going to open for this? Med school is not the only route. |
| Comment: It will grow fast. |

**Proposed Action Items:**
- Identify if there is a process to deal with the process of new undergraduate majors originating in Health Sciences in the future.
- With all the other UCSD global health programs developing, suggest they all get together to share resources.
- It might be helpful to have Dr. Marcus return to HSFC 6-12 months from now to give us an update on their program status.

---

**Andrew L. Ries, MD, MPH, Associate Vice Chancellor for Academic Affairs**

- Dr. Savides asked Andrew Ries and David Rapaport for an update on process of the endowed chairs.
- Dr. Rapaport: In the past ten years CEP has heard 20 cases for endowed chairs at the rate of about 2 per year. We get a letter from the Dean requesting approval and we ask them to come to the

**David Rapaport, PhD**
Chair, Committee on Educational Policy (CEP) meeting to ask questions regarding the money but the letter only comes with the funding. It is not often that the CEP is going to say no because there's always money involved. The conversations are usually good, regarding conflict of interest but it really is a rubber stamp. It is the only smart decision to not turn down money. As CEP chair, I write a letter saying we approve it. That is the final step and it is established.

- Question from Dr. Savides: Is this the only process? Answer: Yes, by the time it gets to the Faculty Council, it is really done. The purpose is to have some faculty input and to confirm the intention of the endowed chair is consistent with the University mission.
- Question from Dr. Bailey: Is it cleaned up by the time it gets to CEP? Would it go to CEP if there were a conflict/I wanted my primary care physician to get the endowment? Answer from Dr. Rapaport: We get to review the gift agreement before it is approved.
- Question: Is the appropriate place to have it reviewed the CEP or the Faculty Council? Faculty Council certainly seems appropriate.
- Question: Is it restricted to academic senate or ladder? Answer: It can be opened up to non-senate faculty. Other campuses have done it.
- Dr. Rapaport: $2 million is standard amount. It could be less than that but it has not been as of yet. These are guidelines but there is no policy.
- Comment: On campus everyone has an FTE – in HS it's used to support salary. The concept is that $2 million pays what an FTE would pay.

<p>| OLD BUSINESS: | NO OLD BUSINESS WAS DISCUSSED | • |
| NEW BUSINESS | NO NEW BUSINESS WAS DISCUSSED | • |
| Adjournment | The meeting was adjourned at 6:12 p.m. | • |
| NEXT MEETING | Tuesday, July 5, 2013, 5:00 to 6:30 pm | Dean’s Large Conference Room BSB1320 |
| ACTION ITEMS | Review of Undergraduate Major in Public Health | • |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Add Williams Ettouati and Joe Ma to the July Faculty Council meeting.</td>
<td></td>
</tr>
<tr>
<td>• Identify if there is a process to deal with the process of new undergraduate majors originating in Health Sciences in the future. Dr. Savides will contact Dr. Master at Academic Senate.</td>
<td></td>
</tr>
<tr>
<td>• Invite Dr. Bess Marcus as well as other program directors involved in Public Health teaching outside of Health Sciences programs to provide status updates to HSFC in 6-12 months.</td>
<td></td>
</tr>
</tbody>
</table>