

## Proposal to Increase Cap on Clinical Track Faculty From 20% to 30% for the Health Sciences Colleges

### I. Overview:

An important part of the mission of the five health science colleges at the University of Iowa is to preserve and optimize human life in Iowa and beyond. They are committed to achieving this mission through the education of future and practicing health professionals and biomedical scientists, the conduct of research in the health sciences, the delivery of patient care, and service to the state as a resource in health policy, public education and outreach. In light of recent fiscal, organizational, and educational challenges, and today's rapidly changing health care environment, health professions education must explore new and more effective methods to prepare students for the professions they have chosen, yet continue to achieve/exceed their goals in the areas of research, service and graduate education. Given the unique requirement that small group patient oriented instruction takes place at the bedside and requires that faculty in this environment must be licensed, credentialed health care providers, the health science colleges cannot supplement faculty with TA's to provide this focused education. This unique dual requirement of providing patient care service and teaching, while maintaining our scholarly productivity and quality, requires that we create additional faculty flexibility that is not possible with the current 20% cap on clinical track faculty.

- The current 20% cap artificially constricts the health science colleges, which must have flexibility to manage fiscal issues in today's academic health center environment. Increased flexibility in combinations of teaching, faculty practice and outreach initiatives will be possible if the cap is increased to 30%.
- A higher cap would provide "strategic flexibility" by allowing the health science colleges to recruit well qualified experts who can focus on patient care and clinical teaching, while enabling tenure track faculty to continue to meet all of their commitments including maintaining their focus on scholarship at the highest level.

Therefore, we propose to increase the cap on Clinical Track faculty to 30% only for the five health science colleges (Dentistry, Medicine, Nursing, Pharmacy, and Public Health) and to retain the current 20% cap for the rest of University. Specifically, this proposal requests modification of section 10.9 b (1) "Salaried appointments" of the Clinical Track Policy, as set for in the University of Iowa's Operations Manual, as follows: "...No more than 30 percent of the total salaried faculty in the five Health Sciences Colleges (FTE) may hold such appointments, although individual colleges may set lower percentage limits." Importantly, the proposed change is supported by all of the health science colleges, and is essential to their continued viability.

### II. Background and Rationale:

#### A. The Changing Health Care Environment: Economics of Health Care

The economics of American health care have been changing at an accelerating rate over the past 20 years. The average teaching hospital is expected to spend an additional \$6.1 million each year through 2003 for uncompensated care (Baker, 1999). Indeed, according to the Association of Academic Health Centers' February 29, 2000

report, The End of Welfare: Health Care & Social Service Implications for Academic Health Centers, social policy legislation signed into law in 1996 has resulted in:

- Increased numbers of uninsured persons
- Changes in patient case mix
- Increased financial pressures for academic health centers (AHCs), resulting from increased costs of uncompensated care, increased costs of charity care, and increased costs of bad debt expenses (Valente & Serrin, 1998)
- Medicaid payment issues
- Workforce changes (need for new types of health professionals)
- Changing roles and responsibilities vis-à-vis underserved populations (pg. 15)

The results of these trends here at Iowa are documented in Table 1, which presents key data concerning the operations of the University of Iowa Hospitals and Clinics (UIHC) during the period 1994-98, the last year for which data are available. Very briefly, what these data show is a dramatic growth in outpatient services (40%) at the expense of inpatient revenue (11%), and an astonishing 115% rise in the growth of uncompensated inpatient services.

Table 1. UIHC Critical Data - 1994-1998

Service	1994	1996	1998	% Increase
Inpatient Admissions	33,649	39,042	40,892	21%
Length of Stay (days)	7.0	5.9	5.2	(25%)
Clinic Visits	483,306	632,138	715,441	48%
Surgery- Percent Outpatient	64.2	75.4	77.9	21%
Gross Revenue*	475.976	549.671	582.951	21%
Uncompensated Service*	61.847	114.899	133.266	115%
Net Revenue*	347.750	379.704	387.753	11%
% Outpatient Revenue	27%	30%	34%	26.2%
Outpatient Revenue (est)*	93.892	113.911	132.223	40%
Inpatient Revenue (est)*	253.858	265.793	255.530	0.6%
Medicare Rate of Increase	2.7%	-0-	0.5%	3.2%
Hosp. Cost Rte of Increase	4.3%	2.7%	2.4%	9.4%

\* - Millions

Source - Profiles, July 1999 (Association of Iowa Hospitals and Health Systems, 109 East Grand Ave, Des Moines, IA; [www.ihhs.org](http://www.ihhs.org))

Furthermore, as part of our social contract, the health sciences faculty have clinical service obligations that drain them financially but serve the state, including, for example, the provision of care to indigent Iowans, Medicare and Medicaid recipients, and prisoners. UIHC also provides care for a disproportionate number of complex, long-term and expensive patients (e.g. multiple trauma, HIV, severe burns) from throughout the state---patients for whom private practitioners either cannot or will not provide care.

## **1. Summary of Trends in the Economics of Health Care**

a) The shift from inpatient to outpatient care. In Table 1, one sees a much larger rate of increase of outpatient visits than inpatient admissions. Outpatient visits are quite demanding on the time of health professionals, so it is not surprising that UIHC personnel find themselves spending more and more time providing these services. One also notes a shortening of average hospital stays and a concurrent increase in the percentage of surgeries which are performed on an outpatient basis. All these trends operate to decrease inpatient revenues and require that increased effort be expended in providing outpatient services.

b) Cost-shifting by HMO's, Medicare, and insurance companies. Health care costs rose at double-digit rates for much of the 1980's. The response of large corporations, which shoulder the cost of much of US health care, was to encourage (translation: require) employees to enroll in HMO's and other health plans, which arbitrarily decreased reimbursement to providers. These efforts resulted in a mammoth 115% increase in unreimbursed hospital costs between 1994 and 1998, which in turn limited the rate of increases in overall hospital revenue to 11% over the period. Moreover, estimated revenues attributable to inpatient services increased only 0.6%, and actually declined between 1996 and 1998. Of course, charges for clinic visits were also reduced, so that whereas the number of visits increased 48%, revenues increased only 40%. Medicare payments were also significantly reduced, and since Medicare accounts for about 42% of total hospital revenues, a significant share of these revenue problems must be allocated to Medicare. Table 1 also shows that the rate of increase in Medicare patients is only about one-third of the corresponding increase in hospital costs.

c) Increased record-keeping requirements. As if these reimbursement reductions were not enough, third party payers also dramatically increased the time required for providers to document treatments provided to patients. Thus, more time must be spent on each clinic visit by faculty personnel.

d) Service activities. In order to provide improved local clinic services to Iowans, and for UIHC to remain competitive in the current referral environment, it has been necessary for UIHC to establish 113 specialty clinics in 33 eastern and central Iowa communities. This not only requires faculty to see more patients, it requires them to travel, sometimes over significant distances, to provide these services.

**2. The Results** The clinical workload of members of the health science faculties has increased greatly, such that means must be found to provide additional clinical personnel resources if UIHC is to remain competitive in the current environment. Nationwide, prestigious Academic Health Centers (e.g. Stanford, Harvard, Minnesota) have not fared well as a result of these economic changes in health care. As a result, corporate systems have recently purchased several academic medical practices, which are being downsized and/or closed, forcing health sciences faculty to look for new opportunities. Specifically, in recent months, Georgetown Medical Center has sold its hospitals and employees to a large corporation (MedStar); George Washington University has also been forced to sell its hospital as has Indiana University; and The University of Pennsylvania is losing more

than \$100 million per year and their entire clinical delivery system is now under evaluation by the Hunter Group. When Academic Health Centers fail, they drain resources from the broader University, such that it suffers both academically and fiscally. Further, according to a recent report in *Academic Medicine* (Kindig, Dunham, & Eisenberg, 1999) researchers are "concerned that the research functions of academic health centers could be endangered as a result of the financial and other pressures on academic health centers." (p. 1193). A number of AHCs are struggling to find ways to maintain or expand the structures and funding required for their research programs while also developing competitive service delivery systems and sustaining their other missions, such as education and care of the poor and uninsured.

Finally, all these trends make increasing demands on the health science colleges/UIHC to provide increased outpatient services, for which additional personnel resources must be made available. Although these data apply directly to the College of Medicine, similar trends are also apparent in the other health science colleges.

### B. The Changing Health Care Environment : Impact on Health Professions' Education

As illustrated above, managed care has altered the delivery of health care services, including dramatic alterations in the roles and practice patterns of health care providers. As a result, the health care workplace will demand new professional skills, new configurations of staff and new numbers of practitioners. The education of future health professionals must take the new market place realities into account (Holmes & Osterweis, 1999). These include, for example: (1) achieving maximum efficiency of patient contact and delivering the maximum quantity of health care cost-effectively; and (2) keeping faculty time and teaching space within health educational institutions productive while using both efficiently. Never before in the history of health care have faculty experienced such claims on their time and productivity. Changes in the health care system demand that health care be patient-centered, of high quality, and efficiently delivered without excessive use of laboratory, hospital or consultant resources (Gordon & Kipnis, 1999).

Coincident with these dramatic economic changes, a significant improvement in health science education has been taking place. Briefly, the changed curricula place much greater emphasis on problem-solving in small group encounters at the expense of large lecture classes. Contact between patients and students has also been increased, which requires enhanced faculty supervision. These curricular changes are labor-intensive for members of the faculty, and adds to their workload. For example, the College of Medicine's new skill and integrative course Foundations of Clinical Practice alone accounts for 7300 faculty contact hours, according to Associate Dean Peter Densen. Importantly, the vast majority of these contact hours (5700) are contributed by clinical track faculty. The payoff has been evident in outstanding medical student performance on boards, and their entry into higher quality residency programs.

Finally, in order to keep pace, changes in curriculum have fostered the development of new community-based sites for health care teaching and practica (See **Figure 1—Health Professions Education in Community-Based Training Centers 1998-99**). These changes are also in response to the increased accountability and responsibility of health professions' education programs to address societal needs. Thus,

the changing economics of health care delivery has made substantial impact on the nature of health professions' education, as summarized below:

- More health sciences education is now taking place in outpatient settings.
- Health sciences faculty are more involved in direct patient care, and also more burdened by regulatory documentation requirements (i.e., Health Care Financing Administration mandates).
- Community-based education, patient care and continuity of care mandate more clinical track faculty to respond to the huge clinical demands and number of patient visits per year. (An analogous situation might be if the School of Journalism had to produce the equivalent of the New York Times on a daily basis)
- As noted earlier, the health science colleges are educating future generations of health care professionals-in-training using other professionals, not TA's. They need more role models for future practitioners who are themselves excellent practitioners. A higher cap on clinical track faculty will decrease use of preceptors, and insure that expert clinicians are teaching health sciences students. Moreover, approximately 40% of courses taught outside of the health sciences at this University are taught by non-tenure track faculty.

This request to increase the cap on Clinical Track faculty is thus in keeping with Chapter 10.1 a.(2): Tenure, "...the University will retain the flexibility to adjust its educational programs to meet the changing needs of students and society, and to take into account advances in the world's knowledge base."

Figure 1  
HEALTH PROFESSIONS EDUCATION  
in  
Community-Based Training Centers  
1998-99



### III. The Current Situation at Iowa

According to policy adopted by the Faculty Senate in 1995, the fraction of clinical faculty in each college of the university cannot exceed 20%. At the present time, the College of Pharmacy has 27% clinical faculty, the Colleges of Medicine and Dentistry

about 20%, and the Colleges of Nursing and Public Health fewer than 20%. Breakdown of all clinical track faculty by college, race and gender is available from the Office of Affirmative Action, and was reviewed in preparation for this proposal.

As part of the mandated review of the clinical track policy, all health science colleges conducted a recent evaluation of the policy in their respective colleges. The detailed results of this review, while relevant to this proposal, are available from the Clinical Track Review Committee, chaired by Sheldon Kurtz. However, it is important to note that reports from the health science colleges uniformly expressed strong support for the clinical track and endorsed raising the cap from the current 20% to 30%.

#### **IV. The Current Situation at Other Institutions**

The Colleges of Medicine, Pharmacy, and Nursing, carried out an informal survey to determine the practice of other institutions as regards limitations on the fraction of clinical track personnel. Not all UI colleges surveyed the same schools, but it is reasonable to infer that any cap at a peer institution would be university-wide. The results are given in Table 2, from which it is seen that the majority of peer institutions have no cap at all on the fraction of clinical faculty, and a few impose a 40% cap. No college has a cap as low as Iowa's. Indeed, the University of Iowa is not setting a precedent, but is actually out of the mainstream of Academic Health Centers by not having a larger clinical faculty track.

Further, to address concerns that increasing the number of clinical track faculty would lower productive scholarship at Iowa we surveyed the top 15 federal fund getters among public Academic Health Centers (note: the University of Iowa ranked #10 on this list). According to data from the American Association of Medical Centers most have a tenure-ineligible clinical track and the most productive schools also have no limit on their clinical track faculty.

Table 2. Clinical Faculty Caps at Other Institutions

School	Pharmacy	Nursing	Medicine
Colorado		40%	No cap
Minnesota	No cap		No cap
Michigan	No cap	No cap	No cap
Ohio State	40%		
Wisconsin	No cap		No cap
UI Chicago	No cap	No cap	
Univ. North Car.		No cap	No cap
Indiana		40%	40%
Arizona		No cap	
UCLA		No cap	No cap
Pittsburgh		No cap	
Univ. Ala. Birmingham			No cap

## **V. Discussion: Clinical Track Verses Tenure Track**

The clinical track and tenure track represent two distinct career paths for faculty in the Health Sciences colleges. The tenure track represents the more traditional career path of the faculty member who teaches and conducts research. Historically, particularly in the College of Medicine, tenure track faculty members in the clinical departments have also provided patient care services. The clinical track is used primarily for faculty who are service oriented, in that they teach and provide clinical service. Clinical track faculty are not required to generate research grants. Neither track is intended to subsidize the other in terms of salary support. They are intended to complement each other and facilitate fulfillment of the Health Sciences colleges' missions of education, research and clinical service. Raising the clinical track cap to 30% would permit the Health Sciences college's further flexibility in meeting their service requirements, delivering their educational programs and enhancing health care external to the campus, which is very beneficial to the state.

### **A. Differences Between Professional and Scientific Staff, Clinical Track, and Tenure Track Faculty in Terms of "Clinical Scholarship/Research/Professional Productivity"\* and Teaching**

1. The differences in the Clinical Track policies between various departments within a Health Science College, or between collegiate units may not be dissimilar to differences in scholarly expectations between a faculty member in the department of English who writes, and a faculty member in the School of Music who performs. Requirements for promotion, and even the terminology (\*) reflects differences among the Clinical Track policies in the various Health Science Colleges.

#### a) Tenure Track

- As required elsewhere in the University, tenure track faculty are expected to teach, provide service and engage in independent inquiry, publishing in peer reviewed, nationally recognized journals.
- write and manage complex grants

#### b) Clinical Track

"Clinical Scholarship" or "Professional Productivity" advances the health sciences through clinical excellence, innovations in diagnosis and treatment, better methods of providing care, and new methods of teaching. Advances in these areas are often published in clinical vs. research journals, and the clinical track faculty member may not always be the first author. Examples might include:

- case study reports
- protocol participation
- development and testing of new operative procedures, more efficient diagnostic methods, or more efficient outpatient services
- inventions

2. Why not make Clinical Track faculty P and S classification?

- Recruitment and retention would be impossible
- Many clinical track faculty teach >50% time (lecturing, small group facilitation, teaching residents, fellows and undergraduate/graduate students) and therefore are ineligible for P and S status.

## VI. The Request

In light of recent health care and educational trends, compelling external data that the most productive Academic Health Centers nationwide have no limit on the number of clinical track faculty, and consistent internal data supporting that academic freedom has been maintained among clinical track faculty, we hereby propose that the current UI policy (Ops. Manual 10.9b(1)) be altered to provide that the Colleges of Dentistry, Medicine, Nursing, Pharmacy, and Public Health be permitted to have up to 30% of the members of their faculties appointed to clinical track positions.

### A. Advantages

1. Tenure-track faculty Tenured faculty members in the health sciences colleges would benefit from this proposal because, with additional clinicians available, their clinic and attending physician duties would not have to increase so that time available for teaching and research would not have to be reduced.
2. Clinical track faculty The clinical track was implemented to allow the Health Sciences colleges to recognize and reward individuals who make extremely important but highly asymmetrical contributions. In the past, such persons were often appointed and restrained in "junior" positions (i.e. as Associates, Lecturers), where they were undercompensated and undervalued. The Clinical Track affords these individuals more flexibility in appointment and retention, and provides them with the opportunity for well-deserved recognition and more financial stability than ever before.
3. Students With more clinical faculty available, students would benefit from greater patient exposure, supervised by enthusiastic and capable clinical staff.
4. The UI Health Care system With additional clinical resources, the economic stability of the system would be significantly enhanced.

### B. Concerns

**1. Undermines definition of faculty, historically thought of as the "triple threat" person. Assault on the integrity of the tenure system.** As noted earlier in this proposal, in the past decade market forces have demanded new curricula, and a much higher level of productivity and service, while the reimbursement per unit of service has decreased dramatically. These factors have increased the workload of faculty in the Health Science colleges, requiring faculty to concentrate their efforts. The higher levels of productivity and efficiency demanded by today's marketplace, and the fact that research in the health sciences is often extremely expensive—requiring federal funding to conduct--- have made it much more difficult for faculty to function as "triple threats". Only the rare faculty member can be an excellent teacher, outstanding clinician, and successfully compete for external research funding. To remain competitive, faculty in the health sciences must concentrate on what they do best, that is, research, patient care and/or teaching. The Health Sciences colleges continue to recognize and reward "clinician scholars", and there has been no effort to



eliminate that pathway to tenure. Indeed, a review of promotions in the Colleges over the last several years substantiates that claim. Increased competition in all aspects of our mission and restricted growth in resources, not development of the Clinical Track, have resulted in a desired, modest, but steady increase in the median accomplishments of faculty at the time tenure is awarded.

While we recognize that implementation and the proposed modest expansion of the clinical track is a change from the traditional university approach to defining faculty roles, the institution has multiple missions that need attention. The approach proposed is an excellent compromise in meeting those missions and assuring financial stability, while at the same time insuring (or perhaps even enhancing) our overall productivity in terms of the traditional missions of excellence in teaching and scholarship. Moreover, it helps us respond to the continuous accountability questions we face from the legislature and the people of Iowa.

**2. Dilutes influence of tenured faculty in governance.** In response to this concern, the Senate may choose to recommend a cap (say 20%) be placed on the percentage of clinical track faculty eligible for membership in the faculty senate as has been done elsewhere. At UCLA, for example, which has two types of clinical track faculty positions, "Professor of Clinical (x) Series" and "Clinical Professor (Compensated) Series", faculty in the latter category are not "conferred membership in the Academic Senate", whereas "Appointees to all ranks in the Professor of Clinical (x) Series are members of the Academic Senate." According to the UCLA operations manual, "The Chancellor, in consultation with the Senate, has established a limit on the number of appointments in this series. If the number of appointees in this series exceeds 1/6 of all Senate members in all the clinical departments on the campus, a Senate committee will review the appropriateness of adding new appointees in this series. For purposes of calculating the 1/6 ratio, current appointees to the Professor of Clinical (x) series are to be included in the number of 'All Senate members', and all Emerti Senate members are to be excluded."

## **VII. Conclusion**

In the past decade, unprecedented changes in health care have had profound effects on health professions' education. The shift to primary health care called for advanced, community-based practitioners who were prepared to deliver primary health care in community settings and underserved areas. Further, the expansion of health care knowledge has been exponential and continues to yield new and better methods of treatment. New models to educate health professionals and deliver competency-based practice have thus emerged that require more clinical track faculty than are currently available under the 20% cap on clinical track faculty in the Health Sciences Colleges. Based on the data and rationale presented above it is our unanimous conclusion that the interests of the university would be very well served by increasing the allowable fraction of clinical track faculty members from the current 20% to 30%. Indeed, we feel this increase is essential to the continued competitiveness of the UI health enterprise that this step be taken without delay.

Proposal prepared by Kathleen C. Buckwalter, Associate Provost for Health Sciences on behalf of the Deans of the Colleges of Dentistry, Medicine, Nursing, Pharmacy and Public Health.

### Citations

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