

**THE UNIVERSITY OF VIRGINIA
HEALTH SYSTEM**

DECADE PLAN

**School of Medicine
School of Nursing
Medical Center
Health Services Foundation
Claude Moore Health Sciences Library**

June 2006

**THE DECADE PLAN
JUNE 2006**

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THE DECADE PLAN EXECUTIVE SUMMARY

In 2003, the Decade Plan was launched as the first combined strategic planning effort involving all components of the Health System with the overall goal of excellence defined by the creation of Models for all of US and recognition of the University of Virginia as one of the top health systems as evidenced by rankings. The plan focused on the five areas of patient care, education, research planning, community service, and cross-mission. Each Decade Committee defined specific objectives and was held accountable with periodic meetings (monthly to semi-annually) with leadership. What have we accomplished in these areas and where are we going?

In 2006, we re-evaluate the Decade Plan. We reaffirm our goals and core concepts.

Our **goal** continues to be excellence, defined as:

- The creation of Models for all of U.S. in which we can demonstrate to others innovative ways to advance the health of America through our core competency of collaboration in patient care, education, research, and service to the community;
- Recognition of the University of Virginia as one of the very top health systems as evidenced by School of Medicine, School of Nursing, and Medical Center rankings.

Since the implementation of the original Decade Plan, and reaffirmed now, our **core concepts** are:

1. Retention and recruitment of the best faculty, students, and staff who continuously innovate whether in programmatic development or individual endeavors. We have recruited Bankole A. Johnson, DSc, MD, PhD, Chair of Psychiatric Medicine; Michael D. Dake, MD, Chair of Radiology; Geoffrey R. Weiss, MD, Chief of the Division of Hematology-Oncology, and Deputy Director of the Cancer Center for Clinical Affairs and Clinical Research; Lawrence W. Gimple, MD, Chief of the Division of Cardiology; George F. Rich, MD, PhD, Chair of Anesthesiology; James M. Larner, MD, Chair of Radiation-Oncology; and Robert M. Strieter, MD, Chair of Internal Medicine.
2. Creation of the best possible facilities. We have in the planning stages facilities in each area of our mission – Medical Education Building (2010); Carter-Harrison Research Building (2008), the Applied Research and Technology (ART) Building (2007), and the Ivy Translational Research Center (2010); and Clinical Cancer Building (2010) and the Children's Hospital (2011).
3. Commitment to diversity in those who work here and those who study here, and to the elimination of disparities in the health of our citizens. Between 2002-2005, the number of under-represented minority students went from the lowest quintile among schools in the country to the top quintile.
4. Living a culture of collaboration, communication and transparency. Well over 80 percent of our faculty say they feel their work environment is collegial, there is a stronger relationship between the Medical Alumni Association and the School of Medicine, information is shared via regular meetings and electronic communications, and budgets and financial performance information is consolidated and shared quarterly.
5. Partnership. There is a strong working partnership among all the entities of the Health System: the School of Medicine, Medical Center, Health Services Foundation, School of Nursing, and Claude Moore Health Sciences Library.

Staff and faculty throughout the Health System have devoted creative effort and vision to carrying out the plans of each committee and working group. The groups realized significant accomplishments and have set additional goals for further improvement. While each individual report details the accomplishments and goals, a highlight from each group follows.

Access, Service and Communication has helped 60 percent of primary care clinics and 50 percent of specialty care clinics meet the UVa target of providing non-urgent, initial appointments within 14 days. Its two-year goal is to have 80 percent of primary care clinics and 66 percent of specialty care clinics meet the 14-day target.

Primary Care conducted an in-depth analysis of primary care and its place in the UVa Health System. An outcome of that study is a two-year plan for redistribution of primary care services within the primary service area east, which includes Albemarle County, the city of Charlottesville, and the 5 surrounding counties of Fluvanna, Greene, Louisa, Nelson, and Orange.

Health Services Foundation rebuilt net assets to \$61.5 million after they had decreased to \$24.1 million in FY02. A two-year goal includes adjusting operations for success in an environment of increased consumer responsibility and involvement in healthcare decision making. The Health Services Foundation, School of Medicine and Medical Center will continue to emphasize alignment of their goals.

Market Strategy established a two-step process for proposal review that is aligned with other internal review processes. Two-year goals include identification and prioritization of clinical areas that the Health System can market successfully based on market indicators (share, growth, financial contribution) and performance metrics (access, service, excellence, quality).

The Buchanan Endowment Awards for Clinical Programs committee developed a robust process review and established teams of physicians, nurses, and administrative staff to develop business plans that meet the Buchanan funding criteria. Over the next two years the committee will further develop criteria for a successful program including market share.

Medical Education developed and introduced the new “Cells to Society” curriculum that integrates basic science and clinical courses centered on the patient, and established two national models – the Cells to Society 3-day introduction and the Clerkship Clinical Skills Education Program. The Center for Humanism in Medicine was created to nurture humanism in medicine and to evaluate the outcomes and effectiveness of a humanism focus on the curriculum. The committee will establish a Medical Education Research Institute for basic research on medical education within the next two years. The School of Medicine will consider a 10-15% increase in the medical school class size after the Medical Education Building opens in 2010. Graduate Medical Education: A Graduate Medical Education innovation grant was created and supported studies that are impacting how we train residents. The GME curriculum will be enhanced through an Academy of Distinguished Educators Resident as Teacher program.

School of Nursing Education piloted a Clinical Nurse Leader (CNL) program, an accelerated 24 month full-time graduate course of study that intends to prepare nurses for clinical practice and leadership at the point of care. Two-year goals include increased collaborative opportunities in the areas of international, global health, informatics, and simulation.

The Claude Moore Health Science Library helped to incorporate quality information resources in major Health System initiatives (e.g., Patient Safety, Patient and Family Education, Health Sciences/MPH). The Persona Project – the development of personalized information delivery systems for medical students as well as educational modules based on preferred learning styles – is a major two-year goal.

Research Infrastructure, Programs, and Faculty implemented a translational research training program designed to fund and bring to market promising translational projects. Among its two-year goals is increased support for faculty researchers and to ensure that the Office for Clinical Research is fully functioning with research cores for study design and statistics. We will build upon our existing strengths in investigating disease (such as cancer, endocrinology, cardiovascular, neuroscience, addiction, aging, digestive health, and biodefense) and in basic science disciplines (such as cell signaling, inflammation, morphogenesis and regenerative medicine, imaging, epigenetics, and structural biology) by adding expertise in Personalized Medicine using the power of genetics, genomics, and proteomics. We will develop the Virginia Institute for Clinical and Translational Research to complement our strong basic science accomplishments.

Graduate Programs consolidated over 20 entry programs into 7 umbrella Biomedical Sciences Graduate Programs that cross departments and schools. A major two-year goal is to improve mechanisms to better integrate Ph.D. training and application of basic research findings to advances in clinical medicine.

School of Nursing Research increased its NIH ranking from 28 in FY02 to 16 in FY03 and FY04, and it has the third largest number of Individual National Research Student Awards. Its two-year goals include increasing research partnerships with the SOM and across Grounds, and increasing NIH-funded R01 research.

Community Service participates in a multi-organization collaboration to provide safety net screening and care to uninsured Appalachian citizens, which has increased the patient volumes served in the July Wise event threefold. Over the next two years, it will work with the Office of Medical Education to evaluate and track service learning outcomes.

Faculty Development established the Faculty Leadership Program as a developmental model reflecting the stages of a faculty career and has presented it as a national model. A two-year goal is to improve retention, defined as 90 percent of retention efforts are successful.

Public Health established the MPH degree and saw significant growth in the MPH program. The Consumer Health Education Institute was established to teach consumers how to choose health care, and the Center on Health Disparities will investigate ways to reeducate health professionals and eventually eliminate disparities in the delivery of health care to minorities, the poor, rural residents, and others with limited access. Two-year goals include creating the Health Disparities and Global Health tracks in the MPH program and beginning to develop ways to reduce disparities (e.g., Telemedicine for rural health care).

The Center for Global Health launched its Fogarty Global Health Framework grant, which enabled new course development in the SOM and across the University. Among its two-year goals is the initiation of a program in which all 4th-year students have the opportunity to participate in an annual “class project” in an underserved country.

The Health System Development campaign has booked \$194,682,622 in gifts/pledges through 1/31/06, or nearly 39 percent of the \$500 million campaign goal. A two-year goal is to integrate basic science with clinical programs in fundraising efforts. We must exceed our target of \$500 million in order to carry out the Decade vision and to provide the capital, endowment, and operating funds that will sustain the programs.

Over the next ten years, we aspire to be among the premier academic health centers in demonstrating the value of the interaction among our missions: patient care, education, research that converts promising outcomes into what Jefferson called “usable science,” and service to the community. We will develop the Virginia Institute for Clinical and Translational Research that will take us from “cell to bedside” and a School of Public Health that will move from “bedside to society.” Our excellence will be evidenced by 20 new Models for all of US and achieving high rankings such as the Medical Center earning a place on the Honor Roll of “America’s Best Hospitals” and the School of Medicine ranking as 20 among the nation’s medical schools, both as determined by *US News and World Report*.

Core Concepts: Progress and Planning

The Decade Plan for the University of Virginia Health System is inspired by a truly great University founded on the values of innovation, accountability, integrity, and collaboration. We can embrace innovation and change so freely because of this solid footing, moving forward in ways others cannot be virtue of how we work together. Collaboration is a core competency for leadership as real solutions to problems can rarely be solved by individuals. We work in teams and thrive that way, creating what Jefferson called “useful science” and leveraging our missions of education, research, patient care, and public service to improve the health of those in the Commonwealth and well beyond.

What have we accomplished in our core concepts thus far and where will we be going from here?

- Retention
 - We have created world-recognized faculty development programs, including Leadership in Academic Medicine, Academy of Distinguished Educators, and Dean’s Leadership Seminars.
 - We will establish leading programs to address life transitions, new faculty orientation, and support the clinical investigator track.
- Recruitment
 - We have recruited the following Chairs and Division Chiefs:
 - Bankole A. Johnson, DSc, MD, PhD, Chair of Psychiatric Medicine (September 1, 2004), whose interest combines medications that target different brain pathways known to be involved in addiction, with behavior-changing techniques in an effort to reduce craving associated with substance abuse.
 - Michael D. Dake, MD, Chair of Radiology (January 1, 2005). He is a widely known cardiovascular and interventional radiologist, and an innovator of new techniques and devices in interventional medicine as it applies to large blood vessels, for example in the development of stents.
 - Geoffrey R. Weiss, MD, Chief of the Division of Hematology-Oncology, and Deputy Director of the Cancer Center for Clinical Affairs and Clinical Research (January 1, 2005) is interested in how the body’s immune system can be marshaled to fight cancer. His research focus is oriented to the management of kidney cancers and other types of cancers of the genital and urinary tracts.
 - Lawrence W. Gimple, MD, Chief of the Division of Cardiology (January 1, 2005). Dr. Gimple’s clinical interests include invasive cardiology, coronary syndromes, and general cardiology. His research interests are in thrombosis, myocardial infarction, and restenosis.
 - George F. Rich, MD, PhD, Chair of Anesthesiology (July 1, 2005). Dr. Rich’s clinical interests pertain to cardiovascular and thoracic anesthesiology. His research interests are in the protective effects of anesthetics on blood vessels and the role of nitric oxide in lung mechanics.
 - James M. Larner, MD, Chair of Radiation-Oncology (November 2, 2005). Dr. Larner’s clinical interests are in neuro-oncology and thoracic oncology, and his research investigates the basic science of cancer through damage to DNA.

- Robert M. Strieter, MD, Chair of Internal Medicine (July 1, 2006), is internationally recognized for his work in lung cancer, pulmonary fibrosis, acute lung injury, and lung transplantation. He is known for his innovations in patient care, such as the development of a critical care hospitalist program, and he is project leader on a specialized program of excellence in lung cancer from the NIH/National Cancer Institute.
 - We are in the process of recruiting department chairs for Molecular Physiology, Emergency Medicine, and Pharmacology. In keeping with the original Decade Plan, by 2012 we will have recruited approximately 50 researchers in basic, translational, and clinical science to add to our current programs as well as planning for new genetic, genomic and proteomic initiatives. We will recruit approximately 70 new clinicians as capacity in the Health System increases.
 - Facilities
 - We have in the planning stages, facilities that will be models for the US in all areas of mission: education, research and patient care
 - Education: The Medical Education building will be a 6-story, 62,500 sq ft facility that features a technology enhanced classroom providing flexibility for a variety of teaching approaches. It will house the Clinical Skills Center, the Simulation Center which will use virtual reality, and student support and student administrative spaces. The building is scheduled for completion in 2010.
 - Research: We have broken ground on the Carter-Harrison Research Building with 200,000 gross sq ft devoted to laboratory research in cancer, immunology and infectious diseases to be completed in 2008; the ART Building with 85,000 gross sq ft devoted to laboratory research in imaging, and housing laboratories for the Department of Medicine to be completed in 2007; the Ivy Translational Research Center with 60,000 gross sq ft to be completed in 2010.
 - Patient care: The Clinical Cancer Building will provide all outpatient services for adults diagnosed with cancer, house a pharmacy, clinical services laboratory, and clinical trials office with capabilities to be the hub of a telemedicine clinical trials network, and a cancer learning center to foster patients' physical and emotional well-being. Scheduled for completion in 2010, it will accommodate emerging advances in genetics, informatics and molecular biology to diagnose and prevent cancer. The Children's Hospital will consolidate pediatric outpatient and rehabilitative care in a bright, friendly space, making care more convenient and less stressful for families. The facility will include an on-site pediatric cancer infusion center and outpatient clinics in primary care, autism, cerebral palsy, diabetes, and other pediatric specialties, as well as 19 pediatric rehabilitation beds for children with spinal cord or head injuries or other traumas requiring long-term care. Pending funding, it is scheduled for completion in 2011. Between 2006 and 2012, the Medical Center will add over 100 beds to accommodate the increase in patient numbers.
 - Disparities
 - Disparities in access to medical education and health care are being addressed. We have improved from being in the lowest quintile to the top 20 percent of medical schools for admitting underrepresented minority students. We have increased diversity among new chair hires as well as the dean's staff. We established the Center on Health Disparities, which has the mission of improving disparities in health care by improving

access for minorities, the poor, those in rural communities (e.g., Telemedicine), and others with limited access.

- Collaboration, Communication, and Transparency
 - A survey of basic science faculty and clinical faculty shows 89 percent and 79 percent, respectively, believe their work environment is collegial.
 - Dissemination of information (faculty orientation and development sessions, electronic newsletter from SOM Dean Garson, improved websites—including committee charges and membership with information on contacting committees for input).
 - The Medical Alumni Association, the SOM, and Development strengthened relationships among the three organizations and implemented a Memorandum of Understanding outlining joint operations. The MAA raised \$7 million for the Medical Education Building.
 - Transparency – budgets and financial performance from the SOM, MC, and HSF consolidated and shared quarterly.
- Partnership
 - All entities of the Health System - School of Medicine, Medical Center, Health Services Foundation, School of Nursing, and Claude Moore Health Sciences Library – have developed strong, mutually supportive relationships.

The remainder of this Decade Plan update is in the form of reports from ongoing committees. Since the inception of the plan, accountability for moving the plan forward has rested with committees that reported semi-annually to other committee chairs as well as: monthly meetings for patient care with the dean and the CEO (Joint Operations Committee for patient care); for research with the dean (Research Advisory Committee), and for education with the dean (Education Deans). This structure of accountability will continue.

ACCESS, SERVICE, AND COMMUNICATION (ASC)

1. Notable Accomplishments

Access

- Developed and implemented quarterly clinic performance summary scorecards and activity reports for clinics to track productivity and efficiency metrics that can be benchmarked to external groups. The reports are used as a management tool by clinic managers and medical directors. The University Health System Consortium (UHC) February 2006 benchmark study for patient access to ambulatory care reports 86 percent of responding organizations have appointment access standards, with the most common standard being non-urgent appointments within two weeks of request. Other common UHC access measures that UVA collects include: patient no-show rate, patient satisfaction with access, speed of answering telephone call, call abandonment rate, and room turn. FY06 YTD results show 60 percent of primary care clinics and 50 percent of specialty care clinics are meeting the 14-day target.
- Implemented ongoing surveillance of non-urgent initial clinic appointment availability that relies on Health System Call Center operators to routinely survey clinics, with results compared an expert scheduling system user to appointment dates in scheduling templates. Problems with scheduling templates have been identified and corrected and training modules conducted for template builders and scheduling staff. Template revision and training are ongoing projects.

To make the discharge process efficient for patients and to increase Medical Center capacity, implemented and championed Discharge by Noon program with challenging but obtainable goals of 33 percent of medically ready patients discharged by 12:00. Recent monthly results are: December 32 percent, January 33 percent and February 31 percent. Related to the timely discharge process, laboratory and pharmacy discharge pathways were developed and successfully implemented. Discharge labs drawn by 6:30 AM are on average reported by 7:37 AM; and 97 percent of discharge prescription requests in by 7:30 AM are turned around by 11:30 AM.

Service

- Standardized much of the clinic operations to create consistent experiences for patients. Implemented standards for normal clinic hours and holiday schedules, environmental appearances, employee career apparel.
- Conducted customer service training for clinic staff in Team Building, Lasting Impressions, and Core Telephone Skills training. Piloted alternative methods for patient financial screening to improve privacy and wait times.
- Implemented mechanisms in the scheduling and registration system to identify patients in need of interpreters so that services can be planned in advance.

Communication

- Developed and implemented policies and template letters to address patient no-shows and late appointments, which pose significant difficulty for many clinics. Also implemented standardized appointment reminder letters with maps to clinics.

- Developed and implemented inpatient/outpatient Medical Director Job Descriptions to strengthen management role with clinic and unit managers. Survey of management partnership between medical directors and clinic managers revealed 70 percent are satisfied with working relationship.
- Provided input for IDX CareCast (electronic medical record) implementation in clinic sites and enhancements to SoftMed dictation system to enable more convenient access for physicians and auto-faxing of clinic notes to referring physicians. CareCast was piloted in three clinics in July 2005 and is being rolled out with a March 2008 planned completion date. Web access to dictation and electronic signature application is now available throughout Health System facilities and offsite through secure remote access.

Other:

- Consistently achieved financial targets for clinic front desk operations and improved co-pay collection notification to physicians using stamp receipt.

Projects in Progress:

- Automated telephonic appointment reminder system is presently in pilot phase with a mid-May deadline to decide whether or not to purchase.
- Automated Call Distribution (ACD) telephone management system has been implemented in 25 percent of the clinics.
- Establish a standard for reporting lab and test results to patients. (Project delayed as piloting of program could not be negotiated with vendor. Guideline development as to how and when to report results is underway).
- Routine quarterly reports on access to care from all diagnostic/ procedural areas.

Projects Delayed:

- Review of transcription services by clinics was postponed with the understanding that standardization of dictation/transcription is not a priority.

2. Two-Year Goals and Metrics for Success

- Timely discharge of medically appropriate inpatients with pending discharge order entered the night before and/or the complete final discharge order is in by 9:00 AM. In February 2006, 27 percent of final orders were in by 9 AM.
 - 50 percent of discharges are out by 11:00 AM. In February 2006, 31 percent of patients were out by noon.
 - 90 percent of rooms turned over (readied and occupied) in 75 minutes.
- Upgrade the current scheduling system so that meaningful appointment availability data can be tracked and measured, thereby improving patient and referring physician satisfaction.
 - *Non-urgent, Initial Appointments:* Primary Care: 80 percent of visits in 14 days; Specialty Care: 66 percent within 14 days.

- *Routine Screening*: 75 percent of visits in 21 days.
- *Requested Diagnostic testing*: 75 percent of visits in 7 to 14 days with specific days to be identified per procedure area.
- *Urgent Appointments*: 90 percent in 24 hours or less.
- Improve patient and referring physician satisfaction with telephone service access to clinics by implementing Automated Call Distribution, minimizing the number of phone prompts and permitting no more than two electronic transfers before reaching a person.
 - Abandonment rate (measures the number of callers hanging up during phone prompts or while on hold) of 5 percent.
 - 90 percent of phones answered within 30 seconds.
 - 75th percentile in Survey Access to Care questions in Press Ganey Surveys (e.g., Ease of Scheduling Appointments, Courtesy of Person Scheduling Appointment).
- Reduce wait times for inpatient beds and surgical procedures by opening a short-stay unit, increasing physical capacity and achieving a rate of 50 percent of medically ready discharges by noon.
 - Eliminate Operating Room holds (patient is held due to lack of bed availability on unit).
 - Reduce Emergency Department or Post-Anesthesia Care Unit boarders (patients admitted to service but bed on unit is not available) to 8 maximum at any given time.
 - 90 percent outside patient transfers accepted in 24 hours.
 - Routine elective surgery scheduled within 3 weeks.
 - Urgent surgery scheduled within 2 weeks.
 - Emergent (not life/limb-saving) surgery scheduled within 8 hours; emergency is always immediate.
 - All available beds open and staffed.
- Improve patient satisfaction with outpatient registration and overall visit by expediting the registration process and decreasing wait times.
 - Rank 75th percentile in Press Ganey Survey Registration and Visit questions (e.g., Ease of Registration Process, Waiting Area Comfort/Pleasantness).
- Improve patient satisfaction with personal issues such as sensitivity to patients' needs and concern with patients' privacy by providing enhanced customer service training and clearly outlining expectations for front-line staff.

- Rank 75th percentile in Press Ganey Survey Personal Issues questions (e.g., Our Sensitivity to your Needs, Staff Concern for Patients' Privacy, Response to Patient Concerns or Complaints).
- Improve turn-around-time for communication with referring physicians by improving accurate referring physician information upon registration and expanding web-based communication via Referring Practice Online (RPO), a system that creates a secure, interactive web portal to community physicians to request appointments and access clinical documentation.
 - 70 percent of all divisions/departments will meet targets:
 - *Outpatient notes*: 11 days.
 - *Operative Reports*: 24 hours.
 - *Discharge Summaries*: 24 hours.
 - Increase the number of referring practices utilizing Referring Practice Online by 100 percent.

3. Five-Year Goals and Metrics for Success

- Timely discharge of medically appropriate inpatients with pending discharge order entered the night before and/or the complete final discharge order is in by 9:00 AM.
 - 60 percent of discharges are out by 11:00 AM.
 - 100 percent of rooms turned over (readied and occupied) in 75 minutes.
- Upgrade the current scheduling system so that meaningful appointment availability data can be tracked and measured, thereby improving patient and referring physician satisfaction.
 - *Non-urgent, Initial Appointments*: Primary Care: Open access for initial visits; Specialty Care: 90 percent in 7 days.
 - *Routine Screening*: 75 percent of visits in 21 days.
 - *Requested Diagnostic testing*: 75 percent of visits in 7 to 14 days with specific days to be identified per procedure area.
 - *Urgent Appointments*: 100 percent in 24 hours or less.
- Improve patient and referring physician satisfaction with telephone service access to clinics by implementing ACD throughout clinics, minimizing the number of phone prompts and permitting no more than two electronic transfers before reaching a person.
 - Abandonment rate (measures the number of callers hanging up during phone prompts or while on hold) of less than 5 percent.
 - 90 percent of phones answered within 30 seconds.

- 90th percentile in Press Ganey Survey Access to Care questions in (e.g., Ease of Scheduling Appointments, Courtesy of Person Scheduling Appointment).
- Reduce wait times for inpatient beds and surgical procedures by opening a short-stay unit, increasing physical capacity and achieving a rate of 50 percent of medically-ready discharges by noon.
 - Reduce Emergency Department or Post-Anesthesia Care Unit boarders to 4 maximum at any given time with a maximum wait time of 6 hours.
 - 95 percent outside patient transfers accepted in 24 hours.
 - Routine elective surgery scheduled within 3 weeks.
 - Urgent surgery scheduled within 1 week.
 - Emergent (not life/limb-saving) surgery scheduled within 8 hours; emergency is always immediate
- Improve patient satisfaction with outpatient registration and overall visit by expediting the registration process and decreasing wait times.
 - Rank 90th percentile in Press Ganey Survey for Registration and Visit questions (e.g., Ease of Registration Process, Waiting Area Comfort/Pleasantness).
- Improve patient satisfaction with personal issues such as sensitivity to patients' needs and concern with patients' privacy by providing enhanced customer service training and clearly outlining expectations for front-line staff.
 - Rank 90th percentile in Press Ganey Survey Personal Issues questions (e.g., Our Sensitivity to your Needs, Staff Concern for Patients' Privacy, Response to Patient Concerns or Complaints).
- Improve turn-around-time for communication with referring physicians.
 - 90 percent of all divisions/departments will meet targets:
 - *Outpatient notes*: 7 days.
 - *Operative Reports*: 24 hours.
 - *Discharge Summaries*: 24 hours.
 - Increase the number of referring practices utilizing Referring Practice Online 200 percent.

4. Resources Needed and Barriers to Success

- Resources Needed
 - A robust scheduling and registration system to realize many of the two and five-year goals outlined in this update. The current scheduling system has limited flexibility and less than optimal functionality.
 - Ongoing training, and required minimal competencies for scheduling personnel and managers as well as all front-line staff.

- Short-stay unit staffing at appropriate level.
- Approach to address pediatric staffing needs.
- Stronger joint direction by Medical Center managers and medical directors of scheduling activities.
- Alignment of incentives for faculty and staff.
- Barriers to Success
 - Traditional team behaviors that result in discharge orders occurring long after rounds and staff not embracing a sense of readiness to ensure actions are taken early.
 - Limited bed capacity.
 - Lack of clear Bed Center management authority for bed/staff utilization decisions.
 - Competing priorities for faculty to do research and teaching may result in sub-optimal clinic provider availability.
 - Lack of knowledge about front-line staffing patterns to meet site-specific telephone and visit volume.
 - Significant variation in financial and human resources across clinics with expectation for same level of service.
 - Difficulty monitoring performance without enterprise-wide dictation/transcription system.
 - Additional support is needed for greater implementation of Referring Practice Online as the process for referral requests relies on manual rework to fulfill request.
 - Additional time and resources are required to install Automated Call Distribution lines in majority of clinics.

PRIMARY CARE

1. Notable Accomplishments

Using a report from Kurt Salmon Associates as a launching point, the Primary Care Coordinating Committee conducted an in-depth analysis of primary care and its place in the University of Virginia Health System.

Based on this information the committee found the following:

- Primary care practice is of great importance to the current and future well-being of the UVa Health System.
- Market analysis indicates the key importance of a primary care presence in the Primary Service Area East (PSA-E) which includes Albemarle County, the city of Charlottesville and the 5 surrounding counties of Fluvanna, Greene, Louisa, Nelson and Orange; because of the volume of hospital services, ancillaries, and consultations derived from this area.
- Data suggest that the patient's primary physician is a key determinant of where procedural services occur.
- Interview data support the need for enhanced communications and mutual information exchange by UVa primary care doctors with their sub-specialty colleagues.
- There is a clear need for physician friendly, easily accessible scheduling of consultations and admissions.
- There is agreement about the need for clear and prompt transmission of information from specialists and medical/laboratory tests within UVa Health System to our primary care physicians.
- Currently, primary care is organized and managed through three different structures; provider-based Clinics (UVa Health System), regional primary care (HSF), and community medicine (A UVa LLC). A non-controlling ownership of a physician network in Culpeper is also in place. This location is in the secondary service area that extends from Madison County north to Fauquier County.

In January of 2005, the Primary Care Committee initiated its Phase 1 work to assess the current state of primary care within the University of Virginia Health System. To accomplish this task the following processes were completed:

- Interviews were conducted and market data were analyzed to understand the impact and value of primary care to the UVa Health System and to understand the distribution of practices in relation to competition.
- An assessment of the future developments that potentially can affect the Health System and primary care.

Based upon this Phase 1 work three task forces were convened, led by committee members and composed of participants involved with primary care in the UVa Health System. The following three task forces have been actively working since November of 2005:

- Integration and Finance Task Force, charged with developing a plan for the administrative integration of primary care clinical services and the financing of these services.
- Metrics Task Force, charged with developing benchmarks and standards. The initial task for this group is to recommend metrics for the “value” of primary care to the UVa Health System.
- Communications Task Force, charged with evaluating current and projected communication needs and developing recommendations for information sharing, problem-solving, and decision-making.
- An Information Technology Task Force to serve in an advisory capacity to HSCS is planned but not yet operational.

2. Two-Year Goals and Metrics for Success

- A new administrative system for managing primary care services will be functional.
- A plan for redistribution of primary care services within the primary service area east which includes Albemarle County, the city of Charlottesville and the 5 surrounding counties of Fluvanna, Greene, Louisa, Nelson and Orange will be in place.
- Increase to from 32 percent to 38 percent market share of primary care physicians in the Primary Service Area East and West (includes Augusta County and cities of Waynesboro and Staunton).
- The number of UVa employees receiving care from UVa physicians will increase by at least 10 percent to assist in reaching the overall market share goal.
- Expand capacity to allow 80 percent of clinics to provide new appointment availability within 14 days. This measure is consistent with and in support of the ASC Committee’s established target for new patient appointment availability.
- Evaluate placement of associated services such as pharmacy, radiology and urgent care in primary care office locations.

3. Five-Year Goals and Metrics for Success

- Distribution of Primary Care throughout PSA to enhance access in support of the ASC Committee’s evolving standards and metrics.
- Consistent practice aesthetic so that patient expectations can be consistent practice to practice and that all Primary Care practices can be branded as UVa affiliated.
- One shared billing system.

- Increase to 50 percent market share in the Primary Service Area-East which includes Albemarle County, the city of Charlottesville and the 5 surrounding counties of Fluvanna, Greene, Louisa, Nelson and Orange. This supports to the Health System's proposed bed expansion project.
- UVa Primary Care Physicians drive access standards and implement cutting edge and innovative models for primary care, such as chronic disease management and preventive lifestyle changes.
- All primary care offices engaged in education of students and residents.
- Electronic applications/Electronic Medical Records that enhance preventive care standards and practice guidelines are operational in all offices.
- UVa affiliated urgent care will be functional throughout the primary service area, providing residents access to care within 30 minutes of their home.

4. Resources Needed and Barriers to Success

- **Derailing nature of perceived access issues**
Discussions focus on appointment availability, and the ability to quickly transfer and admit a patient. The discussion needs to be moved past these important issues as they are improved.
- **Question of value remains unanswered**
The overall value of primary care is questioned by the organization and a consistent value metric is neither monitored nor shared. A value metric will be developed.
- **Designated analytical and support resources**
As the work expands, additional analytic and organizational support will be necessary. Development of a business model will require further support, perhaps including outside consultation.

HEALTH SERVICES FOUNDATION

1. Notable Accomplishments

Financial Performance

- After five years of bottom line losses through FY00, HSF has had operating surpluses in FY01 and FY02 through FY05, and positive bottom lines from FY02 through FY05. The first six months of FY06 show an operating loss.
- From a high of \$63.3 million in FY95, HSF's net assets had decreased to \$24.1 million by FY02. Since then net assets have been rebuilt to \$61.5 million. Contributing to this increase were \$7.6 million in operating surpluses, a contribution from the Medical Center (MC) of \$15.0 million for medical leadership recruiting, and a significant gain on the sale of VASI to the MC.
- Overall median and average compensation for all HSF physicians employed during the entire period of 2001 through 2004 increased at faster rates than available benchmark figures. On average, HSF physician salaries and incentives are at the 50th percentile of those at other academic medical centers as reported by the AAMC in a report that covers all of the 125 accredited medical schools in the US.
- A sharing agreement was entered into among the MC, School of Medicine (SOM) and HSF under which MC operating surpluses above a five percent margin are shared with the SOM and HSF; an agreement that has resulted in transfers of significant funds.
- Financial relationships with the SOM and the MC have been clarified and aggregated in multi-year agreements.
- The MC worked to enhance, and later protect, governmental funding to HSF physicians for indigent care.
- Days-in-Receivables have dropped from 63.0 days to 43.0 days during the period from FY01 to FY05.

Management Performance

- Accomplishments include hiring of talented managers, significant cross-training, and implementation of a pay-for-performance system for all administrative employees.
- An array of payor contracting initiatives have been undertaken that better identify issues, have resulted in improved rates under contracts up for renewal, and involve clinical leadership in contracting decision-making. While it has been noted that there is room for improvement in rates under our two largest commercial contracts, we continue to remind ourselves that negotiations of these contracts was influenced by political pressures from outside of HSF.

Areas of Limited or No Action

- There has not been consensus about whether and how HSF should renew its historical pursuit of entrepreneurial opportunities now that HSF's capital base is once again in the position to capitalize such opportunities.
- Implementation of a durable primary care strategy remains a work in progress.

- Improvements in registration, scheduling, documentation, coding and charge capture have lagged due to competition for resources within the departments and within the MC, as well as IT system limitations.
- An integrated patient scheduling and registration system capable of meeting both HSF and MC needs continues to be an unfulfilled hope.

2. Two-Year Goals and Metrics for Success

Models for all of US

Adjust operations to succeed in an environment of increased consumer responsibility

In collaboration with MC, redesign and rebuild the front-end business functions to identify insurance and payor requirements at first contact, better manage scheduling and registration, collect appropriate payments, triage care, and supply price and quality information to shoppers.

- During the first two years, HSF will provide advice and decision making forums to the MC to enable it to:
 - Reach agreement with the physician community on the operational organization for the front end of the revenue cycle that most effectively and efficiently balances care delivery and financial operation needs.
 - Implement the identified operational organization and install a new scheduling and registration IT system.
 - Assist unsponsored patients in finding funding mechanisms for their care.
 - Develop a detailed plan to supply price and quality information to prospective patients.
 - Develop departmentally based mechanisms to triage care utilizing clinic medical directors.
 - Develop methods to care appropriately for the increasing number of uninsured indigent patients.

Adopt payor-mix goals such that there will be enough paying patients to cover (a) the costs incurred by patients unable to pay, and (b) the costs incurred to fulfill our other missions of research and education.

- During the first two years, HSF will work collaboratively with the MC and the SOM to:
 - Arrive at a consensus understanding of the revenue, cost and mission impacts of patients covered by particular payors on each of the health system entities.
 - Agree on payor-mix goals.

Identify what is needed to remain competitive in the market for patients with good third-party payor coverage.

- During the first two years, HSF will work collaboratively with the MC to:
 - Reach agreement on things needed to remain competitive for patients with third party coverage that reimburses at levels providing a margin sufficient to fund our missions.
 - Establish a plan and timetable for implementation of necessary changes.
 - Identify monitoring mechanisms to verify that actions undertaken are effective.

Develop operational mechanisms to implement if we are not able to achieve the payor-mix goals required to cover (a) the costs incurred by patients unable to pay, and (b) the costs incurred to fulfill our other missions.

Reevaluate and revamp financial understandings among health system entities to improve response times to anticipated financial dislocations.

Create “circuit breakers” that mandate automatic reevaluation and readjustment of financial arrangements if certain metrics or environmental events occur. For example, if Medicare changes (and resultant changes in private insurance payment), result in physician payment that is significantly reduced whereas Medical Center payment is not significantly reduced, the overall mechanism for cross-subsidy in the Health System should be examined and potentially changed. This will be done in a spirit of collaboration (“all boats rise”) and not in a way that causes a “borrower – lender” mentality.

Implement durable primary care and specialty care strategies.

Identify drivers motivating retention and recruitment of the best faculty and adjust compensation and benefit policies as appropriate.

Improve our operations.

Better coordinate demand and capacity, identifying alternative approaches to preserving market share and profitability.

Coordinate provider employment plans with physical capacity plans.

- During the first two years, HSF will work with the SOM to compare its provider hiring plans and expected physician staffing to existing physical capacity (beds, operating rooms, ambulatory facilities, equipment).
 - If expected physician staffing exceeds expected physical capacity, HSF and the SOM will work with the MC to identify alternative ways of increasing physical capacity.
 - If expected physician staffing exceeds expected physical capacity, and alternative ways of increasing physical capacity within the two-year time frame are not identified, HSF and the SOM will modify their physician hiring plans to bring staffing and capacity into line.

Confirm that current capital expenditure plans will generate physical capacity capable of preserving current market share and, if not, identify alternative approaches to maintaining share.

- During the first two years, HSF will work with the SOM and the MC to:
 - Review future demand growth in our identified markets.
 - Compare our current and projected physical capacity (beds, operating rooms, ambulatory facilities, equipment) to market demand to evaluate whether we will have the physical capacity to preserve our market share.
 - Develop a revised capital expenditure and financing plan that will maintain market share if our current physical capacity plan will not preserve our market share.

Modify evaluation and decision-making structures related to business development projects to assure all parties that a level playing field exists.

- During the first two years, HSF will work with the SOM and the MC to:
 - Clarify that all projects are to be reviewed in a consistent manner.
 - Not waste proponents' time if necessary capital and start-up operating funds are realistically not available.
 - Recognize and accept that political risk is a common factor in all business development projects and not require the absence of political risk before a project will be undertaken.
 - Restructure the capital allocation decision-making process to incorporate leaders of all health system entities.
 - Insure that decision making for entrepreneurial activities is truly spread across the HSF, SOM and MC and that overall benefit to the Health System is considered.
 - Have decision-making processes related to risk and reward apportionment clarified to reassure everyone that they are based on the contributions and risks of all the parties necessary for the project's success.

Negotiate rates appropriate to our market position in payor contracts during upcoming contract renewal negotiations

The Health Services Foundation, School of Medicine and Medical Center will continue to emphasize alignment of their goals.

3. Five-Year Goals and Metrics for Success

Models for all of US

Work with the Quality Council to systematize care and reduce costs as important elements of quality improvement.

- Identify ways to initiate a dialogue among faculty leadership concerning how to systematize care.

- Identify and implement change mechanisms based on the ideas generated in the dialogue with providers.

Adjust operations to succeed in an environment of increased consumer responsibility

- Achieve a patient payor-mix capable of supporting (a) the costs of patients unable to pay, and (b) the costs incurred to fulfill our other missions.
- Demonstrate that initiatives implemented to remain competitive in the market for patients with good third party payor coverage have been successful.

Improve Operations

Implement IHIMS

Maintain market share comparable to current market share

4. Resources Needed and Barriers to Success

Threats to current revenue flows

- Loss of income from sharing of MC bottom line.
- Increased numbers of uninsured indigent patients.
- Loss of funding for indigent care.
- Legislated 25 percent cut in Medicare reimbursements to physicians.
- Medicaid reimbursement cuts by Congress.
- Slowdown in collections due to shift of payment responsibility from payors to consumers.

Increased expenses

- Increased unfunded research expenses because of decreases in research funding and/or expenditure patterns shifting unfunded research expenses to patient care funds.
- Increased bad debts due to increasing deductibles under insurance plans.
- Increased bad debts due to increasing numbers of uninsured and underinsured.
- Increased bad debts due to shifts of uninsured and underinsured from other providers.
- Costs to design, implement, and operate front-end infrastructure needed to handle information demands of consumer-driven health plans.
- Costs to create differentiated service levels to retain patients with good third party payor coverage.

- Increased physician compensation to retain faculty in the face of an increasing shortage of physicians and hiring competition from physician groups that have sources of technical and facility fee revenue.
- Increased costs associated with resident work-hour limitations.
- Higher malpractice insurance premiums.
- Shortage of physicians will lead to greater demand, resulting in higher salary costs,
- Increased costs to appropriately fund HSF's defined benefit retirement plan.

Challenges

- Physical capacity below that required to meet current profitable demand.
- A capital plan that probably constrains infrastructure investment (i.e., beds, ORs, ambulatory facilities, equipment) to levels below that needed to preserve current market share over the long run.
- Weak front-end business functions and infrastructure in ambulatory operations.
- Performance measurement metrics (e.g., tying an evaluation of good performance to an arbitrary bottom line percentage – like 5 percent) that may result in decisions that undercut the long term preservation of market share or delay investments needed to deal with a rapidly evolving environment.
- Limited/no monitoring of quality information from outside sources about our operations.
- Little/no payor-mix management experience and capabilities.
- Need for truly joint decision-making on major initiatives, whether capital or operational.
- Need for improved analysis of entrepreneurial projects in terms of the effect they will have on other regional providers.

MARKET STRATEGY

1. Notable Accomplishments

The Market Development Committee was established to evaluate and enhance the Health System's strategy for development of its clinical market, oversee the comprehensive assessment of various patient care markets, and advise the Vice Presidents with regard to specific strategies for enhancing or growing market share.

The initial committee accomplished the following:

- Established guiding principles for new business.
- Completed primary care market analysis.
- Evaluated executive health offerings.
- Developed a program analysis approach.
- Outlined an outreach proposal.
- Reviewed and made recommendations on multiple clinical proposals.

After the initial strategic work, the committee was reconstituted in October 2005 to be more operational as well as strategic. The committee name changed along with leadership and membership. The Market Strategy Committee was charged with defining market development guiding principles, evaluating market assessments, and making strategic recommendations regarding how the University of Virginia Health System can proactively develop market opportunities to enhance, grow, and defend market share.

The Market Strategy Committee has accomplished the following:

- Completed a market evaluation across the Commonwealth that will be updated and reported annually.
- Established a "white paper" that frames a collaborative system-wide approach for clinical service offerings off Grounds.
- Evaluated key outreach principles developed by the University HealthSystem Consortium.
- Identified market strategy guiding principles.
- Established a two-step review process for market enhancement proposals that is tightly aligned with other internal review processes (e.g. Buchanan grant proposal process) and assured a timely process, including a letter of intent and business planning components.

The following is planned for accomplishment before June 2006:

- Implementation of the review process.
- Establish an administrative team for business planning.
- Draft a standard contract agreement that addresses guiding principles.
- Review of market assessments to identify refinements prior to annual update.
- Begin to assess current “off Grounds” initiatives alignment to developed guiding principles and define performance metrics for ongoing evaluation.
- Establish committee market strategy recommendations by critical markets beginning with Culpeper and Augusta, Virginia.

2. Two-Year Goals and Metrics for Success

• **Models for all of US**

There is evidence through the University HealthSystem Consortium that other academic medical centers are challenged in their efforts to integrate and develop effective methods for strategic, market development. The committee structure, market analysis, and review process to grow and defend the Health System’s market position is believed to be a model for others to emulate.

• **Improve rankings**

To the degree that what we do serves as a model for all of US, there may be an opportunity to influence reputational scores; as programs grow and differentiate, the assessment by practicing physicians, deans, and others may also improve rankings.

Performance metrics include:

- UHC or AAMC request of an overview of our process to be shared with their respective memberships.
- At least one other health care system seeks to emulate our process each year.

• **Improve our operations**

Operations will be improved from three key venues. First, providing a consistent approach and execution of clinical efforts off Grounds will establish a brand experience for those with whom we work. Second, the Health System will improve its ability to move as one versus being “one off” by our competitors. And, third, the ability to leverage our strengths and empower our ability to grow and defend our market position will be realized.

Performance metrics include:

- Primary benefit is that market share will be maintained or improve across the service areas across the Commonwealth. The baseline for market share is FY04.
- Secondary benefit will be that as our process is recognized as a model for all of US, there may be influence on reputation scores.

3. Five-Year Goals and Metrics for Success

- **Models for all of US**

We have built the foundation of a collaborative model that should be efficient and facile providing appropriate review and support. UVa Health System's market position will be understood, grown, and defended effectively.

- **Improve rankings**

To the degree that what we do serves as a model for all of US, there may be an opportunity to influence reputational scores; as programs grow and differentiate, the assessment by practicing physicians, Deans, and others may also improve rankings.

- **Improve our operations**

The UVa Health System market position and strategies will align effectively with the organization's mission and vision.

Performance metrics include:

- Market share across the Commonwealth will be maintained or improve annually.
- Out-of-state referrals may increase as clinically differentiated services attract a patient population beyond the Commonwealth.

4. Resources Needed and Barriers to Success

- **Right sizing:** As the Committee seeks to grow or defend the Health System's market position; capacity challenges include but are not limited to the number of active clinicians, the capacity of facilities (inpatient and outpatient) and the demand for our clinical services.
- **Return on investment:** Defining performance metrics for "off Grounds" initiatives will be both quantitative and qualitative. Integrating these into current initiatives and new efforts going forward will need to be disciplined and accountable.
- **Culture:** Cultivating the organizational culture of working collaboratively together versus independently will require consistent reinforcement. This is a transition internally and, based on previous history, will be tested by outside forces as well.
- **Committee performance metric:** Enhanced market position is monitored through discharge volumes to calculate market share. There is no outpatient measure to benchmark for outpatient services. Therefore, inpatient volume must serve as a proxy for market share position. This is not ideal as clinical services move to the outpatient arena.
- **Staff support:** The Health System and its components will need to deploy staff resources to support the evaluation, recommendation and implementation of market strategies.
- **Funding:** Anticipating there are a variety of methods to support off grounds initiatives, the Committee may make recommendations for consistency and equity as well as additional financial support potentially.

BUCHANAN ENDOWMENT AWARDS FOR CLINICAL ROGRAMS

1. Notable Accomplishments:

The Buchanan Endowment Awards for Clinical Programs began in late 2002 for funding cycle beginning in FY03. The Clinical Programs Committee began in 2004 for a funding cycle beginning in FY04. The Clinical Programs Committee existed for one year and then the decision was made to incorporate the process into the Buchanan Endowments Awards for Clinical Programs. A total of \$5 million per year, funded partially by the Buchanan Endowment and partially by Medical Center operating dollars, provide startup of funding for innovative, market-differentiated clinical programs.

- The Medical Center has provided \$10,607,194 to programs in the last four cycles.
- The Buchanan Committee has developed a more robust process for the reviews. This process includes a standard template for submission of materials and significant support from operations, marketing and finance in the development and analysis of business plans. Teams of physicians, nurses and administrative staff work together to develop business plans which meet the funding criteria of the Buchanan Program.

Since they were established, the following grants have been awarded:

FY04	
Advancement of Clinical Trials for Improving Outcomes in NeuroOncology	\$ 1,216,719
Surgical Minimal Approach with Robot Technology	\$ 1,210,500
Virginia Childhood Obesity Program	\$ 957,075
Hand Center Expansion	\$ 425,865
FY05	
Atrial Fibrillation Center	\$ 970,417
COPD: A Comprehensive Patient Centric Program	\$ 977,575
Tomoblade: Whole Body Stereotactic Radiosurgery	\$ 911,000
Human Islet Cell Transplantation Program: Pilot	\$ 1,421,458
FY06	
Neurological Sleep Laboratory	\$ 147,295
FY07	
Pediatric Sleep Disorders Program	\$ 285,375
Stroke Program Expansion	\$ 365,291
Physician Scientist Recruitment Optimizing Advancement of Clinical Trials for Improving Outcomes in Neuro-Oncology (PRO-ACTION)	\$ 397,950
Delivering Premium Vascular Care to the Community	\$ 795,862
Female Pelvic Medicine	\$ 524,812
Total Funding for Buchanan Endowment Grants	\$10,607,194

2. Two-Year Goals and Metrics for Success

Models for all of US

- Increase the quality of Stage I Letters of Intent and Stage II Business Plans submitted to the Buchanan Committee.
 - Increase in the percentage of proposals moving from Stage I to Stage II to 60 percent.
 - Increase in the percentage of proposals receiving funding to at least 50 percent or a total of \$5 million.
 - Percentage of proposals meeting the financial, volume and market share goals after three years initial funding period is above 50 percent.

Improve rankings

- Enhance the visibility of the clinically differentiated programs sponsored by Buchanan.
 - Increase in the program's statewide market share and penetration in primary, secondary and tertiary markets as determined by each individual program.
 - Increase in the program's media exposure as measured by Public Relations.
- Leverage the relationship between translational research and clinical care.
 - Track the number of grants related to areas funded by Buchanan.

Improve operations

- Increase in the availability of faculty members to provide clinically differentiated care.
 - Track the number new faculty supported by Buchanan Funding.

3. Five-Year Goals and Metrics for Success

Models for all of US

- Increase the quality of Stage I Letters of Intent and Stage II Business Plans submitted to the Buchanan Committee.
 - Increase in the percentage of proposals moving from Stage I to Stage II to 70 percent.
 - Increase in the percentage of proposals receiving funding to at least 60 percent or a total of \$5 million.
 - Percentage of proposals meeting the financial, volume and market share goals after three years initial funding period is above 60 percent.

Improve rankings

- Enhance the visibility of the clinically differentiated programs sponsored by Buchanan.
 - Increase in the program's statewide market share and penetration in primary, secondary and tertiary markets as determined by each individual program.
 - Increase in the program's media exposure as measured by Public Relations.
- Leverage the relationship between translational research and clinical care.

- Increase the number of grants related to areas funded by Buchanan by 10 percent over the first two years of the measurement period.

Improve operations

- Increase in the availability of faculty members to provide clinically differentiated care.
- Increase the number the number new faculty supported by Buchanan funding by 10 percent over the first two years of the measurement period.

4. Resources Needed and Barriers to Success

Resources

If we are successful in improving the quality of the Letters of Intent, a greater number of business plans will need to be written and analyzed. Currently the Medical Center staff supporting these services is limited and would need to be increased to meet a greater demand and to monitor the operations of the various initiatives.

Barriers

The current process favors programs that can be operational in the short period of time and achieve operational and financial requirements within a three-year time frame. We continue to look for additional measures of success. The greatest constraint of the Buchanan process is the number of truly clinically differentiating ideas.

MEDICAL EDUCATION

1. Notable accomplishments:

Undergraduate Medical Education (UME)

- Developed and implemented the new “Cells to Society” curriculum with integration of basic science and clinical courses centered on the patient. Three national models have already been developed: 1. The first 3 days of medical school classes (the Cells to Society Introduction) covers one disease, diabetes, in its entirety --taking a student from basic science small group discussions to visiting laboratories, interviewing patients and learning about the societal effects of obesity; 2. Teaching and assessment of Clinical Skills: the Clerkship Clinical Skills Education Program (CCSEP) is a grant supported model program designed to enhance basic clinical skill performance. The program has three goals: the development of clinical skills teaching workshops (30 different skills workshops developed to date); a clinical skills assessment program using standardized and real patients; simulation techniques in objective structured skills assessment exercises (23 exercises developed thus far); and the development of a clinical skills education website (<http://www.med-ed.virginia.edu/courses/clinskills/>). 3. DxRx U.S. Healthcare is a course that presents an overview of healthcare systems, financing, ethics, and medical office practice for fourth year students.
- Students receive training in information management and critical thinking in all years. Teaching focuses on finding, evaluating and using quality information; the training is problem-based and context specific.
- The Center for Humanism in Medicine was created to nurture humanism in medicine to evaluate the outcomes and effectiveness of a humanism focus on the curriculum and to evaluate the impact of the center upon faculty by defining and measuring areas for improvement, e.g., reducing burnout, improved physician-patient relationship. A director of professionalism education was appointed to develop the Professionalism/Humanism program, along with the Center for Humanism in Medicine. The Becoming-a-Clinician ceremony implemented in 2005 for students starting their clinical clerkships focuses on the central roles of humanism and professionalism in the care of patients.
- The Center for Biomedical Ethics has the mission of advancing education, research, and service concerning moral values in health care, including clinical ethics, the ethics of research involving human subjects, ethics and genetics, health care organization ethics, and the history of bioethics. The Center has established a program in Ethics and Policy in Healthcare Systems to conduct research on ethics, policy, and healthcare relating to issues with the “system” such as pharmaceutical companies or the ethics of methods of distribution of vaccine in time of national emergency.
- Between 2002-2005, the average medical student GPA went from 3.66 to 3.74, and the average Medical College Admission Test score from 10.56 to 10.74. The number of under-represented minority students went from the lowest quartile among schools in the country to the top quartile.
- Students with documented financial need are now fully supported through a combination of scholarships and loans.

- The Claude Moore Medical Education Building is on schedule for occupancy in 2010.
- The SOM will consider a 10-15% increase in the medical school class size after the Medical Education Building opens in 2010.
- The highly acclaimed Academy of Distinguished Educators (ADE) was established to identify and reward teaching efforts and to assist in medical education and medical education research.
- High profile teaching awards have been created, including the David C Harrison Distinguished Educator Award, the Robert J. Kadner Award for Outstanding Graduate Teaching, master teacher awards, the Dean's teaching awards, the Faculty Excellence in Humanism Award and student teaching awards for faculty.
- Proposals for medical education research by ADE have been funded at \$100,000/year. We have also established an annual ADE Medical Education Research Poster Session. Examples of funded proposals include John A. Owen, Ph.D., et al.'s "Assessment of predictors of participation in rural practice" focusing on medical students, and Patrick J. Brown, M.D., et al.'s "Measuring resident performance in the NICU," a multi-center study of resident learning.
- A Master of Public Health program was established.
- Students now have access to joint degrees (e.g., M.D./Ph.D., M.D./MPH).

Graduate Medical Education (GME)

- The RAFT (Resident and Fellow Tracking) system is fully operational. Initial results show duty hours compliance is good and programs are using the competency evaluation format. Both the General Surgery and Neurosurgery programs have used weekly RAFT data to document compliance with their 10% exception agreements. Anesthesiology and Family Medicine are using the competency evaluation system in very creative ways.
- Enhancements of benefits and quality of work life issues for residents have been addressed with popular changes to health insurance, meals, and parking.
- A GME innovation grant program to support medical research education was created. Multiple projects have been funded and have highly successful outcomes including Dr. Jeff Young's study of how residents learn to make decisions in acute or emergency situations such as trauma and critical care. Dr. Steve Borowitz is studying the "handoff" process of information exchange between residents at end of duty time.

Continuing Medical Education (CME)

- Programmatic volumes increased 10% from 207 to 227 sponsored activities a year from FY04 - FY05.
- Broadcast technologies have been used to increase international visibility and include programs broadcast to physicians in the Middle East and Europe. National awards have been won by UVa CME and CardioVillage.
 - 2005 EHealthcare Strategy and Trends awarded:

- Gold Award for Best Special Effects (Physician/Clinician Focused site)
- Silver Award for Best Special Effects (Physician/Clinician Focused site)
- A new fee structure was implemented to strengthen the financial viability of the Office of CME.
- UVa is the CME provider for Elsevier Publishing's renowned "Clinics of North America" and its new "e-Dition" CME series.
- UVa will begin serving as the Discovery Health Channel's CME sponsor in FY07.

Goals Planned But Not Implemented.

- Design and implementation of pay-for-teaching model. Substantial preliminary work has been done, but consensus has not yet been reached on the model. The goal is to complete development and implementation.
- Design and implementation of a UME course to focus on the basic science, clinical and population based impact of the major diseases of our time. The course will be offered for the first time when the current first year class completes the core clerkships in 2008. Implementation is dependent on changes in the basic science and clerkship schedules that will be completed in the spring 2007. A course director has been selected and planning has begun.
- Information management and critical thinking - integrated across the spectrum of UME, GME, and CME. Elements of the program have been implemented, but additional basic medical education research is needed to develop a truly integrated plan (see below).
- Development of a medical education research core. To date, medical education research has been funded through the ADE, but there have not been sufficient funds to develop a medical education research core and undergraduate student database. As outlined below, an endowed Medical Education Research Institute is now proposed.

2. Two-Year Goals and Metrics for Success

Models for all of US

- Establish a Medical Education Research Institute (MERI) for basic research on medical education, development and application of personalized learning and teaching models specific to the education of physicians across the spectrum of medical education. Medical education is a varying mixture of traditional classroom activities, professional apprentice learning and case study methodology in an environment increasingly based on adult learning principles. The SOM has the opportunity and the commitment to focus considerable scholarly attention in this effort and consequently to make a major contribution to the field. (How do we learn? How should we teach?)
 - We will study students, residents, and physicians to determine how they learn most effectively.
 - Then, programs will be developed to integrate and align competency-based learning across the entire spectrum of medical education and practice (UME, GME, CME).

- How to instill and assess the concepts and ideals of professionalism, humanism, leadership, collaboration and teamwork into the education environment as early as possible.
- How to teach more effectively in group settings using the TEAL (technology enhanced active learning) spaces in the new Medical Education Building.
- How to use telemedicine increasingly as an educational technology.
- In collaboration with the Curry School,
 - A Certificate in Education program will be developed to equip medical residents with the skills needed to conduct effective research in medical education.
 - A Master of Education in Educational Research will be developed for faculty.
- Continue to introduce new planned innovations in the Cells to Society undergraduate curriculum.
 - Basic Science for Careers to be implemented in 2008.
 - Full implementation of Clinical Skills Education and Evaluation Program for UME and extension to selected areas of GME.
 - Expanded offerings in information mastery.
- Center for Global Health and SOM Curriculum Committee will develop international health curriculum and training sites.
- Expanded teaching of cultural competency, medical economic, business, legal, and cultural factors involved in healthcare delivery.
- Develop inter-professional opportunities with the School of Nursing.
 - Develop thematic seminars (e.g., ethics, professional behavior, team building) and cooperative simulation training programs that enhance the performance of the health care team and improve patient care.
- Pursue combined MD/MBA with Darden.
- Enhance the GME curriculum.
 - GME Certificate program - introductory policy course offered July 2006, three specialty courses offered J-term January 2007, remaining by July 2007.
 - Teach Residents to Teach – Academy of Distinguished Educators Resident as Teacher committee to train residents as teacher, enhanced orientation (June 2006) and web-based tutorials.
 - Develop Learning Portfolio software for a set of Pilot Programs.

Improve rankings

- Receive full LCME re-accreditation.
- Receive full accreditation of Institutional Standards from ACGME.
- Initiate Pay-for-Teaching Program to compensate faculty for teaching time.
- Improve recruitment of best and brightest applicants to the SOM and residency programs. The Admissions Office hosts “A Day at the Medical Center,” inviting pre-medical students and advisors from Virginia colleges and universities to learn about the SOM. The Associate Dean for Admissions visits college campuses speaking personally with pre-medical students about the UVA SOM, admissions requirements and process, and dual degree programs. The Admissions website provides details about the SOM, including a video tour of the SOM.
- Increase endowment for need-based and merit scholarships by initiating efforts toward \$10 million capital campaign scholarship goal.
- Complete architectural plan for Claude Moore Medical Education Building.
- Complete new learning center and 24/7 study space in the Claude Moore Health Systems Library.
- Continue participation in high visibility CME activities.
 - Publish high visibility medical education research related to UME, GME, and CME– how medical students, residents and physicians learn.

Improve operations

- Complete implementation of UME electronic scheduling and evaluation system.
- Create comprehensive student and resident databases for research.
- Reorganize GME office and move to new space.
- Greater than 80 percent of reviewed GME programs obtain full cycle accreditation.
- Incorporate additional quality measures in CME programs.

3. 5-year goals and Metrics for Success

Models for all of US

- Complete implementation of Cells to Society and assessment of the curriculum.
- Five GME certificate programs in operation (Public Health, Health Administration, Law and Ethics, Clinical Research, and Medical Education.) With work with Darden, the School of Law, and the Curry School to develop degree options and programs for our residents.

Improve rankings

- Open the Claude Moore Medical Education Building.

- Endow professorships (at least 10) for partial support of medical educators.
- Improve GME reputation and visibility; e.g., publish 2 papers per year on GME research in major education and/or medical journals.
- Achieve success in obtaining a major medical education grant.
- Continue CME participation in high visibility activities such as the Discovery Health Channel and other print and electronic media through Elsevier Publishing.

Improve operations

- Full implementation and coordination of the educational precinct including the new medical education building, the new learning center and new study space in the Claude Moore Health Sciences Library, and the new simulation center.
- All GME programs on full cycle accreditation.
- Incorporate additional quality measures in planning for CME programs.

4. Resources Needed and Barriers to Success

- SOM support (financial and logistical) for medical educational programs and faculty including a pay-for-teaching model to compensate for faculty teaching time/efforts, cost-of-living increases in the education and student services budgets, and centralized office space for the Office of Medical Education Support. If a pay-for-teaching program is not implemented by 2007, \$75,000/year in additional funds will be needed for the Basic Science for Careers course.
- Funding for Medical Education Research Institute (\$10 million for positions funded, endowment, generation of grant proposals, operations, etc) and endowed support of ADE (\$5 million).
- Maintenance of adequate extramural teaching sites for clinical education in light of changing accreditation standards, economic factors, etc.
- Faculty development programs to teach in new ways.
- Space for simulation and clinical skills training and assessment before the Claude Moore building opens.
- Negative ACGME survey of Institutional Standards.
- Support for GME program directors, job descriptions, and standards.
- For CME, labor intensive challenges of adherence to ACCME Commercial Support and Conflict of Interest/Disclosure Standards.
- Meeting challenges in contract generation and indirect cost recovery rates that have the potential to adversely affect CME ability to compete in the market.

SCHOOL OF NURSING - EDUCATION

1. Notable Accomplishments

- **Implementation of the Clinical Nurse Leader Program**
 - The University of Virginia School of Nursing responded in 2003 to a call from the American Association of Colleges of Nursing to pilot a Clinical Nurse Leader (CNL) program. Nationally, 88 schools of nursing are partnering with 186 health care institutions to develop and implement the academic programs and CNL role. UVA is among 25 percent of participating schools that elected to offer the CNL program via a second degree to MSN (CNL) mechanism. Our CNL program is an accelerated 24 month full-time graduate course of study that intends to prepare nurses for clinical practice and leadership at the point of care.
 - Twenty-two students entered the program during the fall semester 2005, 2 less than the goal of 24 students.
 - 115 applications for the 27 spots in the entering class for fall 2006.
- **Broke ground on the Claude Moore Nursing Education Building**

2. Two-Year Goals and Metrics for Success

- **Create a third year transfer entry point.**
 - The faculty organization voted in February 2006 to create a new entry point into the third-year class. This would allow a cohort of students to enter the traditional program in the summer session, once they have to have completed prerequisites (an anatomy and physiology course and a growth and development course) along with all the general education electives and requirements.
 - By offering the former second degree fundamentals course (NUCO 304) and the existing client assessment course (NUCO 323) in the summer, this cohort of 12-16 could enter in fall 2006 and complete the program by spring 2008. This increases our third year class by 16. We anticipate the program will be very attractive to students studying pre-nursing at Piedmont Virginia Community College as well as our many internal and external transfer applicants.
- **Increase collaborative educational ventures with the SOM.**
- **Increase collaborative opportunities in international, global health, informatics and simulation areas.**

3. Five-Year Goals and Metrics for Success

- **Establish a Doctorate in Nursing Practice degree**

In late 2004, the members of the American Association of Colleges of Nursing (AACN) endorsed the Position Statement on the Practice Doctorate in Nursing. AACN member institutions voted to move the current level of preparation necessary for advanced nursing practice from the master's degree to the doctorate level by the year 2015.

- The University of Virginia School of Nursing has explored the options through an active task force, which proposed a curriculum for the DNP degree at UVA. In early March, 2006 the Faculty Organization voted to accept the proposed curriculum. The next steps are to take the proposal for approval by the Faculty Senate, the Board of Visitors, and the State Council on Higher Education in Virginia.
- **Offer a Psychiatric Mental Health Masters Online**
 - Our psychiatric mental health nursing faculty responded to a HRSA call by submitting a proposal for increasing our offerings of distance learning courses in this specialty area. The program would capitalize on the use of existing technologies for course management as well as garner resources for additional technologies for teaching students at a distance.
 - With experience and skill from current distant learning offerings in Community and Public Health Leadership, Health Systems Management and Gerontology, we anticipate this will be a very popular choice for those pursuing a masters in psychiatric mental health nursing.

4. Resources Needed and Barriers to Success

- Additional space needed.
- Challenges in finding clinical sites continue.
- Challenges in recruiting and retaining preceptors and faculty.
- Challenges in implementing educator clinician role.
- Opportunities for interdisciplinary collaboration in simulation.

THE CLAUDE MOORE HEALTH SCIENCES LIBRARY

1. Notable Accomplishments

Providing quality services to our users

- The Library is an institutional advocate for scholarly knowledge. Through its services and facilities, it has a critical role in the creation of knowledge, the learning of new and past knowledge, and the dissemination and access to knowledge. The Library is recognized by its user community for its strong service ethic and its commitment to a “high tech, high touch” approach.
- The Library continues to provide excellent services, based on user assessments. The Library director’s five-year review, which included a Library review, provided an overwhelmingly positive assessment of the Library staff and the various resources and services provided. This was also borne out by the Association of Resource Library (ARL) LibQual Survey in 2004. A survey of students as part of the LCME self-study and a University Library Student Survey yielded positive ratings on the part of the student community. Satisfaction scores from medical students on library quality factors (accessibility, overall quality and adequacy of computers and web-learning) generally exceeded 90 percent. In the 2005 AAMC Graduation Questionnaire, 84 percent of students responded they were either “very satisfied” or “satisfied” with Library services.

Personalized services

- Departmental Liaisons– the Library has developed a liaison program where library staff proactively contact departments, particularly hospital-based departments, to provide targeted teaching.
- Improved Communications – in recognition of the time constraints of health professionals, the Library redesigned its newsletter to be electronic with short news bites and links to fuller information.

Digital library

- The Electronic Library – electronic resources provide the most effective access to information for clinicians and researchers. To that end, the Library has focused its collection emphasis on increasing access to electronic journals, books and databases. The Library currently has over 2,000 electronic journals, an increase of 66 percent since 2003. To provide additional depth, older electronic “backfiles” are purchased when available.
- “The Carmichael Collection” – a website containing the digitized letters of patients in the early 1800s written to two country physicians in the Fredericksburg area, which provide a unique view of medical and social history of the time.
- The Library’s main web page, the virtual front door of the Library, has been enhanced and redesigned to improve access to the most frequently used resources. Customized portals for students, clinicians, researchers and nurses, have been developed. Subject portals on key topics such as patient safety, patient education and public health have been developed.

Educational initiatives

- Medical students receive instruction in information skills in all 4 years of the curriculum. Teaching is context-specific and focused on information to solve an educational or clinical problem. For example, in POM1 students are required to use specific information resources to answer a clinical question and to critique the resources on their strengths and weakness.
- Library faculty worked with clinical faculty on the Information Management and Critical Teaching task force to develop a strategy for incorporating information management skills training in undergraduate, graduate, and continuing medical education. In POM2, for example, students are required to find patient-specific information and reconcile inconsistent or missing data. This requires synthesizing data from many resources such as the hospital record, clinic notes and knowledge-based resources. Approximately 77 percent of students thought that this helped them learn how to assimilate data from multiple sources to provide better patient care.
- Library faculty taught 5 classes focusing on information management and evidenced-based resources for the new Masters in Public Health program.
- Two successful media “bootcamps” for teaching faculty how to successfully develop and use multi-media content in teaching were held.

Partnerships

- The Library has worked with clinicians and educators to incorporate quality information resources in major Health System initiatives such as Patient Safety, Patient and Family Education, Public Health Sciences/MPH, and Complementary and Integrative Medicine.

Outreach

- Major projects emphasizing access and use of quality health information for consumers, including the JABA Senior Center MedlinePlus project and the Parish Nurse training, were completed. The Mountain Laurel Cancer Resource Center public library collaboration and the Alzheimer’s Caregivers project were launched and completed in Southwest Virginia. In all of these projects, the goal is to increase the knowledge and expertise of community members and health professionals in the availability and use of quality consumer health information resources such as the National Library of Medicine’s MedlinePlus

2. Two-Year-Goals and Metrics for Success

Models for all of US

- The Persona Project – development of archetypal user models that will be used to develop personalized information delivery systems for medical students as well as educational modules based on preferred learning styles. We will be a model in curriculum applied to each medical student learning in their own style.
- Decision Reminder System – analyze the educational impact of an online decision reminder system on medical student learning in a clinical clerkship.
- Enhanced access to important topics in biomedical ethics and humanities through the preservation and technological enhancement of the UVa Medical Center Hour series.

Operational goals

- Renovation of the Library to expand the small group teaching rooms and the 24 hour study area
- Develop a space and collection analysis that identifies collection space needs for the year 2010; identify remaining space in the current facility and possible learning programs that can be supported; identify offsite storage needs that will be required to house print collections.
- Participate in the ARL LibQual 2006 survey on user satisfaction.
- Work with Information Technology & Communication to improve remote access options, particularly for medical students at remote teaching hospitals.
- Work with the University Libraries to implement a “multisearch” platform that will search multiple databases simultaneously to enhance interdisciplinary research.
- Enhanced access to institutional digital archives—systematically digitize and web-enable past issues of the *Medical Alumni News*, the *Drawsheet*, *Helix*, and *Link*.

3. Five-Year-Goals and Metrics for Success

Models for all of US

- Build a Knowledge Enhanced Clinical Information System – in collaboration with clinicians and medical educators, develop educational and clinical knowledge modules that link contextually with the Medical Center’s clinical information system so that students, residents and clinical staff have access to quality teaching and clinical information. A “proof of concept” for pediatrics will be developed for testing. For example, students in the pediatric clinic could access short, web-based tutorials on examining patients with otitis media and the most up-to-date drug therapy protocol.
- Public Health Informatics – in collaboration with Department of Public Health Sciences faculty, develop an educational program that supports graduate level training and experience in public health informatics, including a joint MPH/MLS experience.

Operational goals

- Plan and develop a new space plan for the library that encompasses the vision of a “knowledge and learning commons” precinct so that the Library’s traditional missions are supported as well as providing a facility for enhanced learning.
- Work with the University Libraries to implement innovative search technologies that will improve access to the collections and digital materials available at the University. The Health Sciences Library will remain agile to see independent solutions to needs when necessary.
- Explore options and identify strategies to achieve efficiencies in material processing internally.

4. Resources Needed and Barriers to Success

- Agreement and commitment from Health System leadership and Health System Computing Services on this as a primary goal; technical infrastructure from GE/Intermountain must be developed and in place; an organizational infrastructure within the Health System must be in place to identify knowledge opportunities and to develop or identify content; 2-3 FTE technical support; organizational (people and process) infrastructure for sustainability.
- University Libraries technical leadership and resource commitment with Claude Moore Health Sciences Library as a content specialist for health sciences; the technology proves to provide significant improvements at an affordable price.
- Development of further public health informatics expertise within the Library; develop and field test a public health informatics course for public health professionals; ongoing accreditation of the Masters in Public Health program; ability to secure funding for joint MPH/MLS degree support.

RESEARCH INFRASTRUCTURE, PROGRAMS AND FACULTY

1. Notable Accomplishments

- A major issue addressed in the Research Subcommittee of the Decade Plan in 2003 was enhancing the support for research infrastructure and administration. In the ensuing four years, several key positions have been filled:
 - Assistant Dean for Research, who serves as Director of the Office for Research and administrator of the Research Advisory Committee (RAC, see below), oversees activities such as the summer research program for medical students (MSSRP), faculty nominations for fellowships and awards, and conflict-of-interest matters. The Assistant Dean works closely with the Directors of Space Management and of the Office of Grants and Contracts Administration in the School of Medicine.
 - Associate Dean for Basic Research, who enhances the resources and support for laboratory-based research. The Associate Dean works closely with the Director of Space Management to address space needs and inequities.
 - Director of Space Management, who represents the dean's office and SOM in renovation and construction projects for the SOM and "manages" the allocation and evaluation of use of current research space.
 - Associate Dean for Clinical Research, who enhances and accelerates development of clinical research in the SOM.
 - Director of the Office of Grants and Contracts.
- A School of Medicine Research Advisory Committee (RAC), consisting of faculty leaders in both basic and clinical research, has been formed and functions to advise the dean on faculty retention, evaluation and establishment of priorities for resource allocation and development of new policies and procedures. The RAC reviews the performance of the various cores and programs, and provides input to the dean's office with regard to appropriate funding of these facilities.
 - A space management program developed by the RAC generates data on research funding per square foot, on a yearly and three-year rolling average basis. A target of \$300/sq ft total costs has been set as the minimum for acceptable space utilization by each department or center for each year. Departments with greater than \$600/sq ft are given priority for new space requests. After data collection began in 2003, the policy was implemented in 2006, to ensure that no departments were below this minimum threshold. Through lending, rental, and reassignment of space, no departments will be under target space usage by December 2006.
 - Improved and reorganized Web sites for Office of Grants and Contracts Administration and Office for Research have been developed. These provide new and better-organized information for investigators on UVa and SOM policies, internal and external funding opportunities, compliance, negotiating university administrative offices, etc.
 - Implementation of a translational research training program: The Coulter Foundation Translational Research Partnership is a 5-year program designed to fund and bring

to market promising translational projects. The Foundation provides expert advice to this program working in collaboration with the UVa Patent Foundation and SOM investigators.

- Mechanisms for more rapid implementation of research technologies: A new position has been created in conjunction with the Coulter Foundation Translational Research Partnership to serve as a liaison to departments for the purpose of increasing awareness of intellectual property (IP) issues, identifying projects with the potential to yield IP, and facilitating the development of technology. The individual in this position will also serve as the Coulter Project Manager, working with the teams selected for funding from the Coulter Award.
- The administration of the SOM research core facilities has been centralized with a full-time administrator hired in 2005. An on-line ordering system is in place.
- Insufficient progress has been made toward the goal of increasing assistance to investigators for compliance. A Research Program Manager position is being created to assist faculty in improving their portfolios and the institution in obtaining multi-disciplinary grants.

2. Two-Year Goals and Metrics for Success

Models for all of US

- Create a unified research Web portal, encompassing the separate sites for the Research, Grants and Contracts, and Clinical Trials Offices.
- Develop a stable funding mechanism and policies and procedures for interim funding support for faculty.
- Enhance mentoring/training of junior faculty, especially for clinical research.
- Implement best practices to assist with successful grant applications.
- Develop critical strategies for integrating the research activities of the basic science and clinical departments and incorporating the roles of Centers into building a cohesive, interdisciplinary translational research program.

Goals to improve rankings

- Increase the number of NIH grant submissions by 20 percent (in 2008 compared with 2006).
- Target development of research infrastructure to compete for R&D funding, by identifying specific contracts in areas where we have strengths and targeting development in these programs to specifically address the requirements of the contracts. Potential areas might include biodefense or cancer vaccines.
- Hire 10 to 15 new faculty researchers with the purpose of achieving program excellence. This target represents the first 10 to 15 of the 50 new faculty hires targeted as a five-year goal. New faculty will bring an increase in NIH grant submissions and corresponding grant funding.

- Hire new faculty in the following areas: Internal Medicine, Molecular Physiology and Biological Physics, Pharmacology, Microbiology, Neuroscience, Cell Biology, and Biochemistry and Molecular Genetics.
- Develop a Center for Human Genomics.
- Successfully compete for an NIH Clinical and Translational Science Award.
- Enhance pre- and post-award grant support through improvement of the SOM research website and hiring a research project manager.

Operational goals

- Working with the Office of the Vice President for Research and Graduate Studies, develop a comprehensive listing and source of information on post-doctoral fellow benefits, fair and equitable treatment and rank of all fellows regardless of funding source; development of a council across grounds to discuss policy issues surrounding fellows.
- Complete the Carter-Harrison Building, with 102,000 net square feet to house basic research in cancer, infectious diseases, and immunology.
- Complete the ART Building, providing 18,000 net square feet for the Departments of Internal Medicine and Radiology.
- In conjunction with the VP for Research, create an environment of teamwork and support and establish the Integrated Research Initiative to streamline Human Investigation Committee, Animal Care and Use Committee, and Conflict of Interest Committee submissions and deliberations.
- Create core resources to provide support in study design/biostatistics and for the development confidential database management systems for clinical research.
- Evaluate most important common infrastructure needs of researchers for cores and facilities, including a GMP facility to support translational research initiatives, and coordinate future development, merging, and prioritization.

3. 5-Year Goals and Metrics for Success

Models for all of US

- The Virginia Institute for Clinical and Translational Research (VICTR) will be the home of clinical and translational research activities in the SOM and across the Grounds of the University. VICTR will have its home in the Ivy Foundation Translational Research Building, which will be completed by 2010. The programs of VICTR will promote and enhance interactions of SOM faculty with colleagues in Arts and Sciences, Nursing, Darden, Law and Engineering. Functions will include training in innovation and technology transfer. The infrastructure for this Institute will be developed by year 2, with the full program of in place by year 5.
- Initiate construction of a mouse facility to relieve pressure on existing vivaria associated with individual research buildings, perhaps at the UVa North Fork Research Park.

- Implement a transportation solution for researchers working at the Fontaine site.
- Develop telemedicine as an effective clinical research tool.
- Create a dean's office funding reserve for pilot projects, new investigators and bridge funding.
- The Office for Clinical Research should be fully functioning, with research cores for study design and statistics, human genomics, human proteomics, and human metabolomics.

Research Goals:

The School of Medicine has current strength in investigations of diseases and physiological systems such as cancer, endocrinology, cardiovascular, addiction, neurosciences, digestive health, and biodefense. We are also strong in basic science disciplines such as cell signaling, inflammation, morphogenesis and regenerative medicine, imaging, epigenetics, and structural biology. It is critical to foster these strengths, and enhance the environment for faculty by investments in fundamental infrastructure, school and across-Grounds facilities, and strategic recruitments. During the next five years, we will focus on overarching, multi-departmental efforts adding expertise in Personalized Medicine using the power of genetics, genomics, proteomics, bioinformatics and systems biology, and fundamental mechanisms and diseases of aging. We will develop the Virginia Institute for Clinical and Translational Research to complement our strong basic science accomplishments.

Improve rankings

- Provide research infrastructure and new programs to result in 20 percent increase in NIH funding (2011 compared with 2006).
- Continue hires of new faculty to produce 35 of the projected 50 new hires in the Decade Plan. If each new faculty hire succeeds in securing \$500,000 in yearly NIH funding, reaching the top 25 in NIH funding is attainable.
- Fund-raising for research enterprise and programs – research education (students and fellowships), fostering of young faculty, and rewarding current faculty in mid-career.

Operational goals

- Develop new Cancer Center space for clinical trials, cores for preclinical studies, and tumor and tissue collection.
- Identify funding for additional 60,000 net square feet of research space.
- Implement wireless access in all clinical research areas.
- Re-evaluate space metrics and revise, if necessary; i.e., \$300 per square foot will not likely be applicable.

4. Resources Needed and Barriers to Success

There exist both intrinsic and extrinsic barriers to accomplishing these goals. Money and space are critical elements, for example, in creating research cores for the Office for Clinical Research, development of new research facilities and mouse facility, etc.

Because federal indirect costs comprise a large portion of the SOM budget, it is critical that the level of NIH funding be either maintained or enhanced; further erosion of pay lines may jeopardize this goal. Erosion of funding is likely to decrease faculty morale. Without Development and central support for research education, fostering young faculty and rewarding mid-career faculty, our research enterprise will be eroded.

Lack of space flexibility does not allow best clustering or change in clustering of scientists to address specific problems or to form new collaborative groups without departmental barriers.

GRADUATE PROGRAMS

1. Notable Accomplishments

Prior to 2003-2004, each of our degree and non-degree granting Ph.D. graduate programs recruited students independently. However, in 2004-2005 we implemented a major reorganization of our graduate programs that has greatly simplified and improved the overall quality and attractiveness of our SOM graduate programs. The major accomplishment of the new system includes the following:

- Consolidation of more than 20 entry programs into seven umbrella Biomedical Sciences (BIMS) Graduate Programs that cross departments and schools and include Neuroscience; Cell and Developmental Biology; Biochemistry, Molecular Biology and Genetics; Molecular Medicine; Biomedical Engineering; Structural and Computation Biology and Biophysics; and Microbiology, Immunology, and Infectious Diseases. Students select a Ph.D. mentor and degree program at the end of year 01 but also continue their affiliation with their BIMS program throughout their training.
- Full institutional funding of all first-year students.
- Facilitation of the ability of physician scientists and Ph.D. faculty in clinical departments to participate in training graduate students.
- Implementation of new initiatives in recruiting under-represented minority (URM) graduate students including attendance of BIMS program directors at national URM meetings, an improved student mentoring and advisory system, and more active recruiting at selected undergraduate institutions with a large percentage of URM students.
- Development of various new joint courses and workshops taken by students across all BIMS programs including graduate Physiology and Pathology courses that promote the ability of students to understand and carry out more translational research projects.
- Since the restructuring, applications for the programs have increased 31 percent.
- Preliminary results based on entry qualifications (e.g., grade point averages, GRE scores, number of competing offers for matriculated students), and performance in courses indicate significant improvements in the overall quality of our graduate students.
- The revised system has contributed to major improvements in recruitment and retention of URM students. The minority applicant pool increased 109 percent as a result of the reorganization and other initiatives. Moreover, >20 percent of our domestic BIMS applicant pool and matriculates in 2004-5 were URM students (up from 8 and 12 percent respectively in 1998). In addition, the number of Ph.D. degrees awarded to URM students within the UVa SOM has increased dramatically in recent years from 3.6% of total SOM graduates in 1998 to 23 percent in 2005.
- Extramural training grants from the National Institutes of Health and other granting agencies increased from \$1.6 million in 2001-02 to more than \$3 million in 2004-05. This amount represents more than 28 percent of the total graduate student budget, a figure nearly twice that of many peer institutions.

- There have been major improvements to the overall quality of the M.D./Ph.D. (NIH Medical Scientist – MST) training program in the last few years. Historically our program ranked in the lower quartile of funded NIH MST programs, however during the five-year competitive renewal last year, the UVa program scored among the top third of all funded MST programs in the country.

2. Two-Year Goals and Metrics for Success

Although we have significantly improved our graduate programs in recent years and successfully implemented virtually all major recommendations of the 2002 SOM Decade Plan in this area, there are several areas that should be the focus of future efforts as outlined below.

- **Improve mechanisms to better integrate Ph.D. training and application of basic research findings to advances in clinical medicine, especially in the areas of translational research including use of mouse and other whole animal models, mammalian and human genetics, and bioinformatics.**
 - Implement new courses, workshops, and other training activities to enhance the ability of our faculty and trainees to conduct outstanding translational research. For example, workshops/courses that: a) train students to do small animal surgery and physiological assessments of blood pressure, heart rate, and other physiological parameters as well as imaging methods; b) familiarize students with animal models of disease; and c) educate students on the process by which new drugs and devices are commercialized and obtain regulatory agency approval. Outcome measures will include having students write translational research proposals for grading by faculty.
 - Develop more effective mechanisms to promote productive interactions of medical and graduate students and to build a mutual understanding of professional tracks and how basic research can be translated into advances in medical practice. Outcome measures will include evidence of development of joint research projects between graduate and medical students, and increased frequency of medical students doing an elective research year.
 - Establish a monthly "Dean's Research (Lunch) Seminar" during which speakers give a research presentation that appeals to medical, graduate and nursing students.
 - Establish a special seminar series to highlight translational research, and require that a number of key translational courses in physiology, pharmacology, and pathology be a required component of our graduate core curriculum.
- **Improve overall quality and consistency in the evaluation of faculty with respect to graduate student teaching and Ph.D. mentoring skills/effectiveness.**
- **Develop vehicles for the integration of Ph.D., medical, and nursing students, such as pairing medical and nursing student with Ph.D. students for a research year.**

- **Implement a more rigorous evaluation process of graduate teaching and mentoring and mechanisms to better recognize excellence in this area within the next two years including establishing a minimum of 5 graduate and mentoring awards.**
- **Increase our stipend to at least the 50th percentile within the next two years or to be able to compete for the best students.**
- **Streamline and improve the Ph.D. granting process.**
Although the new integrated BIMS structure is highly attractive to students and provides a very effective training format, the relationship between BIMS programs and Ph.D. degree granting mechanisms in our new system remains overly complicated, and should optimize overall training quality, efficiency, and cost effectiveness.
- **Develop a rigorous but more straight-forward mechanism that facilitates having qualified faculty in clinical departments join graduate programs.**
The outcome measure is to include a question on this issue in our annual faculty survey.
- **Recruit sufficient numbers of high quality physician scientists, and/or provide adequate protected time or infrastructural support for those we have to optimize the chance they will succeed.**
We feel that the recruitment, retention, and success of our physician-scientists is absolutely critical to enhance our ability to effectively train Ph.D. and M.D./Ph.D. students who are going to be the leading biomedical scientists of the future and who can effectively translate basic research findings into advances in clinical practice. We also need to continue initiatives to better support the success of these individuals by providing adequate protected time and outstanding mentoring by senior faculty.
- **Establish a new Ph.D. degree program in translational medicine as part of the restructuring of our NIH GCRC grant.**

3. Five-Year Goals and Metrics for Success

- Continue efforts outlined in two-year goals to improve support mechanisms for physician scientists.

SCHOOL OF NURSING - RESEARCH

1. Notable Accomplishments

- **Increased NIH research funding**
 - Increased ranking from 28th to 16th in country from FY02 to FY03; FY04 16th.
 - Third largest number of Individual National Research Student Awards (NRSA) after University of California San Francisco and Johns Hopkins.
 - 25 percent of doctoral students have NRSA's.
- **Established the Rural Health Care Research Center**

2. Two-Year Goals and Metrics for Success

- **Create new opportunities in clinical research**
 - Increase research partnerships with the School of Medicine and Health System as well as across Grounds.
 - Increase interdisciplinary research collaboration.
 - Increase NIH Funded R01 research.
 - Follow NIH Roadmap path for clinical research.
 - Increase involvement with agencies in rural areas.

3. Resources Needed and Barriers to Success

- Additional space needed.
- Responding to multiple opportunities/requests for involvement in university and health system research studies.
- A limited number of researchers and no funded time to support external agencies in developing their research/evaluation initiatives severely limit taking on additional research projects.
- A faculty with 17 tenured and 8 tenure-track limits our ability to mentor and develop new researchers.
- Many grants are ending; bad timing with the lower funding levels at NIH.

COMMUNITY SERVICE

1. Notable Accomplishments

- Community Service initiatives support a host of outreach opportunities ranging from a collaboration to provide safety net screening and care to uninsured Appalachian citizens to similar services for local uninsured citizens through the Charlottesville Free Clinic and to children of Central Virginia in conjunction with the Boys and Girls Club. Through signature programs and other opportunities the Community Service and Outreach program of the Health System has centralized programmatic functions, increased visibility, and elevated volunteerism to an important institutional mission.

Identification and development of signature programs/models for of all of US

Remote Area Medical Clinic:

- Five-year collaboration in a multi-organizational outreach effort to provide safety net screening and care serving thousands of uninsured Appalachian citizens.
 - The success of the program has increased the volumes of patients served in the Wise July event threefold.

Health Home – Habitat for Humanity house with home telehealth capabilities.

- Successes:
 - Funds now fully committed through Commonwealth of Virginia Campaign for construction of home.
 - Continuum Home Health has tested platforms.
 - UVa Center for Medical Automation engaged and provided experiential outcomes data to support project.

Other activities:

- Database:
 - Developed simple database to capture information for Health System Community Outreach and Service activities in 2004.
 - Working with United Way, national designated volunteer center, to test Points of Lights Foundation software to track volunteer data.
 - Selection of web-based software product for community benefits reporting, and communication to internal/external constituencies is ongoing.
- Proposal review and partial funding of a high school science initiative, in which talented local high school students from underrepresented minority populations will be given the opportunity to engage in basic science research with SOM faculty mentors.
- Partnership with Office of Medical Education to help facilitate first year medical student service learning initiative in the community. All first-year medical students now spend at least 30 hours in placements with community agencies.
- Community Service Award and Recognition program is fully implemented. Nominations are solicited from internal and external constituencies and a peer review process has been established to select awardees. Institutional recognition in the form of a banquet, posters and media related announcements enhance communication of this program.
- Establishment of the UVa Medical Reserve Corps, the first one in the country based in a school of medicine, which currently has over 250 volunteers. Its structure of service-

learning, student leadership development, and interdisciplinary/agency cooperating was recognized as a model by the Surgeon General's office for other universities and health departments.

- National media attention to UVa community service activities. We have received print, radio, and television media coverage for our work with the Remote Area Medical Clinic in several outlets including *The Washington Post*, National Public Radio, and other broadcast venues.
- Community service program has presented two papers at national and regional conferences related to community outreach. The Second Annual University-Community Partnership Conference, July 13-15, 2005, Virginia Tech, poster presentation, "Audiology Services at the Remote Area Medical Health Fair in Wise, Virginia: A Case Study in Collaboration. Outreach Scholarship Conference 2005 – Transformation through Engagement," October 2-4, 2005, University of Georgia, poster presentation, "Collaborative Health Outreach Program, Providing for Unmet Health Care Needs through Community Engagement: A Case Study in Collaboration."

Outreach and service activities/accomplishments:

United Way Laurence Richardson Day of Caring: This event is a day of service when more than one thousand volunteers from local companies and organizations complete much-needed projects for area non-profit agencies and schools.

Fiscal Year	Number HS volunteers	Projects	Hours
FY03	25	8	126
FY04	133	20	664
FY05	260	28	1605
1/2 FY06	266	29	1778

Commonwealth of Virginia Campaign: An annual opportunity authorized each year by the governor of Virginia as a charitable-giving program for state employees, who have their choice of more than 1,300 charities.

Health System Employee Contributions in Dollars

Fiscal Year	TOTAL	SOM	MC
FY03	254,000	150,254	98,158
FY04	288,467	174,461	113,175
FY05	325,623	185,911	130,145
FY06	326,429	191,856	134,573

Safety net screenings: Ongoing initiatives to provide prevention, education and screening services for specific communities and populations to increase awareness, improve health and increase referrals. Example: Remote Area Medical clinic in southwestern Virginia.

Fiscal Year	Patients served	Number of projects
FY04	1134	2
FY05	1707	3
1/2 FY06	1927	1

Health outreach initiatives: Ongoing initiatives to provide prevention, health and safety education and screening services. Examples: Pediatric Fitness Clinic, HIV/AIDS screening, blood pressure checks, senior colonoscopies, bicycle helmet distribution to children, poison prevention programs.

Fiscal Year	<i>Safe Kids</i>		<i>Community based screenings</i>	
	No. Served	No. of Projects	No. Served	No. of Projects
FY04	1247	12	1120	8
FY05	4925	20	530	5
1/2 FY06	5031	19	600	4

Fiscal Year	<i>Health Outreach</i>		<i>Bodytalk</i>
	No. Served	No. of projects	No. of Requests
FY04	6625	6	1850
FY05	7975	19	1029
1/2 FY06	255	4	337

2. Two-Year Goals and Metrics for Success:

- Develop systematic approach to efficiently support and increase participation in Day of Caring (2 percent increase in participation).
- Develop systematic approach to engage more staff members as CVC volunteers, increase efficiently in campaign management, and increase participation in Commonwealth of Virginia Campaign both in numbers of donors and amount donated (2 percent increase each year).
- Develop system to track patients served by UVa Community Service and Outreach efforts in health outreach projects and safety net screenings to determine measurable outcomes and develop strategies accordingly.
- Implement reporting software to provide community benefits report data (capture 75 percent of activities).
- Increase institutional and community visibility of Community Service Award and Recognition program (5 percent increase in number of nominees per year).
- Health System Community Service Presentation at national/regional meetings (2/year).
- Complete construction of Health Home.
- Develop Health System community benefits report for dissemination to diverse constituencies such as legislators, donors, media to include the Board of Visitors and other University and community audiences.
- Additional visibility in local and major media (2/year).
- Develop instrument with Office of Medical Education to evaluate and track service learning outcomes.

3. Five-Year Goals and Metrics for Success:

- Work with United Way to grow the Lawrence E. Richardson Day of Caring program to incorporate more Health System involvement without compromising Human Resource needs (2 percent/yr).
- Increase participation in Commonwealth of Virginia Campaign both in numbers of donors and amount donated (2 percent/yr).
- Increase total numbers of patients served by UVA Community Service and Outreach efforts in health outreach projects and safety net screenings (10 percent increase per year).
- Increase institutional and community visibility of Community Service Award and Recognition program (7 percent increase in number of nominees per year).
- Using reporting software, to capture >90 percent of community service/outreach activities.
- Successful competition for grants based on programs offered seed funding by Community Service and Outreach (1 grant within next 5 years).
- Establishment of institutional endowment for competitive community service program applications. We propose an endowment of \$500,000 to facilitate seed funding of 1-3 programs per year totaling \$25,000 annually.
- In collaboration with the Office of Medical Education evaluate post graduation student outcomes in service learning.
- Increase visibility in local and major media by 25 percent.

4. Resources Needed and Barriers to Success:

- Funding for projects: The creation of an endowment for community service grants will allow the committee to evaluate and fund worthy projects aligned with the service mission of the Health System. Such funding will encourage a uniform process for all proposals but will require a reorientation for many faculty who often attempt to circumvent recognized process to secure funding for projects.
- Safety Net Screenings: Requests for participation in additional RAM-type safety net screening events across the state and for disaster relief efforts have strained institutional resources.
- Dedicated staff time: Additional fractional FTE professional staffing of safety net screenings and (as we learned in the events surrounding Hurricane Katrina) for emergency preparedness, will allow seamless clinical planning and management of post-event clinical workflow. We propose 20 percent salary support for nursing and 10 percent salary support for a physician to oversee the planning and management of post event workflow.

- Dedicated staffing: The addition of one FTE to Community Relations, Outreach and Service office to accommodate program and volume growth.

FACULTY DEVELOPMENT

1. Notable Accomplishments

- Baseline processes were developed, including an annual faculty survey, exit interview, a bi-annual needs assessment from chairs, survey of new faculty and a sampling of annual performance review.
 - Survey of basic science faculty and clinical faculty shows 89 percent and 79 percent, respectively, believe their work environment is collegial.
 - Survey of basic science and clinical faculty shows 49 percent and 57 percent believe their teaching is valued, up from 36 percent and 39 percent, respectively, since the faculty development program was started.
- A widely referenced web presence was established featuring faculty resources, the Faculty Leadership Development Program, and the Academy of Distinguished Educators.
- The Faculty Leadership Program was established.
 - The program is a developmental model reflecting stages of faculty career.
 - The program focused on faculty in their first ten years (up to the award of tenure) and midcareer faculty needs.
 - 110 sessions were held in 2005-06.
 - The program has been presented at several state and national conferences and is being viewed as a model (e.g. Stanford University recently requested an on-site consultation).
 - Modules:
 - Leadership in Academic Medicine (LAM) 2004, 2005, 2006): midcareer.
 - Pilot: inclusion of basic science faculty (2006).
 - Leadership in Humanism (2006): midcareer faculty.
 - Physician Wellness 2004-05, 2005-06.
 - Women in Medicine 2004-05, 2005-06.
 - Thriving in Academic Medicine (2003-06): first ten year faculty
 - Pilots:
 - New Faculty Series (2005-06) orients faculty to the SOM, promotion and tenure process, getting started in research, how to manage people and budgets, and other topics for academic success.
 - Deans Leadership Seminars (new chairs 2006) develops institutional leadership, foster collaboration, and build a community of trust among our departmental leaders.
 - Clinical Investigation Series (2006) helps clinical investigators develop the core skills and knowledge required to be successful.
 - Transitions and Change Seminars (2006) explores issues such as retirement, children, aging, elder care, illness, etc., and the impact on work, personal life, and balance between the two.

- Academy of Distinguished Educators: established in 2003.
The goals of the Academy are to recognize and celebrate outstanding teachers; to give credit for teaching; to sponsor research in medical education; and to establish the teaching portfolio as basis for promotion and tenure and membership in the Academy. A model to identify and pay teachers individually has been developed and will be piloted shortly.
 - Teaching portfolios were established and used in promotion and tenure, membership in the Academy, and awards. A teaching portfolio collects direct teaching activities in the classroom and in the clinic; innovations in the curriculum, course development, and online study materials; learner outcomes; learner and peer evaluations; and documents excellence.
 - An award structure was established and includes the Lifetime Achievement Award for excellence in undergraduate medical education, the Harrison Distinguished Educator Award to recognize long-time excellence in undergraduate medical education, the Master Educator Award for excellence in resident teaching, and the Robert Kadner Award for basic science teaching of undergraduate medical and graduate science students.

2. Two-Year Goals and Metrics for Success

- SOM will be recognized nationally for its faculty leadership programs.
- Develop/expand new faculty programs (recruitment through 3-year review)
 - Models for all of US
 - Submit manuscript for publication in *Academic Medicine*.
 - Word of Mouth website will offer central information about living in Charlottesville, childcare options, benefits, financial planning, and other links to help faculty find helpful information.
 - Improve rankings
 - Reputation: top 8 in public medical schools.
 - Improve operations
 - Improve retention - defined as 90% of retention efforts are success.
 - Maintain or improve faculty satisfaction (currently 79.2% of clinical faculty and 88.6% of basic science faculty say their work environment is collegial).
 - Provide flexible pathways for academic advancement.
- Mature the Transitions and Changes seminars to quarterly programs with web resources from the Health System and UVa HR offices. Provide workbooks for faculty to calculate “the number” and record support networks.
 - Models for all of US
 - AAMC presentation.
 - Descriptive (content and outcomes) articles in *Academic Medicine*, *JAMA*, *Modern Maturity* or *UVa Alumni News*.

- Improve rankings
 - Reputation: top 8 in public medical schools.
- Improve operations
 - Faculty satisfaction improved as demonstrated through exit interviews; faculty will see UVa as an option to return to.
 - Resources available to redirect to new recruits.
- Create a culture of leaders, by ongoing programming for and networking with the Leadership in Academic Medicine graduates; expansion of programs for division chiefs and medical directors (with RN leaders) with creation of a continuous onboarding for new chairs; and develop leadership seminars for mature chairs.
 - Models for all of US
 - Manuscripts for Leadership in Academic Medicine, other programs.
 - Editorial commentary for *New England Journal of Medicine*, *Journal of the American Medical Association*.
 - Develop online case syllabus and curriculum.
 - Improve rankings
 - Reputation: top 8 in public medical schools.
 - Improve operations
 - More effective leadership at institutional, center and department level as demonstrated through networking, collaboration, shared values.
- Pilot leadership program with residents and fellows (SOM and MC): Identify residents seeking careers in academic medicine for program to develop skills in leadership, collaboration, strategic decision-making, and other areas that will lead to excellence in academic medicine.
 - Models for all of US
 - Syllabus.
 - Publications and national presentations to ACGME, AAMC.
 - Improve rankings
 - UVa will be more competitive as a site for resident training.
 - Demonstrate that more of our residents are being placed in academic medical centers.
 - Demonstrate that we are recruiting from our residents and that they are prepared to step into their roles as knowledgeable, effective, productive faculty members.
 - Improve operations
 - Satisfied and effective housestaff. Specific metrics will be determined.

- Improved research and clinical collaborations, NIH funds.

3. Five-Year Goals and Metrics for Success

- Faculty will have flexible career paths, opportunities for personal and professional growth and development, and a community of trust, openness, and shared values.
- Implement the leadership pilot for residents and fellows; develop clinical and research pathways; extend to graduate students in Biomedical Sciences and post-doctoral fellows.
- Academy of Distinguished Educators will create model for students to learn research skills in medical education as part of their four-year curriculum; create database for longitudinal outcomes.
- Offer faculty development/leadership programs with the Darden, Law and Curry schools for cross-Grounds and residential seminars for national and international audiences.

4. Resources Needed and Barriers to Success

- UVa investment in expanding number of community slots for 0-2-year-old childcare.
- Support for Visiting Faculty (\$50,000/year) as presenters for the Leadership in Academic Medicine program.
- Access to leadership assessment tools: Benchmarks 360, Leadership Profile Inventory (\$40,000/year) for division leaders, medical directors and their corresponding RN leader; provide consultations with online editors.
- HSF/HR counseling services (e.g. Faculty and Employee Assistance Program, benefits counseling): faculty will need additional options, plans, services; HSF and HR will need additional staff to meet increased demand.
- Flexibility in policies to craft individual transition plans to meet faculty needs.
- Pilot leadership program for residents and fellows: \$100,000/year.

PUBLIC HEALTH

1. Notable Accomplishments

- **Creation of a new Division of Public Health Policy and Practice and Renaming the Department of Public Health Sciences (formerly Health Evaluation Sciences)**

The new division and department name reflect the creative energy in the Health System that now focuses on population health, research, education, and policy. The Department of Public Health Sciences brings a unique, interdisciplinary perspective to the management and interpretation of healthcare information. Its expanded mission is to create new approaches and technologies for the generation, interpretation, and management of basic and applied health-related data so that individuals, clinicians, communities, and public policymakers can make informed, wise, and equitable choices.

- **Establishment of the MPH Degree and Significant MPH Program Growth**

The University of Virginia Master of Public Health (MPH) degree is an interdisciplinary program designed to prepare professionals for leadership roles in health care policy and management, population-based research, and the community practice of public health. The MPH degree is offered, along with the Master of Science in Health Evaluation Sciences, by the Department of Public Health Sciences, and the two graduate programs share a number of core courses (epidemiology and biostatistics) and electives.

- Since its approval in 2003 by the Board of Visitors and the State Council of Higher Education (SCHEV), the MPH program has grown dramatically in response to student demand, with more than twice the number of students (15) enrolled during the 2005-2006 academic year than was projected. In an effort to keep the program small, we have not actively recruited students. In spite of the lack of a marketing plan, MPH applications have risen from 5 in the first year to 51 in 2006. This impressive growth demonstrates the great demand and opportunities for a public health program at UVa.
 - New MPH courses on public health topics, such as Health Disparities, bring together graduate and professional students from across the university, e.g., Architecture, Nursing, Law, and GSAS.
 - Cross-school courses have led to the development of at least one interdisciplinary public health collaborative research proposal on Youth Tobacco Use in Virginia that brings together faculty from the medical, law, nursing, and business schools.
 - MPH program accomplishments also include community service initiatives, such as hosting and providing faculty for the Virginia Public Health Association meeting in fall 2005 for public health leaders from across the state.

- MPH faculty members are serving on numerous federal, state, and local public health committees, such as the Virginia Pandemic Advisory Committee, and the SOM Dean, who teaches the MPH health policy course, is working with government officials on state and federal legislation on health care for the uninsured and quality of care. The MPH program provides students to work on field placement and internship projects at major state, national, and international agencies, such as the Virginia Department of Health, the Centers for Disease Control and Prevention, and Project HOPE, as well as at other international settings in China and Africa.
- **MPH Joint Programs:** The MPH program serves students from across the university. During its first two years, the program launched two joint professional degree programs, the MD-MPH and the JD-MPH programs, and developed a third joint program, the BA-MPH, with the College of Arts & Sciences that will begin as early as fall 2006.
- **BA-MPH Degree Program:** Third-year undergraduate students with distinguished academic records will be able to apply to the MPH degree program and begin taking graduate public health courses while still finishing their undergraduate degrees. This program will provide students with the opportunity to do significant public health field work and international research over a longer period of time that spans their undergraduate and MPH years. The program will begin in the near future.
- **New Public Health Opportunities Planned for UVa Undergraduates**
 - Global Public Health Minor: A new undergraduate minor in Global Public Health will be sponsored by the Department of Public Health Sciences in collaboration with the College of Arts & Sciences and the Center for Global Health. The minor, which is planned to begin in 2007, will provide courses that introduce global health frameworks, the interdisciplinary measurement of health and disease, and health policy, law and ethics.
- **New Public Health and Health Policy Opportunities for Medical Students**
 - DX-RX course for 4th year medical students: New required 4th year medical school course that introduces students to key health policy and public health issues that will shape their professional practice in the future and challenges them to critically analyze current policy, economic, and legal issues that are raised in journals, contemporary media, and court cases.
 - Medical student internship electives in health policy: Medical students have the opportunity to work with government policy makers through internships that focus on medical and health policy issues, such as Medicaid regulations, state obesity interventions, etc.

- **Certificate Program for Hospital Residents:** The Department of Public Health Sciences is working with the Office of Graduate Medical Education to create courses and provide the administrative home for Certificates of Special Competencies for Residents. Certificates would be awarded for four Graduate School of Arts & Sciences courses in a track. Five tracks are now envisioned: Public Health/Health Policy; Clinical Research; Health Administration; Health Law and Ethics; and Health Education. Graduate course credit could later be applied to an MPH or MS degree. Pilot courses will begin in summer 2006 and J-Term 2007. The program officially is planned to begin in the academic year 2007-2008.
- **Establishment of Interdisciplinary Public Health Centers**
 - **Consumer Health Education Institute** In collaboration with the Curry School of Education, the Consumer Health Education Institute will develop tools to teach consumers how to choose health care and will deliver information in the way best suited to the individual patient. In a novel approach to training, education research will be applied to medical students and residents to develop individualized ways for our trainees to learn.
 - **Center on Health Disparities** The Center on Health Disparities will investigate ways to reeducate health professionals and eventually eliminate disparities in health care that are rooted in race, poverty, rural communities, and other factors such as being uninsured. The center has begun to develop ways to improve health locally such as by using programs promoting healthy vending machine and cafeteria choices for children.

In FY07 the Diversity Scholars Program will be launched. Each Scholar will enroll in the MD-MPH program on the “Disparities track.” Student placement for MPH field work will be directed to rural, underserved, or disadvantaged populations in Virginia. This program will replace the Generalist Scholars Program that was developed to address the dwindling supply of generalist physicians, particularly in the underserved areas of the Commonwealth. Over the 12 years of the program, the majority of the students have chosen to explore issues related to health disparities including service to the disadvantaged populations or in underserved locations. It has become apparent that both generalists and specialists are needed to address health disparities.

2. Two-Year Goals and Metrics for Success

- New population-based research opportunities for students and new research faculty members working on population and community health.

Model: The goal is to create a model that formally bridges many MPH tracks and courses with complementary, interdisciplinary UVa research centers and institutes. The MPH program and centers would share new faculty; seed new research opportunities; and jointly sponsor national and international speakers, conferences, and research symposia.

Metrics for success:

- Hire two new faculty members shared by the Center on Health Disparities and the MPH Program. This would allow the start of a new Health Disparities track in

the MPH program and new opportunities in health disparities and community public health research and policy.

- Hire two new faculty members shared by the Center for Global Health. This would allow the start of a new Global Health track in the MPH program and new opportunities in global health and community public health research and policy.
 - Hire two new faculty members in health policy, economics, or law shared by the Institute for Practical Ethics and Public Life and/or the Center for Biomedical Ethics and/or another University research institute. This would strengthen the research and policy opportunities for students and faculty in the MPH Health Policy, Law, and Ethics track.
 - Relationships developed with at least two other University centers or institutes outside of the Health System, such as the Center for Risk Management (School of Engineering) and the Institute for Environmental Negotiation (School of Architecture).
 - Two annual international symposia: one on Global Public Health and one on Global Health Disparities.
 - A year-long, pan-university speaker series on public health research and policy.
- Expand the number of MPH students.

Metric for success:

- The total number of MPH students would increase to 34, including an increase in the number of joint MD-MPH students and residents and fellows enrolled in the MPH program.
- Begin creating and strengthening programs for a School of Public Health.

Metrics for success:

- One or two doctoral programs in public health, e.g., epidemiology and biostatistics.
- Expanded course offerings and research in environmental health and in social and behavioral health (two of the five core areas of a public health program).
- Establish a UVa task force to develop the mission, university-wide support, and the mechanism for establishing a School of Public Health.
- Create a five-year time line and business plan to incrementally build the educational programs and raise the resources that will lead to an accredited School of Public Health.
- Board of Visitors approval to create a School of Public Health.

3. Five-Year Goals and Metrics for Success

- Three doctoral programs in five of the core areas of public health.

- 30 full-time faculty members in public health disciplines.
- Administrative infrastructure for a School of Public Health, i.e., registrar, admissions office, office of career planning, development office, etc.

Metric for success:

- Announce the opening date for a School of Public Health.

4. Resources Needed and Barriers to Success

Preliminary assessments suggest an endowment of at least \$75 million will be needed to support the annual expenses for a School of Public Health. This includes ongoing faculty expense of \$2.25 million (60 faculty at 50 percent time); administration, \$1 million; startup for 2 faculty per year @ \$250,000; and a School of Public Health building, 75,000 square feet, \$50 million.

In addition, establishing a new school will require significant buy-in from faculty, university administration, alumni, and others. Identifying stakeholders both from within and outside of the University (for instance, state public health and health policy leaders) and working with them to understand and address their needs and interests will require time and leadership.

CENTER FOR GLOBAL HEALTH

1. Notable Accomplishments

Founded in 2001 as one of the nation's first pan-university Centers for Global Health (CGH), the University of Virginia's CGH builds on a 27-year program in Geographic Medicine. The Center's accomplishments and programs are in four areas:

- International collaborative research
- Training fellowships
- UVA student scholar projects abroad
- Global health curricula, speakers, and conferences at UVA

Collaborative research

- Continuing one of the country's longest sustained international collaborations in Northeast Brazil, through the 4th \$2.2 million competitive renewal of our NIH International Collaboration in Infectious Diseases Research UO1 funding for genetics and novel therapeutics to mitigate developmental impairment and address "Long-term Impact and Intervention for Diarrhea in Brazil." (This program started in 1989 and will now continue through April 2010; it is the only program in the country to exceed 2 cycles).
- Receiving a 2.8 percentile ranking on a new \$1.25 million 5-yr RO1 to elucidate the protective effects of APOE4 (the "Alzheimer's gene") against the cognitive impairment from heavy childhood diarrhea burdens (a new "balanced polymorphism" analogous to that of sickle cell-malaria). This grant involves collaborations with Dr. Peter Patrick at the Kluge Children's Rehabilitation Center.
- Building and sustaining international collaborations with institutions and sister Centers for Global Health in Philippines, Ghana, Haiti, Uganda and South Africa as well as Brazil.
- Publishing 4 new textbooks of Tropical Infectious Diseases and Parasitology (in addition to more than 200 collaborative publications with international colleagues).

Training

- Continuing our \$750,000 NIH Fogarty GIDRT (Global Infectious Diseases Research Training) grant.
- Sponsoring and mentoring 8 international CGH research fellows annually for training at UVA (more than 80 have trained here so far with a 100 percent return rate of CGH fellows to become leaders in their home countries and institutions after training).
- Dr. W. M. Scheld's \$2 million grant from the Pfizer Foundation to expand CGH training of US and international physicians and trainees in infectious diseases at UVA and in Africa and other developing areas.

Student scholar projects

- Renewing our \$810,000 Ellison Medical Foundation grant supporting UVA's Center for Global Health model to extend CGH scholar, fellow, and curricular opportunities from the SOM throughout the University (potentially \$1,458,000 if extended for 5 years).
- Sponsoring more than 50 UVA medical and university student scholars in 2005 in mentored global health research and service projects abroad.

- Engaging faculty from the schools of Medicine, Nursing, Arts and Sciences, Engineering, Education, Law, and Commerce as mentors to UVA students conducting projects abroad and international researchers training here.

Global health curricula and speakers

- Launching our 3-year \$405,000 Fogarty Global Health Framework grant enabling new course development in the medical school and across the University, including J-term courses, an undergraduate interdisciplinary global public health minor, a Global Health track in our MPH program, and an outstanding new speaker series in Global Health.
- Awarding 6 global health course development grants to faculty through a competitive university-wide selection process, and planning the first global health Common Course.
- Bringing outstanding visiting speakers for CGH lectures and seminars, including UVA Nobel Laureate (and CGH collaborator), Dr. Ferid Murad.

Other accomplishments

- CGH faculty serving as presidents of the American Society of Tropical Medicine and Hygiene and of the Infectious Diseases Society of America and serving on the Board on Global Health of the IOM.
- Launching our CGH endowment with an initial Brace contribution of \$41,000 and a commitment to raise \$250,000 over the next 5 years.

Planned but not accomplished and why

- Matching endowment efforts with Glenn and Susan Brace following a July 2005 meeting in New Orleans at Kate and Jim Rareshide McPhaille's home were not accomplished this year because of Hurricane Katrina which soon followed on August 29.
- Obtaining a \$20 million-\$30 million donation to name the Center/Institute for Global Health has not been accomplished because we have not yet identified the major donor(s).

2. Two-year Goals and Metrics for Success

Models for all of US

Our goal is to provide a model pan-university CGH that is based in the Health Sciences but engages all disciplines relevant to global health. It builds sustained collaborations across the entire University as well as with sister Centers for Global Health in developing areas abroad. Our purpose is to create a model that shows how top universities can dynamically address global health issues where responses are needed. Our specific goals for the next two years are to:

- Formalize the structure by which faculty from around the University have an association with the Center for Global Health that contributes to CGH's goals, helps them to incorporate global health into the academic teaching, research, and service missions of their respective disciplines and schools, and has the agility to respond to new crises or opportunities where they emerge.

- Link the Center for Global Health with the complementary Master's in Public Health track in Global Health by sharing teaching responsibilities and providing opportunities for mentored student global health research.
- Engage at least 10 UVa faculty in international collaborative research or global health related courses at UVa.
- Initiate a program where all fourth-year medical students have the opportunity to participate in a yearly "class project" in an underserved country.
- Assist our international collaborators in submitting at least 4 NIH or other grant applications to continue research based in their own institutions.
- Help UVa faculty submit at least 3 proposals for grants to build sustained collaborations in research, teaching, or service addressing health disparities.
- Continue the CGH interdisciplinary speaker series as a forum to bring together faculty and students from across the University.
- Share our model with other institutions by presenting at least annually at national conferences.
- Publish at least two articles on UVa global health programs in peer-reviewed journals.
- Host a symposium at UVa to showcase our model for a university-wide program in global health and provide information for other institutions wishing to emulate it.

Improving rankings

UVa's longstanding international collaborations have contributed to the success of our fellowship training program in infectious diseases and international health, which has attracted top fellows from Stanford, Duke, Cornell, Hopkins, Harvard, Yale, and other institutions. More recently, undergraduate and graduate student demand for our global health research and course opportunities have also increased. Comments from students, residents, fellows, faculty, and Deans of Admission to the School of Medicine and the College confirm that UVa's reputation in international health is an important draw and distinguishes us from other institutions. While there is no national ranking for programs in global health, UVa is perceived as a leader. Many of our former US fellows are now leading global health programs in other institutions.

To maintain or improve our standing, however, will require the ability to compete with the other global health programs now gaining prominence around the country. Hence, our goals include:

- Building the number of faculty involved in global health at UVa by engaging current faculty and attracting top new junior faculty.
- Ensuring an ongoing funding source for global health scholars (students designing and conducting projects in developing countries, under faculty mentorship).
- Ensuring an ongoing funding source for training fellowships at UVa for international collaborating researchers.

- Increasing the number of curricular pathways available to undergraduate, graduate, and professional students who wish to pursue global health.
- Strengthening the institutional structure that allows faculty and students from many schools and disciplines to collaborate with each other to address global health issues through research, curricula, symposia, mentoring, and international collaborations.

Two-year metrics for the above goals include:

- Hiring 2 junior faculty who may have joint appointments in the Center for Global Health and another department such as Public Health Sciences, who will serve as mentors to students or visiting fellows focusing on global health and whose research includes international collaborations in developing countries.
- Creating a global health track for medical students.
- Creating a global health track for the MPH program.
- Sponsoring the inclusion of cultural competency training in the undergraduate and graduate medical student curricula to support the development of health professionals with an increased ability to effectively treat international and culturally diverse populations.
- Developing an intensive research experience in global health for UVa Health System residents.
- Creating and implementing an undergraduate minor in global public health with 10-20 undergraduate students each year.
- Adding at least 5 regularly offered courses related to global health to the offerings for undergraduate, graduate, and professional students.
- Formally defining the privileges and obligations of membership in the Center for Global Health, open to faculty from any UVa department or school.
- Identifying funding sources to increase the endowment for scholars and fellows to engage across disciplines in global health.
- Increasing the number of global health scholars by 10 percent each year.
- Increasing the number of global health fellows by 10 percent each year.
- Supporting inclusion of global health curricula into 3 existing study abroad programs.
- Instituting mentor support as part of scholar and fellow awards (i.e., \$3,000 for the student; \$1,000 for the faculty mentor).

Improving operations

To improve operations and accomplish the above, we must strengthen the administrative structure necessary to retain the quality of our growing University-wide programs. This involves:

- Promoting and retaining existing staff and faculty whose experience provides critical administrative leadership as the program grows.
- Hiring at least one additional full-time staff member to manage communications and coordination of faculty, fellows, and student participation from across the University.
- Recruiting new junior faculty in the School of Medicine who can reach across the University and collaborate with faculty in other schools in mentoring students, teaching courses, and conducting international research.
- Raising sufficient endowment to support the actions listed in the above sections when current grant funding expires.

3. Five-year Goals and Metrics for Success

In addition to continuing work and expansion of the two-year goals, our five-year goals include:

Models for all of US

- Hosting an annual symposium at UVa, modeled after the one mentioned earlier, to provide a forum for university-based Centers for Global Health to present and discuss experiences and most productive approaches.
- Providing technical assistance to other universities and international collaborating sites through site visits and invited evaluation.
- Creating a fifth year global health opportunity for the undergraduate degree.

Improving rankings

Formal rankings in global health do not yet exist, but in order to maintain our reputation for excellence and opportunities in this area, we must:

- Further expand the number of CGH collaborating faculty by 50 percent.
- Create an undergraduate major in global public health. Expand global public health minor opportunities to other schools such as Commerce, Engineering, Nursing, and Education.
- Refine and increase enrollment in the global health curricular offerings for medical students and residents described above.
- Continue to ensure support for the growing scholars and fellows programs.

Improving operations

Over the next 5 years, to improve operations and accomplish the above, current space will become severely limiting. Further institutionalizing the Center for Global Health will require dedicated space in the new Carter-Harrison Research Building contiguous with the core strengths in Infectious Diseases and International Health.

In keeping with the principle that addressing global health problems involves more than medical disciplines, the Center for Global Health's effectiveness will depend on cross-fertilization with colleagues across UVa. For example, faculty in laboratory sciences such as infectious diseases, immunology, and microbiology may work closely with colleagues in engineering, economics, epidemiology, or cultural anthropology. Similarly, public health policy, law, and ethics bring vital perspectives on global health. Thus, our Center/Institute should evolve beyond our core in Infectious Diseases and International Health with satellites in Arts and Sciences, Nursing, Engineering, Law, Darden, and other departments and schools. To accomplish these goals we must:

- Double the space for CGH faculty, fellow, and scholar research in the new Carter-Harrison Research Building.
- Double the CGH space in the Corner Building to link medical and University-wide programs in global health.
- Endow 2 new professorships, including one for a new Institute for Global Health director.

4. Resources Needed and Barriers to Success

- Our ideas and model structure for a pan-university Center for Global Health are recognized and emulated by other universities as well as by the NIH Fogarty International Center (in their RFP for Framework Programs in Global Health). CGH faculty have been invited to visit or work with programs at Duke, Vanderbilt, Harvard, University of Washington, Boston University, and Emory, where Centers or Institutes of Global Health are being developed. Several of these institutions have raised endowments of \$30 million to \$100 million.
- We need to establish an endowment of at least \$20 million to \$30 million to create a named Institute for Global Health that can perpetuate what we have begun with ingenuity and grant funding and to retain our leadership position.

HEALTH SYSTEM DEVELOPMENT

1. Notable Accomplishments

The Health System Development Office has developed its \$500 million campaign plan and organizational structure with the Decade Plan as a guide. Clinical fundraising priorities include new facilities for Cancer and Children's and a broad range of programmatic support that will enable Health System faculty and staff to deliver models of care. Research fundraising goals include funds to recruit new faculty, new research space, campaigns focused on major human diseases, and new fundraising mechanisms to engage faculty and educate development staff about research programs. Education fundraising objectives include new facilities (a model Medical Education Building containing a Simulation Center); funding for teaching incentives and recognition, including the Academy of Medical Educators; and funding for scholarships. Our Community Service initiatives include priority outreach programs identified in conjunction with Health System leadership. In addition, the spirit of community engagement informs our relationships with Health System volunteers who serve on our boards and councils.

Campaign preparation/fundraising infrastructure

- Developed a comprehensive \$500 million campaign plan (released in February 2005) with areas of disease focus (such as cancer, cardiovascular, diabetes, neuroscience, and children) extending from basic science to patient care, as well as Medical Education and Nursing Education.
- Created case materials focused on capital projects, including a master case statement and "mini-cases" for Cancer, Children's, Medical Education, and Nursing.
- Reorganized HSDO staffing and operational resources. Departmental programs and alumni territories are now fully staffed.
- Established a constructive collaboration with the Medical Alumni Association/Medical School Foundation (MAA/MSF), including a recently revised Memorandum of Understanding with HSDO.
- Created the University of Virginia Health Foundation (UVaHF) Board of Trustees and recruited 11 members representing diverse expertise and health interests, all of whom have provided substantial philanthropic support.
- Instituted new performance measures for development staff. Visits and contacts increased by more than 70 percent from FY04 to FY05. So far during the campaign (1/1/04-1/31/06), development officers have made 6,896 total contacts, including 3,795 face-to-face visits.
- Restructured center-based volunteer committees, defining volunteer mission and emphasizing fundraising objectives.
- Held the first Volunteer Advisory Forum in September 2005, including more than 200 attendees representing areas across the Health System.
- Implemented "Fundraising 101" to engage Health System faculty as partners in the campaign.

- In collaboration with the Office for Research, created a new searchable database of private funding opportunities for Health System researchers.
- Worked with the Medical Center and School of Medicine to create a Special Guest Services program for hospital patients in order to better identify existing benefactors and future donors.
- Created “Making a Difference” brochure with information on fundraising needs across the Health System. This piece will be included in the Patient & Family Handbook distributed to every patient admitted to the hospital (40,000 a year).
- Provided a variety of venues for development staff to learn about research programs; emphasized 1:1 interaction with individual faculty members in performance goals.
- Garnered recognition from our peers for our campaign achievements.
 - The Health System is a model for campaign efforts across the institution: our case materials are a standard University-wide, and we are among the leading units in percent of campaign goal achieved.
 - HSDO staff members have presented fundraising panels to audiences of clinicians and development professionals at Association of American Medical Colleges (AAMC) and Council for the Advancement and Support of Education (CASE) sessions. Dean Garson and volunteer Randy Shure presented on development to the AAMC deans in spring 2006.

Campaign results to date

- \$194,682,622 in gifts/pledges booked through 1/31/06. This represents nearly 39 percent of the \$500 million campaign goal in 26 percent of time elapsed for the campaign. (Note: This total does not include the Ivy Foundation’s \$45 million gift, which has not yet been booked pending completion of the gift agreement.)
 - Approximately 50 percent of these funds have come from medical alumni and other individuals; the other 50 percent have come from corporations, foundations, and organizations.
 - Total includes \$23.8 million for Cancer, \$3.8 million for Children’s, \$4.2 million for Diabetes, \$4.9 million for Heart, \$48 million for medical education, \$4.8 million for Neuro, and \$10.4 million for Nursing.
 - Total includes 25 gifts of \$1 million and above.
 - Currently there are 34 pending proposals with a total value of over \$22.5 million.
- Secured the lead gift for the campaign: a \$45 million commitment from the Ivy Foundation to establish a new translational research building (MR7) and support the Cancer and Children’s clinical facilities. This is the largest capital gift in the Health System’s history and will be one of the University’s lead gifts at the September 2006 campaign launch. The translational research building funded through this gift will house the newly-created Virginia Institute for Clinical and Translational Research (VICTR).

- Other major commitments include \$12.5 million from the Claude Moore Charitable Foundation to name the Medical Education Building, \$5 million from Claude Moore to name the Nursing Education Building, and \$5 million from the Smithfield-Luter Foundation for cancer prevention programs.
- On track to raise \$30 million for the Claude Moore Medical Education Building.

Plans that were not accomplished

- Increasing the Health Foundation Board to 23 members within the first year (currently 15). We aim to reach 20 members within 2 years and a sustainable board size of 23 within 5 years (see goal sections below).

2. Two-Year Goals and Metrics for Success

Supporting the creation of models for all of US

- Implement “Fundraising 102,” working more closely with clinical chairs and faculty groups, and integrating basic science with clinical programs.

Supporting improvement in rankings

- Leverage transformational gift publicity into national recognition of the UVa Health System.
- Participate in national conferences with peers (AAMC, CASE), presenting to audiences of clinicians and development professionals.

Improving HSDO/UVa Health Foundation operations

Campaign progress

- Exceed 50 percent of campaign goal (\$250 million+) prior to September 2006 campaign launch.
- By FY08, raise a sustainable annual total of \$55-60 million in cash and new pledges. (This figure includes grants.)
- Complete the fundraising campaign for the Claude Moore Medical Education Building.
- Raise funds needed for the Cancer Center clinical facility.
- Focus on fundraising for endowments to recruit and retain faculty who will be creating model Health System programs. This includes funding for endowed chairs and new vehicles for start-up funding for “rising stars.” Goal is to raise \$70 million for these initiatives through the remainder of the campaign.
- Identify a next tier of priority programs in conjunction with Health System leadership.
 - Create the second phase of Health System campaign materials and case statement to be used after the campaign launch, reflecting the University’s overall themes and key messages.
- Redesign PULSE as a campaign newsletter focused on campaign priorities.
- Create fundraising materials for the Academy of Medical Educators and promote it in publications.

- Continue to increase volunteer engagement in the campaign.
 - Hold the second Volunteer Advisory Forum in spring 2007, including training and working sessions for volunteers across the Health System.
 - Engage chairs of program and center-based volunteer groups through regular communication with the Health Foundation Board Chair.
- Launch the Health System Faculty and Staff Campaign in 2007; determine goal for percent participation.
- Grow the Health Foundation Board to 20 members.
- Hire new Cancer Center development team to fill recent vacancies (by fall 2006).
- Publish the Diabetes and Heart campaign “mini-cases.”
- Create a plan and case materials for the \$20 million Neurosciences campaign.
- Foster collaborations between development staff and SOM/MC faculty and staff to create a HIPAA-compliant culture of philanthropy from grateful patients.
 - Define role of development office liaison assigned to a clinical department to encourage faculty identification of grateful patient donors and prospects. Set defined appointment schedules to ensure regular contact with faculty, and emphasize fundraising awareness of, and contact with, other clinical staff.
 - Create single-page development plans for these departments.
 - Continue to collaborate with the Medical Center and School of Medicine on developing amenity-based service programs.
 - Expand and enhance direct mail programs to both donor and acquisition lists.
 - Present on development at LAM 2006.

General

- Carry out a “mid-term” external audit of all Development activities including specific methodology for exceeding the campaign goal of \$500 million.
- Based on outcome of charter legislation and proposed Strategic Initiative Assessment, develop sustainable plans for funding HSDO and UVaHF operations.
- Continue to coordinate projects and messages with MAA/MSF, focusing on parent engagement and reunion programs.
- Build collaborations with Health System Marketing.
- Improve our website and electronic communication with donors.

- Improve coordination of Health System shared prospects and moves management tools (BSR database and reporting).
- Work to improve our state dollars per medical student; currently we are ranked 57 out of 75 public medical schools for state support provided per medical student.

3. Five-Year Goals and Metrics for Success

Supporting the creation of Models for All of US

- Determine specific fundraising goals for model research programs focused on the practice of medicine and the quality of health care.

Supporting improvement in rankings

- Continue to leverage transformational gift publicity into national recognition of the UVa Health System.
- Continue to participate in national conferences with peers (AAMC, CASE), presenting to audiences of clinicians and development professionals.

Improving HSDO/UVa Health Foundation operations

Campaign Progress

- Raise \$500 million by the end of the campaign (12/31/11).
- By FY11, raise a sustainable annual total of \$65-75 million in cash and new pledges. (This figure includes grants.)
- Raise funds needed for the new Children's Hospital clinical facility.
- Raise a total of \$70 million in faculty support for "rising star" scholar funds and endowed chairs by the end of the campaign.
- Raise \$22 million total for fellowships and scholarships by the end of the campaign.
- Sustain the fundraising focus on clinical and research programs in cancer, children's health, diabetes, cardiovascular, and neurological diseases, plus additional program priorities determined in conjunction with Health System leadership.
- As VICTR evolves, determine specific fundraising goals for emerging research areas, e.g. molecular epidemiology, regenerative medicine, drug discovery.
- Continue to redefine campaign priorities, including aspirational goals when appropriate (e.g. the potential inception of the School of Public Health, or named Health System centers).
- Increase the Health Foundation Board to 25 members.
- Identify and raise funds for priority outreach programs (e.g. cancer outreach and prevention, which is critical to gaining NCI comprehensive status).

General

- Improve resources for online giving.

4. Resources Needed and Barriers to Success

- Appropriate and expedited access to patient demographic data must occur in order for the Health System to realize our full fundraising potential.

THE DECADE PLAN: TEN-YEAR ASPIRATIONS

We aspire to be the model for the U.S. in how to generate new knowledge in the laboratory and apply that knowledge to patients, ultimately leveraging success to improving the health of the public: “from cell to bedside; and from bedside to society.” Leading through complex innovation requires natural collaboration, one of the most fundamental characteristics of the Academical Village, and one that distinguishes the University of Virginia.

Through the establishment of the University of Virginia Institute for Clinical and Translational Research (VICTR), a cross-Grounds collaboration will provide a model on how to translate research into ideas and products that can ultimately benefit society (“from cells to bedside”). Through these collaborations, we will seek to develop individualized programs for cancer prevention and treatment, novel ways to prevent or treat addiction, and even how to re-grow a limb through tissue engineering.

We will continue to serve our diverse constituencies, from the individual patient with a simple head cold to the global health care issues facing our world. We will create new models eventually with a School of Public Health addressing the complex legal, ethical, economic, quality, disparity, and cost issues associated with our global society (“from bedside to society”). We will work with patients to educate them on how to be involved in their own care decisions, while training our physicians to know how best to educate their patients. We will seek to eliminate health care disparities, both in the U.S. and around the world. We will develop the model academic health system, incorporating integrated technologies, innovative staffing solutions, state-of-the-art treatment and research facilities and attracting the next generation of health care providers who seek to lead us into a new era of medicine.

As realized through the Decade Plan, these models will result in widespread benefits and will generate significant visibility such that the University of Virginia will achieve top status as a healthcare institution within 10 years. The University of Virginia Health System will be recognized for its Models for all of U.S. and will embody Jefferson’s vision of the University: “A blessing to my own state and not unuseful to some others.”