

THE UNIVERSITY OF TOLEDO
Minutes of the Faculty Senate Meeting of September 11, 2012
FACULTY SENATE

<http://www.utoledo.edu/facsenate> Approved @ F.S. meeting on 10/08/2012

HIGHLIGHTS

Jeffrey Gold, Chancellor & Executive VP for Biosciences and Health Services
Margaret F. Traband, Vice Provost for Faculty Senate
Sammy Spann, Assistant Provost for International Studies and Programs
Tamika Dobbins, Services Excellence Specialist

Note: The remarks of the Senators and others are summarized and not verbatim. The taped recording of this meeting is available in the Faculty Senate office or in the University Archives.

President Michael Dowd called the meeting to order, **Lucy Duhon**, Executive Secretary, called the roll.

I. Roll Call: 2012-2013 Senators:

Present: Ariss, Bailey, Barnes, Cochrane, Crist, Denyer, Dowd, Duhon, Edinger, Franchetti, Gohara, Hammersley, Hewitt, Hey, Hill, Hoblet, Humphrys, Jorgensen, Keith, Kranz, Lee, Langan, Lundquist, Molitor, Moore, Moynihan, Nigem, Ohlinger, Piazza, Plenefisch, Quilan, Randolph, Regimbal, Relue, Rouillard, Sheldon, Springman, Teclehaimanot, Templin, Thompson, Thompson-Casado Van Hoy, Weck-Schwarz, Wedding, White, Williams,

Excused absences: Anderson, Cappelletty, Cooper, Cuckovic, Duggan, Eisler, Ellis, Gilbert, Hottell, Hornbeck, Wilson,

Unexcused absences: Hamer, Giovannucci, Nazzal, Rooney, Tinkel, Willey

II. Approval of Minutes: Minutes from August 28th meeting are ready for approval.

President Dowd: I am calling the meeting to order. Welcome to the second Faculty Senate meeting of academic year 2012-2013.

To begin our meeting, I request Secretary Duhon call the roll.

Thank you, Secretary Duhon. There is an action before I turn to the Executive Committee report. Today is the eleventh anniversary of the attacks to our country on September 11th, 2001. I ask that Faculty Senate observe a moment of silence in remembrance of the 2,977 victims who lost their lives in New York, Pennsylvania, and Washington D.C., and of the 343 Firefighters, 2 Paramedics, and 1 Chaplain who died trying to save the lives of others on that horrible and tragic day.

[Moment of Silence]

President Dowd: Never forget.

Senator Barnes: I wonder if we can also recognize the ten years of war and the hundreds of thousands of other people that have been displaced who also lost lives as a consequence to that event. Those two things are related in that way and we should remember them too as we remember the attacks on the country, let us also remember that.

President Dowd: Thank you, Senator Barnes.

The Executive Committee report will be brief. I'm sure each Senator will be relieved to hear that your Committee on Committees has nearly completed its work of making assignments to standing Senate Committees and some university level committees. Vice President Rouillard is chair of that committee and will give report today on that committee's progress and will report in detail at a subsequent Senate meeting.

Your Executive Committee has been rather busy over the past two weeks. Besides our regular meetings, a week ago we participated in the All Day Leadership Meeting. At that meeting Dr. Penny Poplin Gosetti discussed the report from the Higher Learning Commission, similar to her presentation of that report to the Faculty Senate during our August 28 meeting.

Additional topics discussed at that meeting included the Freeh Report, UT culture assessment, patient satisfaction survey, student learning outcomes assessment, and a budgetary outlook. If any Senator is interested in any of those topics, please let an Executive Committee member know of your interest and we will work to get copies of each presentation.

There were two other presentations given at that All Day Leadership Meeting that warrant discussion. The first was a presentation by Vice Provost Pryor about his "Innovative, Customized Education" program. I would like to describe that program for you today but I cannot. Speaking personally, and not for other Executive Committee members, I can't describe that program because I do not have a clear understanding of what it is or what V.P. Pryor hopes to achieve. Because V.P. Pryor has enrolled students in that program, your Executive Committee intends on inviting VP Pryor to an Executive Committee meeting for detailed discussion of the program and how he hopes this will impact UT students in a positive way.

The other presentation at that All Day Leadership Meeting was given by Dr. Jeffrey Gold and he will present some of that material to the Senate in just a few minutes.

Senator Barnes: President Dowd, can I ask you just a quick question? The names of the reports that you heard which you gave us a big long list on, can we have that list again but a little slower?

President Dowd: Please forgive me, Senator Barnes, for speaking too quickly. The presentations included the Freeh Report, UT culture assessment, patient satisfaction survey, student learning outcomes assessment, and a budgetary outlook

Senator Barnes: Did it say who gave that?

President Dowd: Offhand I do not remember.

Penny Poplin Gosetti: It was Shanda Gore.

President Dowd: If you would like, Senator Barnes, I can email you the agenda for that meeting.

Senator Barnes: I just want that list because I was curious about the culture report.

President Dowd: I would now like to turn to an update on the work of the Committee on Committees. Your Vice President, Dr. Linda Rouillard accepted the position of chair of the Senate's Committee on Committees. For new Senators please note that our Constitution states that the Committee on Committees

be formed each year to name individuals to the various standing Faculty Senate committees. After such individuals are named, the Senate President selects an individual from each committee to chair the committee. Vice President Rouillard has asked to speak today in order to update the Senate on our various appointments. However, before she addresses Senate, I want to thank her and her committee for the hard work they have performed over the past few weeks.

Senator Rouillard: It will be very brief because some of you volunteered and I thank you for that. There is only one committee that is one person short and that is Committee on Elections and I am waiting on a couple of nominations from the College of Medicine. The next step will be, I will meet with Quinetta to talk about the letters and the final list, so you should be getting a letter from the Senate Office by next week. Thanks in advance for that.

President Dowd: Our next speaker today is Dr. Jeffrey Gold, Chancellor & Executive Vice President for Biosciences and Health Affairs and Dean of the College of Medicine. As I mentioned earlier, Chancellor Gold gave a presentation at the most recent All Day Leadership Meeting. I also watched that presentation at a Board of Trustee's Clinical Affairs Committee meeting. The topic of his presentations was the rating and ranking of health centers. For my money, those presentations were among the most informative administrative presentations I've seen in a long time.

His presentations were informative because, first, they addressed an issue that has been at the center of some discussion over the past few months — that of the rating and ranking of our medical center. But, second, Dr. Gold presented an impressive level of detail describing the metrics each rating agency considered or did not consider when constructing their respective rank orders. It is almost never true that there is absolute truth in a number. Instead, numbers, like hospital rankings, have to be interpreted properly. And Dr. Gold provided that interpretation in his presentation. Believing that Senators and the university community would benefit from his presentation, your Executive Committee has invited Dr. Gold to address Faculty Senate.

Chancellor Gold: Thank you, President Dowd. It is an honor to be with you and I certainly share your thoughts about commemorating the 11th anniversary of 9/11. We should add to our memory and thoughts the families and loved ones of those who lost their lives as well as the thousands of people who were involved with the search and rescue; not only widows, but those who are dealing with diseases as a direct response to those difficult days. Anyhow, let me shift gears and talk to you about a subject that is near and dear to my own heart and that relates to the rankings and ratings of hospital systems. Just to give you a little background in this: In my previous life I spent more than twenty years of that life talking about and thinking about rankings and ratings of surgical programs, and data collection, and thoughts about how to measure performance of condition hospital systems etc. and spending a good deal of time trying to help design systems that are effective and yet communicate the appropriate information to the public. So, after twenty years of being involved in this, I sort of monitored and watched the changes that have occurred and therefore I will try to share some perspective with you. I would like to do this in a fairly rapid “fire” fashion if I can. Then, if we have plenty of time after my talk I can answer your questions offline or here. So again, I thank you for the opportunity to be with you. The subject I've brought today is hospital ranking and ratings. I sort of like to use the metaphor of the Olympics as a way of thinking about performance because when you think about Olympic athletes of a sport there are many similarities that can be drawn to ranking and ratings of hospitals. When I first put this talk together for the Clinical Therapy Committee of the Board it was really a format because we were right in the middle of the Olympics games and at that time it seemed judicious.

So, the University of Toledo Medical Center approximately five and a half years ago wrote the concept of iCare. iCare is not a national brand, at least it wasn't then, but it is now and it is a UT concept, it stands for communicating, access, respect, and excellence. By excellence among other things, but what we are talking about is the focus on quality. We define ourselves at the Medical Center as a patient experience-

centered organization where we focus on quality and safety. We are directed and aspired to a membership “Club 100” top-tier academic health centers in the United States and indeed we try very hard to due to a sense of pride. So, what I would like to talk about today and use this ruler as a way for saying that we are constantly being measured, we measure ourselves, we measure from an outside organization, and it is just worth measuring and understanding the structure and function of a ruler to try to help you better understand and make good clinical decisions for yourself and for your family. I think it is worthwhile in remembering when we measure hospitals, doctors, and clinics as to how patients typically make decisions. There are the two ”R’s” that I call reputation and referral. People like to do what their next-door neighbor who has good experience in. They like to do what their doctor tells them what to do or their pharmacist or some other individual that they trust. They go by “is there coverage and convenience?” which also has to do with their insurance company coverage, plus “is there a co-pay and if so, how big is the co-pay?” etc. But there is also convenience, “do I have to drive across the street, do I have to drive across town, do I have to drive across the state to get what I need?” Then there is quality and there is a broader experience, a benchmark experience which are very important factors, but frequently not well described and not well monitored in our current world. All of that is based on this phenomenon of what’s called, “Team Care.” At the end of the day it is the team care the way the doctors, nurses, pharmacists, therapists, and social workers and others work together that really contributes to the reputation, how people make referrals to friends, colleagues, patients, and family etc., what influence quality and experience, and of course, ultimately who makes decisions about coverage and convenience. At the end of the day I would also like to say that I am very fond of talking to our students, residents, and our hospital staff etc. about the quality of care that we like to deliver and the quality of care we would want if we were the patient, or if it was our child, or our parent that was receiving the care. There are all kinds of metrics and rules, but what it means to me who fortunately had a child that received a lot of health care during the last decade of his life, that is the ultimate measure. If it is good enough for your kids and if it is good enough for your mom then it is good enough for us to deliver that quality of care to one of our patients at the Medical Center. If it is not good enough either from the access perspective, from the respect perspective, or any of the iCare parameter and I don’t care what’s in the books it has to make it to the level we would want for ourselves and for those that we really care about. But there are rulers, there are all kinds of metrics and what I would like to do is spend a few minutes and dissect this yellow ruler and talk about our internal continuous quality improving benchmark, our external benchmark, our aspirational goals. And then in the internal and external ranking and reporting systems that are in place and have been in place for a long time continue to evolve etc. So, one of the external rankings is the U.S. News and Worlds Report’s and we will talk about the strength and weakness of all of them in a minutes, but U.S. News and World Report is just one of dozens that are constantly ranking organizations right now, so we can start off here with CMS which stands for the Center of Medicare and Medical Services. Leap Frog just published a ranking of hospitals and hospital systems, Health... just published rankings and hospital systems that is on an annual basis...the center for Health and Human Services, Double MC, the Medical College, Council of Deans and of course the Joint Commission, the Ohio Department of Health, the Center for Disease Control and Prevention, ACaps which is the hospital care of quality information from a consumers perspective, Consumer Reports which has prompted a lot of discussion that we are having now, the University Health System Consortium, Press Ganey and on and on and on. So, all of these have their strengths and weaknesses. It is not that one is bad or one is good. It is not that one is new and one is old, but they are measuring totally different things and it is just as important to understand the similarities and differences of what they are measuring, so when you, or I are, or a family member needs to make a health care decision we can make an intelligent health care decision. But I will tell you that there are other rankings and ratings groups that are very important and those are far less obvious to the average consumer and those will include organizations like: Atena, Anthem, Paramount, Kaiser, BlueCross and Blue Shield, United Health Care, and others. These are the payers. These are the organizations that are the medical insurers for commercial insurance, and Medicare and Medicaid will be the government payers and these are organizations that are constantly ranking and rating quality, but they are also ranking and rating the organization, they are ranking and rating cost effectiveness etc. and various types of economical outcomes

in addition to the purely clinical outcomes that are more popularly reported on the websites and other sources of data. But most importantly to us in an ongoing way, there are literally a thousand quality and efficiency metrics that we track on a day-to-day, week-to-week, month-to-month basis that we use to ask the question, how we are doing that we use to make day-to-day, week-to-week decisions as opposed to many of these other sources that we are weeks, months, years, and some are a half a decade out of date. Then there are the differences and the similarities among and between all of these organizations and I would like to spend the next twenty or so minutes sharing with you and then answering your questions.

Why do we do this? Why are there hospitals ranking and ratings whether they be internal or external aspirational goals reported for a third party organization important? Well, they help us improve clinical outcomes by focusing on best practices. They help us improve patient experience by focusing on best practices. They optimize service, value and cost while delivering high-quality service and appointment, I am talking about nationally and globally. They help us identify best practices and needs for improvement for our health care system. They continually raise the bar. They are not static parameters and benchmarks but continue to evolve. What was standard five years ago is no longer acceptable, but what's acceptable today in terms of outcome probably won't be acceptable in two or three or five years. And that is good because the quality of health care, and the access of health care, and the cost of health care, and the outcomes continue to improve. They assist institution systems and they assist health care professions, and most importantly when they are done well they assist patients. If you have a family member that needs a complex surgery or has been cared for locally and you want another opinion, you want to go to a place that has got breadth and depth of expertise, knowledge, and experience to answer those questions for you and reading systems and benchmarks can help you make that decision then that is exactly what you should do and they function well. Assembly: they assist students intellect and we shouldn't lose track of that, med students, pharmacy students, health students and others, they want to train in hospitals and clinics where the physicians, nurses, and the health care professionals deliver high quality care. So, students make those decisions as constantly and commonly as the purchasers of health care and the insurers of health care. These tracking systems also facilitate policy decisions on a national and on a state-wide level. They facilitate major resource decisions on a federal level. So if a ranking system measurement tool happens to be an excellent tool and financial decisions are connected to it, that is wonderful. If the tool happens to be anecdotal or inaccurate and major funding decisions were made based on it then that is not quite so good. It facilitates payers' decisions as we talked about a minute ago and it also guides all different types of professional choices. All of the health care professional that we use in our day-to-day life and our family uses are constantly making best practice decisions that are not only based upon journal articles, national meetings, and clinical research trials, but are also based upon data scraped from large clinical and administrative databases which forms the basis of large studies which then influence the standard care and human practices. So all of these things are answers to the why we do this and what the altruistic reasons might be.

Now, I would like to spend a few minutes and talk about the question on how because therein lies some of the fundamental similarities and differences between all of these internal and external rating systems. So, let's start off and talk about the difference between primary and secondary data. For those of you who do research and I am sure that is most of you in this room, you will know that there is a lot of difference between reading data that somebody else has collected and published and building upon it, compiling it, or sharing it, than it is collecting the data yourself and verifying its accuracy in making sure it meets certain minimal, statistical, or other validity testing. It is also very important to know whether the data that you are making important decisions upon is self-reported or reported to an outside verified or audited tool. To give you an example, Press Ganey data has all its strengths and weaknesses and it is self-reported and it is not audited in any way whereas some CMS Medicare data is primary audited and verified at 100% and is anything and everything in between. Let's talk about the sampling process for a second: When you are talking about hospital safety, are you talking about all specialties that are cared for in the hospital or are you talking about one or two? Are you publishing a report that only focuses on

orthopedic care and if your family member needs heart surgery what is the relevance of that? Are you talking about the quality metrics across the entire institution, do you include all of those? Size and statistical powers and samples are obviously critical. If you are talking about a hospital that does 60 cardiac surgery operations a year and they had five people that got a wound infection that will seem like a lot. But, if you are talking about a hospital that does 2,000 open-heart operations a year and five get a wound infection you are probably talking about a much smaller percentage for sure, but you are also talking a much higher degree of statistical power when you can reach a comparative conclusion between five out of 60 and five out of 1,000 or 2,000. Yet, none of these national public studies talk to you about statistical power because in the overwhelming majority of them there are none. Either within an institution there is not statistical power when you are doing smaller anecdotal samples, but at least you can track and train over time. If you are comparing and scraping secondary data sources it becomes a lot more difficult. Randomizations are samples randomized, but unfortunately that is rarely the case specifically when you are talking about patient reporting. People that tend to report tend to report for a number of reasons just like the students that tend to fill out the surveys tend to choose the fact that they are going to fill out a survey for one reason or another and we all don't know what they happen to be. Other sources of data are worth commenting on: administrative data is on almost all these national registries and reporting systems and commercial reporting systems are scraped from large administrative databases and they include things such as age, gender, date of admission. Charge data which was specifically scraped through Medicare has to do with admitting, diagnosis, discharge diagnosis, length of stay and procedures performed etc., the things you get from a typical billing form. Clinical data includes a lot more than that and that would include things such as other clinical risk factors. I want to give you an example when you are talking about risk factor adjustment and severity: you would probably imagine in my former ~~of~~ field of expertise that if a 55-year-old gentlemen with no previous surgery and no other medical problems comes in for a triple-bypass surgery, their risk for having that operation is totally different than the 85-year-old lady who had three previous operations and is a diabetic, has hypertension, and an amputation and had four previous heart attacks and spent half of their previous life in the hospital. And yet, there are all kinds of methodologies (?) to adjust the risk, but in most of these reporting systems there are not risk adjustments, so you are comparing the outcome of risk adjusted institutions. So, most of the academic medical centers in the United States including ours for that matter tend to deal with patients that other institutions frankly don't want to deal with. Well over half of my referrals in my previous life didn't come from referring cardiologists to a cardiologist patient they came from other surgeons who for one reason or the other did not want to deal with the patient; either they were too complex or they tried and were unsuccessful etc. So, when you look at institutions like the Cleveland Clinic, they are truly a safety-net institution as to a very large extent are we because we receive patients from all over this community that frankly don't want to be treated where they are originating from or the doctors or hospital systems don't have the resources or desire for that matter and the experience. Just to give you an example of one of the recently published studies: infection rates on discharge was one of the parameters that was reported. It turns out, about half of the infections that we report are actually transferred to us from patients who were operated on from other hospitals who that hospital chose not to treat, so we treated them and we discharged them, so we report them. The hospital where the original surgery was done did not report them as an infection because they did not treat them for that, we treated them, and therefore we report them. It is not good nor is it bad, it is just simply the matter of understanding how the data is compiled and put together and how the consumer, you, I, and others need to analyze it. External validation and auditing: we touched upon that a minute ago about the overwhelming majority of the hospital compared data be it Joint Commission or be it any number of others such as Leapfrog and U.S. News. It is not audited and again, it does not make it good, you just have to understand that you are looking at data that is to a very large extent gained. I will give you one example of our many years in New York State. We reported outcomes of cardiac surgery and we reported hospital mortality and the thirty hospitals that did cardiac surgery in New York State, several of them created a hospice unit inside the hospital and when they had a patient that had cardiac surgery that was doing poorly and they thought did not survive the hospitalization they transferred the patient to the hospice. They discharged the patient from the acute care division and they

technically were discharged alive and they were admitted to the hospital service that could have been down the hall and passed away, and that was not treated as hospital mortality. New York State's learned a little bit from that and it is now a thirty-day mortality and...mortality, so if you die in the hospital, or hospice, or unfortunately if you were run over by a "bus" on the twenty-ninth day and you are coming back for your post-op visit after running a marathon, it doesn't matter, *you won't just be nearly dead but really quite sincerely dead*, my favorite quote <laughter>. I would hate to leave you with the fact that you think that hospitals and practitioners etc. do try to make themselves look good as possible when they understand what is measured and what is not measured and adjusted accordingly. Scope reporting: is another very important parameter and what I mean by system and site, when you read statistics for St. Luke's Hospital or statistics from Blanchard Valley you pretty much know what they are talking about. If you read statistics from New York Presbyterian, they own over twenty hospitals and 140 practice sites, so which hospital are you talking about? Are you talking about Cornell or are you talking about Presbyterian? Or are you talking about New York Methodist in Queens or which in between? Or are you talking about the whole system. Unfortunately, these ranking and rating organizations don't rate that apart for the most part. Then this completeness and exclusion which is one of the facts that seem to have escaped the recent Consumers article report; only 18% of you from...in the United States were included in that study which means that 72% either did not have the data or refused to comply and provide the data to them as opposed to our approach to this which is to be totally transparent in what we do. Our own internal philosophy on quality, safety, and patient experience is to collect the data in an open, transparent fashion, make sure it is accurate, and then hand it back in a very timely fashion to the people who can make accurate decisions for what to do with it. In so doing it, we provide all of the information directly as cleanly as possible to the state and to the feds etc., so any national organization and commercial organization that does ranking and ratings has access to our data.

Another point that I want to talk to you about is peer comparison: who do you want to compare yourself to? Well, we like to compare ourselves to the Club of 100 and we like to compare ourselves to partners, to Ohio State, we like to compare ourselves to USM, and Stanford and others. Not to say that we do not value the work that is being done in a small community hospital or in primary care outreach hospitals in the community, but the aspirational goals that we have which is how we are doing compared to the Club of 100. That has to be the University Health System Consortium and the Council of Teaching Hospitals. The Council of Teaching Hospitals are the top 330 academic hospitals in the United States, the UHC (University Health System Consortium) is 115 hospitals that have agreed to participate and share data and share best practices etc. and we transparently provide that information and benchmark ourselves against those institutions as well. Again, it is not that we do not care how we look compared to Blanchard Valley, or Henry County, or Wood County, or St. Luke's or others, but it is not our aspirational goal. Those are the institutions that don't teach students, residents, they are not dealing with the same complexity of cases that we deal with day-in and day-out, so we are much more interested in an "apples to apples" comparison. What do we do? Well, obviously the University of Toledo Medical Center through its internal and external benchmark aspirational goals ranking and reporting are constantly looking at accreditation and certification. We look at patient safety and quality for our internal processes and outcomes, and external processes and outcomes, sentinel events and root cause analysis, standard of care and risk management, and a bazillion external benchmarks. So, we just don't look at knee infections and hip infections, we look at every type of possible infection. We look at every length of stay. We look at patient satisfaction across the entire board. We look at our institutional representation and that is measured in any number of different ways. It is measured by U.S. News and it is measured by others. But, we also have focus groups within the community and nationally that are measuring our reputation. We are also interested in a student learning environment. We are very interested in the academic performance of our students because we want to have an environment where we have excellent learning going on and that the performance of our students and the clinical benchmark testing is good or better than other institutions. We look at our ability to recruit and retain physicians, nurses, and pharmacists in our organization. We look at our employee and staff satisfaction. We look at patient billing and our

compliance with billing in particular with government payers. We look at our financial performance and all we care about is the ranking and rating of these rating agencies as well. We care what... and others say about us because they have financial stability of our enterprise. And of course, we are also very concerned about national ranking and ratings and we take all of that very seriously, the good, the bad, and the ugly that goes with it.

So, let me share with you my ruler and it was actually Scott Scarborough's suggestion and I actually give him credit for saying, "Think of this like a ruler with multiple pieces." So, accreditation standards might be in one piece of the ruler. Safety and quality might be in other sections of the ruler. Patient experience, academic success of our students, benchmarks, aspirational goals, economic performance, and reputation might be in another section. Let's just take one little area as an example, and let's take patients... We use Press Ganey as an outside third party and validated source and they ask nine typical questions such as the following: discharge instructions, room cleanliness, quiet, privacy, pain management, medication explanation, how fast was the assistance when you hit the call button, nurse communication, doctor communication, would you recommend the hospital in the overall rating? This is a pretty standardized ranking system. It is a very small anecdotal sample and it probably represents between 3-5% of the acute care division of the Medical Center. But, it is a way of measuring patient experience and it is what we do, this is what we come up with what so-called, "HCAHPS" reports. What HCAHPS reports is between six and eighteen months old and that is a very important consideration, the timing because institutions change rapidly; some change not at all and some change faster than others. Let's look at another section, let's look at one tiny snip of quality for a minute and look at hospital-acquired infections. We already talked a little about what was reported in some of the national surveys, but we track transplant infections, skin wound infections, bladder catheter infections, chest wound infections, hips, knees, ventilators, and shoulders etc., we track every single hospital-acquired infection and we do it real time on a monthly basis and we feed it back to the physicians and the nurses that are involved. As a result of that, it is not the same because we don't periodically see action flows in the action rate, but we are dealing with is a real time fashion and not waiting for an outside source to comment on. So, let's just make it even more complex, it is not just our yellow ruler in the middle here that looks at the inpatient mid-surgery experience, but we are looking at quality and safety in patient experience in the emergency room. We are looking at it in behavioral health centers, inside and outside, inpatient and outpatient. We are looking at it in all of our inventory care in the operating room etc. We have it down to the last floor, the last experience of a given patient, or a given patient family because unfortunately when you paint an institution with a brush if their neurology service is spectacular and their pediatric service is the worst in the state and as a result of that they get an average score, I don't know how that helps neurology service improve nor does it send the right message to the pediatric service that really needs all that improvement. So, having the granularity of the data is typically important, but when you come down to a single number or a single grade, for example Leapfrog just gave us a "B+" across all of the health centers of the United States. What does that mean? We have services that are "A+" and we have services that are, "C-" I mean I really hope that we don't have any that are "F's," but we have a pretty wide spectrum of services, so to "box" the institution and say it is a "B+" or 24 points, or 67 points, or a two zero grading metric, maybe it is a pass/fail I don't know what the right grading metric is, but in citing communication and citing competition it is probably good. Another dimension that I point out to you is time. When you read these reports are you dealing with this year, last year, three years ago, five years ago etc? So, let's just take a look at a couple of these common ones because I would like to talk about them: Press Ganey is the single most widely recognized patient experience external validating measuring tool. It is a good tool and as I said, it represents 3-5% of our patient experiences across the Medical Center which means it's anecdotal, it's self-reported, and it's not audited, and frankly there is little or no statistical power, and it is certainly not for an individual service or an individual physician. It tells you nothing about the accreditation of the hospital or clinic. It tells you nothing about safety and quality. It tells you only about experience and it tells you about it 6-18 months ago, but it does not tell you what is going on right now. It tells you nothing about the experiences and the success of a learning environment of students' academic success. It tells

you nothing about the institution benchmarks, aspirational goals, economic performance, or reputation, absolutely nothing. But in the area of patient satisfaction and patient experience there is an anecdotal limited and it happens to be the best there is. So for all of those things, if you go to the website and read the Press Ganey scores you should enjoy them and understand them for what they are, but also understand what their strengths and limitations are. Again, it is not my intent to derogate or to praise any of the ranking and rating systems; it is really my intent this afternoon as it was with Dr. Dowd the last time we met to talk about just understanding the strengths and the weaknesses. Let's look at UNOS, the United Network for Organ Sharing: they have nothing to do with accreditation. They have nothing to do with safety or patient experience. They have no academic intents on measurements at all. They could care less about our aspirational goals. They know nothing and care nothing about economics or our reputation, absolutely nothing. They are interested in only one thing which is the certain quality outcome of solid organ transplantation a year or two years ago. They are interested in what was your 12-month graph survival last year. They are interested in whether our charts are complete and the signatures are legible, but again, only in solid organ transportation. So, if you were to read a UNOS ranking report and say what does that mean when you are at the Medical Center and happen to need a transplant, it happens to mean a lot. But, if you would happen to have a child with asthma then it does not mean anything and yet people publish this and sometimes misinterpret it. The U.S. News is a little bit broader: the U.S. News is typically a year old and it does have quality and safety parameters which is about a quarter of the ranking. It does have patient experience which is about a quarter of the ranking. It does use national benchmarks which are about a quarter of the ranking and then a quarter of the ranking is reputation. So, those are the five areas of U.S. News. This is their 23rd year for doing it. For all the good and the bad of U.S. News it at least allows you to do one chart because it is fairly consistent over time. Frankly, I happen not to like U.S. News because I don't think they are good with ranking and rating higher education. As a matter of fact, half the deans of the Medical College do not fill out the reputation forms because we believe that they are not sending the right message to potential students who are applying to med. school. I don't actually think they do the hospital industry a whole lot of good because they are not risk-adjusted systems for the most part. They do make an effort to use other benchmarks which I think is somewhat reasonable. Let's look at consumers: They are a little bit different. They don't make any attempt, but to look at the intake of patients and the acute care divisions. So, they are not looking at what's happening in your OR. They are not looking at your behavioral health systems. They are not looking at your ED etc. By looking at data they are comparing and contrasting data that is in various ages and this was their first year of prime to do it and I give them a lot of credit for trying. I've been a subscriber to their magazine for a very long time. I do make automobile, washing machines, and refrigerator decisions based upon the ranking and ratings all the time. However, I think they have some work to do on health care rating and rankings although I am confident that they will be doing better. Dr. Schultz who is the editor of the entire health care section is actually going to be joining us this fall on campus and is going to be talking to us about what their aspirational goals are and we are going to be working with him to try to enhance what they are doing and at the same time to let us learn from what they are doing and to try to make us a better health care organization. I want to point out to you that there is nothing in the data section about accreditation, however there is a little bit about safety, a little bit about quality, experience, and benchmarks. There is nothing about students' academic learning environment of their success of course. There are no aspirational goals, no reputation, or economics and the data is as recent as 2011 back to 2007. I've seen some institutions go from excellent to poor back to excellent in a five year period. Again, another limitation is that they are trying to create a single grade for the entire institution which we talked about a few minutes ago can be problematic. One of the comparisons that was very interesting to me, if you like, take cardiac surgery at one of the community hospitals in this community that will remain nameless and compare it to Cleveland Clinic; if you were a patient in that community and you made a decisions, and say Cleveland Clinic scored half as well as this small community hospital of Northwest Ohio and you took your loved one to that community hospital, boy will you ever be making a mistake my friend. So that gets into that whole issue of who's accountable for this and how the data is being used. This is Joint Commission and Joint Commission is very interesting because they do look at accreditation, safety,

quality, and patient experience. They have no interest in academics, economics, or our reputation. They do an interesting thing however, that is they do not rely on secondary data. They do not rely on anecdotal data, they come and they visit. So for us, last November they had five people who spent five days here and they talked to our doctors, nurses, pharmacists, and patients. They look in every “closet” and under “every sink” and they look through literally thousands of health records and they reach their own conclusions as opposed to the data that we provide them this was validated, audited, on-site data. Again, it does not make them to be the “be-all end-all” because there are many parts of what they do that are inaccurate. If you look at the academic learning environment, nothing at all. If you look at the national reputation, nothing at all, but for all of the things that they do they do it pretty well.

President Dowd: For clarification, are they announced or unannounced visits?

Chancellor Gold: They are unannounced visits. They come in unannounced fashion approximately every three years and they show up in force and they are here to stay. This is an example of a page out of a recent University Health System Consortium file that we were sent, U.H.C. U.H.C. is the one-hundred and thirty-one academic medical centers in the United States, so this is Partners, New York Press, Stanford, Emory, N.Y.U etc. that is the 131 organizations. Just to give you an idea of this chart, this is not published in a magazine and it does not show up in the U.S. News and World Report. It does not show up in other types of magazines, but it is one of the data comparisons that I really like and I am going to share it with you. This is 100% sample of every patient discharged in a year from The University of Toledo Medical Center that is broken down into ten deciles. At the left here you have the lowest chance of dying in the hospital and at the right you have the 10% at the highest chance of dying in the hospital. So, what you see are the bars of the columns that are the number of patients that were actually discharged. We are the lowest risk category, but it is a very healthy number especially in the higher risk category. The solid line is the predicted mortality of patients this year in each of the ten deciles. So, in the lowest deciles you imagine in predicted mortality there should be nobody dying and then in the little circle (the diamond) represents that nobody died. In the next category they are predicting a few more people should have died. If you were to look at this graph and we are really proud of this, and it has nothing to do whether the “coffee is hot or fresh” and it has nothing to do with if the “room is quiet or not,” but it has to do with the fact that between this straight line which was predicted not by Blanchard Valley, Henry County, and Wood County, but predicted by comparing us to Harvard and Stanford and all the others, there are 167 people who walked out the hospital this year who should have statistically died. I will tell you that is not the “be-all and end-all” metric, but it is a metric. Think about it, if I had to explain that to “Joe the Plumber” what that meant to somebody standing in line at Kroger, it is a lot easier to say that Leapfrog gave us a “B+” because that means a lot more to people. But, if I was to tell you, who are obviously research scientists who understand the comparisons here that the risk adjusted mortality compared to the ‘Club of 100’ hospitals is quite favorable for us, particularly in the high-risk categories, that is meaningful. And if you were to look at other institutions and compare them, frankly that is the kind of stuff that should really underline some of these ratings. In summary, we are constantly defining, measuring, and analyzing lives and improving the outcome at our Medical Center. We are always asking the question, what is important, and how we are doing, and what’s wrong, and what needs to be done, and how do we guarantee performance? Our goals here are very simple. We want to understand the metrics whether they are ours or others. We want to learn the most possible. We want to communicate effectively to our entire hospital and clinical workforce. We want to approach this entire process with humility, no matter how bad the rating and ranking may be. It is not our goal or our job to call it out for being bad, it is the contrary; it is our goal and job to find out what we can learn from it. We try to share best practices and minimize distractions, set aspirational goals, exceed standards, and set standards wherever possible, exemplify excellence, and maintain balance. It is this very delicate balance between the iCare standards and any number of outside rankings and ratings that does occupy us because every time we adjust our standards and our metrics, if they are not particularly valid and if they are anecdotal or something like that, it takes time, money, and people’s attention in a system that is already deprived of all the above.

Now, let me just pull out a couple of cautionary things here because if ratings and rankings, whether they are done internally, or externally, or if they are done well, we really benefit greatly. But if it is not done well (they are in red on the screen) we can hurt outcome experience, we can create unnecessary cost and distractions, we can misidentify best practices, misguide improvement, and we can confuse patients and students. If you thought that cardiac surgery ratings for an average community hospital were better than the Cleveland Clinic and I had an infant with hypoplastic heart syndrome and I went to Blanchard Valley for that operation then that would be nothing short of a tragedy. First of all they wouldn't take the child, but if they would that would be nothing short of a tragedy. Blanchard Valley is very good with what they do, believe me I just called them out for an exemplar of their well-run community hospital. If it is not done well it will affect policy decisions on the federal level, it will affect issues on resources, payers, misguide academic program, and it will create a new unit that we don't want for our students and our faculty teaching. So, when I spoke to our faculty, our students, staff, and our residents at the Medical Center our goal and our call to action was to continue to improve the human condition, to be assured of our ability, and not to hinder ourselves but to use those measurements to build a better future for ourselves and for the patients we currently care for and in the future, to exemplify our iCare values every day, to expand our ambassador role, and to take great pride being part of an institution that really cares about quality and safety. I assure you all across the United States the intense focus on patient experience is frankly not there.

I would like to close with this Olympic metaphor. This photograph was taken of Michael Phelps the day he won his 19th gold medal. The reason I like this metaphor is because Michael Phelps is arguably the finest Olympic athlete that ever lived. However, he doesn't participate in gymnastics and he doesn't participate in decathlon, and he doesn't participate in any number of other winter and summer Olympic sports. Furthermore, he does not excel in every aquatic event and in the events that he does excel in he does not win every race and in the races that he wins he does not excel in every single lap; he has his good days and his bad days and his good laps and his bad laps. When I look at the University of Toledo Medical Center or any other medical center for that matter or any other medical center that I've been involved with, we have months when the infection rates are above normal and we have months when the infection rates are zero. We have months when the infection rates are zero and months that the admission rates are high. We have months when the readmission rates are zero and something else is slightly out of "wack." So, to say that his performance in the free style event is the only way to mark him as an Olympic athlete would probably be an unfair designation and not allow you to really assess his true excellence. To say that he is not a very good gymnast will probably not be a way to assess his Olympic style and his impact on the United States Olympics Games. So it is a constant battle just like it is with Michael Phelps, to try to excel in every race, every lap, and every stroke. In spite of himself in every race, every quarter, and every lap it is a work in progress. To say that we are not constantly improving will be incorrect. To say that we don't have constant areas to improve in frankly will also be incorrect. We have lots of areas to improve in. There were 112,000 people who died in the United States last year from hospital acquired complications that probably should have left the hospital alive. That is tragic and unacceptable and we all need to focus on it and do better. We have to understand the metrics and measuring systems by which they are compared. Anyhow, I thank you for your time and I appreciate it very much. I am very willing to take any questions and comments now, or off-line, or any way that would be effective. Dr. Dowd, thank you for the invitation.

President Dowd: No, thank you for coming and sharing this information with the university community. Are there any questions for Chancellor Gold?

Chancellor Gold: Dr. Brickman is also here with us and he has been very involved, Dr. Brickman, are there any thoughts to add to?

Dr. Kris Brickman: Obviously, Dr. Gold pretty much summarized that quite well in a half hour. He summarized our efforts, our focus, and of course things have become much more public. So again, it puts the spotlight on us and we have to specifically make sure that we are on our game and that is pretty much what this is about.

Anonymous Speaker: Just to comment, you had that earlier slide with the campaign with the helicopter flying above better positions. The 167 people that should have died, but did not should have come from a lot of people, so I would love to see a similar campaign for other professions on the Health Science Campus; maybe Nurse's Week there can be a big billboard or some kind of celebration of the other professions as well because I know that's been noticed, I had people talk to me.

Chancellor Gold: This is last year's sign. This year's sign actually does have a much broader section of health professionals. We are a team. We are only as good as the quality of the team. Your point is extremely valid; no single human being does this alone.

Anonymous Speaker: Dr. Gold, I appreciate your presentation and I think I took away from it that there are pluses and minuses to all of these kinds of grading systems, but what I don't understand is why there is a big banner up outside of the hospital that declares one of those rankings and celebrates the "A+" that we got with that one and it is confusing to the community. I mean we are obviously not going to put a banner up with a "C-" but I don't follow that if we are looking at these as all pluses and minuses.

Chancellor Gold: Historically, we have not done that. Historically, we have been very understated in our achievements and there was a very dramatic feeling by our physicians, and our nurses, and by our Board of Trustees etc. that we were just not telling the community about the excellence and trying to connect this concept to the university quality health care as a referral center and as a transport center etc. and frankly we wanted to do something to recognize the staff and team work and have a celebratory event at the Medical Center and so we chose this as one way to do it. I certainly understand your comment and very much appreciate it. U.S. News happens to have been around for 23 years and they happen to be pretty widely recognized, but frankly it could have been the "snake" chart as we like to call it. We could have put a picture of a "snake" chart in the lobby of the hospital, but it probably would not have sent the same message to our nurses, and pharmacists, and others; but, I hear you, but it is by no means our intent. Next year, who knows, because we have eight specialties that we are recognized for, but that is a regional ranking, it is not a national ranking. We have the honor among institutions to have a national ranking in the single digits and there is no one in Northwest Ohio that is in that category and barely in Southeastern Michigan if you want to know the truth. We are the number one hospital in orthopedic surgery over the last ten years. So, your point is well taken.

Senator Rouillard: Thank you for this presentation because it was extremely informative and I learned a great deal. I would like to follow-up with the previous question because I am struck by the fact that you are admitting that none of these rankings and reports are the final word and you are concerned about misleading people or giving people less than the best information that they need to make patient decisions, medical care decisions. I also ask, why pick the U.S. News and World Report? I looked at the ways that they weighed the criteria and I am very troubled by it. There is a survival score that counts for

32.5%. There is a patient safety score that counts for 5% of the total ranking number. Reputation counts for 32.5% and other care-related services for 30%. According to what I saw on their website, the weight for reputation is nearly one-third of the final score, and how do they calculate that reputation? Well, they send a survey to 200 physicians randomly selected in each specialty with a response rate of 41% which means about 80 physicians on average are making declarations about their opinions to rank these specialties. If, as you say that you need to give people a shorthand way to make their decisions, then this is perhaps not the best one to be choosing and this one can also be quite misleading.

Chancellor Gold: I think they all can be misleading. I think they all have their strengths and their weaknesses. If there's any advantage to U.S. News it is that they been doing it for more than two decades.

Senator Rouillard: Given the scandals.

Chancellor Gold: However, I am open to your thoughts. I can tell you in surgical procedural recording in this quest system and the S.P.S system etc. are comprehensive all non-anecdotal, statistically relevant, peer reviewed, benchmark, and audited systems, but unfortunately they only produce very limited snippets and they are not terribly time sensitive. There is no right answer here. The reason we invited the people from Consumers', the U.S. News, and from other age caps and USC to our campus to talk about this is to try to see if we can contribute to create a better system and a better way of conveying useful information to consumers to make intelligent decisions. Let's go back to orthopedic surgery which is the number one ranking in the orthopedic surgery – if you were to have a child with asthma that's truly unrelated. So, it's just about what happens to work for the needs for an individual and your family can be facing at any given time. I think that the message here, the broader question here is that there are wonderful quality programs and a total focus on improving quality on a safety medical center that is frankly not pleasant. And the overwhelming majority, even peer academic medical centers...to the extent that it is misleading, but we need a better system. I will take that as a serious charge because we have been focused on that for a very long time and we will continue to be focused on it.

Senator Barnes: I just want to ask a question because I did not get a chance to ask it the last time, it is short. Can you tell me if it is standard operating procedure when something goes seriously wrong and it is clearly an accident to put the nurses on leave but leave the doctor in place, is that common?

Chancellor Gold: Every sentinel event undergoes a root cause analysis. A root cause analysis is a group of individuals that is actually led by a nurse, who is head of the quality system looks at the event and talks to a bunch of different people and makes a determination what we need to do on an interim basis and what we need to do on a permanent basis and every single one is different; some only involve physicians, and some only involve nurses, and some involve a combination of physicians and nurses. It is completely dependent upon the detail of what happened and what needs to be done to assure safety in the environment that you prevent such an event from ever happening again. There is no "cookie cutter" approach here.

President Dowd: Again, thank you for coming to Senate. I hope you come back to Senate perhaps later this semester for updates and developments on the Health Science Campus and I look forward to the Chancellor and Provost forums.

Chancellor Gold: I have intention for every single Senate meeting that I am in town to be with you and to answer your questions.

President Dowd: Our next speaker is Margaret F. Traband, Vice Provost for Faculty Affairs. I asked Peg Traband to come to Senate today so that first, she may introduce herself to the few Senators who are unfamiliar with her many years of service to UT and, second, to describe briefly to the Senate the job responsibilities of the Vice Provost for Faculty Affairs. Her activities should be of great interest to all faculty members.

Vice Provost Traband: Thank you, Dr. Dowd. I would like to introduce myself to those who I do not know me here in the Senate and give you a brief background on myself. I want to talk to you about what I believe is important and the work that I do for the faculty, advancing the faculty and assisting the faculty in their professional development. I've actually been at the University of Toledo since the 1974 -75 academic year, I came as an instructor, I have thirty-eight years of service and I am working on my thirty-ninth year. For twenty-one of those years I have been a full professor. I've been a faculty member at the Community and Technical College, the College of Education and Allied Professions, the College of Health and Human Service and post-merger, the College of Health Science and Human Service. My tenure is in the Judith Herb College of Education Health Science and Human Service. I served four years as department chair and nine years as an associate dean and one year an interim dean and this is my fourth year as a vice provost. So I have been at the university for a long time, I have not had the same job here..., I have a wide breadth of knowledge and I have worked with many of you who are in the Senate and I was actually a senator myself when I was in the College of Health and Human Services. As Vice Provost for Faculty Affairs I am responsible for writing summations of the annual review of the tenure-track faculty members, promotion and tenure reviews, and the five-year assessments; I then present those to the provost which then moves on to the president. Last year I reviewed and wrote summaries for 153 dossiers. You can imagine that it is a lot of work, but I can tell you the first time I did it I was going like, "Oh yeah," but in reality it is... What it has done for me is I really appreciate all the great work that is being done. I look at the progression of the faculty as they progress from first year, second year, third year, fourth year, and the fifth year, which is the final year of the review of their dossiers towards tenure. I got really excited this year because what I was seeing in the faculty dossiers is a real emphasis as the university has emphasis on teaching, the quality of teaching, the active of learning that is occurring, and I did not want that to be lost as it went through and I wanted the Board of Trustees and the president to appreciate this great work. So, working with Provost's Office I created a document in which I highlighted each one of the faculty that were candidates for tenure and promotion. There were twenty tenure candidates. I listed their names, their colleges, departments, and areas of research. I featured the innovative and exciting things that each one of them was doing and this document actually ended up in the Board book each time the tenure candidates came up. I really wanted people to understand what wonderful faculty we have here at the University of Toledo and what they have contributed to the student learning. This last year we had a promotion of sixteen faculty to full professor, twenty faculty members to tenure to associate, and thirty-one for post-tenure review. All the other numbers were in the annual reviews. So, that is a big portion of what I do from January through May. Again, it is really an exciting time for me because I see the progress and I see faculty receiving other grants or the article that they were working on get published. It was very rewarding and I feel like a quiet cheerleader in my office for all of your colleagues. I think research collaboration is very important. I created a spreadsheet identifying all

the areas of research. I got excited about their research when I was seeing this person was working on Great Lake Waters or something to do with fresh water. So, one of the things that I would like to re-emphasize and to put in the Minutes for other people to read is please go to the research database ??? http://www.utoledo.edu/research/collaborativegrants/expertise_directories.html (or is it one of the ones listed on this page?? <http://www.utoledo.edu/offices/provost/main/nfo/research.html>

Because she wanted it reflected in the minutes) which is a really valuable resource. I am going to ask if the website can be put into the Minutes, so people can register their research area. It is like a spider web; if this researcher is working on a project and someone else is also working on a similar project in another college or campus, it is important to connect them. There are a lot of people, we are a big campus and we are doing a lot of different things. What I want to say is, we do not have to go outside of Toledo for a prophet because I think there's a whole lot of them working right here at the University of Toledo and we can really help each other. One of the other responsibilities that I have being Vice Provost for Faculty Affairs is New Faculty Orientation. This year was the first year that I was involved in New Faculty Orientation with Wafaa Hanna from the Health Science Campus. We collaborated on the New Faculty Orientation from the Health Science Campus and the Main Campus. We also involved Dr. John Gaboury who is the Executive Director of Learning Ventures and Dr. Constance Schriener who is in the College of Medicine who is working on faculty development. Together, we are really working to support our new faculty. We actually have 51 new faculty who have joined us this year in various areas. We have some fabulous new faculty members. The New Faculty Orientation is continuing and historically it has been two days at the beginning of the first week when the contract begins, but this year we are continuing that on the first Friday of every month, from 9-11 a.m. New faculty are coming together and we are continuing to support them. This past Friday we gathered and learned more about our students. We talked about their financial aid and the resources available to them. We are constantly supporting our faculty during their first term here. We are going to be talking next month about assessment. We are going to talk to our new professors about test construction; again the students love us until the first test. So we are going to work through some of those issues. We are also going to be working with the tenure-track faculty and we already had a breakfast to look at some of the challenges that they might have, of course their dossiers are due January. Their biggest challenge is to write their philosophy of teaching, research, and service. Dr. Barbara Schneider is going to work with them and help them with their writing because that is big challenge for them in those areas. In closing let me just say, the University of Toledo faculty are a rich resource and I think that if you know new faculty members in your department please reach out to them. We are looking for mentors for helping the new faculty because they are overwhelmed as you can well imagine and we are going to reach out to many of you who have great talents across the university to help our new faculty and to help each other. Thank you.

President Dowd: Any questions for Vice Provost Traband? No? Then I want to thank Peg for coming to Senate today to help us understand her position and job responsibilities. Our next speaker is Ms. Dobbins. In the middle of August, your Executive Committee met with Ms. Tamika Dobbins, who has the title "Service Excellence Specialist." Your Executive Committee asked Ms. Dobbins to come to Senate and describe her activities. In a nutshell, Ms. Dobbins — like so many others at this institution serves to improve conditions and daily life for students at UT. Before meeting with Ms. Dobbins in August, I personally was unaware of her position and of her office. Her invitation today is an attempt by your Executive Committee to help get the word out to our community of the important work Ms. Dobbins does on a daily basis.

Tamika Dobbins: Good afternoon. I am Tamika Dobbins and I work in the office of Student Experience on the Main Campus. The information that I am going to share with you for the next couple of minutes is regarding Rocket Rapid Response which is a service recovery program that we use in our office for responding to students who have issues, concerns, and/or questions. Our office was formerly known as the student customer service office, but the name has since changed, and my focus has been to increase awareness throughout the campus community. We are located in Student Union, Rm. 2521 and actually all of our information is located on the screen; it is everything that you will need to know about the office for the student experience and Rocket Rapid Response. Our focus, again, is to respond to questions/issues that students are dealing with, yet they are being unanswered or not appropriately addressed. When I speak to groups about the office, I'll say if a student has a general question and does not know where to go to have it addressed, we can assist and hopefully point them in the right direction. Or if there's an ongoing issue that a student is dealing with and they have been sent to several offices, have spoken to several faculty members, and they are not getting anywhere, then we can help them navigate through that process and get them to an end result that works for them, in order to make their student experience better. So that is the focus in our office. On the screen you'll see that there are a couple of ways that one can reach out to us: UToledo.edu/feedback is our website and it will take you right to the Rocket Rapid Response system and you can type in your personal information and input your questions and concerns; this information will come right to our office and we can begin to respond and act upon it. I worked as a hall director here for four year before leaving and coming back and I dealt with a lot of issues with the students, but many of the concerns that were brought to me were not related to residence life at all, but could have been related to financial aid or dining etc. So, many times I found myself being a sounding board for students who did not know where to go to have their issue addressed, or they were frustrated that they were not getting the proper help they needed. I think it is important for faculty and staff to be aware of our program and aware how to get in contact with us because I am sure many of you have been in that position where a student comes and they may have a question about an assignment or about a paper and then you hear other non-related issues affecting their experience. My focus directly is to be responsive and we want to handle resolutions between one to five business days. Granted, there will be some issues that may take a little longer, but usually by the time it gets to us they have dealt with it for a week or several weeks and so, we want to be rapid with it, respond and get students back on track. Are there any questions about Rocket Response or what I do?

President Dowd: If any Senator would like additional information please contact the Senate office and we will get that information to you. I want to thank Ms. Dobbins for coming to Senate and, more importantly, for what you do for our students every day. Our final speaker today is Dr. Sammy Spann, Assistant Provost for International Studies and Programs. Many of you will certainly recognize Dr. Spann from his previous presentations to Senate and because he is a fixture across our campus. Dr. Spann met with Executive Committee members and presented a host of new and exciting ideas. Rather than trying to summarize all of that now, your Executive Committee asked Dr. Spann to address Senate today to give an overview — and some details — of his thoughts and plans for this year.

Dr. Spann: Thank you so much for allowing me to come speak and I hope to come to other venues. In January the center for our office was finally renovated. The intent was to see about...our national efforts. About four weeks ago Dr. Jacobs approved our international global strategic plan for the University and

he is also going to talk about it this Thursday in the State of the University Address. To say the least, our international efforts at the University of Toledo are picking up. Other than pulling all the different components together, my role in all of this is to also help faculty through faculty – internalize the campus. I am a big proponent for helping getting students out there, but there is a large part of me that wants to get faculty involved as well. Our Study Abroad has improved 60% from the last eighteen months. Even though 60% sounds like a lot we came from 123 to 270 students; other universities our size are twice as big. We have an aggressive goal in the next 18 months to take it to four-hundred. We just hired our Study Abroad Coordinator who will start next Monday and she will be taking on that challenge very aggressively. I just want to go down the list to touch on some bullet points then I will go to questions and answers. This is just to highlight the Senate on the activities that we are doing, but also to put out there if there are any suggestions, research, and/or ideas that you are interested in I will invite you to bring that to us so we can help build that. Starting with the center, we have created a committee called GPS, Global Programming Specialists and what they are responsible for is that they are offering educational, social, and interactive programming for mainly students, but also interactive faculty and staff. The things that we don't think about: we have an all-female shopping trip that is going to an outlet mall that has over one hundred stores. The reason why this is important is because our Saudi women are not allowed to travel with men alone. So, also we are looking at a cultural aspect and making opportunities available for them. We are also going to have a coat drive where we are going to take students to Burlington Coat Factory because a lot of our international friends are coming from warmer climates and they do not realize until "December 23rd or January 15th" that they need a coat. We are also taking some domestic students as well so our international friends are not buying sandals, they are buying boots. The idea is to help integrate our international students and scholars into the university as well. An article was published in the Chronicle that stated 60% of international students feel disconnected from...and we took that to heart and we want to try to make it that we create some opportunities where we can have our students more ingrained in our culture. We are a passport agency. Any student, faculty, or staff member that wants to get a passport, we have four secretaries who are passport agents that will take you from beginning to end to get your passport. Any student or faculty member that is going to do a Study Abroad program that gets approved by our office and the University – we are going to pay for their passport. That sounds pretty aggressive, but I think we can do it. We have the ReCycle project that is currently going on. We put it in the newspaper about three weeks ago asking for bicycles so our international students can be able to rent a bicycle for \$25.00 per year. The Police Department donated six bikes and now we have over twenty-five bikes that were also donated by people in the community, faculty, students, and staff. This is for students who cannot drive or should not drive to be able to get around campus. We are also working closely with Global Health and Dr. Kris Brickman. We have our first group of students who are coming over this year. We have some apartments and housing in the Loft that those students will be staying to do their medical rotations. We are looking at increasing our international presence with Global Health and with nursing, pharmacy, and the others. We are going to have our second annual Study Abroad fair this year where we will be giving out two iPads and two passports and this is going to be September 24th from 11-2:00 p.m. We are inviting you to come and I am going to have vendors from all over the nation who are going to come and talk to students about doing Study Abroad. I think we are going to have about thirty different vendors. Some of those vendors also are geared to help faculty do faculty lead programs. What our initial to get to is to have faculty members who want to take a group of students to a research area, the ideas that faculty members will generate the syllabi and we will have someone help put together the actual program from the beginning to end. It means that someone will be there to receive you and help you go through the

program. We know that it is very stressful for those faculty members that do Study Abroad with students because they have to put a lot into it not having many resources or not having medical resources available, but we are working towards getting that resolved. I have already met with several of you one-on-one and you had the opportunity to see some of the things that we are working on. Our American Language Institute is under new leadership, Barbara...retired over the summer, but our numbers are up, 87 new students and they are enrolled in ALI. We have a total of ten new international students this fall that are up from 183. We have a lot of other activities that we are putting together for them. We have over sixteen different programs that are put together and you are going to start seeing those. We have a boat cruise for international and our faculty, plus we are going to have it catered by a restaurant. We want to talk and welcome them in our country and the University of Toledo. Are there any questions?

Senator Regimbal: Dr. Spann, I just want to congratulate you on the brochure that you have on places to eat that has an international flair. I just thought that was so cool and I tried to call you about three times, but you were always buried with meetings.

Dr. Spann: Thank you. I probably should have had that on here as well. We do have an international food guide that talks about all international restaurants in the city of Toledo that's in a ten mile radius of the university to be specific. This year we are working with a restaurant that is going to be the restaurant of the week and there is going to be 45% off to anyone that holds a University of Toledo ID (the restaurant that we are working with only). We don't have all of them approved because they all haven't agreed on that yet. We are also going to have a monthly trip and we just purchased a 15-passenger van and we are going to have a monthly trip to an international restaurant, anyone can sign up for it. We are going to go and eat and have you rate the restaurant. So, we have those fun and exciting things as well, but we want to stick close to the academic side of it.

Senator Molitor: Just to follow-up with Senator Regimbal, the next time you come to a Faculty Senate meeting make sure you bring a box of those pamphlets.

Dr. Spann: I will. I promise I will do that.

Senator Jorgensen: Are there any recruitment to the USAC program for faculty to reply before next January?

Dr. Spann: The best recruitment are the people who are participating in it, so would you like to talk about it?

Senator Jorgensen: You can teach English-speaking students in another country for a semester and you while remaining a UT employee. Your students will be from UT and other schools. They can take their foreign language there, but they are not able to take their science or economics in another language and so you can go teach them your subject. This summer I visited the German university where I am going to be in January 2014. I felt very welcomed by them.

Dr. Spann: And the company that we are using is paying for the faculty that's coming over. They are also paying the University for their absence and provide instruction for their courses. We have a couple

more that we are working with right now that we are trying to get into an agreement with. We also have additional funding to help with the airfare.

Senator Rouillard: This will be a good time to put in a plug for the USAC programs that allows faculty to go abroad and study and I will thank you again for my experience last summer in Spain for the FIDA award. It was a wonderful experience to remind myself what it feels like to be in a foreign country, and what it feels like, what our students have to go through when they are studying abroad, and all of the adjustments one needs to make.

Dr. Spann: Thank you so much.

President Dowd: Thank you, Dr. Spann for coming to Senate today. I look forward to your future presentations to Faculty Senate. Do we have any old business? Any new business? Are there items from floor? No? Then do I have a motion to adjourn?

IV. Meeting adjourned at 6:00 p.m.

Respectfully submitted by:

Lucy Duhon
Faculty Senate Executive Secretary

Tape summary: Quinetta Hubbard

Faculty Senate Office Administrative Secretary.