College of Veterinary Medicine  
Compact for Fiscal Year 2003-2004  

A. Introduction  
The College of Veterinary Medicine exists to improve the health and well-being of animals and people through high-quality, progressive education, service, and research activities. In 2001-2002, the College continued to make substantial progress in introducing innovative academic, research and service programs. Here are some highlights.  

Education  

DVM degrees. A total of 78 professional students received their DVM degrees in May 2002. Of these, 51 graduates accepted positions in private practice, 40 in Minnesota. Thirty-nine accepted positions in small animal practice, nine in large animal and equine practice and two in mixed animal practice. Fourteen accepted internships or academic positions at other institutions.  

Graduate degrees. Eleven graduate degrees were conferred; 5 masters and 6 PhDs.  

Internships/residencies. Nine veterinarians completed internships, three of which were in large animal medicine and surgery, and six in small animal medicine and surgery. Three veterinarians completed residencies in clinical specialties, two completed residencies in small animal internal medicine and one in small animal surgery.  

Outreach/continuing education. The faculty participated in 204 continuing education programs and 114 outreach programs in state, national, or international meetings. The College sponsored 27 conferences attended by a total of 1,681 veterinarians. The College also sponsored 34 extension programs in conjunction with the Minnesota Extension Service.  

International exchange programs. The College continues to enhance educational opportunities of students with international exchange agreements. Exchange relationships now exist with Argentina (Universidad Nacional de Rio Cuarto), Hungary (Laszlo Szent Istvan University), Korea (Seoul, National Research Institute, Graduate School of East-West Medical Science, Kyung Hee University), Morocco (Institute Agronomic et Veterinaria Hassan II), Spain (Autonomous University of Barcelona), Thailand (Kasetsart University, Khon Kaen University, Chulalongkorn University), and Uruguay (University of the Republic, Montevideo).  

New programs. Recognizing the importance of Minnesota’s equine industry, the College established the University of Minnesota Equine Center. Its vision is to become the premier program for advancing the health, wellbeing, and performance of horses.  

The College launched the Transition Management Facility, a unique collaborative project with a dairy that gives veterinary students hands-on experience with large populations of dairy cows in the weeks before and after giving birth. The facility, an hour outside the Twin Cities, also provides opportunities for educating veterinary practitioners, conducting clinical and applied research, and showcasing new management techniques for the dairy industry.  

Working with the University’s School of Public Health, the College launched a unique four-year joint DVM/MPH degree program. The innovative program, which allows veterinary students to receive both degrees in four years, was designed to meet the rising national need for public-health veterinarians to work in areas such as food safety, emerging infectious diseases, and bioterrorism. A program that allows mid-career veterinarians to receive an MPH was also initiated.
Service

Veterinary Teaching Hospital. In 2001-02, 39,946 cases were admitted to the VTH representing an increase of 8,068 over the previous year. This increase was primarily in canine and feline cases.

Raptor Center. The Raptor Center continued its treatment and rehabilitation work. The Center admitted 647 birds of prey, including 108 bald eagles, and released 206 birds into their natural habitat. The Raptor Center staff conducted 975 educational programs for schools, community organizations, and corporations nationwide, reaching 247,104 people.

Veterinary Diagnostic Laboratory. The VDL conducted more than 1 million laboratory tests, with the number of accessions increasing from 51,451 in 2000-01 to 56,618 in 2001-02. When the swine industry experienced a major outbreak of porcine reproductive and respiratory syndrome in 2002, a new VDL-developed test was instrumental in detection and reporting of the disease, thus helping to mitigate losses to the swine industry.

New programs. The College established the Center for Animal Health and Food Safety (CAHFS) to strengthen the College’s ability to provide resources, support and leadership for key animal and food related public health issues. The Center has forged strong relationships with state agencies and commodity organizations and has taken a leadership role in providing training on emerging issues.

The Veterinary Teaching Hospital established a full-time dental practice for small animals, joining only three other veterinary colleges to do so. Additionally, the VTH added an integrative (alternative/complementary) service and enhanced its behavior services. An out-patient clinic was opened in Apple Valley.

Research

Funding. Research support during FY 2001-02 was $15.4 million, comprising 32 percent of the College’s budget. Faculty submitted 145 research proposals to various agencies requesting a total of $18.5 million in support. Eighty-three (or more than half) of these proposals received awards, totaling $9.08 million.

Inventions. Faculty had 7 invention disclosures and received 6 invention licenses. An avian pneumovirus vaccine, developed by College faculty, received U.S. Department of Agriculture approval.

Publications. Faculty published 146 articles in refereed journals and 22 books and/or book chapters in 2002.

Development. Contributions for 2002 were up slightly over the previous year. Contributions to the College from alumni, clients, corporations and friends of the College totaled $6,907,231, and contributions to The Raptor Center were $651,168 -- for a combined total of $7,558,399. The University of Minnesota initiated Campaign Minnesota in October 1999 with a goal of $1.3 billion for the entire University. That goal was reached in May 2002. The goal for the College and The Raptor Center was $28 million. From October 1999 through June 2002 a total of $28,621,344 was raised.
Major Long-Term Goals/Priorities

1. Improve the health of Minnesota’s animals and its people by enhancing the vitality and excellence in animal health and comparative medical research *

5 Yr Strategic Plan Goals: Focus on basic and clinical research (emphasis areas include food animal infectious diseases, food safety, chronic disorders in dogs and cats (oncology, cardiology, urinary disorders) and development and evaluation of animal models of human disease). Use functional genomics to address basic and clinical research needs. Build graduate programs to national prominence. Ensure that new and existing faculty have adequate research laboratory space. Build a new animal isolation facility on the St. Paul campus. Enhance CVM molecular diagnostic capabilities.

Accomplishments:
- The College developed a comprehensive communication program and biennial request to the Legislature to strengthen its position as a value to Minnesota. Materials were developed to support the request and seminars were given to veterinary associations and civic groups throughout the State.
- To focus on basic and clinical research, Richard Isaacson was hired as the Veterinary Pathobiology Department Chair. His first year was spent working with faculty to develop a long-term vision for the department and to strengthen research opportunities. In addition, faculty positions in microbial and animal genomics were filled with outstanding individuals that will strengthen the College’s basic science research programs.
- A Summer Scholars Program was initiated which allows veterinary students to gain research experience. The program was funded from internal CVM funds and a grant from Merck-Merial.
- The $2 million fundraising campaign for the Alvin and June Perlman Oncology Chair was successfully completed. Elizabeth McNiel was hired into a tenure-tract oncology position and an oncology residency program was instituted. The Chair search will move forward as the endowment grows.
- To build graduate programs to national prominence, the College allocated $200,000 in funds to support graduate student stipends. In addition, USDA and NIH training grants were submitted. The CVM graduate programs developed new educational models to increase the number of DVMs in PhD programs.
- To enhance clinical investigations, the VTH added a new Research Coordinator position.
- To ensure that new and existing faculty have adequate research space, laboratory space was renovated for the new Pathobiology Chair and microbial genomics faculty member. A program plan was developed to include the animal isolation facility into the U of M’s 6-year Capital Project list. One disappointment was that funding to renovate the VDL Molecular Diagnostic Laboratory, approved in both the House and Senate bonding bills, was vetoed by the Governor.
• To enhance our interactions with the Academic Health Center, a veterinary pathology core was developed as part of the Cancer Center NCI grant renewal and implemented the service.

Relationship to AHC Strategic Plan: Goal 2, Objective 3. (www.ahc.umn.edu)

New Long-Term Goals/Priorities:

• To enhance basic and clinical research, recruit and hire an outstanding faculty member to chair the SACS department (compact fund request).

• To enhance basic and clinical agricultural-related research, request compact funds to replace loss in FY04 Minnesota Experiment Station funds (compact fund request).

• To build nationally recognized infectious disease and food safety programs, develop a vision and strategic plan for CVM infectious disease programs and hire a molecular epidemiologist.

• To build a nationally recognized comparative medicine program, develop a vision and strategic plan for CVM comparative medicine program. Begin planning for comparative medicine center in CVM.

• To enhance CVM research program national recognition, increase the number of grant submissions by 25% by developing and initiating a new research incentive plan, enhancing grant preparation infrastructure and improving communication of grant availability.

• To enhance research programs to national prominence, develop and implement an infrastructure resource plan to support submitting at least 3 large multidisciplinary grants.

• To build graduate programs, obtain at least $50,000 from the industry to support the new Summer Scholars Program.

• To ensure new and existing faculty have adequate research space, develop a plan to convert the Old Anatomy Building into administrative space and convert existing administrative space into translational research laboratory space. Complete renovation of VDL brucellosis/molecular diagnostic laboratory (pending legislative funding).

• To enhance CVM research programs, continue efforts to include new isolation facilities on the St. Paul Campus in the U of M 6-Year Capital Request. Seek partners, identify possible funding sources, analyze survey results, and proceed with an implementation plan.

Financing: We are requesting $50,000 in recurring compact funds and $100,000 in nonrecurring compact funds to aid in the recruitment of a Chair for the Small Animal Clinical Sciences Department. This was part of Dr. Klausner’s start-up request when he became Dean. The CVM will invest an additional $100,000 in recurring and $200,000 in nonrecurring funds for the Chair position. In addition, we are requesting $100,000 to replace loss in MN Experiment Station funds to ensure excellence in agriculture research. In addition, we are requesting continuation of previous recurring compact allocations. Predesign for Dairy Barn/Old Anatomy renovation was funded last year.
New FY04 Compact Funding Request

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<td>Comparative Medicine</td>
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<td>Molecular epidemiologist</td>
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2. Increase the safety of Minnesota’s food animal products

5 Yr Strategic Plan Goals: Enhance the safety of Minnesota food animal products. Limit the impact of emerging infectious diseases. Promote public health through enhanced recognition of the importance of the human/animal bond.

Accomplishments:

- To enhance the knowledge of public health professionals and veterinarians, initiated two high impact and broadly visible “just-in-time” training events on chronic wasting disease and West Nile Virus for over 600 veterinarians, students, extension educators, food processors, and food service professionals.

- To increase the number of veterinarians with advanced public health training, inaugurated a veterinary public health residency program, which allows veterinarians to expand their knowledge and earn an executive MPH in public health practice. In addition, the College partnered with the School of Public Health to develop and launch a new DVM/MPH program.

- To raise CVM visibility in public health and emerging infectious diseases, the Center for Animal Health and Food Safety (CAHFS) hosted a critical-issues roundtable regarding food safety, which attracted individuals from food safety centers across the country.

Relationship to AHC Strategic Plan: Goal 3, Objectives 2.0 & 3.5. (www.ahc.umn.edu)

New Long-Term Goals/Priorities:

- To become a nationally recognized leader in food safety through its teaching, research and outreach programs, complete a detailed, strategic business plan for the CAHFS, establish internal and external advisory boards, and develop a proactive communication and marketing campaign.
• To financially support the Center, submit at least two proposals to federal agencies, foundations, and industry associations and submit at least one major food safety grant.

• To educate the public, deliver two target programs based on feedback from potential program participants.

• To increase the number of veterinarians with advance public health training, increase enrollment in the DVM/MPH program to 30 students, increase utilization of adjunct faculty in the program, identify potential partnerships with other CVMs, create marketing materials, and develop funding plan to support infrastructure (compact fund request).

• To increase CVM’s visibility in public health and emerging infectious disease, conduct at least 2 just-in-time or other continuing education programs, participate in at least 4 major technical/policy meetings, establish the CAHFS external advisory board, host 1 major technical/policy meeting, and develop and implement PR strategies, including (marketing, speaking engagements, bylined trade/news media articles, press releases and interviews).

• To enhance CVM leadership in identification of emerging disease, renovate the VDL to expand molecular diagnostics, Johne’s disease, and chronic wasting disease laboratories.

Financing: The CVM/SPH requests recurring funding for infrastructure support for the combined DVM/MPH program and the executive MPH program.

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<th>EXPENSES</th>
<th>Total from previous Fiscal Years</th>
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<tr>
<td>Food Safety faculty</td>
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<tr>
<td>CVM/SPH infrastructure support for DVM/MPH Program</td>
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<td><strong>TOTAL EXPENSES</strong></td>
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| CONTRIBUTIONS                                 |                                  |                             |
| TVET                                          |                                  |                             |
| AHC                                           | 100,000                          | 150,000                     |
| Central                                       |                                  |                             |
| Private/Foundation                            |                                  |                             |
| Public Health                                 |                                  |                             |
| **TOTAL CONTRIBUTIONS**                      | **100,000**                      | **150,000**                 |
3. **Build a stronger veterinary health care delivery system in Minnesota**

**5 Yr Strategic Plan Goals:** Improve Minnesotans’ access to high quality, cost-efficient veterinary care in partnership with the veterinary community. Ensure that there are sufficient, well-trained veterinarians to meet the needs of rural Minnesota. Improve the productivity, competitiveness and sustainability of Minnesota’s dairy and swine industries. Increase the number and utilization of certified veterinary technicians. Improve the health, well-being and performance of Minnesota’s horses. Provide high quality care for companion birds.

**Accomplishments:**

- To ensure adequate numbers of dairy practitioners in Minnesota, initiated student rotations at the Transition Management Facility (TMF) in Baldwin, WI. In addition, secured $477,000 in private funds to support the TMF operation.

- To ensure adequate numbers of well-trained veterinary technicians in Minnesota, completed a feasibility study to determine career opportunities for veterinary technicians with a BS degree. In addition, implemented a receiving day for technicians in the VTH to enhance the opportunity for veterinary students to develop a better appreciation of the veterinary team.

- To assure access to high quality, cost-efficient veterinary care, established a VTH off-site specialty care service in Apple Valley. In addition, conducted a feasibility study to assess the need for other off-site specialty services.

- To enhance outreach to the poultry industry, developed a funding strategy with the Minnesota Turkey Growers Association for a new faculty position in poultry pathology/poultry extension and hired an avian pathologist/extension educator.

- To enhance service to the equine community, raised private funds toward the $6 million goal for the Equine Center Building. A pre-design was completed.

- To improve the health, well-being and performance of Minnesota’s horses, developed an equine undergraduate program with COAFES to be offered for the first time in Fall 2003.

- To increase the number of students interested in food animal practice, developed and implemented a “fast track” admission plan (VetFast) with COAFES.

- To ensure the prudent use of drugs in food animals, developed a “best practices” model in cooperation with the Minnesota Veterinary Medical Association and the dairy industry.

Relationship to AHC Strategic Plan: Goal 3, Objective 3.0 & 4.0; Goal 1, Objective 3; Goal 6, Objective 3.0. ([www.ahc.umn.edu](http://www.ahc.umn.edu))
New Long-Term Goals/Priorities:

- To improve Minnesota’s access to high quality, cost-efficient veterinary care, implement one or two additional VTH off-site specialty care locations or mobile services.

- To improve quality and efficiencies of services, explore the development of a state-wide veterinary healthcare delivery system that utilizes primary, secondary, and tertiary providers.

- To provide state-of-the-art services, implement a digital picture archiving and communication system for radiography in the VTH (as a prelude to developing regional telemedicine system).

- To maintain national leadership in food animal veterinary diagnostic medicine, recruit and hire a nationally recognized veterinary pathologist with expertise in food animal veterinary diagnostic pathology and recruit and hire a VDL veterinary epidemiologist (with SPH) with expertise in disease surveillance.

- To enhance diagnostic surveillance, continue efforts to include VDL in the National Animal Health Laboratory Network.

- To maintain VDL accreditation by the American Association of Veterinary Laboratory Diagnosticians, prepare for AAVLD site visit in June 2003.

- To expand relationship with the Minnesota Department of Health (MDH) and Department of Agriculture, collaborate with MDH on bioterrorism laboratory response.

- To increase the number of students interested in food animal practice, implement VetFast Program by creating marketing and recruitment materials. Develop dairy and swine certificate program targeting other CVMs and mid-career professionals. Develop online web-based materials to provide information to support Minnesota’s dairy industry.

- To increase the number and utilization of certified veterinary technicians, implement model of “veterinary extenders” in the VTH.

- To develop a nationally recognized equine program at the U of M, utilize UMEC organizational umbrella to strengthen teaching, research, and service programs and promote equine faculty capabilities and activities through website and PR initiatives.

- To establish an equine undergraduate educational program in Animal Sciences, design curriculum, hire 1 FTE faculty member in COAFES/CVM, and promote undergraduate equine program widely through PR initiatives.

- To build the UMEC facility and program, secure 75 percent of the $8 million fundraising goal.

- To provide high quality care for companion birds, develop and implement outreach programming to promote responsible bird ownership.

**Financing:** The CVM will fund all items in this goal.
4. Support Minnesota’s agricultural, biotechnology and pharmaceutical industries

5 Yr Strategic Plan Goals: Increase the number of clinical trials offered by CVM. Increase the number of veterinary students who choose a career in industry.

Accomplishments:
• To continue its support of the turkey industry, CVM faculty developed an avian pneumovirus virus vaccine that was approved for use by the USDA.
• To increase the number of veterinary students who choose an industry career, developed and taught a new elective in industrial veterinary medicine course.

Relationship to AHC Strategic Plan: Goal 2, Objective 2.0 & 4.0; Goal 3, Objective 3.0.

New Long-Term Goals/Priorities:
• To expand Clinical Investigation Center services, develop and implement a business plan.
• To build strong links with Minnesota’s biotech and pharmaceutical industries, make personal contacts with industry.
• To implement and increase the number of the DVM and graduate students interested in clinical research, add a clinical trials course to DVM curriculum, create a database of interested students, advertise clinical trials and promote 2003 Summer Scholars Program opportunity through website.

Financing: CVM will fund items in this goal.

5. Improve Minnesota’s natural environment.

5 Yr Strategic Plan Goals: Ensure financial and mission related success of The Raptor Center. Promote the health and teach the value of Minnesota’s wildlife.

Accomplishments:
• To ensure continued leadership position of The Raptor Center, developed a short-term strategic plan developed and redefined the Center’s mission to include companion birds. Created a development plan to increase the number of donations.
• To enhance The Raptor Center’s educational programs, hired an education director.

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<tr>
<th>EXPENSES</th>
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<th>Total FY 2003-04</th>
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<tr>
<td>Veterinary Pathologist</td>
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<td>TOTAL CONTRIBUTIONS</td>
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• To promote the health of Minnesota’s wildlife, the VDL implemented CWD diagnostic testing and surveillance in Fall 2002.

New Long-Term Goals/Priorities:

Raptor Center:
• To ensure financial and mission related success of The Raptor Center, increase the number of >$100,000 donations; and hire development director, membership coordinator, and membership assistant. Develop and implement fundraising plan for 2003-04 to generate adequate resources to cover program expenses.
• To ensure financial and mission related success of The Raptor Center, develop a new 3-year strategic plan, increase profile and impact of key messages through written publications and website, reorient clinic focus toward avian conservation medicine program, and increase engagement of volunteers in strategic and tactical functions.
• To enhance The Raptor Center’s education and outreach programs, build partnerships with educators, DNR and CNR. To create K-12 interdisciplinary thematic curriculum focused on under-served populations (inner-city and out-state), build a schedule of on-site adult and family based programs, and increase off-site paid programs by 20%.
• To create a wildlife curriculum and expand outreach programs, develop DNR rotations and develop a series of monthly continuing education lectures.

• To develop a West Nile virus vaccine, seek resources, partnerships, and technological capacity and implement a fundraising plan.

VDL:
• To expand surveillance for Transmissible Spongiform Encephalopathies, prepare for CWD during Fall 2003, and assist the USDA and Minnesota Board of Animal Health with eradication of prion-associated diseases.
• To promote the health and to teach the value of Minnesota’s wildlife, seek participation of wildlife/DNR officials on VDL advisory committee and fund a joint intern/residency program with the MN Zoo.

Financing: The CVM will fund all items in this goal.

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<th>From Previous Fiscal Years</th>
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<td>TOTAL CONTRIBUTIONS</td>
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6. Prepare CVM graduates for successful careers and life-long learning

5 Yr Strategic Plan Goals: Ensure selection of students with attributes that predict success in the profession. Increase the number of collaborative learning opportunities within the U of M and maintain strong and vibrant DVM curriculum with other colleges of veterinary medicine. Better integrate professional program with continuing education programs.

Accomplishments:
- To enhance the veterinary College’s admissions process, a study was completed to define behavioral competencies of successful veterinarians and implemented a process to incorporate the study’s findings into the CVM admissions process.
- To enhance graduate preparedness, initiated a curriculum outcome assessment plan and held practitioner focus group meetings. Participated in creating a Model Curriculum for Veterinary Career Development (led by MSU). Spring 2003, veterinary students participated with other students in the new AHC clinical skills laboratory.
- To increase the number of veterinarians working in public health, implemented a combined DVM/MPH program and an MPH program for mid-career professionals.
- To enhance DVM skill development, developed a new outcome-based community rotation; implemented a clinical dairy rotation at the Emerald Dairy in WI; created opportunities for leadership skill building by creating a Business Club and offered DVM students opportunity to attend human/animal bond seminar with practitioners at MVMA meeting. Initiated an Alternative Medicine Clinic in May 2002.
- To increase the public’s knowledge of veterinary medicine, presented the Colleges first successful Mini-Vet School program in Fall 2002.

Relationship to AHC Strategic Plan: Relates to Goal 1, Objective 1.0 and Initiatives 1.11, 1.21-1.26, 1.32-1.34; Goal 1, Objective 4.0 & Initiatives 4.0, 4.1 & 4.21; Goal 6, Objective 1.0, Goal 8. (www.ahc.umn.edu)

New Long-Term Goals/Priorities:
- To increase the number of experiential opportunities for students, implement outcome-based community preceptorships in small animal community practice and establish a position of Director of Experiential Education (compact fund request).
- To ensure selection of students with knowledge, skills and attributes that predict success in the profession, develop and implement admissions guidelines that incorporate these behavioral competencies. Institute a behavioral-based interview into the process.
- To increase the number of food animal students, implement ‘VetFast’ plan for early admissions.
- To ensure students are prepared for career success, analyze outcome assessment data and formulate a plan of action for curricular change. Add new VTH based business course to CVM curriculum.
- To enhance international experience, move International Programs to the Office of Academic Affairs and work with U of M’s International Office to develop a CVM program.
• To develop tools to enhance student learning, create a DVM curricular map, explore use of PDAs for class work and clinics, market educational products, review teaching technologies, and create course outcome assessment tools for 10% of CVM courses.

• To reduce and refine animal use in curriculum, create a database of animal use options and alternatives.

• To increase the number of collaborative learning opportunities, participate in development of AHC Physiology course(s).

• To better integrate professional program with continuing education programs, identify opportunities to market clinical rotations opportunities to private practitioners. Explore developing certificate programs that will allow practicing veterinarians to refocus their careers and attract students from other CVMs. Explore developing a national dentistry training center.

Financing: The CVM requests recurring funding for a Director of Experiential Education from Compact funds.

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<th>EXPENSES</th>
<th>New FY04 Compact Funding Request</th>
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<td>Director of Experiential Education</td>
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<tr>
<td>Private/Foundation</td>
<td>Total Contributions: 30,000</td>
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7. **Build a culture of service and accountability**

**5 Yr Strategic Plan Goals:** Ensure that service in the VTH and VDL exceed customer expectations. Provide ‘one stop shopping’ in the Office of Student Affairs for professional and graduate students.

**Accomplishments:**

- To enhance service to referring veterinarians and VTH clients, conducted systems analysis to maximize efficiencies; initiated satellite VTH service in Apple Valley; and developed and initiated a VTH volunteer program. Developed process to ensure consistent and effective complaint response. Redesigned the billing process to ensure an accurate estimate at the time of client discharge.

- To enhance service to VDL clients, developed same day molecular PRRS testing for swine industry. Expanded laboratory hours of operation by including evening hours. In February 2003, large swine enterprises and
veterinarians beta tested electronic submission to streamline data capture and enhance analysis.

- To enhance service to VDL clients, expanded molecular diagnostic testing capabilities, received funding to install a chemical cremation system, and conducted a study to assess feasibility of building a BSL-3 Ag laboratory.

- To provide better service to professional students, initiated a student counseling service. In addition, established a graduate student database to track student information.

**Relationship to AHC Strategic Plan:** Goal 7, Objectives 3.2 & 5.2. (www.ahc.umn.edu)

**New Long-term Goals:**

- To ensure outstanding service to referring veterinarians and VTH clients, continue to conduct systems analysis to maximize efficiencies, develop and implement client, rDVM, and employee satisfaction surveys, and improve website.

- To enhance service to VDL clients, continue to expand molecular diagnostic testing capabilities, and develop new tests for PRRS (detects US and European strains with one test), influenza virus, and Johne’s disease. Install a chemical cremation system to ensure proper waste disposal, and establish partnership with industry to develop integrated disease surveillance system (PIC and Pfizer contributed $150,000)

- To provide better service to professional students, market student counseling services or determine why there is low interest.

- **Financing:** The chemical cremation system is being funded by U of M Facilities Management. Other items in this goal are funded by the CVM.

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<tr>
<th></th>
<th>Total from previous Fiscal Years</th>
<th>Total FY 2003-04</th>
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<td>TOTAL CONTRIBUTIONS</td>
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8. **Strengthen CVM operational efficiency and financial health**

**5 Yr Strategic Plan Goals:** Increase all sources of college funding. Increase college efficiencies. Increase the effectiveness of CVM space utilization.

**Accomplishments:**

- To help meet veterinary workforce needs and to enhance CVM revenues, CVM faculty approved the addition of 10 nonresident students to the DVM class for Fall 2003. Space analysis was completed to accommodate this increase.
• To enhance CVM revenues, an ad hoc department reorganization committee was convened to explore reducing the number of departments from 4 to 3. Planning was completed to implement change.

• To enhance VTH revenues, opened satellite service in Apple Valley, continued process improvements, and implemented a new VTH clinical pathology information system.

• To enhance VDL revenues, developed strategies to diversify the client base, completed strategic plan, and started implementing major plan goals.

Relationship to AHC Strategic Plan:  Goal 6, Objective 1.1; Goal 4, Objectives 1.0 & 1.4. (www.ahc.umn.edu)

New Long-Term Goals/Priorities:
• To increase CVM revenues, develop and initiate a plan to gain financial support for new DVM/MPH and executive MPH programs.

• To enhance CVM revenues, implement new salary saving incentive plan. Develop a business plan for continuing education programs. Develop a plan to ensure full cost recovery on all CVM research grants. Work with the Veterinary Hospital Association to explore the concept of developing a companion animal research fund using a portion from cremation fees.

• To enhance VTH revenues, implement clinical incentive plan and reduce number of subsided necropsies.

• To increase tuition revenues, increase the number of enrolled “off shore” students, develop an affiliation agreement with Western University College of Veterinary Medicine and St. Georges University.

• To enhance VDL revenues, evaluate market opportunities to increase submissions of companion animal laboratory samples. Develop a business plan to ensure profitability Endocrinology Laboratory. Develop strategies to diversify the VDL client base and to expand partnerships with other veterinary diagnostic laboratories and private industry. Develop a VDL communications plan.

• To maximize outreach revenues, explore offering continuing education/extension/Complete Scholar classes and make recommendations.

• To enhance fundraising revenues, establish major gifts development position in the VTH. Conduct focus group to determine if practitioners would support the concept of a MRI Center and develop new priorities for 3-5 mini campaigns.

• To enhance The Raptor Center revenues, develop and implement new fundraising strategies, develop and market new educational programs, and complete new operational/infrastructure plan.

• To increase College efficiencies, implement merger of VDM and CAPS departments, hire Chief Operating Officer, and implement operations reorganization plan that will centralize many CVM operations. Institute interdisciplinary grants infrastructure support plan. Centralize EEO process.

• To increase effective space utilization, complete predesign study for renovating the Dairy Barn and Old Anatomy buildings and present administrative area.
Analyze 2003 CVM space inventory data and update actual space usage. Develop a detailed maintenance program with Facilities Management to ensure existing facilities are better maintained. Rennovate lecture rooms, labs, etc. to accommodate the increased class size. Update/upgrade VTH facilities to accommodate expanded clinical activities. Consolidate graduate student offices into a centralized area. Increase surgical suites.

- Develop a business plan for the Veterinary Medical Center that will assure its future in fulfilling its education, research and service mission.

**Financing:** The CVM will fund all items in this goal.

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9. **Improve CVM visibility and strengthen CVM reputation**

**5 Yr Strategic Plan Goals:** Develop communication strategies to support and promote CVM strategic goals. Increase public awareness of how veterinary medicine benefits both animal and human populations. Develop an infrastructure to promote CVM accomplishments.

**Accomplishments:**

- To ensure that CVM communications and public relations strategies support each of the CVM strategic goals, restructured staff support, hired a part-time journalism student, leveraged writing resources, updated the CVM website, and developed key messages to drive communications efforts.
- To develop an infrastructure to support communications and public relations efforts, reorganized communications and public relations database to target equine, bovine, swine and wildlife.
- To build support for the CVM, conducted first Vet School for VIPs program, developed communication messages and data for a possible request to MN Legislature, developed a database of key contacts and provided presentations to civic and veterinary groups throughout Minnesota.

**Relationship to AHC Strategic Plan:** Goal 1; Objective 2.2; Goal 3, Objective 1.1; Goal 6, Objective 2; Goal 7, Objective 1.3. (www.ahc.umn.edu)

**New Long-Term Goals/Priorities:**

- To develop communication strategies to support and promote strategic goals, create and implement communications plan, develop key messages to drive communications efforts, and update the CVM website with strategic information.
• To enhance distribution systems, review and improve internal distribution systems, enhance database with targeted publications to support individual center and department objectives, and evaluate greater use of e-vehicles to streamline time and costs.

• To maximize strategic public relations opportunities, identify, prioritize and pursue opportunities by conducting editorial roundtables with Star Tribune and Pioneer Press education, ag, feature and public health writers, and seek inclusion of pet care Q&A column in Star Tribune.

• To maximize website as a key source of student recruitment, create and implement plan to implement U template, to enhance navigation and improve content.

• To support strategic plans of individual department and centers, develop strategies and communication plan to enhance VPB department image. Develop marketing and communication plan for CAHFS, VDL, VTH, and Raptor Center.

• To influence public policy and legislative development, hold Vet School for VIPs, create clear, consistent objectives and messages, expand distribution of key communications vehicles to legislative audiences and producer group advocates as appropriate.

• To develop an infrastructure to support communications and public relations, expand communications outreach to internal U news functions and publications, expand communications capabilities with an emphasis on strategic planning, writing and media relations expertise, leverage existing materials and activities with broader range of audiences, develop close partnerships with SPH, COAFES and key state agency communicators, and evaluate methods of tracking local and trade media coverage.

Financing: The CVM will fund all items in this goal.

10. Maximize the potential of all who work and learn at the CVM

5 Yr Strategic Plan Goals: Create a strong sense of community with the college. Develop leadership potential. Provide excellent human resource management and expertise.

Accomplishments:
• To enhance professional student leadership opportunities, implemented CUPES service-learning opportunity for students in public health rotations and added communication component to Integrative and Practice Readiness courses.

• To provide an incentive for excellence in clinical activities, began development of a unified clinical incentive plan for regular, contract, and clinical faculty who work in the VTH.

• To ensure competitive salaries for faculty and staff, developed promotional system in CAPS and SACS departments for P&A faculty.

• To increase the number of faculty and staff awards, created database of available awards and regularly sought out nominations.
• To increase learning opportunities for faculty and staff, offered courses in stress management, software training, and respectful workplace.

• To increase service to employees, developed an employee handbook, created orientation materials and policies and adopted new procedures.

Relationship to AHC Strategic Plan: Goal 1, Objectives 1.0, 2.0, 4.0 & 6.0; Goal 7, Objective 3.0. (www.ahc.umn.edu)

New Long-Term Goals/Priorities:

• To ensure diversity in the student body, market, DVM, DVM/PhD and DVM/MPH programs to underrepresented minorities.

• To increase the number of faculty and staff nominated for campus and national awards, implement infrastructure to increase the number of faculty and staff nominated for campus and national awards and add administrative support for Awards Committee.

• To integrate graduate students into CVM community, place students on committees, combine orientations, provide opportunity and encourage participation in continuing education programs, and combine DVM and graduate student graduation ceremonies.

• To increase the number of semester and sabbatical leaves for faculty, develop and implement Careers Committee recommendations.

• To ensure faculty and staff have adequate human resource information, conduct human resources audit, develop plan to clarify roles and responsibilities of HR team, and draft HR vision, mission and value statement.

• To ensure supervisor skills are adequate to meet HR needs, assess HR skills of departmental administrators and establish professional development plans.

• To increase faculty, staff and student leadership and professional training opportunities, develop and implement training opportunities for staff. Conduct media and presentation training. Seek opportunities for faulty to sit on external committee/boards.

Financing: The CVM will fund all items in this goal.

C. Workforce Issues/Diversity Goals

A concern has been voiced regarding our future ability to train and provide veterinarians in rural areas and replacements for present academic faculty. We are addressing this concern in a variety of ways. We are increasing the DVM class size from 80 to 90 students (with an emphasis on recruiting applicants with public health or food animal interest). We have also created a new early admission/early decision program called VetFast (Veterinary Food Animal Scholars Track) to target undergraduate students with an interest in food animal practice. To increase future academic faculty, we are offering a summer research program for DVM students.

We have recently created a dual degree DVM/MPH program to meet the emerging need for veterinary professionals in this discipline. In addition, this program will hopefully attract minority students who may be more interested in this part of the profession than a clinical practice focus. We plan to
actively recruit students from underrepresented minorities to apply for admission to this dual degree.

The College currently employs 889 individuals (faculty, staff, house officers, and students) with a workforce composition of 66% female, 34% male, and a minority population of 12.6%.

The College of Veterinary Medicine is committed to expanding the areas of diversity in its student body. While there are relatively few applications for admissions from minorities, the College is examining a number of broad factors related to diversity for use in the application process, including race/ethnic status, gender, rural/urban mix, interest in and commitment to underserved areas of the veterinary profession, and others. The application cycle for Fall, 2004 is already closed as of October. However, planning for the process described here is underway, and it will be effective by, and used during, the 2005 review cycle.

The process will define and articulate the diversity factors used and the rationale for their inclusion. It will also guide the review and, if needed, redesign, of the application form, which will elicit, and be used to collect, data in relation to the desired factors for diversity. Students will be clearly informed of this collection and how these data will be used in the admission process. The process will involve procedures which will take these data directly forward into the evaluation and admission parts of the process. It will avoid the use of separate tracks and racial or ethnic quotas. An individualized review of applications will continue to be conducted.

This process will also utilize a periodic but regular review of the efficacy of these procedures and their effectiveness in meeting the diversity goals of the College.

Since 1992, CVM tenure/tenure-track faculty head count has decreased by 14 percent.

Relationship to AHC Strategic Plan: Goal 5, Objective 1.0, Initiative 1.0.

D. Student Management

The College of Veterinary Medicine admitted a class of 80 to the Doctor of Veterinary Medicine program for the 2002-03 academic year. A total of 311 students are currently enrolled in the professional program, of which 79% are women and 4% are minorities.

The College is a part of the national application process for veterinary medicine (25 of the 27 U.S. veterinary colleges are a part of the system). For the Fall 2002 entering veterinary class, the college received a total of 676 applications (676 from nonresident applicants, 184 from regional applicants – MN, ND, SD and Manitoba). Approximately 75% of the entering class was selected from the regional applicant pool. Of the 676 applications, 91 were minority applicants (almost double from last year), of which 13 were offered admission and 4 accepted our offer.

E. Facilities Issues

The CVM completed a Facilities Development Plan. Identifying collegiate facilities needs based upon programmatic goals. It further outlined an overall forward-looking strategy to improve the CVM's physical resources.

One of the CVM's primary facilities goals is to modernize its research space. Towards that end, CVM renovated an
oncology lab, converted former outmoded office space into a modern pathobiology lab and converted former outmoded research space into a state-of-the-art genomics laboratory. These three projects represent a total of 2,500 ASF renovated into modern research space. In addition, the CVM completed a predesign for a new Equine Center. Its purpose was to develop a building plan, budget and timetable for constructing a new equine center - a center which will better enable the CVM faculty to conduct research as well as to provide clinical services.

Another CVM facilities goal is to modernize teaching areas. One of the CVM's three large lecture rooms was upgraded to include new carpeting, upgraded lighting and upgraded electronic media. A necropsy teaching lab was renovated by rebuilding elevated viewing platforms, refinishing the floor, reconfiguring the ventilation ductwork and repainting the walls. The ventilation system in the microbiology lab is inadequate. With ambient conditions varying widely throughout the day due to an undersized and obsolete HVAC system. CVM completed a predesign for a new system and, as of March 2003, it is in the construction bidding phase. The goal is to install a new HVAC system by May 2003.

To enhance student interactions, and with the financial assistance from AHC, the CVM purchased and installed casual seating in one of the student commons areas. It enables students to congregate in small groups, to share ideas and to socialize.

Adding seminar space was one of the critical elements identified in the Facilities Development plan. A new seminar room is currently under renovation and scheduled to be available in May 2003. It is the result of combining two inefficient spaces into one larger space that affords greater flexibility and capacity.

Several initiatives focused on upgrading the clinical facilities. A new small animal surgery suite was constructed from former office space. It is adjacent the existing surgery suite and adds to the space the clinic is able to devote exclusively to surgery services. In partnership with Facilities Management, the Large Animal Hospital renovated new equine stalls and installed new equine floor matting. Facilities Management further agreed to a space swap, transferring some of their assigned space to the clinic in return for other space that served their needs. This new clinic space will be converted into a patient examination and treatment area.

Private funding - a combination of corporate and client gifts enabled the CVM to construct an outdoor Memories Garden. It is furnished with benches, tables and chairs, and is set in park-like atmosphere to enable hospital clients to spend quiet time with their animal.

The CVM concluded a predesign for a chemical tissue digester. It is intended to safely and efficiently dispose of animal carcasses eliminating the need to use incineration or landfill services. The scheduled installation date is July 2003.

2003 - 04 Facilities Initiatives:

Complete pre-design for Dairy Cattle Barn. Pre-design process is scheduled to begin in late summer.
Complete installation of tissue digester in DLab. Pre-design is complete. Goal is to begin final design, construction and bid process this upcoming summer with the installation complete by Nov, 2003.

Begin construction design and bid phase for Equine Center. Pre-design is complete. Final design and construction phase can begin as soon as 80% of development goal is achieved.

Complete installation of new HVAC system in Rm 325 Vet Sci (microbiology lab). Pre-design discovered several building infrastructure issues that require further analysis and which are currently underway. Goal is to complete installation by this upcoming summer.

Complete teaching lab and lecture room enhancements to accommodate the increased class size. Modify Rm 104 AnSci/VM, add seating in 125 AnSci/VM, add lockers, adjust computer lab access, etc by August 15th.

Consolidate grad student offices into A-325 VTH. Space will require renovation and new furnishings. Scheduled to be substantially complete by July 2003.

Renew/upgrade AnSci/VM Rms 161/165 into more modern research lab space. These rooms were recently returned to CVM by AnSci dept and they require upgraded casework, benchtops etc. Goal is to complete this project by Sept/Oct 2003.

Upgrade VTH clinic facilities to accommodate increasingly specialized clinic activities. VTH plans to relocate endoscopy function and to convert underused space to clinic services.

Final planning remains to be completed with goal of modifying space by approximately Dec 2003.

In association with the Assoc Dean for Research, begin planning for BL - 3 facility.

F. Additional Financial Issues

i. **Tuition** – The agreed upon tuition revenue estimate is $6,338,992 for fiscal year 2003-04 (8.25% increase over 2002-03).

ii. **ICR** – The agreed upon ICR revenue for the College is estimated at $610,000 for fiscal year 2003-04 (4.5% increase over 2002-03).

Meeting the State Recission

Programmatic Reductions – see Attachment 1

CVM Cabinet to begin discussing options for FY05 reductions in December 2003.

Regental Delegation of Authority

Regental delegation of authority from the Sr. VP for Health Sciences to the Dean is done; this delegation from Dean to department heads will occur in FY04.
G. **Compact Development**

The Dean consulted with the members of the Administrative Council and Faculty Council within the College of Veterinary Medicine to assist with identification of specific goals for the FY 03-04 compact. The College of Veterinary Medicine’s Strategic Plan was reviewed and used as a basis for development of these goals and priorities along with the input from these consultative groups. A revised compact document was disseminated to each consultative group for their final review.

H. **Data Profile/Critical Measures**

None

I. **Reports**

MGMA Report – see Attachment 2

Summary of compact allocations – see Attachment 3

### Summary of Compact Allocations – Multi–Year - Attachment 3

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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Key for table, previous page
T = tobacco, C = compact, A = AHC other source, P = permanently moved on allocation worksheet, R = college reallocation of resources

Graduate School / VP Research College Investments FY03-04

<table>
<thead>
<tr>
<th>Investment</th>
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</thead>
<tbody>
<tr>
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<td></td>
<td>$ 97,995</td>
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</table>
Proposed Compensation Plan for the Clinicians of the University of Minnesota Veterinary Medical Center (VMC)

This document summarizes the recommendations of the VMC Compensation Planning Committee to the Dean regarding a compensation plan (“Plan”) that will be used to determine and pay partial or full compensation to tenure, tenure-track and clinical specialist clinicians for clinical services they furnish through the University of Minnesota Veterinary Medical Center (collectively the “Clinicians”). This document is organized into the following six sections:

I. Implementation Timeline and Process - Summary
II. Introduction and Background - Why Develop a New Plan?
III. Compensation Plan Goals/Design Principles
IV. Proposed New VMC Faculty Practice Plan Architecture – Overview and Details
V. Plan Implementation Process and Timeline
VI. Process for Communicating and Adopting the New Plan

I. Implementation Timeline and Process -- Summary

It is anticipated that a conceptual outline for the new Plan as summarized here will be approved (subject to potential additional modifications based on Clinician comments) in the near future.\(^1\) The final Plan will be gradually implemented over a three-year period such that the “fully implemented” Plan model (described here) will be fully implemented and in place beginning on July 1, 2006.\(^2\)

During the implementation period various activities will be undertaken as required for Plan implementation including the development of additional infrastructure, data and reporting mechanisms as required by the new Plan. The implementation timeline will also provide Clinicians with sufficient time to understand and adapt to the Plan in light of the new Plan’s requirements. Central to the implementation process is a reasonable level of income protection

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\(^1\) The general Plan outline summarized here has been tentatively approved by the College Dean. The final Plan will be subject to approval in accordance with University of Minnesota policy.

\(^2\) Although this document outlines the “fully implemented” model for the new Plan, the Plan will, under all circumstances, be subject to potential adjustment based on any Board of Regent mandates or changes in University policies. In the event of such mandates or policy changes, the Compensation Advisory Committee will provide recommendations that meet the requirements of the implementation of the mandate or policy change, while also promoting the goals, objectives and spirit of the Plan as outlined here.
as the Plan is implemented (meaning that Clinicians should not be fearful of significant
decreases in compensation as the Plan is implemented). Section V provides a detailed
discussion of the implementation process and timeline.

II. Introduction and Background – Why Develop a New Plan?
The need for a new Plan is driven by a combination of external and internal pressures for change.

In the external environment, clinical practice revenues from the VMC have historically supported
the academic mission of the University of Minnesota College of Veterinary Medicine (“College”).
Current and anticipated future pressures on the funding of higher education will most likely
increase the importance of clinical practice revenues in supporting the College's mission and
Clinician compensation.

The pressures outlined above are coupled with market forces that are influencing the College’s
ability to recruit and retain qualified Clinicians. The College and VMC’s future recruitment and
retention success will depend, at least in part, on the ability to provide all Clinicians – including
tenure/tenure track faculty and clinical specialists – with opportunities to increase their
compensation levels. The new Plan is designed to create such opportunities by creating a
means for all Clinicians to earn more money through the VMC clinical enterprise.

Internally, the College and VMC have historically been creative in developing and implementing
incentive compensation and staffing models for some VMC Clinicians. This has permitted the
successful recruitment of clinical specialists to build clinical programs within an academic
setting, while permitting tenure faculty to focus on teaching and research. Yet close review of
the incentive compensation plans currently existing in the VMC reveal problems that need to be
addressed to align compensation with future direction and strategy. These include:

- The existing plans apply to clinical specialists but not to tenure/tenure track Clinicians
  (even though these clinicians work side by side in many settings);
- Historically, only a subset of all clinical specialists have actually earned incentive
  compensation under the existing plans;
- Lack of direct linkage of the existing incentive compensation arrangements to the
  ongoing fiscal solvency and growth of the VMC and the College due to the individualized
nature of current incentive arrangements (which results in payment of incentive regardless of the fiscal condition of the particular Specialty/Division);

- No express consideration of Clinician teaching, research, or other obligations in determining Clinician compensation levels;
- No requirement for fiscal responsibility and accountability within the existing plans;
- Lack of clear definition and accountability for teaching, research, service and clinical service obligations at individual Clinician level;
- Lack of clear and aligned incentives for productive clinical group practice, effective cost management, and enhanced operating infrastructure;
- “Double counting” of work as part of existing plan and difficulty in crediting work to individual clinicians, e.g., ancillary services;
- Lack of incentive and reward for reasonable clinical practice growth and pursuit of new practice opportunities across VMC as a whole, and within its various Division/Specialties;
- Lack of clear support by funding source for teaching, research, and service activities; and
- Limited opportunity for more market-competitive salaries with associated recruitment and retention challenges.

The Medical Group Management Association (MGMA) Health Care Consulting Group was retained by the VMC in the Fall 2002 to assist in developing a new compensation plan for use with VMC Clinicians. In December 2002 the MGMA consultants conducted individual confidential interviews with VMC Clinicians to identify the optimal goals and design features of a new compensation plan, and to obtain Clinician views regarding the strengths and opportunities associated with the existing compensation arrangements. MGMA has also met and worked with a VMC Compensation Planning Committee (“Committee”) comprised of select Clinicians and VMC administrative leadership.

Over the past few months the Committee and the MGMA consultants have conducted a series of seven separate committee meetings for the purpose of identifying the specific goals and design principles of a new Plan, examining and debating potential compensation plan options including options related to Plan architectures, measurement etc., and proposing a new Plan that is part of the broader VMC faculty practice plan.
As part of their work the MGMA consultants also conducted a survey of other private and public sector veterinary medical centers that include large numbers of clinicians with subspecialty practices. The survey collected market data relating to peer clinician compensation, production, benefits, working conditions and other variables in order to provide additional information and perspective regarding these important issues. The survey revealed that on balance, University of Minnesota College of Veterinary Medicine Clinicians receive compensation, benefits and combined “total benefit” that is generally between the median and 75th percentiles for clinicians in the same veterinary subspecialty as measured by the survey. Although this suggests that the College and VMC compensation levels currently compare favorably to peer organizations, the new Plan is designed to provide a means for Clinicians to earn additional compensation as consistent with market demands.

The primary emphasis of the proposed new Plan is the determination of Clinician compensation. However, the Plan may also be viewed as an important component of the larger financial management system within the College and VMC, which together serve a number of important purposes including:

- Determining funds flow through and from the VMC clinical practice enterprise;
- Determining funding sources and the methodology for paying Clinician compensation and incentive for their clinical practice and related activities in the VMC;
- Providing infrastructure in support of the VMC and clinical practice enterprise;
- Providing funding support of other VMC and College programs and operating infrastructure from clinical practice cash flows; and
- Provide incentives for a multidisciplinary practice within the VMC.

The remainder of this document summarizes the Plan that is recommended based on the Committee’s work.

III. Compensation Plan Goals/Design Principles

The goals of the new VMC Plan as identified by the Compensation Planning Committee consist of the following:

1. Fair, equitable, and consistently applied.
2. Promote and reward the academic mission -- teaching, research and service.
3. Promote work and productivity. Reward in relation to effort.
4. Promote quality care, quality teaching and research.
5. Promote long-term viability.
6. Individual and organization accountability and sound business practices.
7. Promote working together to achieve common goals.
8. Competitive salaries that support recruitment and retention.
9. Transparent, well communicated, and understood Plan.

These goals have been used to guide the development of the proposed Plan discussed in the following sections. In addition, a number of “design principles” and “working assumptions” have also been used to inform the new Plan, including:

- Create a common “architecture” for all Clinicians as it relates to Clinician activities and pay related to the Clinician’s clinical practice activities in the VMC, with appropriate variations by appointment type (e.g., tenure, clinical specialist)³
- Develop a Plan that accommodates the requirements of the existing academic merit/promotion guidelines applicable to tenure/tenure track faculty, while also providing a vehicle that allows for greater opportunity for incentive and accountability based on faculty activities through the VMC clinical enterprise⁴
- Relate funding sources to activities and effort
- Reward activity at individual Clinician, VMC Division/Specialty and VMC levels
- Reward work and effort -- both direct and indirect
- More appropriately consider certain true costs such as supplies etc. in the compensation system.
- Recognize the reality that there is considerable overlap in activities and funding between College and VMC, e.g., tenure and clinical specialists work side by side, clinical specialists engage in teaching etc.
- Realize improvements in practice efficiency so that additional funds are available for Clinician compensation

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³ The Plan outlined here is limited in its application to tenure/tenure-track faculty and clinical specialists who engage in clinical service activities through the VMC. Residents, interns and other clinicians are not included in this Plan.
⁴ The new Plan will not eliminate or replace the requirements of the merit/promotion guidelines as applicable to tenure and tenure-track faculty members. It will, however, provide a vehicle for the clinical practice activities of these faculty members to be more closely linked to their overall compensation, as discussed in greater detail in connection with the Plan description.
➢ Expect clinicians to generally work at similar clinical production/work levels within the same specialty; while considering differences in resources
➢ Recognize some distinction for academic rank and between full/part time status
➢ Promote a multidisciplinary practice within the VMC.

In addition to the various goals and design principles outlined above, an underlying practical goal of the Plan is to help create an incentive structure at various levels (individual Clinician, VMC Division/Specialty and VMC) to increase VMC revenues to enable VMC Clinicians to sustain or increase their compensation levels, while also supporting and promoting the future development of the VMC and College as a whole.

IV. Proposed New VMC Faculty Practice Plan Architecture -- Overview and Details

The FULLY IMPLEMENTED version of the new Plan (after completion of the full 3 year transition/implementation process) will be comprised of several components as illustrated in the graphic below:

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UMVMC Compensation Plan Architecture

Basic Incentive

- Specialty Component (50%) -- Mission-Specific Goals
- Individual Component (50%) -- Individual Production/Goals

Additional Incentive

- Specialty Portion (Performance vs. Budget (40% of surplus))
- VMC Portion (Performance vs. Budget (15% of surplus))

Base Salary

Base Level Performance Expectations
- Minimums. Subject to reduction if fail to meet
  - Teaching
  - Research
  - Clinical Services
  - Professional services (e.g., committee work), outreach, etc.
```
Key features of this basic architecture include:

- **Compensation Components:**
  - **Base Salary** linked to defined funding levels. The Plan will not reduce Base Salary levels for existing Clinicians, but it will build on the existing salary levels while taking into account specialty, history and related factors in connection with the establishment of base salaries for new Clinicians.
  - A **Basic Incentive** component of compensation that would be budgeted for and awarded based on performance at the individual Clinician and Division/Specialty or team levels.
  - Opportunity for **Additional Incentive** based on the fiscal performance of VMC as a whole and the performance of the Clinician’s respective individual Division/Specialty within the VMC.

- **Performance expectations** associated with the Base Salary and linked to different aspects of the academic missions -- teaching, research, clinical service, service through the VMC.

- **Clear targets and goals** at individual Clinician, Division/Specialty and VMC levels that will serve as eligibility criteria for receipt of portions of the Basic and Additional Incentive components of compensation (and which will be required to be met before defined portions of incentive compensation are paid).

- **Standard Plan administrative practices** including those related to budgeting and measurement.

These components are described in greater detail below.

A. **Compensation Components:**

1. **Base Salary**

As at present, Base Salary for each Clinician will, in essence, be guaranteed under the new Plan. The new Plan will not result in a decrease in the Base Salaries earned by individual Clinicians, although steps will be taken over time to provide, to the extent possible, for a portion of anticipated total compensation that will be “at risk.”

Under the fully implemented model the Base Salary will equal approximately 85% of the total anticipated compensation for each clinical specialist (although 100% of the total anticipated
compensation will be budgeted and planned for). By illustration, if under the fully implemented model clinical specialist X has total anticipated compensation of $100,000, then clinical specialist X’s Base Salary when the plan is fully implemented would be $85,000, and the remaining $15,000 would be “at risk” via the Basic Incentive component discussed below. Once a full 15% of total anticipated compensation is at risk, increases in Base Salaries for clinical specialists will return to the present system in which increases are based on market and fiscal conditions.

For tenure and tenure track faculty the portion of Salary that will be “made available” will be limited to the portion of total anticipated compensation that is linked to the faculty member’s clinical practice activities. The faculty member would still, however, be subject to the merit review process and as such, other portions of his/her compensation would be subject to decisions consistent with that process based on teaching, research and other criteria.

The Plan will also provide for a more uniform approach to determining Base Salaries for Clinicians who join the College and VMC in the future. Base Salaries of new and existing Clinicians will be managed over time such that Base Salaries for surgical and non-surgical specialties will generally be assigned within defined ranges, linked to academic rank, specialty and experience in order to promote a philosophy of fairness in paying similar levels of compensation for the same work performed by similar clinicians.

**Performance Expectations for Base Salary**

Minimum performance expectations will be defined and associated with receipt of the Base Salary related to clinical practice activities, with potential reduction of the total Base Salary for a Clinician’s failure to meet the basic performance expectations. Failure to meet basic performance expectations can also serve as grounds for termination or other sanctions consistent with existing arrangements and University policies. **Note: Tenured faculty will follow the post-tenure review process.**

The performance expectations will constitute minimum levels of performance that should be able to be met by all Clinicians. Specific performance expectations will be linked to the following basic measures and integrated with other systems of Clinician evaluation (i.e., U of M promotion requirements):
Teaching (e.g., assigned clinical sessions, rounds, call, etc.), and didactic education as assigned in advance.

Clinical practice proficiency and competence (consistent with U of M promotion requirements).

Clinical production per .1 of clinical time or “CFTE” (with CFTE calculated as outlined below). This will provide a minimum standard of clinical productivity and performance, while providing a uniform means to compare the productivity of Clinicians in the same specialty. Each Clinician will be required to meet or exceed 100% of their assigned target for Total Credited Revenues to participate in any incentive component (Basic or Additional) -- exception 85% for basic specialty and incentive.

Participation in other administrative activities (e.g., assigned administrative tasks, attendance at Division/Specialty administrative meetings, VMC meetings, etc.).

Other performance expectations as determined by the Division/Specialty and linked to Division/Specialty goals (as appropriate).

Clinicians who fail to meet the minimum performance expectations will be ineligible to participate in either the Basic or Additional Incentive components.

As consistent with existing merit and performance guidelines, tenure and tenure track faculty will continue to be evaluated, and merit raises based upon, performance in relation to teaching, research and other criteria as expressed in those guidelines.

**Practical Objectives -- Base Salary and Performance Expectations**

In practical terms, the Base Salary and Performance Expectations are intended to:

- Provide a stable level of compensation (via the Base Salary component);
- Provide greater consistency to Base Salaries paid to similarly situated Clinicians for similar types of work that is linked to clinical service activities and funds;
- Promote greater “shared expectations” and a higher level of Clinician understanding and accountability related to the particular Clinician’s contribution to the VMC and College’s mission (via clearly defined performance expectations);
- Recognize and accommodate the distinctions between tenure/tenure track faculty and clinical specialists, while also working to treat these two types of Clinicians in a similar manner with respect to their common/shared activities (e.g., clinical service, clinic based education, service), and
Allow for a more rational and planned approach to the deployment of Clinician resources as consistent with sound business practices.

2. **Basic Incentive**

The “Basic Incentive” component under the fully implemented model will be equal to approximately 15% of total anticipated compensation that is allocated as part of the budget process to as compensation for the clinical activities of each Clinician. Both tenure/tenure track faculty and clinical specialist Clinicians will participate in the Basic Incentive, but the participation of tenure/tenure track faculty will be limited to the portion of their total anticipated compensation that is linked to their portion of time devoted to clinical activities or CFTE. In the fully implemented model the total amount in the Basic Incentive will be budgeted and planned for on the assumption that each clinician within the VMC will earn the full amount of the Basic Incentive.

The total Basic Incentive will be divided into two incentive categories:

a) **Individual Component.** 50% of the amount allocated to the Basic Incentive will be allocated among the Clinicians in the respective Division/Specialty who exceed their target for “Total Credited Revenues” from clinical service. Clinicians must meet at least 85% of their Total Credited Revenue target (based on their clinical FTE or “CFTE”) to participate in the Specialty Component of the Basic Incentive. The method for determining each Clinician’s Total Credited Revenues is described in the discussion below related to standard administrative practices. In general, however, the Total Credited Revenues allocated to individual Clinicians will consist of the sum of the Clinician’s personally generated revenues, plus additional partial credit for indirect revenues (i.e., anesthesiology and radiology services).

Those Clinicians that achieve 100% of their respective target for Total Credited Revenues will share in the Individual Component in an amount not to exceed the amount of money that was placed in the Individual Incentive pool based on the Clinician’s CFTE. Those Clinicians that fail to meet 100% of their respective target for Total Credited Revenues will not

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5 The methodology used to calculate CFTE is described below under Standard Plan Administrative Practices. A uniform methodology will be used to calculate CFTE for all Clinicians.
participate in the Individual Component nor will they participate in the Additional Incentive (discussed below). Those that achieve at least 85%, but less than 100% of their Total Credited Revenues target will participate in the Specialty Component as discussed below, and those that fail to meet at least 85% of the Target will only receive their Base Salary and will not participate in any incentive compensation.

b) Specialty Component. The remaining 50% that is budgeted to the Basic Incentive portion will be awarded based on the Division/Specialty’s performance in relation to three specific “specialty” or Division/Specialty-specific goals:

1) Operational Goals -- Achievement of a specific operational improvement target for the particular VMC Division/Specialty (e.g., better charge capture, enhanced scheduling etc.) during the subject Plan year.\(^6\) Note: Although this portion of the incentive is initially directed at Division/Specialty related improvement in VMC operations, the specific goals and measures associated with this portion of the Basic Incentive will be modified over time. This means, for example, that in the future this portion of incentive will be changed to focus on other goals such as clinical teaching performance, enhanced client satisfaction, record completion standards and others;

2) Revenue Goal -- Achievement of Division/Specialty revenue target (based on budget)\(^7\); and

3) Profit/Loss Goal -- Achievement of Division/Specialty profit/loss target (based on budget).\(^8\)

The full amount budgeted for the Specialty Component will be allocated in equal amounts across the three goals referenced above (e.g., if $6,000 allocated to the Specialty Component, then $2,000 would be allocated to each of the Operational, Revenue and Profit/Loss Goals). The portion of the Specialty Component that is earned for performance in relation to each respective goal (e.g., Operational Goal, Revenue

\(^6\) These goals will be defined and agreed to annually through consultation involving the Department Chair, VMC administrator, VMC Medical Director and Division Head.

\(^7\) Income from Resident services will be included in determining the revenue and profit/loss goals for each respective Division/Specialty.

\(^8\) For certain Divisions/Specialties the revenue and profit/loss goals for the particular Division/Specialty will include consideration of certain high cost items (e.g., chemotherapy drug costs) that are used by the Specialty, even though these costs are currently included in the budget of another VMC division. Applicable expenses will hit the division where the revenue is captured.
Goal, Profit/Loss Goal) will be allocated among the Clinicians in the Division/Specialty in proportion to the Clinician’s CFTE. As noted above, only those Clinicians who achieve greater than 85% of his/her Total Credited Revenues target will participate in the Specialty Component. Those that achieve more than 85%, but less than 100% of their targets will participate in the Specialty Component on a reduced percentage basis (e.g., if achieve 92% of target, receive 92% of amount otherwise available for Specialty Component).

**Example:** The following example will illustrate the allocation of funds to the Basic Incentive’s Individual and the Specialty Components, along with the distribution of funds to individual Clinicians based on hypothetical performance.

Division A consists of 4 Clinicians. Based on their Total Budgeted Compensation, status (tenure/tenure track faculty or clinical specialist) and CFTE, the total amount budgeted to the Individual Component and Specialty Components for each Clinician is summarized in Table A below.

<table>
<thead>
<tr>
<th>Doctor</th>
<th>CFTE</th>
<th>Total Budgeted Compensation</th>
<th>Total Budgeted to Basic Incentive</th>
<th>Target (budgeted)</th>
<th>Operational Goal (budgeted)</th>
<th>Revenue Goal (budgeted)</th>
<th>Profit/Loss Goal (budgeted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. A (Tenure)</td>
<td>0.25</td>
<td>$110,000</td>
<td>$4,125</td>
<td>$2,063</td>
<td>$688</td>
<td>$688</td>
<td>$688</td>
</tr>
<tr>
<td>Dr. B (Clin. Spec.)</td>
<td>0.85</td>
<td>$90,000</td>
<td>$13,500</td>
<td>$6,750</td>
<td>$2,250</td>
<td>$2,250</td>
<td>$2,250</td>
</tr>
<tr>
<td>Dr. C (Clin. Spec.)</td>
<td>0.65</td>
<td>$75,000</td>
<td>$11,250</td>
<td>$5,625</td>
<td>$1,875</td>
<td>$1,875</td>
<td>$1,875</td>
</tr>
<tr>
<td>Dr. D (Clin. Spec.)</td>
<td>0.8</td>
<td>$85,000</td>
<td>$12,750</td>
<td>$6,375</td>
<td>$2,125</td>
<td>$2,125</td>
<td>$2,125</td>
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<tr>
<td>Total</td>
<td></td>
<td>$360,000</td>
<td>$41,625</td>
<td>$20,813</td>
<td>$6,938</td>
<td>$6,938</td>
<td>$6,938</td>
</tr>
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</table>

The targeted amount of Total Credited Revenues and actual performance for the Clinicians in this hypothetical division based on CFTE are outlined in Table B below.
Table B

<table>
<thead>
<tr>
<th>Doctor</th>
<th>CFTE</th>
<th>Total Credited Revenue Target (CFTE x 10)</th>
<th>Actual Total Credited Revenues</th>
<th>Difference from Target</th>
<th>% of Target</th>
<th>Hit/Miss Target?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. A (Tenure)</td>
<td>0.25</td>
<td>$25,000</td>
<td>$28,097</td>
<td>$3,097</td>
<td>112%</td>
<td>Hit</td>
</tr>
<tr>
<td>Dr. B (Clin. Spec.)</td>
<td>0.85</td>
<td>$85,000</td>
<td>$90,898</td>
<td>$5,898</td>
<td>107%</td>
<td>Hit</td>
</tr>
<tr>
<td>Dr. C (Clin. Spec.)</td>
<td>0.65</td>
<td>$65,000</td>
<td>$61,789</td>
<td>-$3,211</td>
<td>95%</td>
<td>Hit @ 95%</td>
</tr>
<tr>
<td>Dr. D (Clin. Spec.)</td>
<td>0.8</td>
<td>$80,000</td>
<td>$97,069</td>
<td>$17,069</td>
<td>121%</td>
<td>Hit</td>
</tr>
</tbody>
</table>

Only those Clinicians who 100% of their individual Total Credited Revenues targets will participate in the Individual Component of the Basic Incentive. Because Drs. A, B and D exceeded their targets, they will receive the full Individual Component of the Basic Incentive that was budgeted to them as illustrated in Table C. However, because Dr. C only achieved 95% of his/her target, Dr. C will not participate in the Individual Component. Dr. C will, however, be able to participate in the Specialty Component of the Individual Incentive because Clinicians who achieve at least 85% of their individual target/goals for Total Credited Revenues will participate in the Specialty Component of the Basic Incentive at a corresponding level.

Table C

<table>
<thead>
<tr>
<th>Doctor</th>
<th>Amount Budgeted</th>
<th>% of Target</th>
<th>Amount Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>Target (budgeted)</td>
<td>% of Target</td>
<td>Amount Received</td>
</tr>
<tr>
<td>Dr. A (Tenure)</td>
<td>$2,063</td>
<td>100%</td>
<td>$2,063</td>
</tr>
<tr>
<td>Dr. B (Clin. Spec.)</td>
<td>$6,750</td>
<td>100%</td>
<td>$6,750</td>
</tr>
<tr>
<td>Dr. C (Clin. Spec.)</td>
<td>$5,625</td>
<td>Missed (95%)</td>
<td>$0</td>
</tr>
<tr>
<td>Dr. D (Clin. Spec.)</td>
<td>$6,375</td>
<td>100%</td>
<td>$6,375</td>
</tr>
</tbody>
</table>

Amounts budgeted for the Specialty Component of the Basic Incentive are allocated based on performance in relation to achievement/non-achievement of the Division/Specialty goals. As noted above, Clinicians must achieve at least 85% of their individual Total Credited Revenue targets to participate in this Specialty Component portion of the Basic Incentive. Each Clinician
will share in the Specialty Component based on the amount budgeted to the particular component, subject to an adjustment where the Clinician achieved at least 85%, but less than 100% of the Clinician’s individual Total Credited Revenue target. Table D illustrates this and assumes that all three Division/Specialty goals are achieved. However, Table D takes into account the fact that Dr. C only met 95% of his/her individual Total Credited Revenue target and therefore, receives only 95% of the amount otherwise budgeted to this component.

<table>
<thead>
<tr>
<th>Table D</th>
<th>Amount Budgeted</th>
<th>Specialty Component</th>
<th></th>
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<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td>Doctor</td>
<td>Operational Goal (budgeted)</td>
<td>Revenue Goal (budgeted)</td>
<td>Profit/Loss Goal (budgeted)</td>
<td>Hit/Miss Target – Individual Level</td>
<td>Total Earned for Achievement of Division/Specialty Goals</td>
</tr>
<tr>
<td>Hit/Miss Goal</td>
<td>Hit</td>
<td>Hit</td>
<td>Hit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. A (Tenure)</td>
<td>$688</td>
<td>$688</td>
<td>$688</td>
<td>Hit</td>
<td>$2,064</td>
</tr>
<tr>
<td>Dr. B (Clin. Spec.)</td>
<td>$2,250</td>
<td>$2,250</td>
<td>$2,250</td>
<td>Hit</td>
<td>$6,750</td>
</tr>
<tr>
<td>Dr. C (Clin. Spec.)</td>
<td>$1,875</td>
<td>$1,875</td>
<td>$1,875</td>
<td>Missed (95%)*</td>
<td>$5,344</td>
</tr>
<tr>
<td>Dr. D (Clin. Spec.)</td>
<td>$2,125</td>
<td>$2,125</td>
<td>$2,125</td>
<td>Hit</td>
<td>$6,375</td>
</tr>
<tr>
<td>Total</td>
<td>$6,938</td>
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<td>$6,938</td>
<td></td>
<td>$20,814</td>
</tr>
</tbody>
</table>

*Dr. C only receives 95% of amount otherwise allocated due to Dr. C’s failure to meet Target.

**Other Comments Regarding Basic Incentive**

- **Budgeted Deficits.** In limited instances, deficits can be used for purposes of the budgeted profit/loss at the Division/Specialty levels. When a Division/Specialty has a budgeted deficit, the Division/Specialty’s performance will be measured by reference to the budgeted deficit to determine if the target has been achieved, and to determine if a Specialty Component of the Basic Incentive has been earned. For example, if a Division/Specialty has a budgeted deficit of -$200,000 and the Division/Specialty’s actual deficit is -$50,000, the Division/Specialty has met its budgeted profit/loss target and a Basic Incentive will be...

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9 As with any business, a deficit in one Division/Specialty will require that another Division/Specialty must have a budgeted surplus (to provide funds to help make up the budgeted deficit). For this reason, budgeted deficits should generally be as small as possible, limited to a very few Division/Specialties and rare.
• paid. Funds will be available for the Basic Incentive in this instance because those funds were budgeted for and because the Division/Specialty has met its budget target.10

• Resident Revenues and expenses. In determining the budgets for each Division/Specialty, income and salaries that are expected to be generated from resident activities will be included in the budgeted amounts.

**Practical Objectives -- Basic Incentive**

The practical objectives of the Basic Incentive are to:

➢ Promote a greater level of teamwork by Clinicians working in individual VMC Divisions/Specialties;
➢ Promote closer attention to Division/Specialty budgets and the performance required to meet or exceed budget and other targets;
➢ Provide incentive and encourage incremental changes in Division/Specialty operations as a means of enhancing VMC efficiency;
➢ Promote greater responsibility and accountability for Clinician performance;

3. **Additional Incentive**

Additional Incentive constitutes additional funds that would be available for compensation above and beyond the Base Salary and Basic Incentive referenced above. The availability and payment of Additional Incentive would be contingent upon the overall financial performance of:

1. The financial performance of the VMC as a whole (**VMC Portion**), and
2. The financial performance of the particular Division/Specialty in relation to the Division/Specialty budget (**Specialty Portion**).

The total amount available for payment as Additional Incentive will be divided into two separate pools as described below.

10 A Division/Specialty that achieves its budget target will receive 100% of the funds allocated to the Basic Incentive pool for payment as Basic Incentive compensation. It is anticipated that at some future point in time the Plan will be modified to provide that the failure of a Division/Specialty to achieve its budgeted profit/loss target will result in a reduction of Basic Incentive pool on dollar for dollar basis, although this will not be implemented in the near term. This concept is raised here, however because it is consistent with the concept of fiscal responsibility in that the VMC and its Division/Specialties cannot
a) The first pool will be funded based on the financial performance of the VMC as a whole. This VMC Portion will only be funded and available for distribution if the VMC achieves its budget as a whole.\textsuperscript{11} This VMC Portion will be funded in an amount equal to 15% of the VMC surplus over VMC’s budget (with that budget including the development fund assessment discussed below). This portion will not be funded or paid if VMC fails to meet its budgeted surplus.

Example:

\begin{align*}
\text{VMC budgeted profit/loss -- revenues over expense} & \quad = \$200,000 \\
\text{Actual performance -- revenues over expense} & \quad = \$300,000 \\
\text{Actual surplus} & \quad = \$100,000 \\
\text{Amount in VMC Portion of Additional Incentive} & \quad = \$15,000
\end{align*}

To promote teamwork in support of the VMC as a whole, all Clinicians who achieve 100% of their targets for Total Credited Revenues will receive part of the VMC Portion of the Additional Incentive. The amount that will be paid to each Clinician who participates in this portion will be based on the Clinician’s Base Salary from clinical activities (determined by multiplying the respective Clinician’s Base Salary x his/her CFTE), expressed as a percentage of the total Base Salaries from clinical activities for all Clinician’s participating in this portion of the incentive.\textsuperscript{12} Those Clinicians who do not achieve 100% of their individual targets for Total Credited Revenues will not participate in the VMC Portion of the Additional Incentive.

\textsuperscript{11} The VMC budget target will include allocation of funds to a “development fund” that will be used to support the VMC’s growth and development. The development fund is discussed in greater detail below in section B – Standard Plan Administrative Practices. The development fund assessment will be set at 2-3\% of revenues during the initial year of the new Plan (FY 2003-2004).

\textsuperscript{12} The formula for calculating the portion to be paid to an individual Clinician is as follows: (Clinician Base Salary x Clinician CFTE)/(Total Base Salaries of all Clinicians Participating in VMC Portion x CFTE of all Participating Clinicians).
Example:

Amount available for VMC Incentive $15,000
Clinician Z Base Salary ($100,000) x CFTE (.25) $25,000
Sum of base salaries of clinicians participating
  In VMC portion x CFTE of participating
  Clinicians (Hypothetical) $290,000
  Clinician Z Percentage of Total (25,000/290,000) 9%
  VMC Portion Allocated to Clinician (9% of $15,000) $1,350

b) The second pool called the **Specialty Portion** will be determined and awarded based on the performance of the Division/Specialty in relation to its budget target. This portion would be funded by multiplying any surplus over the budgeted profit (or loss) for the Division/Specialty, by a uniform percentage (e.g., 40%). The uniform percentage will be the same for all Division/Specialties in the VMC (with the exact percentage determined from year to year based on VMC finances).

Example:

Division Budgeted profit (loss) = (-$50,000)
Actual performance – profit (loss) = +$25,000
Surplus over budgeted profit (loss) = $75,000
  Funding of Specialty Portion (40%) of surplus = $30,000

- Only those Clinicians who meet at 100% of their target for Total Credited Revenues will be eligible to participate in the Specialty Portion of the Additional Incentive.
- This portion of Additional Incentive will be allocated on an agreed upon basis as determined by the Clinicians in the particular Division (e.g., 25% equal share based on CFTE; 75% production), or in the absence of agreement regarding a preferred allocation methodology, based on a straight percentage of production basis (e.g., based on the percent to total of Total Credited Revenues in excess of target).
- In some cases the budget target for an individual Division/Specialty will be a budgeted deficit, as illustrated above.
To promote legal compliance a cap will be established on the total amount of Additional Incentive that can be earned by any Clinician. This cap will be expressed as a percentage of Base Salary for the particular Clinician and will constitute an absolute maximum on the total amount of Additional Incentive that could be paid, regardless of the amount that is available or due under the Plan; provided that the cap can be waived on a case-by-case basis by the Dean. This is important for legal compliance purposes and to prevent a windfall incentive payment. For present purposes the cap is anticipated to be set at 75% of the Base Salary. Under no circumstance may Clinicians receive compensation that is not deemed to be reasonable and consistent with fair market value.

B. **Standard Plan Administrative Practices.**

Standard approaches to measurement and fiscal administration will serve as a foundation for the new Plan. Standardized practices will be implemented in the following areas:

- **Budgeting.** Fiscal responsibility and accountability will be required and the College, VMC and VMC Division/Specialties must, under all circumstances, be managed to assure financial solvency. The new Plan relies on VMC Division/Specialty budgets and performance in relation to budget or other targets. Because of this, standardized budgeting practices will be implemented and it is anticipated that Clinicians in individual VMC Division/Specialties will most likely seek greater involvement and understanding of the budgets in their respective Division/Specialty. VMC administration will exercise oversight authority to promote fiscal responsibility and accountability at all levels within the VMC, subject to the ultimate authority of the Dean.

- **Development Fund.** To provide funds for further development of VMC’s clinical enterprise (i.e., equipment purchase, practice outreach sites, funds for new programs etc.), a “development fund” will be created through an assessment on clinical practice revenues. The assessment will be imposed on a uniform basis (as a percentage ranging from 2 to 10% percent of clinical revenues), budgeted for and assessed "off the top" from all clinical revenues. The development fund will be determined and included as part of the VMC budgeting and planning process and has been set at 2-3% for FY 2003-2004. This fund will be implemented in a gradual manner over the plan implementation/transition period.
• **Clinical Revenues.** Clinical (individual and/or divisional) revenues will be defined by CVM policy, but shall, in general, consist of all revenues from clinical service activities and activities for which Clinicians receive compensation due to the presence of veterinary medicine training and a veterinary medicine license, regardless of where furnished. All revenues generated through the VMC will be counted in the compensation plan. Any revenues generated outside the VMC must fall under collegiate policy.

• **Determination of Clinical FTE.** Each Clinician’s “clinical full time equivalent” (“CFTE”) will be defined as the portion of time during which an individual Clinician is scheduled to be “on clinic” in the VMC or in another VMC-sponsored setting. The CFTE assigned to individual Clinicians is relevant to the Plan in connection with the determination of uniform performance expectations related to clinical practice productivity and the identification of clinical practice targets in connection with the determination and payment of incentive compensation.

The Plan will use a standard (uniform) methodology to determine each Clinician’s CFTE for Plan purposes. That methodology builds on existing data sources -- (1) the clinical service schedules for Clinicians in individual Division/Specialties, and (2) the Student Rotation Enrollment schedules for the same time period. These data sources will be combined with standard assumptions (outlined below) to initially determine CFTE levels. The methodology and assumptions may change and evolve as the Plan is implemented and additional data sources are developed.

The following general assumptions will be used to determine CFTE:

- Each Clinician’s **scheduled time** in VMC clinics (as set forth on the clinical service schedules) will be used to determine CFTE.  

- The involvement of students in a clinic due to student rotations will be assumed to reduce the clinical practice efficiency of Clinicians working in the clinic by 20%. This reduction will initially be applied to all Clinicians working in the clinic, but the means of applying the reduction may be modified in the future as additional data sources are developed to more closely track teaching involvement. The precise application

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13 To achieve this the clinical schedules of Clinicians will be set in advance in blocks of time (e.g., 6 months or more).
of this reduction will be determined by the Compensation Advisory Committee as the scheduling and reporting systems evolve, but the overall goal will be to ultimately provide the reduction to those Clinicians who do, in fact, work with students as part of their clinical practice (while not providing the reduction to those who are not working with students during a particular period of time in clinic).\textsuperscript{14}

- “Full time” clinical service for each Clinician will be defined and a practice efficiency reduction applied to calculate the “Adjusted Days of Clinical Service” for each Clinician. For example, the current full-time clinical requirement is four days per week during week in which the Clinician is scheduled to be on clinic. To recognize a 20% practice efficiency reduction for when the Clinician is on clinics when there are also students, the Clinician would be assumed to work with the students and he/she would be credited with 3.2 Adjusted Days of Clinical Service (representing the 20% practice efficiency reduction from 4.0 as discussed above).

- Full time clinical practice for all Clinicians will be assumed to equal 208 days per year. (364 days - 104 days (weekends) - 52 days (30 days vacation, 10 days CME, and 12 days other time off (Note: CME and other time off subject to Department Chair approval of defined activity) = 208 days per year).

- The number of Adjusted Days per year is divided by 208 to determine the Clinician’s CFTE. Example: If a Clinician’s adjusted days are 40, the particular Clinician’s CFTE is 40/208 or .19 CFTE (19% of time devoted to clinical activity).

**Measurement of Clinician Work and Production.** The new Plan will use “Total Credited Revenues” as the best measure to reward both (a) direct clinical practice “work” (the fruits of each Clinician’s personal activities) and (b) indirect work or “production” (e.g., the total product of the clinician’s efforts including additional services that must be “sold” to and managed with the client by the attending clinician such as costs of supplies and certain ancillary services). Total Credited Revenues are generally defined as: charges as defined in the current compensation plan, minus certain contractual and other adjustments, discounts and ancillary service charges, but with some credit for indirect revenues as discussed below.

The VMC billing and information system will be modified to change the way that anesthesia and radiology services (collectively “ancillary services”) are treated. Today, credit for such ancillary services is allocated to the attending clinician, and the clinician providing the

\textsuperscript{14} Similar adjustments will be made for drive time to outreach/satellite clinics.
ancillary service (radiologist or anesthesiologist) receives no formally assigned “credit” or production for their efforts.

The VMC information and billing system does, however, permit tracking and exclusion of ancillary service billings that are ordered by clinicians other than radiologists or anesthesiologists. Therefore the new Plan will provide credit for direct individual Clinician work (e.g., that which he/she personally performs), plus credit for indirect work -- ancillary services that are not furnished by the attending Clinician, but which must nevertheless be sold to the client and managed.

To recognize the “indirect” revenue generation of attending Clinicians, under the Plan the attending Clinician will initially be credited with 30% of ancillary service billings, and the clinician providing the ancillary service will receive credit for the remaining 70% of the ancillary service billings).

The following example illustrates the method of handling such “direct” and “indirect” work effort (including resident work)

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjusted revenues</td>
<td>$209,465</td>
</tr>
<tr>
<td>Less anesthesia (Anes)</td>
<td>(38,657)</td>
</tr>
<tr>
<td>Less medical imaging (MI)</td>
<td>(20,204)</td>
</tr>
<tr>
<td>Plus 30% of Anes. + MI</td>
<td>17,658</td>
</tr>
<tr>
<td><strong>Total Credited Revenue</strong></td>
<td><strong>$168,262</strong></td>
</tr>
</tbody>
</table>

The Total Credited Revenues referenced above reflects the total adjusted revenues (gross charges minus contractual adjustments as measured in the current compensation plan), less adjusted revenues for ancillary services, plus credit for 30% of the ancillary service charges for indirect revenues.

The Total Credited Revenues number will be used in the Plan as follows:

- In determining and measuring clinical production performance expectations (with the same expected level of production per .10 CFTE to be used for all clinicians in the same Division/Specialty); and
In connection with the allocation the Additional Incentive.

Changes will be made to the VMC’s information system and billing processes in the future to track the billings at the level of individual radiology and anesthesiology clinicians.

- **Plan Administration – On-going Modifications.** Although efforts have been taken to consider key details in connection with plan implementation, it is inevitable that specific details and factors that cannot be anticipated will need to be addressed as the Plan is implemented. For this reason a “compensation advisory committee” (akin to the current compensation planning committee) will be created to provide on-going guidance as the Plan is implemented. All recommendations of the compensation advisory committee would be subject to the ultimate decision-making of the Dean and others as consistent with University policies and practices.

**Practical Objectives -- Standard Plan and Administrative Practices**

The practical objectives of implementing standard practices for the plan and in connection with budgetary administration include to:

- Promote greater linkage between the College and VMC mission and sources of funds (generally referred to as “mission-based budgeting”);
- Provide for planned support of the growth and development of the VMC clinical enterprise, thus enabling future development (via the development fund);
- Promote greater attention and accountability for scheduled clinical service time and the VMC budget, and encourage Clinicians in the same specialty to work at similar levels when it comes to clinical production, while reasonably recognizing differences in resources and responsibilities (via the uniform means to measure CFTE);
- Reasonably recognize the direct and indirect revenues that are produced by individual Clinician effort (via the determination of individual Clinician Total Credited Revenues); and
- Provide for reasonable levels of compensation that will be paid to VMC Clinicians assuming acceptable performance, while providing an opportunity to increase compensation above existing levels with enhanced performance.
V. **Plan Implementation Process**

The new Plan will be gradually implemented over a 3-year period. The following transition process assumes implementation to the fully implemented plan beginning in year 4. This will provide adequate time to develop required infrastructure for Plan administration (including data sources, reporting formats, Clinician participation in budgeting processes etc.), and to provide VMC Clinicians with adequate time to understand and adapt to the Plan and its underlying incentive system.

The timeline outlined below is designed to provide for a gradual “roll out” of the Plan, while also making reasonable progress toward implementation in a step-wise manner. The compensation advisory committee will oversee the implementation process and that committee will, in conjunction with VMC administration, will have the ability to recommend modifications to the Plan and the implementation to the Dean.

**Plan Year 1 – FY 2003-2004 (Fiscal year beginning July 1, 2003). Transition steps:**

Note: The basic Plan implementation timeline outlined below assumes that the University of Minnesota will mandate no pay raises during FY 2003-2004. The implementation process would be changed slightly if pay raises are provided for by University action.

A. **Total Base Salaries for individual Clinicians to remain at their FY 2002-2003 levels.** Any additional compensation in excess of the Base Salaries will be generated through the Additional Incentive component.\(^{15}\)

B. **Income protection for individual Clinicians to be set at 95% of the amount of compensation that would have been earned under the current plan during the respective FY.** This income protection mechanism is designed to protect the incomes of Clinicians who have historically received incentive compensation during the implementation/transition period so that these Clinicians do not face excessive risk of reduced compensation due to the transition to the new Plan. During the implementation period the Clinician will be paid the **greater** of (i) the amount of money (cash

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\(^{15}\) Subject in all instances, to availability of sufficient funds in the College and VMC.
compensation) they would receive under the new Plan, or (ii) 95% of the total compensation they would have received had the current plan remained in place.\footnote{Such comparisons would be subject to adjustments in the underlying fee structure. This means, for example, that if the VMC fees are increased by 5% or more due to inflation or other factors, the fee increase would be considered to ensure an “apples to apples” comparison of performance in one fiscal year, as compared to performance in the following fiscal year.}

C. Operational changes made in VMC to accommodate Plan to include:

1. Adopting a mission based budget for the FY 2003-2004 to serve as the initial starting point for the new Plan, to include a 2-3% development fund assessment. Communicating the details of the budget, budget assumptions, revenues, profit/loss targets etc. to Clinicians (to be completed by start of FY 2003-2004, July 1, 2003).

2. Implementing an integrated Clinician scheduling system for purposes of determining CFTE (to be completed within first three months of fiscal year). This will require each Division/Specialty to identify scheduled time “on clinic” for each Clinician in six month scheduled increments. Other changes, as necessary, will also be made to the standard approach to determining CFTE as described above such that schedules and CFTE can be defined as of October 1, 2003.

3. Changing the VMC billing/charge capture and related systems to track billing at the individual clinician level for radiology and anesthesiology (to be completed within first six months of FY 2003-2004). These changes will enable the VMC to track the actual services furnished by individual anesthesiologists and radiologists, as well as related information as necessary to operate the Plan.

4. Institute standard reporting/performance feedback reports etc. for clinicians showing billings (individual), minutes, performance versus target at individual and Division/Specialty levels etc.

5. Compensation advisory committee to meet as required to define additional details related to new Plan, consider adjustments, oversee implementation, etc.
D. Department Chair, in conjunction with VMC Medical Director, to define Base Salary performance expectations in consultation with each Clinician. Such performance expectations to be in all mission areas -- clinical service, teaching, research and administration – as applicable to Clinician work activities.

E. Division/Specialty goals to be assigned related to operations improvements, revenues and profit margins (as required for the Basic Incentive). Clinicians in each Division/Specialty to pursue those goals.

F. Targets for clinical production per .10 CFTE to be assigned and applied to performance during the second six months of the Fiscal Year.

G. Development Fund assessment to be included in FY 2003-2004 budgeting process at 2-3% of VMC revenues. This assessment will be rolled out in accordance with an agreed upon plan (e.g., 2-3% in first year, 5% in second year, 8% in third year and 10% thereafter).

H. Additional Incentive, if any, to be paid based on Division/Specialty and VMC actual performance vs. budget during FY 2003-2004.

Plan Year 2 – FY 2004-2005. Transition steps:

I. Total Base Salaries for individual Clinicians to remain at FY 2002-2003 (current year) levels. As in the initial year of Plan implementation, any additional compensation over and above the Base Salary levels for individual Clinicians would be earned through the Basic and Additional Incentive components.

J. Income protection program to remain in place for Clinicians who have previously received incentive compensation at 92% (reference Plan Year 1, B).

K. Development Fund assessment to be imposed at 5% beginning in Year 2.

L. Basic Incentive component in Year 2 will equal the difference between the Total Allocated Compensation and the amount of Base Salaries in the particular
Division/Specialty. Specified goals and objectives for earning Basic Incentive to be determined and applied.

Plan Year 3 – FY 2005-2006. Transition steps:

M. Income protection program to remain in place for Clinicians who have previously received incentive compensation at 90% (reference Plan Year 1, B).

N. Total Allocated Compensation for each Clinician to be determined as part of budget. Basic Incentive mandated to be no less than 10% of the Total Allocated Compensation for the Clinicians in the particular Division/Specialty.

O. Basic Incentive goals and objectives determined and applied to amount in Basic Incentive Pool. Based on current information related to University funding, this is likely to be the first year that funds would actually be budgeted for Basic Incentive.

P. Development Fund assessment imposed at 8% (or other amount as consistent with roll out plan).

Plan Year 4 – FY 2006-2007 (fully implemented model). Transition steps:

Q. Base Salaries set at 85% of Total Allocated Compensation. Basic Incentive set at approximately 15% of Total Allocated Compensation.

R. Full Development Fund assessment to be imposed at 10% (or other amount as consistent with roll-out plan).

S. Other features of Plan to become fully operational such that fully implemented plan exists.

Other Activities During Initial Plan Year(s):

• Institute administrative process to make decisions and refine the basic Plan as outlined here based on need.
VI. **Process for Communicating and Adopting the New Practice Plan**

1. The Compensation Planning Committee has reviewed the current plan, identified goals and design objectives for the new Plan, analyzed new Plan options and initiated consultation with VMC Clinicians regarding the new Plan through numerous progress reports. This report outlines the Committee’s recommendations regarding a new Plan that can *begin to be* implemented beginning July 1, 2003.

2. Following tentative approval by the Dean of the concepts outlined here, this outline of the proposed Plan will be distributed in writing to all Clinicians for review. A meeting of all VMC Clinicians will be held on Monday evening, June 16, 2003 to review the Plan. Discussions will also be scheduled with Clinicians in individual Divisions/Specialties during the day on June 17 and 18. The purpose of the meetings will be to provide education regarding the Plan proposal, and to obtain Clinician comments and suggestions regarding the Plan.

3. Based on the input received from the discussion forums, the Committee will determine if further refinements to the proposed Plan are warranted. The Committee will make any modifications that are deemed warranted, then recommend the final Plan to the Dean for approval and communication to all Clinicians.

4. A Compensation Advisory Committee will be established to oversee Plan implementation. The implementation plan has been devised to recognize the new Plan’s major impacts to Clinicians, College and VMC, while also implementing the new Plan over a reasonable period of time.