Minutes
FACULTY SENATE
UNIVERSITY OF COLORADO SCHOOL OF MEDICINE
May 10, 2016
4:30pm – 5:30 p.m.
Location: Anschutz Medical Campus – Academic Office 1 Building, Room 7000

Welcome – Faculty Senate President Jennifer Richer, MD, called meeting to order. Approval of Minutes from April, 2016, meeting. Moved, seconded, and approved by acclamation.

Dean Reilly’s Comments
Department of Psychiatry Chair is opening up and a search committee is forming.

Presentation for Approval of New Division of Hospital Medicine – David Schwartz, Chair, Department of Medicine; and Steven Lowenstein, Associate Dean for Faculty Affairs

Dr. Schwartz provided a history of the Hospitalist Program here in the Department of Medicine. First hospitalist hired 12 years ago, now over 50 employed; provide care for 40-50% of patients on the medical service. When first hired, hospitalists functioned as general hospitalists. Over these 12 years, general hospitalists are now the majority of the inpatient physicians, whereas general internal medicine typically works in the outpatient environment.

Training programs have distinct attributes when comparing general internal medicine and hospitalists. Examples include; general internists have primary care residency, whereas hospitalists typically train in a specific training track; both disciplines typically have separate grand rounds within the educational framework of the hospital, and; each group has a separate academic meeting nationally.

Several programs around the country have hospitalist programs, and care may extend to neurology, orthopedics, and will likely include care extending to the cardiology service. A natural progression would suggest that, as a division is founded, fellowship will follow.

Finances are in evolution. “Break even” was the prior goal, but the increasing proportional volume of the hospitalists’ patient population means the effort requires a larger revenue stream for the hospital.

Steve Lowenstein, MD Associate Dean for Faculty Affairs described potential benefits and drawbacks of a separate division.
Given the divergence of educational focus, research, and clinical responsibility, it makes sense to have a separate division. Two divisions would
create organizational efficiency and allow each to benefit and compete for research and educational dollars.

Unanswered questions as to the potential drawbacks of two divisions include: Whether general internal medicine attendings can continue to teach on the inpatient services; What is the impact on resident teaching, and experience on inpatient service? and; How would salaries be impacted? and; What would be the impact on research efforts?

Question from Senator: Do hospitalists make money, or are they disadvantaged by their payer mix?
Dr. David Schwartz: The hospital is committed to making this work, but the exact balance sheet is not available. If we go forward, that will be a big part of the success. Financing will be similar to other divisions in Department of Medicine, rather than just subsidies from the hospital. Transparency is important.

Comment from Senator: What makes sense about this is the division of labor. But realize we are contributing to the demise of ‘generalism.’ General surgery is going away for example. We are, with this step, making it difficult for medical students to see an example of a generalist.

Response from Dr. David Schwartz: The future of general internal medicine faculty will still attend on general medicine and on the ‘Acute Care of the Elderly’ service. This will also allow general medicine establish a greater identity in research and clinical care.

Question from Dr. Rebecca Sands Braverman: Any concern about the quality of care in this (new arrangement)?

Senator’s response: Some evidence suggests no difference in care, but there are upsides to having outpatient physicians come into the hospital to care for their patients.

Response from Dr. David Schwartz: This is why we created the physician-scientist's ward, so there will be exposure to these physicians caring for patients in the hospital.

At this point, Faculty Senate President Jennifer Richer, MD, called for a motion to vote on approval of the issue under discussion to move to the executive committee for further approval, which was seconded. A vote was taken by a show of hands. Vote: For 25  Against: 1  Abstain 0
Motion approved, this issue will move to the executive committee for further approval.

Ethic’s Team Role in Patient Care
Jean Abbott, MD, Professor Emerita, Department of Emergency Medicine.
Ethics Consultation Service has value to the hospital in moving treatment decisions forward, typically shortens ICU and hospital stays, and can assist in clarifying decision points in patient care.

Two committees exist on this campus, at Children’s Hospital and University Hospital. Both committees have similar makeup with an emphasis on diverse membership, led by trained consultants who provide consultation services.

As an example of the volume of work completed by the committee, last year 80 consults were completed, averaging about 5 hours per consult. Characteristics of University and Children’s consult topics include shared decision making in shaping the plan of care, religious or cultural differences, or in instances of care that is not indicated.

Both hospitals have noted the significant impact of moral distress. Staff may feel their moral integrity is being threatened, and they cannot feel they can perform their job as they were trained to do. The tempo of clinical care, uninsured patients and vulnerable populations can all take a toll on providers and the Ethics Team is a resource to help with this.

Goal of Ethics Consultation is for outreach, support 24/7, and training and ultimately to be recognized as THE Ethics Committee resource in the state and region. The expertise that the committee brings is not only in core competencies but in quality and performance improvement. This exists in a collaborative way between the University Hospital and Children’s.

Roles include rounding in the MICU and providing considerable education on ethics questions that frequently arise, advising programs, and program review.

A specific example was provided by Dr. Abbott. The Unrepresented Patient Initiative (those who have no family or proxy and who cannot speak for themselves) was developed to assist in this population and developed a white paper. After a lengthy process, a proxy law was brought about. The proxy laws have been changed to allow physicians to be the proxy of last resort. This is one way an ethics consultation can evolve at the policy level to improve the clinical setting for providers.

Research Interest

What are the quality domains of a good ethics consult? Provider satisfaction or patient satisfaction as potential markers of a quality ethics consult are the objects of investigation.

Senator question: The distribution of problems seems to underweight psychiatric illness.
**Dr. Jean Abbott:** The overlap of psychiatric illness often underlies many of the other problems, and psychiatric challenges are often longitudinal.

**Dr. Steve Lowenstein:** I’d imagine that there are many overlaps and that psychiatric illness often underlies and permeates many of the consults.

**Question from Senator:** Will it be the treating physician acting as a proxy of last resort?

**Abbott:** It is often a second physician, under the oversight of the Ethics Committee.

**Senator question:** In the experience where a son wants to keep a patient alive, but the patient desires to die, how does the ethics team help?

**Dr. Jean Abbott:** The Ethics Team would try to discern what the patient’s voice would be, and what the clinical course would dictate. The solution being developed is the “non-beneficial treatment” plan. We strive to hear all concerned parties, consider appropriate and inappropriate alternatives, and advise the team accordingly.

**Senator question:** Is there a potential for outpatient consults?

**Dr. Jean Abbott:** Yes, checking AMION can reveal the on call ethics consultant. Monthly and quarterly rounds may occur and also help disseminate the skill and insights to hospital services.

**Senator question:** What about those in moral distress?

**Dr. Jean Abbott:** The appropriate place or care for the patient is a challenging concern of the hospital and staff.

**Dr. Steve Lowenstein:** In the legislation, who appoints the proxy?

**Dr. Jean Abbott:** The provider asks for a volunteer.

Senator: Would volunteers tend to have a similar bend?

**Dr. Jean Abbott:** It is understood that they are standing in as a proxy, not as a physician.

**Senator question:** What about a guardian ad litem

**Dr. Jean Abbott:** Hard to get, and good for one decision only and must be a lawyer, and because of these constraints, is not workable.

**Dr. Steve Lowenstein:** The first effort is to get a court-appointed guardian, but that was not a timely or helpful solution. Additionally there were no funds or careful
and quick turn around. Concerns included that physicians would not have the best interest of the patient in mind.

*Dr. Jean Abbott:* The role of public guardianship is not nimble enough to meet the need over time. These patients present challenges, but we will see if this can succeed.

**Department of Psychiatry Update**

*Dan Savin, Associate Professor, Department of Psychiatry*

Integrated care across the US where psychiatry is integrated with internal medicine and primary care. The hope and advantage is that addiction and mental health care can be delivered more effectively and be reimbursed more favorably.

**6 Initiatives in the Behavioral Health Service Line**

1. Psychiatry has typically been isolated from other departments, particularly due to carve-outs for mental health benefits. Integration of psychiatry and substance abuse treatment is a goal.
2. Integrate psych with primary care, neurosurgery, infectious disease, and neurology (nonepileptic seizure clinic, for example)
3. Build better consult liaison teams.
4. Reduce the length of stay in the Emergency Room. The goal through adding more staff to improve the care for individuals, rather than just housing patients.
5. Telebehavioral Health to help with consultation load begins with neurology in 2017. This type of consultation may be covered by Medicare, making patient consultation easier.
6. Improve access to outpatient care in psychiatry, including addition of new social workers. However, access to psychiatry still will likely be insurance dependent in the near term.

**Student Mental Health Service**

Two locations including: Campus Health Center at Anschutz Health and Wellness Center and the Student Mental Health at Building 500, 2nd Floor. Services include:

- Acute stress management (including anxiety or depression), Counseling or triage, assessment, treatment or referral of mental health disorders, Medication prescription, monitoring and support
- Domestic violence, sexual assault, trauma (in coordination with the Advocacy and Support Center)

178 new evaluations for students in 2014-2015 Academic Year
President Jennifer Richer question: Who can initiate a student evaluation? What’s the best way to get a student the help they need?

Dr. Savin: It’s best if the student comes on their own, but faculty can support the student in seeking care. We do work with a faculty member’s recommendations to have a student get the help they need, but typically this is on a case-by-case basis.

Senator question: Is there a similar model to medicine where there are psychiatrists seeing outpatients and teaching all the time?

Response by Dr. Savin: Combination approaches 60% that sees patients and teaches. We work with VAMC, DHMC, Children’s, and about 20% of our faculty work exclusively inpatient.

Next Meeting
June 14, 2016 4:30pm
Anschutz Medical Campus – Academic Office 1 Building, Room 7000

Meeting adjourned 5:30 pm by President Jennifer Richer, MD.

Respectfully submitted,

Michael Overbeck, MD
Secretary, Faculty Senate.