An Administrator's Guide to Departments of Internal Medicine

Fifth Edition

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1 WELCOME FROM AIM PRESIDENTS

Whether you lead a department, division, or other administrative group in the academic environment, this guide will serve as a comprehensive resource in your management of the clinical, research, and teaching aspects of our field. We hold unique positions intended to support and promote excellence in the scholarship of discovery and the application of that knowledge in the care of patients and training of the next generation of clinical and research faculty.

Working closely with chairs, chiefs, and other faculty leaders, administrators lead strategic planning and review efforts, implement new programs, ensure compliance, maintain and invigorate existing programs, and assume fiscal responsibility for their scope of operations. There is no single career pathway for administrators—individuals may enter the field with experience in financial management, research administration, medical education, or clinical practice, or with no previous experience in academics or clinical care.

Although the role of the internal medicine administrator varies by department, we are commonly expected to provide advice and input on any or all aspects of the management of a department or division. We balance these operational requirements with staff recruitment and development while responding to the needs of faculty and other administrators. While we serve as stewards of our department and its resources, we must also make time to invest in ourselves and our skills development. Administrators of Internal Medicine (AIM) provides that opportunity for us all to learn together.

AIM is the professional home for over 1,300 academic administrators who are committed to developing the skills and network connections needed to take on these challenges, while building and supporting our leaders in health care.

As members of AIM and the Alliance for Academic Internal Medicine (AAIM), you will have opportunities to network with a broad range of academic internal medicine professionals, to participate in national conferences and access resources to increase knowledge on a variety of relevant topics. AIM members are encouraged to share their insights with faculty and other administrators through committee work, poster sessions, and workshop presentations at our national educational conference and through other Alliance networking opportunities.

Each of us has benefited from our participation in AIM and we encourage you to be "active consumers" of all that AIM and AAIM have to offer.

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2 THE LANGUAGE OF ACADEMIC INTERNAL MEDICINE

COMMONLY USED ACRONYMS

AAMC..... Association of American Medical Colleges

ABIM ..... American Board of Internal Medicine

ABMS.....American Board of Medical Specialties

ACGME ..... Accreditation Council for Graduate Medical Education

ACUME ....Administrators/Coordinators Certification in Undergraduate Medical Education

APD..... Associate Program Director

CCC ..... Clinical Competency Committee

CLER .....Clinical Learning Environment Review

CME..... Continuing Medical Education

CMS .....Centers for Medicare & Medicaid Services

DGME ..... Direct Graduate Medical Education

DIO ..... Designated Institution Official

ERAS..... Electronic Residency Application Service

F32..... NIH mechanism = NRSA Individual Postdoctoral Fellowship

GME .....Graduate Medical Education

IGME .....Indirect Graduate Medical Education

IMG.....International Medical Graduate

ITE ..... In-Training Exam

LCME ..... Liaison Committee on Medical Education

NBME.....National Board of Medical Examiners

NIH..... National Institutes of Health

NRMP..... National Resident Matching Program

NRSA .....National Research Service Award (NIH)

PD .....Program Director

PEC ..... Program Evaluation Committee

PGY..... Post-Graduate Year

RRC-IM ..... Residency Review Committee

TAGME.....Training Administrators in Graduate Medical Education (Certification)

T32 .....Institutional Training Grant

UME ..... Undergraduate Medical Education

USMLE .....United States Medical Licensing Examination

DEFINITIONS

Accreditation Council for Graduate Medical Education (ACGME) Provides accreditation for residency and fellowship training programs.

Administrators/Coordinators Certification in Undergraduate Medical Education (ACUME) Organization that provides certification for undergraduate medical education professionals.

American Board of Internal Medicine (ABIM) Provides certification for physicians in internal medicine and its subspecialties.

American Board of Medical Specialties (ABMS) Conglomeration of medical specialty boards that collaboratively set standards for physicians to achieve and maintain board certification.

Associate Program Director (APD) Residency program leadership position that supports the program director. The ACGME sets minimum guidelines for the number of APDs required based on program size.

Association of American Medical Colleges (AAMC) Nonprofit organization that represents accredited US and Canadian medical schools as well as numerous teaching hospitals and health systems. The AAMC offers numerous services, most notably of which include ERAS and cosponsorship of LCME.

Categorical Track Standard three-year training for internal medicine that leads to board exam eligibility.

Centers for Medicare & Medicaid Services (CMS) Federal agency that works with state governments to administer Medicaid and is responsible for administering Medicare services.

Chief Resident Resident at the PGY3 or PGY4 level with administrative responsibilities for the program. At some institutions, the chief resident holds a junior

faculty rank. Roles and responsibilities for these positions can vary greatly among institutions.

Clerkship Required medical student clinical rotation in a core specialty (e.g., family medicine, internal medicine, obstetrics and gynecology, psychology, surgery).

Clinical Competency Committee (CCC) An ACGME required committee composed of three or more faculty members. The main function of the CCC is to review resident progress and advise the program director. As part of this function, the CCC is required to review milestones for all trainees twice per year.

Clinical Learning Environment Review (CLER) Type of review conducted by ACGME to assess an institution's learning environment. The six core focus areas in which institutions are assessed include patient safety, quality improvement, transitions in care, supervision, duty hours oversight (inclusive of fatigue management and mitigation), and professionalism.

Continuing Medical Education (CME) Educational credits that are required to maintain licensure. Specific protocols must be followed for educational activities to qualify as CME.

Core Competencies Six domains as deemed by ACGME in which residents are evaluated and must demonstrate proficiency to graduate. These include patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

Core Faculty Designated program faculty that dedicate at least 15 hours per week to program activities. ACGME sets a minimum requirement for the number of core faculty needed based on the size of the program.

Designated Institutional Official (DIO) Head of the GME office. Responsible for oversight of all GME training programs at a sponsoring institution.

Direct Graduate Medical Education (DGME) Medicare payments made to teaching hospitals for costs directly related to the training of residents (resident stipends and fringe benefits, salaries and fringe benefits for faculty who supervise residents, institutional overhead costs, clerical personnel, and accreditation fees).

Duty Hours The time residents spend participating in patient care, education, or administrative activities as part of their training program. Duty hours reporting with individual program and institution oversight is an ACGME requirement with specific regulations.

Electronic Residency Application Service (ERAS) A service provided by AAMC for medical students applying to residencies and fellowships and the programs that participate in the National Resident Matching Program (NRMP). ERAS is utilized by students to apply to programs, medical school dean's offices to upload transcripts, residency and fellowship programs to review applications, and letter of recommendation authors to upload letters.

F32 NIH-funded individual fellowship award for the purpose of research training.

Fellow Trainee who has completed residency and is pursuing further education in a specialty or subspecialty area.

Graduate Medical Education (GME) Physician training that occurs after completion of medical school and prepares the trainee for independent practice and board eligibility. GME is inclusive of residency and fellowship training.

Housestaff Term used to describe a residency or fellowship trainee at any level (PGY1-8).

Indirect Graduate Medical Education (IGME) Medicare payments made to teaching hospitals to offset the associated costs of training residents in recognition of the differences in the patient care costs between teaching and nonteaching hospitals.

Intern Resident in his or her first year (PGY1) of training.

Liaison Committee on Medical Education (LCME) Accrediting body for US medical schools.

Milestones ACGME defines milestones as "competency-based developmental outcomes that can be demonstrated progressively by residents and fellows from the beginning of their education through graduation to the unsupervised practice of their specialties." Training programs must report resident progress to ACGME by utilizing predetermined milestones on a biannual basis.

National Board of Medical Examiners (NBME) Organization that provides assessments of health care professionals inclusive of USMLE, which is administered mainly to medical students.

National Institutes of Health (NIH) Federal agency dedicated to medical research. Each of the 28 agencies composing NIH have a unique research or administrative focus.

National Research Service Award (NRSA) Highly prestigious type of NIH grant that funds doctoral and postdoctoral trainees.

National Resident Matching Program (NRMP) Organization that provides a mechanism for matching the preferences of applicants for US residency and fellowship positions with program preferences. This process is commonly referred to as "The Match."

Post-Graduate Year (PGY) The number of continuous residency and fellowship training years after medical school training. Trainees are typically referred to as PGY1, PGY2, PGY3, etc., to provide the distinction of their training level.

Preliminary Year Typically one year of internal medicine residency training that precedes entry into an advanced specialty residency training program.

Program Director (PD) Designated physician faculty member responsible for oversight of all operations of a residency or fellowship program.

Program Evaluation Committee (PEC) Program committee required by ACGME to evaluate the educational activities of the program and address any areas of noncompliance in regard to ACGME standards.

Residency Review Committee (RCC-IM or RRC) Subcommittee of ACGME that develops and interprets guidelines and regulations for internal medicine residency programs.

Resident As defined by ACGME, "any physician in an accredited graduate medical education program, including interns, residents, and fellows."

Sponsoring Institution The entity that assumes responsibility for a graduate medical education program.

Sub-Internship (Sub-I) In-depth medical school rotation that usually occurs in the fourth year but can take place late in the third year and provides the opportunity for medical students to have a patient care load equal to that of an intern. Medical students with a focused subspecialty interest will often undertake a sub-internship experience in their chosen area during the third or fourth year of medical school.

Subspecialty Further specialization of core training. Divisions or sections within departments of medicine are typically representative of these subspecialties (e.g., nephrology).

T32 NIH-funded Institutional Training Grant that allows institutions to provide service awards to selected individuals for predoctoral and postdoctoral research training in specified research training areas.

Training Administrators of Graduate Medical Education (TAGME) Organization that provides certification for graduate medical education administrators.

Undergraduate Medical Education (UME) Medical school training received prior to entering residency, which results in receiving a Doctor of Medicine (MD) degree.

United States Medical Licensing Examination (USMLE) Three computer-based examinations required to obtain a full medical license. It is administered by the Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners (NBME). Step I is usually taken after the second year of medical school, followed by Step II in the fourth year of medical school, and concluding with Step III, which is often taken during residency training.

3 ADMINISTRATOR'S NEED-TO-KNOW LIST

Internal medicine administrators come to their positions from a wide range of backgrounds. For some, it is their first experience working with physicians or in higher education. In addition to possessing core skills in financial and human resources management, administrators are expected to gain an in-depth understanding of the research, educational, clinical, and administrative missions of an academic internal medicine department.

Departments of internal medicine are commonly organized into administrative units that are overseen by the chair of medicine's office. Divisions within the units are arranged by educational programs and subspecialty medicine topics (e.g., cardiology) and are managed separately. The scope of responsibilities managed at the department level and the roles held at the division level vary among institutions based on their school of medicine's organizational structure and management arrangements with affiliated medical centers.

Departments of medicine are large, diverse, and dynamic. Academia is predicated on the testing of new theories, the development of cutting-edge practices, and creative implementation of practices in all mission areas. Administrators work with faculty, trainees, and staff to facilitate these professional aspirations in a fiscally responsible and compliant manner. Administrators new to a position or new to the field soon learn a new language (or languages) and are welcomed into this community of people in similar roles willing and able to help.

But how do administrators get started? Here's a list of the top 10 areas where new administrators could begin their focus, with suggestions on areas to explore as they transition into their new role and responsibilities:

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1.	Institutional and departmental overview	» Review health system and department's mission, vision and values. » Review your structure of the health system and department. » Meet faculty and staff leaders in the department and health system, and listen to any concerns, challenges or opportunities. » Understand the department's or subspecialty unit's business continuity plans. » Review important dates on the department's calendar. » Review key departmental and health system policies, including those on compliance (both mandatory and role specific) internal controls, and conflict of interest. » Understand the affiliation with any local U.S. Department of Veteran's Affairs (VA) Medical Center(s) and how that relationship is defined. » Review referring physician satisfaction data.
2.	Financials and Funds Flow	» Build understanding of department and health system's finances, management reports and metrics. » Understand funds flow into, and out of, the department. » Review budget process and calendar.

3	Faculty	» Understand faculty tracks for the medical school.
		» Overview appointment and promotion processes.
		» Review annual calendar of faculty activities:
		  » Sabbaticals
		  » CV reviews
		  » Performance reviews and merit program
		  » Effort reporting, disclosure of outside activities
		» Understand compensation structure and components of salary.
		» Review faculty satisfaction data.

4	Staff	» Meet with HR Manager to review key policies, processes and calendar. » Understand performance management and annual review processes. » Review employee engagement data. » Understand employee roles and employment classifications.
5	Research Administration	» Review department's research performance standards, and expectations for protected time for research. » Understand research reimbursement for the department. » Tour relevant research labs. » Understand pre- and post-award processes and policies and infrastructure. » Review space assignments, funding per square foot, and other metrics for both wet and dry lab research programs. » Understand bridge funding, cost-sharing, retention and other research-related policies.
6	Teaching Administration	» Review department's teaching performance standards, and expectations for protected time for teaching. » Understand departmental reimbursement for teaching. » Review department's role in medical student teaching. » Review structure and activities of residency and fellowship programs. » Review teaching effort commitments.

7	Clinical Administration	» Review department's clinical performance standards, and expectations for clinical assignments.
		» Understand departmental reimbursements for clinical activities (productivity and clinical administrative roles).
		» Tour clinic and procedural areas, including call center units.
		» Review clinical productivity data:
		  » RVUs (Relative Value Units)
		  » Clinic visits
		  » Discharges
		» Review patient satisfaction data.
		» Be aware of anticipated arrival of accreditation bodies (e.g., The Joint Commission).

8	Development/ Philanthropy	» Meet Development Team lead. » Review endowments, professorships and other gift funds. » Understand your role in the development process.
9	Charge capture/ billing	» Meet Revenue Cycle lead. » Overview of clinical services (both inpatient and outpatient). » Review key metrics.
10	Become an active and engaged member in AAIM	» Learn AAIM organizational structure and constituent groups. » Review AAIM publications and resources. » Review AAIM invoice to ensure all appropriate faculty and staff are enrolled in AAIM. » Network with your AAIM colleagues. » Register for the next AAIM Week Conference!

4 COMPARING AND CONTRASTING DEPARTMENTS OF INTERNAL MEDICINE

Departments of internal medicine are often the largest and most complex departments within schools of medicine and teaching hospitals. These departments conduct administrative activities that span all mission areas of an institution. Because of their size and institutional impact, internal medicine departments require a unique approach for effective management. It is important to note, however, that organizational structures are evolving with the changing academic health care environment. This section provides an overview of contrasting organizational structures and financing of three real institutions that represent different ownership structures at a particular moment in time. It also provides examples of various roles and internal administrative structures of departments with divisions as well as institutional relationships with entities such as centers and institutes.

Key organizational differences among departments of internal medicine include:

- The extent to which operations are centralized versus decentralized.
- The size of respective operations at the departmental versus divisional level.
- The administrative "home" for various activities—institution, department, or division.
- Funds flow and financial control practices.

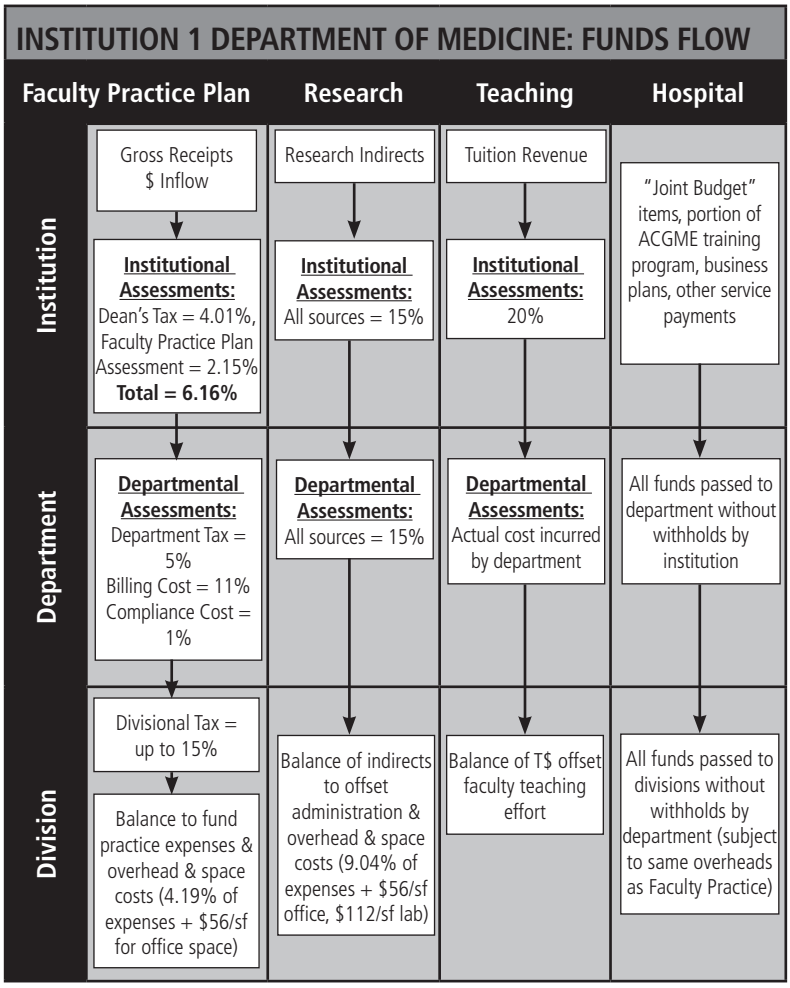
INSTITUTIONAL STRUCTURE #1 – UNIVERSITY WITH UNIVERSITY-OWNED PRACTICE PLAN, WITH FACULTY PRACTICING IN BOTH THE UNIVERSITY MEDICAL CENTER AND A PRIVATELY OWNED HOSPITAL

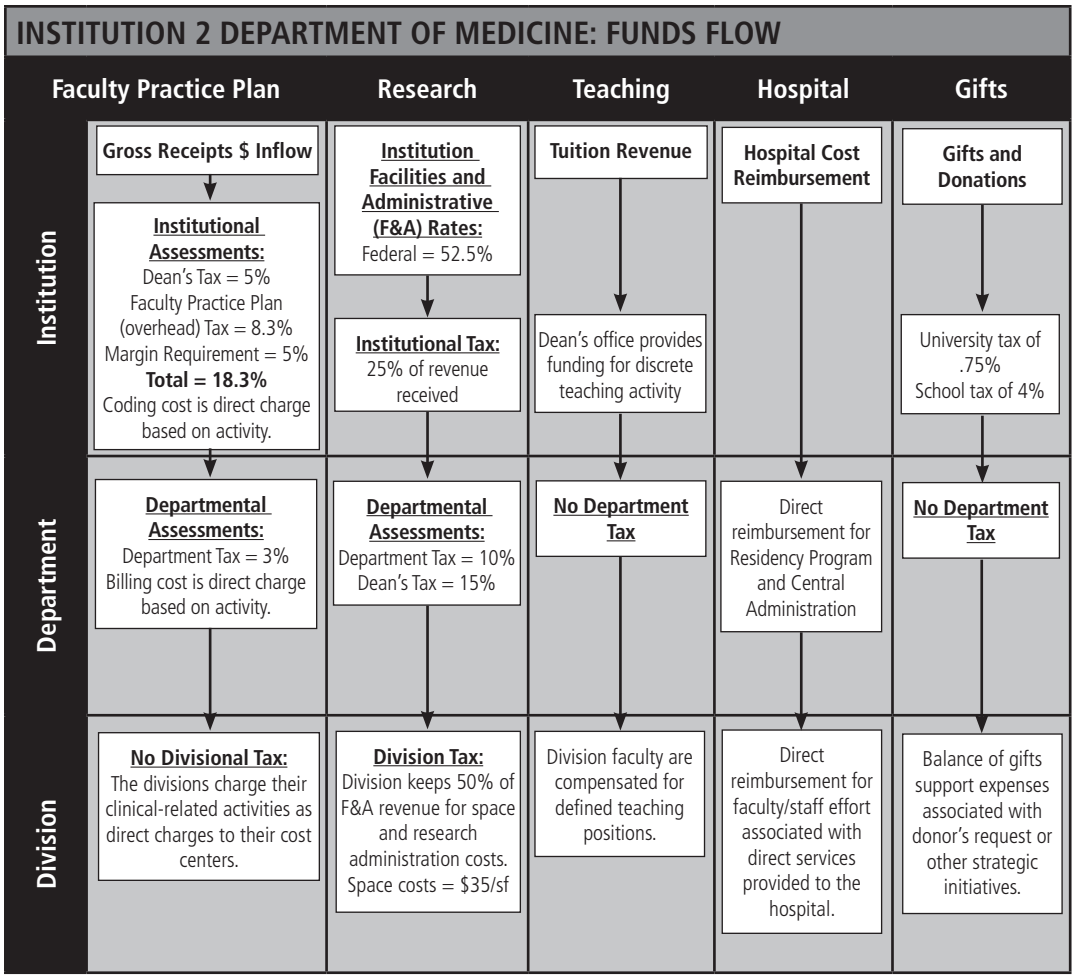
Chair of Medicine

- Vice Chair – Education
- Vice Chair – Clinical Programs
- Vice Chair – Research
- Vice Chair – Quality
- Vice Chair and Director – Residency
- Director – Clinical Trials
- Director – Research Development
- Director – Education Programs
- Division Chiefs

Vice Chair – Finance and Administration

- Division Administrators
- Operations/Human Resources
- Grants Administration
- Billing Compliance
- Physician Billing
- Faculty Practice Finance
- Faculty Practice Management
- Accounting/Finance





INSTITUTIONAL STRUCTURE #2 – UNIVERSITY WITH PRACTICE PLAN ORGANIZED AS A SEPARATE FOUNDATION, WITH FACULTY PRACTICING IN UNIVERSITY HOSPITAL

Chair of Medicine

- Vice Chair – Education
  - Director, Undergraduate Education
  - Director, Graduate Education (Residency Manager)
- Vice Chair – Faculty Affairs
- Vice Chair – Clinical Affairs
- Vice Chair – Development and Innovation
- Division Chiefs

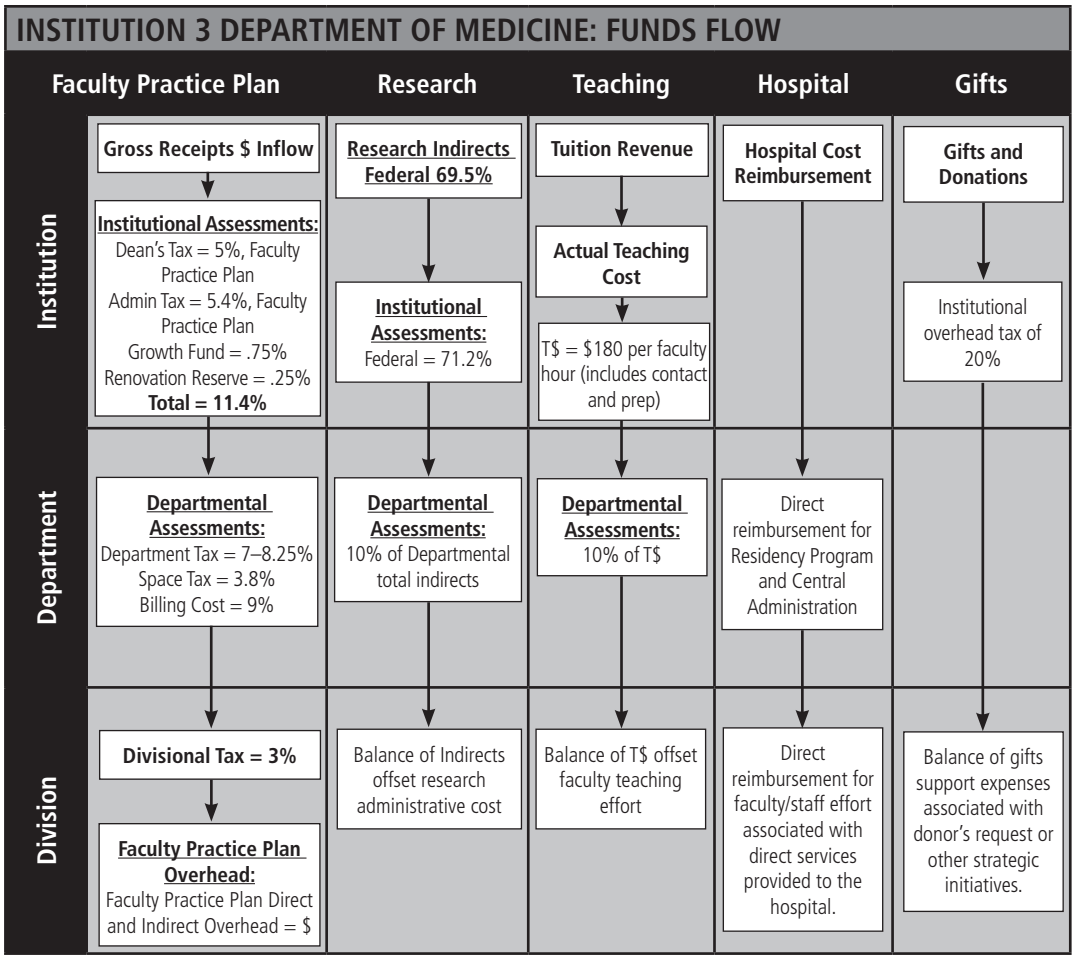
Administrator

- Division Administrators
- Director, Administration and Organizational Development
- Director, Research Administration and Development
- Director, IT and Communications
- Accounting/Finance

INSTITUTIONAL STRUCTURE #3 – SCHOOL OF MEDICINE WITH SCHOOL-OWNED FACULTY PRACTICE PLAN WITH FACULTY PRACTICING IN SCHOOL-OWNED MEDICAL CENTER

Chair of Medicine

- Division Chiefs
- Vice Chair – Education
  - Fellowship Directors (dual reporting)
  - Residency Office Administrator
  - Global Health Program
- Vice Chair – Research
  - Division Research Directors (dual reporting)
  - Space and Facilities
  - Director, Biostatistics
  - Director, Clinical Epidemiology
  - Director, Clinical Research
  - Grants Manager
  - Research Core Laboratories
- Vice Chair – Bioinformatics
  - Director, Clinical Informatics
- Vice Chair – Quality Assurance
  - Divisional Q & A Directors (dual reporting)
  - Quality Analyst



- Associate Director, Faculty Practice Plan Services
  - Divisional Faculty Practice Plan Medical Directors (dual reporting)
  - Patient Quality Manager
  - Practice Managers
  - Coding Specialists
  - Call Center
  - Faculty Practice Plan Billing Services
- Director, Ambulatory Service
  - Divisional Clinical Medical Directors (dual reporting)
- Vice Chair, Professionalism
  - Director, Ethics
- Vice Chair, Voluntary Affairs
- Vice Chair, VA Affairs

Chief Administrative Officer

- Division Administrators
- Service Centers
  - Finance
  - Communications
  - Appointments and Promotion
  - Information Technology
- Director, Research Administration and Development
- Director, IT and Communications
- Accounting/Finance

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CLINICAL PRACTICE MANAGEMENT IN DEPARTMENTS OF INTERNAL MEDICINE				
	Site 1	**Site 2**	**Site 3**	**Differences and Comments**
Revenue Cycle (RC)	Departmental oversight with hybrid centralized and decentralized operations between department and divisions; practice plan primarily policy setting, contracting, and back-end revenue management (A/R). Department provides reports, analytical support, and oversight.	Hybrid responsibility for certain aspects of the revenue cycle. Coding and collections, contracting, and A/R completed by practice plan central; precertification and appointment management completed by department personnel.	RC operations managed centrally by department under director of RC. Department-owned clinical billing office, and standard RC policies and procedures throughout all practice sites. Some policies are dictated by institution's practice plan. Divisions are responsible for review and analysis of monthly reports.	» #1 = Hybrid, shared » #2 = Hybrid, shared » #3 = Centralized
Clinical Practice Supervision	Multiple locations throughout ambulatory care building; each subspecialty has practice manager with joint reporting relationship to division administration and to departmental director of faculty practice management.	Two clinical centers (cardiology and cancer) have hybrid management with central and department. Medical specialties and gastroenterology practices managed by the department.	Two multispecialty outpatient practice sites for eight divisions, managed centrally under department practice manager and medical director. Some divisions have outpatient sites that are division specific, where practice manager reports into divisions but follows departmental revenue cycle standard operating procedures.	» #1 = Divisionally based » #2 = Divisionally based » #3 = Centralized
Compliance	Billing compliance oversight at department level with joint reporting to institutional compliance officer.			» #1 = Departmental » #2 = Institutional » #3 = Institutional

FINANCE				
	Site 1	**Site 2**	**Site 3**	**Differences and Comments**
Labor Distribution/ Salary Allocation	Divisions responsible for labor distributions; complete online or paper forms as appropriate with department as final approver.	Divisions are responsible for their labor distributions (all personnel). Financial systems are updated through the use of DOM central staff utilizing a database for confirmation and reconciliation.	Divisions allocate salary based on effort. Transactions are processed through institution HR transaction system, and are routed through DOM central and finance for approval.	All = Division with departmental oversight (and approval)
Budget Preparation and Monitoring	» Division administrators prepare all budgets for all fund types. Some enter budgets directly into budget system; others provide Excel spreadsheets to department for entry. Payroll-related budget entries are done by department. » Monthly review is done by department of professional practice revenue; quarterly review of operating results for all fund types is done by department and meetings between chief administrative officer and division administrators.	» Division administrators prepare their budgets for clinical and research activities. » Clinical budgets are reviewed once a year when established and reviewed monthly via variance analysis. » Research budgets are prepared with submissions and are reviewed monthly via variance analysis.	» Divisions prepare budgets on DOM central template for all business units: research, clinical, etc. » Budgets are reviewed and approved by DOM central and uploaded in central database. » DOM central generates monthly budget variance reports and meets with division administrators to discuss variances and develop corrective action plans when appropriate.	**Budgeting:** All = Divisions have primary responsibility for management and reporting to DOM. **Monitoring:** #1 = Institutional review of department #2 = Institutional review down to division level #3 = Institutional review of department
Reporting	Department provides standard revenue cycle reports and quarterly operating result reports for all fund types as well as by physician individual profit and loss results. Ad hoc reporting available to all divisions via various databases.	Department provides reporting database for clinical productivity reporting and labor distributions. Cognos financial reports are generated for sponsored and non-sponsored accounts.	Department generates reports for mission-based activities for all levels of the organization: department, division, service line, faculty, etc., via SQL and web servers. Institutional initiative underway to develop data warehouse with central institutional reporting.	All = Provide standard monthly reports; divisions do ad hoc reports or request ad hoc reports as needed. Practice plans at all institutions provide standard clinical financial reports.

HUMAN RESOURCES/FACULTY AFFAIRS				
	Site 1	**Site 2**	**Site 3**	**Differences and Comments**
Staff (recruitment, promotions, terminations)	Joint responsibility – primarily department level: submission of request to school, posting of job, and preemployment screening.	Largely a division-based event, reviewed and approved by department staff and supported by an electronic platform at school and practice plan.	Primarily a divisional function. Division submits request to DOM via online recruitment system, then routes it to institution. Posting is posted by institutional recruitment, which is responsible for screening and recommending candidates.	» All = Division initiates; department approves and implements in various ways » #3 = Screening done by institutional staff
Faculty (recruitment, promotions, tenures)	» Division: recruitment process, draft offer letter, provide data for appointment. » Department: final offer letter review, appointment process, present to appointment committees, on-boarding.	Initiated from annual hiring plan and organized/supported through a hybrid effort between the department and division.	Recruitment needs may be initiated by division or DOM; business plans and offer letters are prepared by DOM and sent to the dean's office for approval; faculty appointment and promotion review and recommendations are made by DOM A&P committee, and then sent to the institution.	» All = Hybrid for initiation of recruitment » #3 = Department prepares business plans and offer letter » #1 and #2 = Divisions prepare offer letters and hybrid for business plan
Faculty credentialing	» Division: interact with faculty to get data, etc. » Department: manage process, submit forms, interact with faculty practice office hospital.	Process initiated by division with departmental oversight and coordination with hospital privileging staff.	DOM A&P manager interacts with faculty and collects data. Data are populated into DOM central database, which automatically populates managed care applications for the Faculty Practice Association.	» #3 = Centralized at department level #1 and #2 = Hybrid, function shared between department and division
Annual Salary Determination	» Faculty: division makes recommendation for subsequent review and approval by department and school. » Staff: guided by respective institutional policy on an annual basis.	» Faculty: based on faculty compensation plan. » Staff: guided by respective institutional policy on an annual basis.	» Faculty: based on faculty compensation plan. » Staff: guided by respective institutional policy on an annual basis.	» All = Department-based faculty compensation plans that require institutional review and approval » Staff incentive programs » #1 and #2 = formal incentive plan for CAO; informal for division administrators » #3 = informal plan for CAO

RESEARCH ADMINISTRATION				
	Site 1	**Site 2**	**Site 3**	**Differences and Comments**
Pre-Award Management	Faculty interact mostly with division (multi-investigator or limited opportunity to interact with department); limited review of proposals by department.	Completed in the divisions with review before submission to office of sponsored research by department. Research administrators/ division administrators perform this role.	Divisions are responsible for preparing all pre-award documents and budgets, which are reviewed by DOM research administrators, and are then submitted to the school's grants and contracts Office.	#2 and #3 have a department-level administrator who reviews all proposals
Post-Award Management	Division has primary responsibility; department reviews accounts to ensure accounts are in balance (creating a central post-award function).	Completed in the divisions for account setup, procurement, expenditures, subcontract setup, etc.	Divisions are responsible for account management of each project, with central monitoring of unbudgeted funds and deficits by DOM.	
Procurement and Expenditure Activity	Division (lab personnel or other support staff in administrative offices) with support from department on an as-needed basis.	Done in the individual research program by faculty or staff. Heavy use of technology for these operations.	Initiated by lab via online procurement system that routes transactions for approval and generates a purchase order. Results in centrally generated reports on expenditure activity.	
Effort Reporting	Divisions review and present to faculty for approval (online system) with significant oversight and follow-up by department.	Pre-reviewed by division administrators and certified by faculty.	Effort reports are generated by institution based on salary allocations, and are sent to divisions for review for faculty to certify.	
Technical and Financial Reporting	Technical report by faculty member through division. Financial report prepared by central university with review by division.	Technical reporting completed by division faculty. Financial reporting is a hybrid model between division staff and central grants office.	Technical report by faculty member through division. Financial reporting is prepared by the institution and reviewed by the division.	#2 has some financial reports initiated by the divisions

5 THE CLINICAL MISSION

Medical schools and teaching hospitals meet core needs of the medical community. Medical schools own or establish partnerships with hospitals to establish teaching clinics as an extension of the physician practice and provide inpatient and outpatient training experiences. The teaching clinic and inpatient services provide opportunities for trainees to build relationships with patients by participating in the patient's care: to manage complex patient situations while under the supervision of a senior physician. While some patients may be reluctant to seek care from physicians-in-training, others feel they benefit from the longer appointment sessions and the comprehensive care received in a teaching facility. Many medical schools are partners with community hospitals and private physician practices to best meet a broad range of training requirements.

Revenues resulting from clinical practices contribute significantly to meeting a department of medicine's operational and overhead costs. In recognition of clinical income as a critical component of an organization's revenue stream, administrators and faculty leaders are actively involved in clinical operations and oversight. Administrators and physician leaders are commonly responsible for physician faculty recruitment and timely completion of credentialing, compliance, and faculty appointment requirements. Physician faculty and clinical staff may have dual appointments with an academic institution and a clinical entity (e.g., medical center). Depending on the ownership model, administrators and physician leaders may also be responsible for hiring and managing nonphysician clinical providers, overseeing billing and coding processes, and managing facilities. Working with physician faculty and other process partners, the administrator and physician leaders may participate in long-range and strategic planning initiatives, financial oversight, and compliance activities while encouraging the research and teaching missions that are also core to academic internal medicine.

The local financial and organizational structure will determine the role and authority of administrators, staff, and faculty leaders involved with clinical management, and the clinical revenue cycle.

This chapter provides an overview of several key components of the administrator's role in managing the clinical mission, including the revenue cycle,

DEPARTMENTAL MANAGEMENT BASIC:	
Clinical Revenue Oversight	» Confirm the ownership model for the institution. Identify and understand roles and responsibilities for units managing each component of the clinical revenue cycle. » Determine who needs to access data needed for clinical revenue management and reporting. » Determine appropriate metrics for establishing, measuring and monitoring provider productivity. » Develop systems for distribution of metrics or other dashboard tools. » Identify and understand institutional practices and policies for distribution of clinical revenues (clinical provider and facility fees).
Clinical Provider Recruitment and Onboarding	» Establish guidelines for recruitment and retention of key clinical producers. » Understand the institutional processes for ensuring timely and complete appointment of clinical providers with active clinical privileges, billing rights and required electronic health systems access. » Create a plan for providing timely and ongoing provider trainings (e.g., compliance).
Clinical Research Compliance	» Understand guidelines for conducting clinical research and means of differentiating clinical research activities in alignment with billing and compliance requirements.
Teaching Activities	» Understand clinical teaching services and advocate for the value of training activities to clinical practice.
Provider Productivity	» Develop a clear methodology for defining clinical effort. » Establish clear, consistent principles for provider compensation.

faculty practice plan, and clinical full-time equivalent (FTE) and compensation plans.

OVERVIEW OF THE CLINICAL REVENUE CYCLE

The clinical revenue cycle refers to the process of ensuring that provided clinical services are documented to qualify for payment. The role of departments of medicine in this process varies from institution to institution, so administrators and physician leaders need to understand their respective roles and responsibilities for each step in the clinical revenue cycle. All academic entities, regardless of organizational structure and ownership model, will be working toward the goal of implementing business practices intended to maximize clinical revenue while maintaining compliance with all applicable institutional and payer regulations. Management of the clinical revenue cycle is an extremely complex undertaking with clinical billing and reimbursement practices regulated by a number of federal and local regulations. Revenue for any clinical practice will vary based on patient population, payer mix, and expense write-off policies. Administrators and physician leaders should understand the institution's specific guidelines. Many academic organizations establish a faculty practice plan to help manage these processes.

Faculty Practice Plan

A faculty practice plan is an organized group of faculty physicians and other health care professionals who treat patients in a health care system. Patient care providers in the clinic environment extend beyond the physician faculty. In addition to physicians, the patient may have fellows and residents, medical assistants, nurses, or advance practice providers such as nurse practitioners and physician assistants as part of their care team.

A faculty practice plan may handle some or all of the following activities:

- Clinical documentation and billing process: coding, remittance and collection of clinical charges
- Compliance education and training
- Provision of malpractice coverage
- Coordination of clinical programs and referral
- Contracting with insurance companies
- Strategic/long-range planning

Primary Care

Internal medicine physicians provide adult wellness and prevention care in addition to managing chronic and acute care conditions. Primary care clinics provide outpatient care to adults for a variety of health care conditions while the primary care providers (PCPs) establish a care management program. Depending on the organization, PCPs may also lead inpatient care services.

Specialty Care

Primary care physicians may refer patients to specialist physicians for management of chronic conditions that require specialized care. Patients requiring disease-specific treatment are referred to specialists for ongoing care and their progress is communicated back to the referring PCP. Depending on the patient's insurance carrier, access to specialty care may require authorization specifying the reason for the increased level of care. Once referred, treatment by a specialist can usually continue indefinitely, with the patient returning to the PCP for other routine treatment.

Clinical Documentation

Clinical care is generally provided in an ambulatory (outpatient) care capacity, in a procedural facility (e.g., endoscopy suite), or as part of an inpatient hospital stay. Documentation of each provider service is mandated and monitored by federal agencies. Specific rules govern the roles and responsibilities of attending physicians, residents, and other providers involved with patient care. For a charge to be "captured" and submitted for payment, clinical care must be documented accurately and completely. Each piece of care documentation is reviewed to ensure that data points are included to confirm "why" clinical care was needed and "what" type of service was provided.

The "why" of clinical care is assigned a diagnosis code from the International Classification of Disease, version 10 (ICD-10). The "what" is also assigned a Current Procedural Terminology (CPT) code that identifies the professional service provided. These codes are essential for payment of charges. Services are also assigned a value, referred to as a relative value unit (RVU). The RVU represents the overall value of a clinical service, including facility usage, malpractice coverage, and provider services. The provider service portion of the RVU is designated as the work RVU (wRVU). RVUs and wRVUs are tracked as evidence of productivity of specific clinical services or clinical providers.

The organizations listed below may provide a more in-depth analysis of clinical regulations as well as various models of clinical practice management that may be adapted to local organizations.

- Medical Group Management Association: www.mgma.com
- Institute for Healthcare Improvement: www.ihi.org
- American College of Physicians: www.acponline.org
- Medicare: www.medicare.gov

OVERVIEW OF TEACHING PHYSICIAN GUIDELINES

One of the primary activities that differentiates academic medicine from private practice is the mission to educate future generations of medical professionals. The physicians in this teaching capacity are often called "attending" or staff physicians, and their job is to be the ultimate authority for the patient's care and oversee the activities of the learners (e.g., medical student, resident, fellow). Academic physicians may work with learners in various stages and disciplines who are participating in clinical activities. The level of participation will vary by training level; for example, medical students may shadow a physician during his or her clinic while a subspecialty fellow will be the primary caregiver for the patient, and the attending physician will serve as supervisor and advisor.

These educational activities, while critical to the role of the medical school and teaching hospitals, have a cost associated, because of decreased clinical productivity and increased complexity of the revenue cycle. Learners are not as experienced in patient care and need more time to evaluate and treat a patient than if the attending physician were providing the services alone. Another challenge may be that the physical space of the clinic or inpatient unit may not be adequate for complementary teaching activities (e.g., didactic teaching sessions), causing the attending and learners to have to travel away from the patient care location to participate in these activities. The problem of decreased productivity is universal among academic practices, but the methods to fund these efforts are different between sites. Education funds typically come from three sources:

- Funds from the medical school or dean's office to recognize physician roles as faculty of the medical school
- Funds from a partner medical center to support salary expenses for residents
- Funds created through surplus clinical revenue or other nontraditional sources, such as philanthropy or partnerships with other hospitals and health systems such as Department of Veterans Affairs medical centers or community hospitals

Regardless of the source of revenue, there is unlikely to be a clear methodology for allocating educational funds to physicians in recognition of their teaching efforts. It is important to develop a clear and transparent process for this allocation, because misrepresenting effort spent on educational activities causes an inaccurate accounting of effort committed to clinical practice and therefore inaccurate representation of overall productivity and capacity for clinical caseload. Some of the most common options to allocate education funds to physicians who participate in teaching activities include assigning a time value that can be priced based on hourly rate or other standard rate or protecting some percent of a physician's time so he or she may dedicate that time to education. There is also some required funding of administrative roles such as residency and fellowship program directors, which will diminish the total pool of resources available to distribute. These methodology decisions will ultimately be informed by the department's approach to managing a provider's total effort profile.

OVERVIEW OF CLINICAL FTE

Since academic physicians have obligations beyond clinical care, systems need to be developed to determine what percent of an academic physician's total effort is dedicated to clinical activity. The effort is commonly referred to as clinical FTE (cFTE). Methods to calculate cFTE vary between organizations. cFTE is a widely used metric that allows practices to benchmark their clinical productivity to other academic practices. Three potential methods to calculate cFTE are outlined below.

- Time-based calculation – Each clinical activity is assigned a time value and a physician is credited with that value when scheduled to that clinical assignment. For example, two weeks of inpatient clinical service might be worth 5% effort and a weekly half-day clinic session might be worth 10% effort. If a physician has one weekly half-day clinic session and provides four weeks on inpatient service on the intensive care unit (ICU), then that physician would have an assigned cFTE of 20% using this methodology.
- Revenue-based calculation – Using this approach, all physicians begin as 100% cFTE and can reduce this effort through revenue or designated effort committed in support of other nonclinical activities. Any percentage of salary or effort that is not supported by other revenue sources is considered clinical. For example, if a physician has 30% salary support on a grant, that individual

would be eligible to be assigned 70% cFTE using this methodology. This method is sometimes referred to as CARTS (clinical, administrative, research, teaching, service/strategic) or mission-based budgeting, because revenue to support faculty salary is divided into buckets that align with the mission activity of the academic unit.

» wRVU-based calculation – In this approach, actual wRVU productivity for the individual is compared to the practice's wRVU benchmark. For example, if the wRVU target is 5,000 and the physician generates 2,500 wRVUs, that provider would have an assigned cFTE of 50%.

Once a practice has defined a full-time cFTE and calculated the total cFTE for the group, a relatively simple calculation can be made to determine any gap between clinical demand and supply. For example, if a full-time cFTE can manage an outpatient clinical practice of 3,000 patients and there is a demand of 12,000 patients in the marketplace, the practice needs a total of four cFTE to meet the demand. This level of demand could be met by either four physicians working at 100% cFTE or eight physicians working at 50% cFTE each.

OVERVIEW OF FACULTY COMPENSATION PLANS

Compensation should reward faculty productivity in a fair and transparent manner. At the most rudimentary level, a compensation plan defines activities with an assigned value that count toward productivity. It is important to understand the various types of compensation a physician might receive. Compensation has many components including some nonmonetary components, though salary and incentive payments are considered the core components of compensation.

An important component of building a faculty compensation plan is to develop clear metrics to define success. The most common way to objectively measure success is to compare actual performance to external benchmarks.

Salary benchmarks help judge the level of cash-based compensation of a provider to national norms. The most commonly used databases to benchmark compensation for academic practices are produced by the Medical Group Management Association and the Association of American Medical Colleges. Both have benchmark data specifically tailored to academic physicians, who almost universally have base salaries and incentives lower than their private practice peer group. Compensation benchmarks can help measure an individual provider or practice against the marketplace, and be applied to internal salary equity analyses. The percentile benchmark a practice uses as a goal for compensation or measure of success will be based on financial realities of the individual practice.

The gold standard to measure clinical productivity is the RVU. An RVU represents the overall value of a clinical service. The RVU calculation includes facility usage, malpractice coverage, and provider services. wRVUs are meant to reflect the time, skill, and intensity of the service a physician provides, and they vary widely, as illustrated by the examples below, though RVU values are subject to change:

» Level 3 (average) return patient in clinic = 0.97
» Cesarean delivery = 18.39
» Transplantation of heart = 89.50

The RVU for each service is set and periodically updated by the American Medical Association Specialty Society Relative Value Scale Update Committee. This committee is an expert panel of physicians across specialties.

The number of wRVUs a physician might be able to generate annually is influenced in large part by specialty. Surgical specialties have some of the highest wRVU benchmarks, while nonprocedural specialties such as general internal medicine and endocrinology have the lowest. Many groups and associations publish annual RVU and wRVU benchmarks by specialty. Some examples of the most used databases come from the Faculty Practice Solution Center, the Medical Group Management Association, and the American Medical Group Association. The database an individual practice uses may be influenced by specialty, regional variation, or institutional preferences. The percentile benchmark (25th, 50th, 75th) used as a threshold for incentive payments will vary based on a practice's payer mix, overall profitability, and other factors. Note that due to macroeconomic factors such as payer mix, regional variation in Medicare rates, insurance contracts, and scarcity or surplus of the physician workforce, the percentile benchmark used for wRVU performance may not be equivalent to the percentile used for compensation benchmarks. For example, in a practice with an unfavorable payer mix, wRVU performance at the 50th percentile might be necessary to support salaries at the 25th percentile.

Increasingly, quality is becoming an essential part of physician compensation models. Examples of quality metrics include patient satisfaction, timely and clinically appropriate documentation, and metrics

emphasized by the hospital or health system such as length of stay management and cost containment. Patient satisfaction data are often derived from patient satisfaction surveys. Reductions in patient length of stay in the hospital contributes to reduced expenses and is often associated with improved patient experiences. All physicians and care providers are expected to complete clinical care documentation in a timely manner that contributes to improved care—particularly when several clinical providers are involved in the care of a single patient.

For an academic practice with demands in education, research, and the requirement of academic success in addition to clinical care, it is essential to create metrics that recognize and reward nonclinical performance in addition to counting wRVUs and publicly reported quality metrics. Academic activities that might be considered in judging an academic physician's total productivity include percent of salary covered by extramural funding, number of publications or successful grant submissions, hours of teaching medical students, or number of mentees. Such scholarly activities are numerous and varied and should be customized to reflect the priorities and values of the individual academic department. Most of these activities lack a direct funding stream, so any financial rewards associated with academic productivity will need to come from other sources, such as excess clinical revenue or other discretionary accounts.

Finally, there are faculty-level administrative obligations associated with each of the three missions, and the administrator needs to recognize that these obligations diminish the opportunity for maximum productivity. Some practices may choose to protect part of each week or a percent of a wRVU target to recognize the effort required for these administrative duties, which can include clinical director roles, documentation requirements, clinical care coordination, participation on committees in the hospital and medical school, and participation in quality of care activities for hospital partners.

Compensation plans for academic practice have unique challenges, because they must develop metrics around and reward all areas of the tripartite mission while recognizing that many activities required of an academic physician do not have sufficient revenue streams attached. These complexities, coupled with the specific financial arrangements and challenges within each department of internal medicine, will likely result in each practice needing a tailored compensation plan, but every compensation model can adhere to some basic principles and best practices:

- Metrics should be developed to align clinical provider behavior with the goals and strategic initiatives of the organization.
- Strong faculty compensation plans attract and retain faculty by rewarding individual productivity and achievement in a manner consistent with shared institutional objectives.
- Compensation plans that have the opportunity to increase total compensation when metrics are exceeded as well as the potential for salary decreases due to underperformance will ultimately match productivity with compensation.

Fairness and transparency are critical components in securing maximum physician faculty buy-in for reimbursement models. The metrics for success should be clearly defined and individual progress toward goals should be monitored and communicated regularly to give individuals sufficient information to change behaviors to meet expectations. The most successful plan will also have administrative metrics and expectations, such as a narrative that clearly outlines the methodology for calculating productivity and incentive payments, as well as standard recurring dates when incentives are paid.

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6 THE EDUCATION MISSION

The overall purpose of the education mission is to train the next generation of physicians and scientists. As the largest clinical department in a school of medicine, a department of internal medicine provides important training for three groups: medical students, residents, and fellows. In addition, many departments of internal medicine have robust continuing medical education (CME) programs that are used by other academic physicians and community practitioners alike. Faculty in departments of medicine are frequently the educational leaders asked to serve as medical school course directors, classroom instructors, preceptors for clinical rotations, and mentors. Faculty serve on admissions committees, curriculum development committees, accreditation preparation committees, and program evaluation committees, among many others.

Schools of medicine offer undergraduate medical education (medical school), graduate medical education (internships, residencies, and subspecialty clinical and research fellowships), and CME. At the resident and fellow level, physicians-in-training are considered the pipeline for future faculty. They are also viewed as a talented pool of students who provide significant clinical services for the department and hospital. Training activities emphasize time spent developing clinical, teaching, and research skills balanced against time spent providing clinical service. Residency and fellowship programs must meet rigorous training criteria set both nationally by the Accreditation Council on Graduate Medical Education (ACGME) and locally by institutional offices of graduate medical education (GME). Institutions may also opt to offer nonaccredited clinical fellowship training experiences in addition to postdoctoral research experiences for individuals who hold PhDs. The recruitment of residents and fellows is competitive among departments of internal medicine. Adjustments in time spent in skills development versus provision of clinical services may influence an applicant's view of the program.

Faculty often cite the enjoyment of teaching physicians-in-training as one of the key reasons they work at a medical school rather than in a private clinical practice or in private industry as a researcher. Leveraging this key retention element can be challenging to departments trying to balance programmatic needs with limited funds designated for education program support expenses.

KEY POINTS FOR ADMINISTRATORS AND FACULTY LEADERS:

- Understand the breadth and scope of the educational mission within the division/department.
- Review core commitments to medical student programs, intern/resident training and mentoring, and clinical and research fellow training and mentoring.
- Understand accreditation and governing policies and obligations.
- Identify funding allocations for teaching and educational leadership responsibilities.
- Identify and document "unfunded" teaching activities.
- Identify funding available for trainee salaries at all stages of training.
- Identify funding available for non-salary training activities.
- Coordinate with undergraduate and graduate medical education offices to confirm management roles and responsibilities and staff training opportunities.
- Understand billing and compliance requirements for clinical teaching services.

TRAINING PROGRAM ADMINISTRATORS

Program administrators (PAs) are responsible for the day-to-day administration of ACGME residency/fellowship training programs. The PA assists the program director (PD) in developing and maintaining the educational quality of the training program and ensuring compliance with ACGME accreditation standards and other regulatory requirements. The PA functions as a liaison between the PD, residents/fellows, the institutional GME office, participating training sites, and other departments, and must be knowledgeable about patient care/operational activities at the various training sites in which their residents/fellows rotate. Within this framework, the PA:

- Coordinates educational activities (e.g., didactic conference schedule, Grand Rounds) that support

the program's curriculum and adhere to ACGME requirements.
- Provides guidance to residents/fellows on program and GME policies, and nonclinical aspects of the program.
- Establishes and disseminates annual rotation, clinic, and call schedules.
- Manages dissemination and completion of resident/fellow, faculty, and program evaluations.
- Coordinates accreditation activities including ACGME program reviews and reporting.
- Manages duty hours and evaluation reports and ensures reporting and completion compliance.
- Tracks resident/fellow training time for effort and activity reporting.
- Ensures GME policies and procedures are enforced, and that departmental and program policies and procedures are created and enforced.
- Coordinates the resident/fellow recruitment and selection process.
- Assists the PD and faculty in planning, developing, and implementing residency/fellowship program quality improvement projects.

ACCREDITATION OVERVIEW

Accreditation is a voluntary peer-review process designed to attest to the educational quality of new and established educational programs. Accreditation for the vast majority of US graduate medical education is obtained through ACGME. The organization responsible for accrediting US medical schools is the Liaison Committee on Medical Education (LCME). ACGME conducts both institutional and program reviews whereas LCME focuses on program accreditation. Both organizations offer set standards that must be met to maintain accreditation with a focus on overall quality and improvement.

ACGME accredited residency and fellowship programs are required to submit data to ACGME annually, inclusive of the following: program update, resident survey, and faculty survey. Additionally, milestone reporting on individual trainee performance occurs twice per year. These data are collected and reviewed by specialty-specific review committees within ACGME. Annual data that suggest a potential problem can trigger a focused or diagnostic site visit to obtain additional information; otherwise, the standard cycle for accreditation site visits is every 10 years.

Clinical Learning Environment Review (CLER) visits are intended to assess the overall educational environment at the institutional level. The CLER visit is composed of six core focus areas: patient safety, quality improvement, transitions in care, supervision, duty hours oversight (including fatigue management and mitigation), and professionalism. The CLER visit process engages hospital leadership, representative trainees, program directors, and core faculty through meetings and direct observation that take place during tours of the training site. CLER visits are part of the ACGME's Next Accreditation System, which is still in the early implementation stages. The initial projections are that CLER visits will take place every 18 to 24 months.

It is important to note that, in regard to residencies and fellowships, it is possible to have nonstandard or non-ACGME accredited positions. Individuals may undertake advance clinical training in a nonaccredited program. Fellow status commonly extends beyond the duration of an ACGME-governed program for individuals participating in research training in addition to clinical certification. Many departments of medicine accept postdoctoral researchers holding PhD degrees for research experiences. These experiences would not be governed by ACGME guidelines, nor would a combined program where standard training is condensed to obtain dual certification in four years versus six years.

LCME accredits complete and independent medical education programs that lead to the MD degree if 1) the schools are operated by universities or medical schools chartered in the United States or Canada and 2) the medical students are geographically located in the United States or Canada for their education. Accreditation of Canadian medical education programs is undertaken in cooperation with the Committee on Accreditation of Canadian Medical Schools. By judging the compliance of medical education programs with nationally accepted standards of educational quality, LCME serves the interests of the general public and of the medical students enrolled in those programs.

To achieve and maintain accreditation, a medical education program leading to the MD degree in the United States must meet the standards contained in this document. The accreditation process requires a medical education program to provide assurances that its graduates exhibit general professional competencies that are appropriate for entry to the next stage of their training and that serve as the foundation for lifelong learning and proficient medical care. Although LCME recognizes the existence and appropriateness of diverse institutional missions and educational objectives, it does not believe that local circumstances justify

accreditation of a substandard program of medical education leading to the MD degree.

LCME regularly reviews the content of the standards and elements and seeks feedback on their validity and clarity from its sponsor organizations and members of the medical education community. Changes to existing standards and elements that impose new or additional compliance requirements are reviewed by the LCME's sponsoring organizations and are considered at a public hearing before being adopted. Once approved, new or revised standards are published in *Functions and Structure of a Medical School* (F&S) and in the relevant version of the Data Collection Instrument, which indicates when the changes become effective. Such periodic review may result in the creation or elimination of a specific standard and/or element, or a substantial reorganization of F&S content.

The F&S is organized according to 12 accreditation standards, each with an accompanying set of elements. Each of the 12 LCME accreditation standards includes a concise statement of the principles that represent the standard. The elements of each standard specify the components that collectively constitute the standard; they are statements that identify the variables that need to be examined in evaluating a medical education program's compliance with the standard. LCME considers the totality of a program's responses to each of the elements associated with a specific standard in its determination of the program's compliance with that standard.

RECRUITMENT

Recruitment of residents and fellows is accomplished through the National Resident Matching Program (NRMP), commonly referred to as "the Match." On its website, http://www.nrmp.org/match-process/match-algorithm/, NRMP describes the match algorithm.

> ". . . a mathematical algorithm to place applicants into residency and fellowship positions. The algorithm is "applicant-proposing," meaning the preference expressed on the rank order lists submitted by applicants, not programs, initiate placement into residency training. As a result no applicant could obtain a better outcome than the one produced by the algorithm."

A standard cycle is used for both the residency and fellowship match programs. The process is generally highly competitive, with more applicants than available positions for residency programs. In 2015, more than 41,000 domestic and international applications were submitted for the 30,000 residency positions available in the United States. Programs across the country all compete for the best of the best, and applicants frequently apply to numerous programs (sometimes in excess of 20 to 30). The competitiveness for fellowship programs can vary widely based on geographical location and specialty, but internal medicine programs are routinely in high demand.

Match data are published at http://www.nrmp.org/match-data/main-residency-match-data/.

EDUCATIONAL MISSION COSTS

Education mission costs include salary and fringe benefit expenses for faculty who teach, direct medical school courses, or act as residency or fellowship training program directors or core training program faculty. Administrative staff members also support these activities. Most departments have staff dedicated to the support of some undergraduate medical education (UME) activities (e.g., the third-year clerkship in internal medicine) and GME activities (residency program coordinators, fellowship program coordinators, and other support staff). There are also expenses associated with the general administration of programs (e.g., in-training exams, trainee scholarship support, office supplies and expenses) and the overall wellbeing of trainees (e.g., professional travel, food, social events). Some costs are incurred by the chair's office (UME residency program) and other costs are incurred at the division level (GME subspecialty fellowship programs).

Because ACGME requires more outpatient training experience for residents, some departments support community-based physicians who help provide this training.

FUNDING SOURCES FOR THE EDUCATIONAL MISSION

How each institution funds the educational mission and the adequacy of that funding varies across institutions. Indeed, funding for some parts of the mission may be more robust than others and depends in part on availability of funding from partner schools, hospitals, and affiliated training sites (e.g., Department of Veteran Affairs (VA) hospitals, community hospitals). Institutional funding typically comes from three sources: the school of medicine dean's office, medical centers associated with the school, and intradepartmental transfers of clinical revenue with the source reflecting the type of education being provided (e.g., UME versus GME).

Funding for Undergraduate Medical Education

Many dean's offices provide "teaching support" for UME. The source of these funds is often tuition revenue collected by the school of medicine. The calculation for this support varies across institutions and is often based on a set dollar amount per teaching or contact hour of faculty. The amount is usually fixed regardless of faculty specialty. Many institutions provide an additional, separate amount (calculated as a percentage of salary and fringe benefit expenses) for faculty who coordinate courses or are course directors. Some institutions pay for UME using a dollar amount per educational value unit. Clinical clerkships and elective courses are not always rewarded in the same way as required medical school courses—some schools include these courses in their calculations, others do not provide teaching funds for electives, and still others may create a separate payment mechanism. It is rare that the medical school provides direct support for faculty who teach students on clinical rotations.

Funding for Graduate Medical Education

Partner hospitals may provide funding for GME. AAMC provides an overview of the relationship between Medicare and GME funding. (https://www.aamc.org/advocacy/gme/)

The Centers for Medicare & Medicaid Services also provides details on direct graduate medical education (DGME) and indirect graduate medical education (IGME) (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dgme.html and https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Indirect-Medical-Education-IME.html). Medicare provides funding to hospitals in the form of DGME and IGME. These sources are accessed by partner or affiliated hospitals for their funding of programs in departments of medicine.

Depending on the organizational and corporate structure of the institution, interns and residents—commonly post-graduate year (PGY) 1 through PGY3—are often paid directly by the partner hospital. Clinical fellows may or may not be paid by the hospital. Other post-graduate trainees (research fellows) are rarely, if ever, paid by the hospital. This section refers to clinical trainees commonly called interns, residents, or clinical fellows; departments often label trainees in their first three years of training as residents and refer to trainees in subspecialty training programs as fellows.

Hospitals typically provide funding for a set number of residents at varying levels of PGY training. Some institutions provide funding for part or all of the clinical fellow stipends. This funding may be calculated as a set amount per individual or as a set amount per PGY level. Hospitals may also provide funding toward other GME expenses, such as the salary and fringe benefits of the residency program directors, associate program directors, and residency program administrative staff. Many hospitals will also provide some funding for the directors and administrative staff associated with clinical fellowship programs. This funding may be a set amount per year and may be in lieu of or in addition to an allocation of administration, supervision, and teaching dollars from Medicare Part A for the supervision and teaching of clinical physicians-in-training. In addition to coming from the major affiliated or partner teaching hospital, "hospital funding" may also come from VA and community hospitals for those departments with these types of affiliations.

Other Funding for the Educational Mission

Another major source of revenue for the educational mission comes from the department's clinical margin; that is, a cross-subsidization of the educational mission by the clinical mission.

Departments may subsidize implicitly through the chair's clinical tax or, more rarely, explicitly by requiring divisions to cross-subsidize each other. In the case of the latter, explicit discussions among the chair, vice chair for education, and division chiefs are important to ensure appropriate budgeting is in place. If the former and more common approach, funded via department tax, is used, then budgeting and monitoring is done by the chair's office.

Salary support and other support of faculty who teach may also be provided through endowed chairs or professorships, internal grants, external grants, and philanthropic sources.

OTHER FINANCIAL ASPECTS OF THE EDUCATIONAL MISSION

If the department chooses to allocate any of the educational revenue or expenses to its divisions, then it should provide the allocation methodology; in some departments, further review and an approval process may be warranted. Department administrators should be prepared for requests for departmental support from divisions that have former chief residents as fellows because these individuals delayed training and are now at higher PGY levels, or from divisions that have individuals who "short track" out of the medicine residency program into a specialty fellowship program

and thus cause financial shortfalls for a division that had not anticipated—and therefore had not budgeted for—an additional physician-in-training expense.

Administrators have several opportunities to improve the educational margin. They can advocate for changes in the allocation formulas that would yield higher revenue from partner schools or hospitals. Hospital support for clinical fellows could be added to the revenue stream or could be increased if some current support is provided. Physician effort and expenses could be reviewed to evaluate the proportion of time spent in teaching activities so that accurate data may then be presented to the dean's office in support of a request for additional funding for the educational mission. Appropriate reimbursement for moonlighting activities of internal medicine physicians-in-training on other services (e.g., emergency medicine) can be sought to boost the revenue stream. Research physicians-in-training can apply for additional funding from external sources such as individual training grants or specialty fellowship awards. Divisions within the department can evaluate the feasibility of sharing fellowship coordinators. Last, both the training period and the number of physicians-in-training can be reduced if they are approved by and in compliance with the accreditation agency.

To fully understand the financial impact of the educational mission, department administrators need to accurately allocate faculty and staff's teaching effort and compare those costs to revenue streams. Concurrently, administrators need to consider the benefits of the service provided by trainees and the satisfaction faculty derive from working with students and housestaff.

PERFORMANCE METRICS

Departments can assess the performance of its graduate and undergraduate training programs in many ways. The following are examples of common assessment measures:

GME PERFORMANCE METRICS:

Programs may review a number of metrics to determine their success and national standing. ACGME review requirements are denoted with *; programs commonly review the following:

- Match ratio—Did the program successfully match with preferred candidates?
- Exam pass rates (e.g., In-Training Exams, USMLE, American Board of Internal Medicine pass rates*).
- Trainee milestone accrual timeline and graduation rates.
- Scholarly output.
- Surveys of current and past trainees
  - Trainee Evaluations of Faculty*
    - ACGME requires that trainees are given the opportunity to evaluate faculty at the end of each assignment or twice annually for longitudinal assignments. Conducting an overall review of this data can provide insight into the performance of faculty as a whole or by section.
  - Overall Program Evaluations
    - Faculty evaluation of the program*—conducted annually by the program
    - Trainee evaluation of the program*—conducted annually by the program
    - End-of-rotation feedback*
  - Research Mentor Evaluation
    - Annual program review*
    - ACGME Faculty Survey Report—includes national benchmarks
    - ACGME Resident Survey Report—includes national benchmarks

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7 FINANCING AND GME: ESTIMATING AND COMMUNICATING THE COST OF RUNNING A RESIDENCY PROGRAM

Graduate medical education (GME) funding is rooted in the establishment of Medicare in 1965. The federal government funds GME positions through two mechanisms: direct graduate medical education (DME) funding that compensates the cost of medical education and indirect medical education (IME) that compensates for the higher patient care costs associated with teaching programs. Over the years, these budgets have risen considerably, with Medicare paying for approximately 100,000 positions and DME and IME costing $3 billion and $6.5 billion, respectively, per year.

Attempts to rein in the federal deficit have made GME funding a target. In a 2010 report, the Medicare Payment Advisory Commission (MedPAC) wrote that "Medicare's IME adjustments significantly exceed the actual added patient care costs these hospitals incur." MedPAC also wrote that approximately 50% of IME is not "empirically justified"; it suggested redirecting one-half of IME ($3.5 billion) to incentive payments. As part of the 2013 budget, the Obama administration proposed reducing IME by $9.7 billion over 10 years starting in 2014 and asked the Secretary of the Department of Health and Human Services to assess GME program outcomes.

In this context, the Institute of Medicine (IOM) Committee on the Financing and Governance of GME was formed to address costs, improve funding transparency and accountability, and improve the physician workforce to reflect the nation's needs. The general recommendations include using Medicare GME to influence the health care system workforce and care delivery; transitioning from a GME finance system based on cost to one focused on performance-based outcomes; improving transparency, accountability, and fairness; and encouraging innovation.

Many GME leaders are concerned about how potential cuts to GME funding could affect residency programs. A survey of designated institutional officers (DIOs) asked how decreases in GME dollars would affect their institutional programs and positions (1). A theoretical 50% reduction would lead to 35.9% of core programs closing and 24.5% of core positions being lost.

In preparation for potential cuts to GME funding, this article provides a framework to estimate the cost of running a residency program and recommendations on how to communicate a program's value to institutional officers.

ESTIMATING THE SERVICE NEEDS AND COSTS OF RUNNING A RESIDENCY PROGRAM

Many departments face questions from hospital administrators regarding the cost-effectiveness of housestaff and whether alternative staffing models provide better value. The first step is to conduct a needs assessment of the number of housestaff necessary to provide services on each unit. The second step is to conduct a financial analysis of a department's resources, which may provide a program director with the evidence that not only are housestaff a cost-conscious choice, but that more housestaff are needed.

This article uses an example from an internal medicine residency training program. Located in the northeastern corridor, the program is composed of 99 core housestaff with full-time equivalent (FTE) support allocated among three sites (FTE support in parentheses): Hospital X (52), Hospital Y (36), and Hospital Z (11).

Needs Analysis

Figure 1 uses Hospital X as an example. Adding up column 6 provides the total required staffing hours on an annual basis; at Hospital X, the value is 211,293 hours. To determine how many FTEs are needed to provide this work, determine the average number of hours worked per year per house officer. Accounting for vacation time (which is four weeks at the program), the Hospital X house officer averages 2,976 hours. Dividing 211,293 by 2,976 provides the number of FTEs required; at Hospital X, 71 FTEs are required. Thus, while Hospital X supports 52 FTEs, it is getting 71 FTEs' worth of work.

FIGURE 1. HOUSESTAFF NEEDS ANALYSIS

Hospital X	Number of Housestaff	Days	Hours	Allocation %	Required Staffing Hours
Chief Resident	1	365	24	100	8,760
Floors-Days	15	313	11	100	51,645
CCU-Days	1	365	12	100	4,380
ICU-Days	5	365	12	100	21,900
Med Consult	1	365	24	100	8,760
ER	1	260	9	100	2,340
Night Service (Admitters, Night Float, ICU)	6	356	12	100	25,656
Admitters	2	365	12	100	8,760
Continuity Clinic	21	260	5	100	27,300
Subspecialty Clinic	21	260	5	74	20,202
Cardiology Consult	1	260	10	50	1,300
Dermatology Consult	2	156	5	100	1,560
Endocrine Consult	1	260	10	60	1,560
GI Consult	1	260	10	75	1,950
Geriatrics Consult	1	260	10	100	2,600
Palliative Care	1	260	10	100	2,600
ID Consult	1	260	10	100	1,600
Nephrology Consult	1	260	10	50	1,300
Pulmonary Consult	1	260	10	50	1,300
Rheumatology Consult	1	260	10	70	1,820
Neurology Consult	1	260	10	100	2,600
Elective/Scholarship	3	260	10	100	7,800
Quality Service	1	260	10	100	2,600

Hospital X: The hospital and the services provided.
Number of Housestaff: The number of housestaff needed to support each service daily.
Days: The number of days housestaff support each service.
Hours: The number of hours per day to support each service (either in-house or at-home call).
Allocation Percentage: If services cross sites, the percent allocated to the current site.
Required Staffing Hours: The product of multiplying columns 2-5 provides the "housestaff manpower hours" to support each service.

Financial Analysis

With potential cuts to GME, hospital administrators are pondering whether it is more cost-effective to replace housestaff with mid-level providers or attendings. To address this question, repeat the needs analysis by replacing housestaff with an alternative provider. At Hospital X, housestaff and mid-levels work on average 62 and 50 hours per week, respectively, which correlates to 1.1 mid-level FTEs for every one housestaff FTE. A more accurate analysis requires looking at the costs associated with employing house officers versus alternative providers. These costs include salary plus benefits for each provider type in addition to including the additional costs of employing a house officer (these "hidden" costs are summarized in **Figure 2** for the training program). When including

FIGURE 2. TRAINING PROGRAM'S ANNUAL ADDITIONAL (OR "HIDDEN") COSTS		
Annual Core Program Expenses	**Totals**	**Per Housestaff**
Salary support for Program Director and APDs	$220,000.00	$2,315.79
Salary support for administrative staff	$208,000.00	$2,189.47
Academic-related travel (housestaff and faculty)	$145,000.00	$1,526.32
Food (at didactic and administrative sessions)	$114,800.00	$1,208.42
Recruitment costs (food, materials, etc.)	$40,800.00	$429.47
Online signout/handoff system	$32,000.00	$336.84
Educational/book fund	$28,500.00	$300.00
Graduation expenses (celebration, awards, etc.)	$17,100.00	$180.00
Simulation/standardized activities	$14,900.00	$156.84
Social events	$12,000.00	$126.32
Alliance for Academic Internal Medicine annual fees	$10,000.00	$105.26
In-training exam	$8,000.00	$84.21
White coats	2,900.00	$30.53
Online education	$2,800.00	$29.47
Total	**$856,800.00**	**$9,018.95**

costs in the FTE calculations at Hospital X, replacing mid-level providers with housestaff would save $2.25 million annually.

Additional factors, such as length of stay, readmission rates, and patient satisfaction, can also be measured when comparing housestaff to other providers. An analysis at the same program of length of stay and direct patient care costs comparing hospitalist-resident versus hospitalist-mid-level provider teams showed a potential savings of $16 million over a three-year period had mid-levels been replaced by housestaff (2).

ESTIMATING AND COMMUNICATING THE COSTS OF A RESIDENCY PROGRAM WITH HOSPITAL LEADERS

In considering how to best communicate the results of an analysis, first evaluate the reasons for conducting the exercise. As hospital reimbursements decline and the future of public support of GME is questioned, many teaching hospitals are examining the financial standing of their training programs. Additionally, academic institutions are increasingly becoming part of ever-larger health systems with variable experience, and perhaps even interest, in medical education. There is substantial risk that such analyses by an institution will not fully consider the impact of closing or downsizing a program. Being forewarned is being forearmed: it allows us to better defend programs and perhaps make changes to better strategically position ourselves, especially if evaluation shows a cost advantage of downsizing or eliminating a program.

The ideal situation is to develop a good, collaborative working relationship with your hospital or department finance leaders. Often, they will welcome your interest and can be a valuable partner in designing analysis and obtaining necessary data. Your final results should be reviewed.

It is important to understand the priorities of the hospital/system leadership with respect to the direct and indirect impact of the teaching programs. Does the institution value your contributions to research? Care of the underserved? Physician recruitment and supply? Quality and clinical productivity? What is the beneficial impact on specific service lines, outside affiliations, or community physician engagement? This information will help you emphasize the most effective components of a program. Showing a cost advantage of downsizing or eliminating a program is particularly important in the analysis since it can often justify the expense.

With whom at your institution should you communicate your findings? It is generally best to proceed up the chain of command. Eventually you want to engage your senior leadership, such as the chief medical officer, chief financial officer, and chief executive officer of your hospital, but first you need to garner the support of individuals between you and the C-suite. Starting with individuals who are likely to

be supportive of the teaching programs is helpful, but at some point you will have to engage people who are more skeptical of the value of medical education.

Be prepared to defend your analysis (assumptions and methodology) and address follow-up questions. Some important issues to consider include the impact of reductions in GME funding (look at different levels of reductions, but especially the loss of 10% and 50% of IME because those changes have been proposed nationally). If your institution has positions in excess of its capitated allocation, you may want to consider the financial ramifications of various levels of downsizing. Another potential aspect of analysis is the "efficiency" of your training program. What is the per-resident cost and how does it compare with benchmark data? There is a paucity of data, but a 2011 analysis yielded an estimated cost of $130,000 per resident inclusive of salary (3) and an updated study published in 2014 showed a range of $180,000 to $220,000 per resident (4). Can GME help further reduce costs or improve quality? DIOs may want to consider the differential cost of programs. Smaller programs and more outpatient-intensive programs tend to cost more per resident (4,5). A financial argument may exist to target such programs for reductions.

Ultimately, this exercise is about effectively engaging institutional decision makers about the value of a teaching program(s) to your hospital and community and advocating for GME overall.

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8 RESEARCH ADMINISTRATION

Research administration is the practice of managing the grant and contract life cycle. Working with the principal investigator (PI), the research administrator oversees the project timelines associated with grant submissions and contract development and coordinates with funding agencies, contract entities, and institutional offices of research to accept awards. The research administrator also works in coordination with the PI for project implementation, award reporting, and financial management.

These responsibilities are executed in an environment of competing priorities and complex compliance requirements. The PI and research administration team are simultaneously required to meet the expectations of achieving the stated aims of the proposed research project or designated contract milestones while conducting the research according to all financial guidelines and regulatory considerations of the funding sponsor (e.g., federal, state, private nonprofit or industry, donor) and the investigator's institution. By their very nature, investigators are "idea people" and the true innovators who will consistently develop research strategies that challenge current systems, practices, and resource allocation models.

Biomedical research organizations are often heavily funded by the National Institutes of Health (NIH) and other federal entities. As such, most research institutions will build core research management systems with the intent of meeting the federal government's uniform guidance. (Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards - https://www.federalregister.gov/articles/2013/12/26/2013-30465/uniform-administrative-requirements-cost-principles-and-audit-requirements-for-federal-awards.)

The federal Office of Management and Budget is responsible for ensuring that all award recipients adhere to practices that will promote sound administrative and financial management. Grants and contracts are awarded funds for the direct conduct of research and corresponding facilities and administrative fees (F&A, frequently referred to as indirect costs) to support the oversight and management of direct research award activities. The overarching goals of the Uniform Guidance are to ensure that all funds are expended in a way that is:

- Consistent (with the aims of the proposal).
- Allowable (under the terms of the award document and in compliance with the investigator's home institution).
- Reasonable (research is conducted with consideration for cost containment).
- Allocable (an appropriate percentage of a cost is associated with the funding source).

Additionally, all research needs to be conducted in a manner that meets federal regulations pertaining, but not limited, to:

- The employment of research subjects (human and animal) and hazardous materials in the conduct of research.
- Reporting and mitigation of financial conflict of interest on the part of all investigators.
- Management of effort commitments on the part of all investigators.
- Documentation of cost-sharing obligations on the part of the institution.
- Documentation of research progress and consortia arrangements.
- Authorization to conduct research in collaboration with foreign entities or outside the United States.
- Compliance with clinical trial registration requirements.
- Compliance with the NIH public access policy: https://publicaccess.nih.gov.

Departmental administrative and faculty leadership need to ensure that departmental systems are developed to provide the necessary support and infrastructure to meet the needs of investigators. Administrators are encouraged to develop an understanding of the type of research being conducted within the department and how the research contributes to or diverges from the educational and clinical missions of a department of internal medicine.

Departmental management basics include:

- Establish a system to evaluate planned proposals for "mission fit," project feasibility, and resource allocation.

- Support a wide range of research awards including, but not limited to, independent research projects, training and career development awards, translational research, and clinical trials.
- Establish financial management practices to withstand audit while supporting a user-friendly summary.
- Understand the institutional approach to negotiation of nonstandard award terms and conditions and awards with F&A fees of less than the federally negotiated rate.
- Determine metrics for tracking research activities (e.g., research space assignments and resource allocation as square footage based on the value of awards).
- Establish guidelines for determining allocations for recruitment, retention, and bridge funding.
- Identify and understand institutional practices and policies for departmental recovery of F&A fees.
- Create a plan for providing timely and ongoing staff training.

Key points for faculty investigators include:

- Investigators should understand both the obligations of accepting an award (sponsor and institutional) and the specific terms and conditions of the award.
- PIs are responsible for ensuring the accuracy of all award expenditures.
- PIs should understand when multiple awards may be retained, as some awards may not be compatible.
- Award activation/access may be delayed until all compliance issues are addressed.
- PIs may not commit greater than 100% of committed effort to all activities (funded research and other scholarly activity, clinical care, and educational obligations).

In addition to accessing institutional resources, the National Institutes of Health, Institutional Offices of Sponsored Research provide many resources for staff new to research administration. Similarly, staff and investigators should become familiar with resources provided by the National Institutes of Health (or other funding agencies) and the Office of Management and Budget. NCURA (National Council of University Research Administrators) and SRA (Society for Research Administration) are the two prominent professional societies for research administrators.

RESEARCH ADMINISTRATION PHASES

In general, research administration begins with developing a proposal and preparing it for submission and concludes with the submission of a final financial and scientific report. In addition to institutional policies, new research administrators need to be familiar with the institutional structure for research administration oversight and each funding agencies' requirements for managing the entire life cycle of an award. Research administration activities are typically grouped into two categories: pre-award and post-award. Research administrators often specialize in one of the two areas of management.

Institutional pre-award and post-award offices typically have well-developed websites with extensive resource materials. The new research administrator should review the institutional websites to become familiar with institutional processes, forms, timelines, federal requirements, and available training opportunities.

PRE-AWARD

Research administrators must be familiar with the types of proposals:

- New proposal: Submitted for initial funding.
- Revised proposal: Submitted after changes in response to the sponsor's critique.
- Noncompeting or continuation proposal: Submitted to receive the annual funding allotment

KEY RESEARCH ADMINISTRATION PROCESSES	
Pre-Award Activities	Proposal development, review, approval, and submission Contract review, negotiation, and execution Compliance oversight, review, approval, and submission of annual reporting requirements
Post-Award Activities	Award acceptance, compliance documentation, and research account(s) set-up
	Financial management of grants, including expenditure management, faculty effort oversight, cost transfers, cost-sharing documentation, invoicing, and sub-recipient monitoring
	Closing awards
	Transfer of existing awards to or from the institution

of a previously approved multiyear grant or contract.
- Competing continuation or renewal proposal: Submitted for funding beyond the initially approved project period; many sponsors require that PIs adhere to the New Proposal Deadlines for these submissions.
- Contract: Submitted where the institution agrees to perform specific work as defined and controlled by the funding agency.
- Supplemental proposal: Requests additional funding to expand the original scope of the research project.

Research administrators should meet with investigators to plan proposal submission, taking into consideration not only the funding agency's deadline but also the institutional deadline. It is vital that the requirements of all broad agency announcements, requests for proposals, and requests for applications are followed and reviewed by both PI and support staff. If questions arise, the sponsor will be available to clarify; obtain clarifications in writing as appropriate. Prior to commencing with proposal development, confirm that the applicant is eligible to apply and that the amount of funding available is sufficient to support the proposed project. Additionally, review the announcement for allowable F&A rate calculations and review all necessary components needed for a complete and accurate submission.

Every proposal includes both a scientific and a business section. The scientific section includes the project's scope of work and strategy for implementation as well as supporting citations and appendix materials.

Common components of the business section are:

- Cover page with PI and institutional contact information.
- Performance site information.
- Abstract.
- Research resources and environment information.
- Biographical sketch for PI and other investigators.
- Letters of support or reference.
- Budget—include only allowable costs, confirm accurate salary and fringe benefit rates, and apply appropriate F&A calculation.
- Budget justification.
- Consortium/subcontractor information.

Institutions may have additional review requirements including, but not limited to:

- Requirement for all investigators to declare financial conflicts of interest.
- Documentation of any mandatory or voluntary cost-sharing commitments.

COST SHARING

It is important to recognize the need for cost sharing in the application guidelines and accounting for it in the proposal budget. Cost sharing may be mandatory. Mandatory cost sharing includes matching funds required by the agency (e.g., $500,000 institutional funding for equipment on a $4 million program project grant) and institutional salary support required by the agency because an investigator's base salary exceeds the NIH/sponsor salary cap. (https://grants.nih.gov/grants/guide/notice-files/NOT-OD-16-045.html)

For example, if the NIH salary cap is $187,000 and the PI salary is $210,000, and the PI spends 50% effort on the NIH project, then only $93,500 of salary expenses may be charged to the grant (i.e., 50% of the salary cap). Since 50% of the PI's full salary is $105,000, in this instance $11,500 of the investigator's salary (the difference between $105,000 and $93,500) and corresponding benefits with associated indirect costs must be "cost shared" and provided by the institution. Unless the institution agrees in writing to provide mandatory cost-sharing

support, the department will be responsible for these cost-sharing expenses.

Cost sharing may also be voluntary. The institution could offer to provide support such as 10% of the PI effort or the annual rent on a given amount of space. As noted, indirect costs must be calculated on items that are voluntarily cost shared. Departments should expect to pay any voluntary cost sharing unless another party has agreed in writing to do so. Whether voluntary or mandatory, all cost sharing must be accounted for appropriately in both the project budget and the department's institutional budget. Research administrators may also need to track these expenses within the institution's accounting system.

POST-AWARD

Once an investigator is notified that a proposal will be funded, the PI should work with staff to ensure that all compliance needs have been addressed so the award can be activated.

Common compliance concerns to be resolved prior to award activation include, but are not limited to:

- Approval for use of research subjects (human and animal) in the conduct of research.
- Approval for use of hazardous materials in the conduct of research.
- Resolution of financial conflict of interest on the part of all investigators.
- Management of effort commitments on the part of all investigators.
- Authorization to conduct research in collaboration with foreign entities or outside the United States.

PIs and research administration staff should understand the terms and conditions of each award. Award budgets may need to be adjusted at time of award to reflect changes to the award total or scope of work. Adjustments may also be required to address changes in salary, salary caps, fringe benefits, or F&A rates made between the time of submission and the time of award.

During the post-award period, financial management of the project is emphasized. Post-award management can be challenging—unlike the deadline-driven atmosphere of the proposal submission process, post-award activities typically have flexible deadlines. Consequently, letting the ongoing review of existing awards drop lower on a list of competing priorities can be tempting but should be avoided in light of the resulting audit exposure.

Effective post-award management practices are predicated on a program of ongoing review of expenditures. Post-award staff are tasked with ensuring that investigators and research staff are using the correct funding source and allocation for allowable expenditures on scientific projects. Staff should coordinate with the PI (and institutional oversight office as necessary) for any communication with the sponsor. Common communication scenarios include obtaining clarifications of guidelines, addressing changes in effort, or obtaining approval to rebudget available funds.

Staff are expected to review and reconcile all expenditures on a scheduled basis and make corrections as necessary. Once a budget is reconciled, review expenditures with the PI to coordinate planned changes to assigned investigator or staff effort and ensure cost-sharing obligations are being met and recorded.

In addition to reviewing prior charges, post-award teams are responsible for developing, and preparing budget forecast (projection) reports. These teams will also work with investigators to document subcontract site activity and monitor sponsor payments or invoicing requirements. Following award terms and conditions, the post-award team will coordinate with central offices to ensure timely submission of financial reports and completion of award close-out activities.

Budget forecast (or projection) report preparation shoudl include:

- Anticipate payroll and non-payroll expenditures for each budget period and provide to the PI for review, input, and updates.
- Projection reports should be developed for each budget/award and by organizational units (e.g., PI, lab group, division).
- Projection reports should analyze expenditure trends, funding sources, and award end dates to inform department or division leadership.
- Projection reports should include the process to address anticipated deficits or surpluses at the end of a budget period.
- Projection reports should include plans to address sponsor requirements for obtaining approval to carry over a surplus or obtain a no-cost extension to complete project activity.
- Institutional financial systems may not meet all the needs of departmental staff—it is common for individual units to track certain data in parallel tracking systems.

Monitoring subcontract site activity:

- Coordinate with the institutional office of sponsored research to ensure all subcontract awards are issued and modified in a timely manner.
- Coordinate with subcontract sites to ensure that invoicing occurs on a regular basis with adequate documentation.
- Implement a system for PI review of and approval of expenditures to include documentation of activity occurring during the invoice period.

NIH

Departments of internal medicine commonly work with funding from the NIH and US Department of Veterans Affairs (VA).

NIH, an agency of the US Department of Health and Human Services, is the primary federal agency for conducting and supporting medical research. With 27 institutes and centers (ICs), NIH pursues knowledge about the nature and behavior of living systems and applies that knowledge to improve people's health and save lives. First published in 2009, the *Biennial Report of the Director* is a good reference tool for understanding how these activities are integrated and is available at http:// biennialreport.nih.gov.

Funding Mechanisms

NIH uses three instruments to provide funds to extramural organizations: grants, cooperative agreements, and contracts. Grants for health-related research and research training projects constitute the largest category of NIH funding. Research project grants are awarded to an institution on behalf of a principal investigator to facilitate the pursuit of a scientific objective. Research grants range from one to five years; the investigator initiates the research and the awarding NIH institute has little programmatic involvement. Awarding the funds to the institution ensures that a grant recipient has adequate facilities, financial stability, and accountability for the funds. Research grants may include subcontracts to individuals at other organizations (known as sub-recipients) who will perform key components of the work.

Each IC has its own mission area and will allocate funding to mechanisms and areas of emphasis depending on that mission. Investigators and research administrators should be familiar with these areas of emphasis and support prior to starting the submission process.

Institutes and Centers at NIH
National Cancer Institute (NCI)
National Eye Institute (NEI)
National Heart, Lung, and Blood Institute (NHLBI)
National Human Genome Research Institute (NHGRI)
National Institute on Aging (NIA)
National Institute on Alcohol Abuse and Alcoholism (NIAAA)
National Institute of Allergy and Infectious Diseases (NIAID)
National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS)
National Institute of Biomedical Imaging and Bioengineering (NIBIB)
National Institute of Child Health and Human Development (NICHD)
National Institute on Deafness and Other Communication Disorders (NIDCD)
National Institute of Dental and Craniofacial Research (NIDCR)
National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)
National Institute on Drug Abuse (NIDA)
National Institute of Environmental Health Sciences (NIEHS)
National Institute of General Medical Sciences (NIGMS)
National Institute of Mental Health (NIMH)
National Institute of Neurological Disorders and Stroke (NINDS)
National Institute of Nursing Research (NINR)
National Library of Medicine (NLM)
Center for Information Technology (CIT)
Center for Scientific Review (CSR)
John E. Fogarty International Center (FIC)
National Center for Complementary and Alternative Medicine (NCCAM)
National Center on Minority Health and Health Disparities (NCMHD)
National Center for Research Resources (NCRR)
NIH Clinical Center (CC)

Peer Review

By law, investigator-initiated grant and cooperative agreement applications for NIH funding are evaluated at two levels. The scientific assessment of a proposal is separate from policy decisions about

the scientific areas to be supported and the level of resources to be allocated.

The first level of review is the evaluation of scientific and technical merit. Scientific review groups, established by scientific disciplines or medical specialties, consist of 16 to 20 external scientists with expertise in various disciplines and areas of research. The reviewers study the applications before meeting as a group; some reviewers are assigned to prepare written critiques. The most competitive projects (usually the upper one-half of all submissions) are fully discussed and given a priority score based on scientific merit.

National advisory boards or councils of the NIH funding entities perform the second review. Each panel includes 18 to 20 individuals—scientists and nonscientists—chosen for their interest in issues related to health and disease. Panelists review the applications in a broader context, including relevance, program goals, and available funds. They also perform the scientific assessment of the proposal.

Contract projects are subjected to a multifaceted review process that begins at the NIH institute at the staff level and ends with a technical evaluation, usually conducted by a group of nonfederal scientists. Awards are made based on the best final offer judged to be most advantageous to the government. More information about the peer review process can be obtained by visiting the NIH Center for Scientific Review website at https://grants.nih.gov/grants/peer-review.htm.

VA RELATIONSHIPS

VA provides federal benefits to veterans and their families. The second largest of the 15 cabinet departments, VA operates programs for health care, financial assistance, and burial benefits.

The mission of the VA health care system is to serve the needs of America's veterans by providing primary care, specialized care, and related medical and social support services. Nationally, many VAs are unified contractually with medical schools to share goals for research, teaching, and clinical care through collaborative arrangements.

Faculty appointments typically occur in one-eighth increments at VA medical centers (VAMCs). Faculty may have part-time VA appointments and share appointments at both the affiliated school of medicine and VAMC. These faculty receive salary support with associated fringe benefits from VAMC and from the medical school and, if applicable, from the faculty practice plan. Faculty members with multiple payroll appointments will require support to monitor and coordinate activities.

VA Research Programs

The VA Medical and Prosthetics Research Program was established to improve health care for veterans and to emphasize research on injuries and illnesses specifically relevant to the veteran population.

The VA research program is exclusively intramural; only VA employees holding at least a five-eighths salaried appointment are eligible to receive VA awards. Unlike other federal research agencies, VA does not make grants to colleges and universities or to non-VA entities. The program offers a dedicated funding source to attract and retain high-quality physicians and clinical investigators to the VA health care system (6).

VA research efforts are divided into four research services. The Biomedical Laboratory Research and Development Service supports basic science and preclinical research related to diseases that affect veterans. The Clinical Science Research and Development Service administers investigations aimed at instituting new, more effective clinical care. The Health Services Research and Development Service identifies and promotes effective and efficient strategies to improve the organization, cost effectiveness, and delivery of health care at the patient and system levels. Finally, the Rehabilitation Research and Development Service integrates science, engineering, and medicine to develop concepts, processes, and products that improve the quality of life for impaired and disabled veterans.

VA conducts an array of research pertinent to the veteran population and has become a leader in such research areas as aging, Alzheimer's disease, chronic diseases, women's health, post-traumatic stress disorder, and other mental health issues. VA researchers played key roles in developing the cardiac pacemaker, the CT scan, radioimmunoassay, and improvements in artificial limbs. VA clinical trials established the effectiveness of new treatments for tuberculosis, schizophrenia, shingles, and high blood pressure.

One of the most popular research programs is the Merit Review Award Program. The program supports investigator-initiated research conducted by eligible VA investigators at VAMCs or VA-approved sites. It is the principal mechanism for funding basic, preclinical biomedical, and behavioral studies as well as clinical studies of disorders and diseases. The program also provides two training opportunities—the Merit

Review Entry Program and the Career Development Award Program—for developing independent investigators.

CLINICAL AND INDUSTRY RESEARCH

What Are Clinical Trials?

Before a pharmaceutical or biotechnology company can initiate testing in humans, it must conduct extensive preclinical or laboratory research. This research typically involves years of experiments in animal and human cells as well as compound testing on animals. If this stage of testing is successful, a company provides this data to the Food and Drug Administration (FDA) by submitting an investigational new drug application. The application requests approval to begin testing the drug in a clinical trial.

A clinical trial is a research study among human volunteers to further explore the preclinical or laboratory research. Carefully conducted clinical trials are the fastest and safest way to find treatments to improve health. Interventional trials determine whether experimental treatments or new ways of using known therapies are safe and effective under controlled environments. Observational trials address health issues in large groups of people or populations in natural settings.

What are the different types of clinical trials?

- Treatment trials test experimental treatments, new combinations of drugs, or new approaches to surgery or radiation therapy.
- Prevention trials seek better ways to prevent disease in people who have never had that disease or to prevent a disease from returning. These approaches may include medicines, vitamins, vaccines, minerals, or lifestyle changes.
- Diagnostic trials are conducted to improve tests or procedures for diagnosing a particular disease or condition.
- Screening trials test the best way to detect certain diseases or health conditions.
- Quality of life trials (or supportive care trials) explore ways to improve the comfort and quality of life for individuals with a chronic illness.

The clinical testing of experimental drugs normally consists of a three-phase process, with each successive phase involving a larger number of people. Once FDA has granted a New Drug Approval, pharmaceutical companies also conduct post-marketing or late phase III/phase IV studies.

Phase I Study

Phase I studies primarily assess the drug's safety. This initial phase of testing in humans is done in a small number of healthy volunteers (20 to 100). The study is designed to determine what happens to the drug in the human body—how it is absorbed, metabolized, and excreted. A phase I study will investigate side effects that occur as dosage levels are increased. This initial phase of testing typically takes several months. Approximately 70% of experimental drugs pass this initial phase of testing.

Phase II Study

Once a drug has been shown to be safe, it must be tested for efficacy (i.e., does it work?). This second phase of testing may last from several months to two years and involve up to several hundred participants. Most phase II studies are randomized trials. One group of participants will receive the experimental drug, while a second "control" group will receive a standard treatment or placebo. Often these studies are "blinded"—neither the participants nor the researchers know who is getting the experimental drug. In this manner, the study can provide the company and FDA comparative information about the relative safety of the new drug and its effectiveness. Only about one-third of experimental drugs successfully complete both phase I and phase II studies.

Phase III Study

In a phase III study, a drug is tested in several hundred to several thousand participants. This large-scale testing provides the company and FDA with a more thorough understanding of the drug's effectiveness, its benefits, and the range of possible adverse reactions. Most phase III studies are randomized and blinded trials.

Phase III studies typically last several years. Seventy to 90% of drugs that enter phase III studies successfully complete this phase of testing. Once a phase III study is successfully completed, a pharmaceutical company can request FDA approval to market the drug.

Post-Marketing—Late Phase III/Phase IV Studies

In late phase III/phase IV studies, companies have several objectives:

- Compare a drug with other drugs already in the market.
- Monitor a drug's long-term effectiveness and impact on a participant's quality of life.
- Determine the cost-effectiveness of a drug therapy relative to other traditional and new therapies.

Who Pays for Clinical Research?

All clinical research studies have costs. These costs may be assessed from the perspective of the participant, the third-party payer (insurance), or the health system where the study is being conducted. Prior to the initiation of any research study, the costs of that study should be estimated and it should be determined if the resources available are sufficient to cover those costs. Items that generate costs include not only tests and services outlined in the protocol, but also the costs of study staff to collect data, costs of administrative staff to track study parameters, and fees to pay for institutional review board (IRB) oversight. The consideration of each trial should include PI assessment of the infrastructure required for the proper conduct of clinical research and apportion it accordingly.

Studies can receive sponsorship or funding from multiple sources. These sources include the investigator, the investigator's department or division, NIH, private foundations, and the pharmaceutical industry. Sponsors may choose to provide a specific list of those tests or services for which they will provide funding, or they may provide a flat compensation rate per participant. Regardless, it is essential that the investigator assess which tests and services performed as a part of the study would be considered as usual care (i.e., tests or services that would be performed absent the study) and which are for data-gathering purposes only (i.e., have no direct benefit to or impact on the participant's care and would not be performed absent the study). While the former may be funded by the sponsor or may be submitted to the participant's insurance company as they would be outside a clinical study, the latter must be paid for by the sponsor.

The informed consent process should outline the tests and services that are the participant's responsibility, either verbally or in the informed consent document. Requirements will vary by institution. When inadequate communication with potential participants occurs, participation can be misconstrued as free to the participant. Tests and services the investigator thinks are usual care and are not specifically outlined by the sponsor as being provided for in the budget for the study may be submitted to the participant or the participant's insurance. This distinction should be emphasized to potential participants. It is important to outline those tests or services provided by the study with the indication that all other expenses for tests and services are part of usual care and the responsibility of the participant or the insurance company. The study team should recommend participants contact their insurance company to understand the limitations of their own policy with respect to research.

From the perspective of the insurance company or third-party payer, the National Coverage Decision (NCD) increases access of Medicare patients to investigational therapies. NCD provides for the ability to submit to Medicare claims related to the administration of, toxicity monitoring for, and treatment of adverse events related to an investigational drug or device. The extent to which other payers, such as commercial insurers and state Medicaid programs, honor NCD should be determined at a local level.

Last, significant administrative costs are incurred during the conduct of clinical research. These costs should be objectively evaluated and discussed to determine an institution or investigator's desire to cover these costs using funds from individual studies or central funds. These costs include administrative costs related to budget preparation; contract negotiation; IRB submission; phone, fax, and copy charges; and study coordination for screening failures. Negotiation with sponsors may include line items in the budget related to each of these costs based on the study team's assessment and the needs of the institution.

What Happens during a Clinical Trial?

The clinical trial process depends on the kind of trial being conducted. The clinical trial team includes physicians and nurses as well as social workers and other health care professionals. They check the health of the participant at the beginning of the trial, give specific instructions for participating in the trial, monitor the participant carefully during the trial, and maintain communication after the trial is completed.

Some clinical trials involve more tests and physician visits than the participant would normally have for an illness or condition. For all types of trials, the participant works with a research team. Clinical trial participation is most successful when the protocol is carefully followed and the research staff is regularly involved.

A protocol is a study plan on which the clinical trial is based. The plan is carefully designed to safeguard the health of the participants as well as answer specific research questions. A protocol describes what types of people may participate in the trial; the schedule of tests, procedures, medications, and dosages; and the length of the study. While in a clinical trial, participants following a protocol are seen regularly by the research staff to monitor their health and to determine the safety and effectiveness of their treatment.

Who Participates in Clinical Research?

People participate in clinical research for a variety of reasons. Individuals who volunteer for phase II and phase III trials can gain access to promising drugs long before these compounds are approved for the marketplace. They typically receive care from the physicians conducting the trial during the course of the study. Sometimes they may not have had access to these physicians for non-trial visits or procedures. This care also may be free.

All clinical trials have guidelines about who can participate. The use of inclusion and exclusion criteria is an important principle of medical research that helps to produce reliable results. The factors that allow someone to participate in a clinical trial are called inclusion criteria; factors that bar someone from participating are called exclusion criteria. These criteria are based on such factors as age, sex, the type and stage of a disease, previous treatment history, and other medical conditions. Before joining a clinical trial, a participant must qualify for the study. Some research studies seek participants with illnesses or conditions to be studied in the clinical trial, while others need healthy participants. It is important to note that inclusion and exclusion criteria are not used to reject people personally. Instead, the criteria are used to identify appropriate participants and keep them safe. The criteria help ensure that researchers will be able to answer the questions they plan to study.

How Is the Safety of Participants Protected?

Participant rights and safety are protected in two important ways. First, any physician awarded a research grant by a pharmaceutical company or NIH must obtain approval to conduct the study from an IRB before the trial begins. This review board, which is usually composed of both physicians and nonphysicians, is charged with evaluating the study protocol to ensure participant rights are protected and the study does not present an undue or unnecessary risk to the participants. All institutions that conduct or support biomedical research involving people must, by federal regulation, have an IRB that initially approves and periodically reviews the research.

Second, anyone participating in a clinical trial in the United States is required to sign an informed consent form. This form details the nature of the study, the risks involved, and what may happen to study participants. The informed consent tells subjects that they have a right to leave the study at any time. Informed consents also outline participants' responsibility for any costs of visits or procedures.

The ethical and legal codes that govern medical practice also apply to clinical trials. In addition, most clinical research is federally regulated with built-in safeguards to protect the participants. The trial follows a carefully controlled protocol. As a clinical trial progresses, researchers report the results of the trial at scientific meetings, in medical journals, and to various government agencies. Safeguarding of data pertaining to individual participation is of paramount concern and a central tenet of the ethical conduct of human subjects research.

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ADDITIONAL RESOURCES

This chapter is compiled from information provided online by CenterWatch Clinical Trials Listing Service at www.centerwatch.com and An Introduction to Clinical Trials at www.clinicaltrials.gov/ct/info/whatis. For more information and additional resources, please visit these websites.

9 FACULTY AFFAIRS

According to Association of American Medical Colleges (AAMC), the management of faculty transitions has become a core function of academic medicine administration and is critical to the operations and growth of academic medical centers. Faculty management guidelines are established to support and codify organizational structures for faculty activity as well as expectations for appointment, general advancement, promotion, and tenure.

The management of these faculty activities is usually governed by university statutes and policies. General topics covered by these reference materials would include appointment types and procedures, rank and tenure requirements, nonrenewal and dismissal procedures, faculty development, and, perhaps, diversity and inclusion issues.

Because each school develops its own policies, administrators and faculty leaders should be familiar with their institution's policies and procedures as they pertain to faculty activities.

- Understand the criteria for appointment (academic and medical staff) and promotion to each faculty track.
- Know the expectations for participation and productivity based on track, rank, and contractual agreements with faculty members.
- Educate faculty members about expectations and develop systems for reviewing and documenting progress toward meeting promotional criteria.
- Understand and provide education about compensation models and departmental finances.
- Establish systems for tracking and disseminating metrics data.
- Confirm roles and responsibilities for performance management issues.
- Explore existing programs and the creation of programs that would support faculty development and advancement.
- Provide formalized, regular, and ongoing mentoring and career counseling opportunities.
- Recognize all contributions to the academic mission:
  - Clinical
  - Teaching and education
  - Research and scholarship
  - Administration
  - Service and mentoring
- Model and promote professionalism in all areas of the academic mission.
- Identify and support opportunities for professional development experiences of all departmental constituents.
- Get to know faculty as individuals and understand their academic and professional interests.
- Educate staff members about the mission and priorities of the division/department and their role, as well as the role of the faculty in each area of the mission.
- Recognize and address administrative burden concerns where possible.

FACULTY TRACKS

Each school of medicine develops its own approach for "tracking" faculty based on interests and activity profile following. Career tracks and pathways typically follow the lines that academic medicine follows: clinical care, education, and research. Naturally, academic physicians and researchers can pursue a career in other ways and directions, but these are the three principal missions, and, when criteria are established for the consideration of candidates for promotion, achievements in these three areas are those most commonly measured. Across institutions, there is great variation in faculty tracks and policies.

Research conducted by Coleman and Richard on the topic of faculty tracks has charted the evolution of this phenomenon. Academic tracks were less important 30 years ago, when faculties were smaller and interdepartmental work was less common. But in the current system, traditional departments may hold less weight and the evaluation of a faculty member's contributions to the field has become more complex to assess. Tracks aid in this process. A candidate's accomplishments can be more readily categorized, and those with specialized knowledge can assess candidates more effectively.

Coleman and Richard's work reported that, on average, MD-granting medical schools in the United States generally offer three or four development tracks. For the schools that offered two tracks, the most common distinction between the tracks was tenured and nontenured. In other words, the tracks were not oriented toward a mastery of material. The institutions with more than two tracks offered career

path opportunities for faculty members within these various tracks.

Institutions may also elect to confer a limited-term appointment option for individuals working to meet a temporary need. Individuals may also elect to pursue a limited-term appointment to bridge the gap between trainee status and appointment to a tenured or nontenured track. Many institutions employ a courtesy or voluntary title for community practitioners in need of clinical privileges at the teaching hospital to acknowledge other contributions to the academic mission. Larger institutions with multiple local affiliated sites may also use specific titles to help differentiate between primary appointment sites.

Research Track

The research track is intended for faculty whose principal career is research. These individuals are often involved in time-limited research programs with no or minimal teaching responsibilities. Faculty members holding a PhD are more likely to be appointed to this track, although MDs may elect to this track if their research agenda constitutes a significant component of their career plan.

Investigator Educator Track

The investigator educator track is used for faculty with major efforts in research and teaching/mentoring. These individuals are expected to publish their work in peer-reviewed journals, obtain extramural funding for their research from national granting agencies, and ultimately achieve national or international peer recognition in their fields. Although faculty members in this track may also fulfill clinical responsibilities, those clinical and clinical teaching activities may not be a major criterion for promotion in this track.

Clinician Educator Track

The clinician educator track is used for faculty who focus their efforts in teaching and administrative leadership/service in addition to clinical care. Teaching is an important criterion for appointment and promotion to senior ranks. Teaching is one of the core missions of the school of medicine, and it can take numerous forms and involve a variety of learners. Teaching occurs in lectures and small discussion groups, during clinical rounds and procedures, and in the context of research training and mentoring. Faculty members may participate in the education of medical and graduate students, allied health professionals, residents and post-doctoral fellows, practicing physicians, faculty investigators, and others in the community.

Faculty on investigator educator and clinician educator tracks make scholarly contributions to the institution and are appointed with similar titles—assistant professor, associate professor, and professor of the department of medicine. The distinction between these two tracks relates to the different criteria required for promotion to senior academic ranks.

Clinical Track

The clinical track is mostly for faculty who primarily contribute to the clinical service mission of the school. This track may be the only one available to voluntary faculty—those faculty members who are not employed by the institution but have admitting privileges to the teaching hospital. The clinical track is appropriate for faculty whose primary contributions occur within the clinical realm and for whom teaching is performed predominantly in the course of clinical duties, rather than in lieu of clinical duties. For example, these individuals may precept or supervise the clinical care delivered by residents or fellows.

In this track, the term "clinical" is part of the designation of academic rank. That is, it may precede the rank, as in clinical assistant professor, or it may be inserted just before the department designation, as in assistant professor of clinical medicine. Again, the distinction between the clinical track and the clinician educator track centers on the different criteria required for promotion. Sometimes the designation of clinical assistant professor (as opposed to assistant professor) of medicine may be the designation the school of medicine uses to distinguish between salaried faculty and voluntary faculty.

Other Tracks

Last, some institutions have no tracks. Instead, they may ask, in the promotion guidelines, for the recommenders to identify one of the three or four missions (clinical, research, education, and possibly leadership, administrative service, or community service as a fourth mission) the candidate excels in, and to list one additional mission the candidate actively collaborates in. Every institution's Appointments and Promotions (A+P) guidelines should provide specific information on tracks and procedures.

PROTECTED TIME

Protected time is a concept that supports early career faculty progress toward promotion. Typically, one cannot successfully compete for National Institutes of Health (NIH)-supported research without having both hypotheses developed and data collected. Protected

time is support provided locally (either through the department or the dean's office, or through other resources available through the institution), that pays for the faculty member time before they receive significant external support. Ideally, the funding is generous enough to cover a significant period of time, so that faculty members can reasonably be expected to accomplish something substantial. For example, a commitment may be made to provide 50% full-time equivalent (FTE) for research development activities paid over the course of two years. At the end of this period, through arrangements agreed on prior to the protected time, the supported faculty member(s) may have targeted end points, like grant applications ready for submission for career development awards. A common target for early career researchers is an NIH career development award—often referred to as a K award in recognition of the mechanism type. For more information, see http://grants.nih.gov/training/kawardhp.htm.

The key to a university's ability to provide protected time for early career investigators is the availability of unrestricted funds to support the faculty member. These funds are not easy to acquire—it can take years of effort. The funds are typically either found in end-of-year surplus funds that are permitted to remain with the department endowments or they are donated to the department by generous local individuals or foundations.

APPOINTMENTS, PROMOTION, AND TENURE

Each institution has an established process for appointing its faculty, along with how the promotions and tenure review take place. These policies may be established in university or school statutes and are often summarized in faculty reference materials. Administrators should have a thorough understanding of the process to ensure that any commitments made to a prospective candidate conform to university and school policies.

The appointment process starts during the recruitment phase. A letter of intent or a letter of offer is developed by the division chief and department chair to include information on how the candidate will be considered for appointment. Most employment offers include the conditions that must be met for a candidate to be considered for an appointment. The criteria include a review and verification of academic credentials as well as a review of references. Many schools also require background checks to review for malpractice history, Medicare sanctions, and any research sanctions. To avoid problems during the formal appointment process, some schools and departments have established a pre-appointment process that assists the faculty in compiling the required documents for review.

While the faculty appointment process is usually separate from the clinical credentials and privileging process, it is useful to review all of the required documents before finalizing any binding offers of employment to ensure candidates can fulfill the responsibilities of their proposed role. Applications for clinical privileges are normally handled through either a medical staff appointment office or the faculty practice plan and the affiliated teaching hospitals. The administrator should be familiar with the process and the time required to complete the process, including the time needed to obtain state medical licenses and Drug Enforcement Administration certificates, and approval to participate in and bill insurance plans as well as review and approval of clinical privileges to practice their specialty. Review procedures can vary greatly by institution and the time needed to complete the process can delay the ability for new faculty members to begin providing services.

Appointments

Academic appointment is the process by which individuals are given an academic rank in the school of medicine. When physicians are hired for work in the department, they may or may not already have an academic rank from their prior institution. Some institutions will accept the rank provided by the prior institution, and others require newly hired faculty to start at the beginning, with references and letters. Check with your school's Appointments and Promotions guidelines to see where your institution stands. If your institution will not accept a prior institution's academic appointment, you may need to begin the process months in advance of your candidate's arrival to the institution, so that the new hire can be fully appointed on day one. If your institution will accept a prior institution's appointment, then the lateral transfer will follow an abbreviated process.

Entry-Level Academic Rank

Different institutions hire early career faculty at different ranks. Some institutions hire physicians directly from residency or fellowship training at the rank of instructor, while others do so at the rank of assistant professor. Check your institutional guidelines to see how these various scenarios are handled.

Other Appointments

Institutions may have a wide array of academic titles. Depending on the structure and organizational composition of the academic medical center, other appointments may include adjuncts, joints, and volunteer faculty. These positions might be a function of affiliate organizations or practices. Check with your institutional guidelines to see how these various scenarios are handled. In addition, you may review the *Handbook of Academic Titles* by Michael I. Shamos (http://euro.ecom.cmu.edu/titles/titlebook.htm).

Promotion

The role that academic rank plays varies widely among institutions. In many institutions, compensation is tied to academic rank; thus, faculty members are incentivized to pursue a higher academic rank to earn a higher salary. In others, compensation may be tied only to clinical productivity, years out of training, or other review guidelines.

To consider a faculty member for promotion, the faculty member's eligibility must first be established. It is not uncommon for the school to require a minimum time in rank before the faculty member is considered eligible.

Typically, the standard for initial appointment or promotion to assistant professor is the establishment of a local reputation as an expert in an element of one of the three (or four) missions. The standard for promotion to associate professor is the establishment of a regional reputation as an expert in an element of one of the three (or four) missions. Last, the standard for promotion to professor is establishment of a national or international reputation as an expert in an element of one of the three (or four) missions. The standards are the same for consideration of promotion within the ranks of research or clinical track.

Faculty members on the clinical track—or, in the absence of tracks, voluntary faculty—also need to demonstrate their expertise and contributions to the institution through scholarly activity, including publications in peer-reviewed journals. Other criteria may include industry-sponsored research whose results, ideally, would be published.

Faculty members need to be recognized outside the institution for their role (depending on the track, if there are tracks). It can be demonstrated through scholarly activity (publications in peer-reviewed journals), participation in leadership positions in national societies, or as members of editorials boards of journals.

Assessment of a faculty member's local, regional, and national/international reputation follows a fairly standard review process at most institutions:

- The CV is reviewed and evidence of scholarship is evaluated. The evidence is generally publication in peer-reviewed journals of the candidate's academic area and the quality of those journals, grant support for research, participation (not merely membership) in regional or national societies, participation in editorial boards of scholarly journals, or invitation to the candidate to either speak, deliver grand rounds, or participate in a panel in a setting that is viewed as academically rigorous.
- The support letter written by the candidate's chief (for review by the department of medicine's A+P Committee) and by the candidate's chair (for review by the school of medicine's A+P Committee). At some institutions, this would be the Promotion and Tenure (P+T) Committee.
- The letters of reference written by faculty members from within and outside the institution at the rank the candidate is pursuing or at a higher rank.

Some institutions may require additional materials.

- Teaching portfolio or dossier.
- Faculty self-assessments.
- Clinical teaching or other evaluations of the faculty member's performance.

Once the faculty member's eligibility is established, his or her file may be reviewed by the department's A+P Committee (or P+T Committee), before the file goes to the school's A+P Committee. The departmental committee serves as a gatekeeper and advocate for the candidate. It typically reviews the candidate's file and provides feedback to the candidate's division chief.

The promotions process can have two or more parts.

- Review of the file by the department A+P Committee.
- Review of the file by the school's A+P Committee.
- Review at the university level by the designated office (e.g., Academic Human Resources).

The file that is reviewed by the department's A+P Committee generally contains two core elements:

- The candidate's CV.
- The letter of support written either by the chief or the candidate, and addressed to the chair of the department's A+P Committee chair and signed by the candidate's chief.

Generally, the feedback from the department's A+P Committee takes one of three forms.

- The candidate is far from prepared to be considered for promotion by the school's A+P Committee. The committee will inform the candidate's division chief of the weaknesses and deficiencies in the file. The candidacy does not go forward to the school's A+P Committee until the weaknesses and deficiencies have been resolved.
- The candidate is prepared to be considered for promotion by the school's A+P Committee, but further editing of the promotion file may need to be done before submission to the school's A+P Committee.
- The candidate is prepared to be considered for promotion by the school's A+P Committee.

The candidate's file is sent to the school's A+P Committee when it is ready for consideration. That file generally contains three elements.

- The candidate's CV.
- The letter of support described above, but this time rewritten and signed by the department's chair and addressed to the chair of the school's A+P Committee.
- Letters of support written by internal and outside references, as described by the school's promotion guidelines. These letters can be produced in a couple of ways, depending on the customs and procedures of the school.

In one scenario, the department or school's A+P Committee asks the candidate for a number of references, usually four to six, and the committee requests letters of support from some or all of them. After a minimum number of letters have been received, usually two to three, they are read by a member of the committee. If the letters are sufficiently strong to support the promotion, the candidate's file is scheduled for review by the full committee. If the letters are not sufficiently strong, the committee can move down the original list of four to six references and request additional letters, reviewing them as they arrive, to determine if the candidate's file is sufficiently strong to be considered. If, after exhausting the list and receiving the letters, there is not a strong case to be made for promotion, the candidate's application is denied. This process can take months, depending on how promptly the references write letters, the frequency with which the committee meets, and the candidate's position in the queue for consideration. Departments may elect to delegate some of these responsibilities to the division chief to initiate and complete.

In a second scenario, the department's A+P Committee forwards the candidate's CV and support letter from the chair to the school's A+P Committee. The school's A+P Committee then determines, based on the candidate's subspecialty and field of accomplishment, who the right references should be and sends out requests for letters of support from people who should best know the work of the candidate, if he or she indeed has established a reputation in his or her field. After the school's A+P Committee reviews the candidate's file, it forwards its results to the chair, who then forwards the results to the candidate's chiefs, who will then inform the candidate whether the promotion is approved.

Tenure

Academic tenure is primarily intended to provide faculty members with the "academic freedom" to practice their profession free of external biases or control. Attaining tenure requires candidates to demonstrate a strong record of performance compared with their colleagues in the areas of teaching, research, and clinical care. Some schools may also require administrative and community service as well as professional peer recognition.

Faculty members are normally recruited into tenure-track or non-tenure-track positions. In rare cases, faculty members may be granted tenure upon employment if they have already attained an exceptional record of performance at another institution. The rules for becoming tenured are found in the faculty handbook or university statutes. Tenure decisions may be made in conjunction with the faculty promotion process.

While tenure systems remain well established in US medical schools, the percentage of clinical faculty on tenure tracks has declined. According to a survey by the Association of American Medical Colleges (AAMC), only 42% of clinical faculty were either tenured or on the tenure track in 2004, compared with 57% in 1985.

From an administrative perspective, tenure decisions can have economic considerations at some institutions. Tenure may provide some form of income protection,

presumably to enable faculty members to pursue the creation of fundamental new knowledge without the threat of job loss if they fail to do so. Some schools have developed a post-tenure review process to eliminate "lifetime" tenure. Faculty dismissals for cause can be complex legal and administrative proceedings; administrators should seek advice from well-informed university officials to provide appropriate advice and counsel to departmental leaders.

FACULTY CONTRACT ISSUES

Many schools retain the services of their faculty through contract mechanisms frequently referred to as faculty employment agreements. These agreements outline the general obligations of the university and the faculty member with respect to his or her professional services. The contracts include the specific term of the appointment and define the faculty member's rank, tenure status, and compensation. One issue not well defined in some faculty contracts is income earned outside the university. A thorny issue may be the practice of "moonlighting." Schools that have a limited ability for faculty members to earn competitive salaries within their institutions may permit faculty members to practice their profession outside of their faculty duties. If moonlighting is permitted, policies should be developed to clearly delineate a faculty member's university obligations as well as place specific limits on the amount of moonlighting that is allowed.

OUTSIDE INCOME AND CONFLICT OF INTEREST

Many medical school faculty members are experts in their fields and are frequently called on to provide consultation in their areas of expertise. Faculty members may be compensated for these services. Institutions should have policies to determine whether this income is considered part of a faculty member's university compensation or whether the income personally accrues to the faculty member. Outside work and income should be tracked and evaluated relative to the institution's conflict of interest policies. Extramural funding agencies and professional societies also require full disclosure of any external relationship that could create a conflict of interest (http://grants.nih.gov/grants/policy/coi/).

The Centers for Medicare & Medicaid Services (CMS) tracks and makes public data about physician participation in outside work for compensation from private entities such as pharmaceutical companies and device manufacturers. The National Physician Payment Transparency Program: Open Payments is required by the Affordable Care Act. The "Sunshine Rule" finalizes transparency and physician ownership. The rule's purpose is to create greater transparency and increase the public's awareness of financial relationships (https://openpaymentsdata.cms.gov/).

MEDICAL STAFF BYLAWS

Medical staff bylaws outline the governance and operation of a hospital's medical staff and define the eligibility and qualifications for membership. Medical staff members of a teaching hospital are usually required to hold a faculty appointment in a medical or dental school. Admittance to a medical staff requires that the members maintain standards of care as collectively determined by the medical staff.

The board of directors of a hospital, through its chief executive officer, makes appointments, reappointments, and revocations of clinical privileges. These actions are taken only after receiving recommendations from the medical staff office.

Most hospitals are required to seek accreditation by the Joint Commission. The Joint Commission prescribes that governing boards establish appropriate policies and procedures to meet specified quality standards (6).

The hospital's governing board delegates authority to the medical staff to elect or appoint officers of the medical staff to conduct the daily activities of the group. The group establishes an internal committee structure to provide medical staff representation in the decision-making process. Such activities include establishing standards of quality and providing mechanisms to monitor the quality of services.

In addition, the medical staff develops policies about standards of physician conduct and determines what qualifications are required to maintain membership. Last, the medical staff recommends what actions should be taken when a member fails to maintain those standards. The ultimate decision to remove a member from the medical staff rests with the board of directors.

CLINICAL CREDENTIALING AND PRIVILEGING

Physician credentialing is the process of gathering information about a physician's qualifications for appointment to the medical staff, whereas delineation of clinical privileges denotes those specific services and procedures that a physician is deemed qualified to provide or perform. To ensure appropriate quality of care, physicians must request permission to perform specific services and procedures, and even get

permission to access the patient's chart. The physician requests that the medical staff grant "privileges" to provide these services.

The medical staff has a credentials committee that reviews requests for privileges and then evaluates the requestor's credentials to determine if:

- The requestor has the needed training and experience to provide the requested service.
- The hospital has the required resources to adequately support the physician who desires to provide the requested services.
- The requestor is not the subject of outstanding malpractice proceedings.

Credentials committees play a key part in maintaining the overall quality of patient care within their organizations. The committees normally establish requirements for re-credentialing and continuing medical education to ensure that medical staff members continue to demonstrate competence.

Credentialing activities are often carried out in a process that is parallel to and consistent with the Ongoing Professional Practice Evaluation (OPPE) and the Focused Professional Practice Evaluation (FPPE) processes. OPPE is a regular review, designed and carried out by the institution, the purpose of which is to identify clinicians who may be providing low- or unacceptable-quality care. OPPE reviews are generally carried out through chart reviews of a sample of the clinician's charts. FPPE is engaged when a clinician is identified as a possible low-quality provider; it is used to confirm this identification through a focused investigation. The credentialing process often relies on the results of the OPPE and FPPE reviews when making decisions.

SEARCH AND RECRUITMENT

The search and recruitment process aims to attract top-quality candidates to institutions. As such, the process should reflect that purpose and represent the mission, vision, and values of the institution and department.

The search and recruitment process should follow appropriate timelines. It is often useful to set a target completion date and then work backwards from that date. Setting milestones along the way is important. Faculty searches vary in length, and when recruiting at the highest levels, this process may take from several months to a year. Document each step of the process so that you can manage guidelines, nominations, applications, search committee preparation, interviews, and so on.

Job Announcement

The hiring authority and administrator should develop hiring goals and a clear job description, keeping in mind the goals of not only the department but also the institution, especially if diversity and inclusion are values set forth by the institution. Administrators should use Human Resources (Academic Human Resources) and the Dean's Office as resources in writing announcements that comply with the institution as well as with federal and state laws.

Some institutions or programs may have a minimum number of days for which open positions must be posted. It is important to note that these positions could be advertised through institutional or departmental websites, job boards, conferences, professional organizations, and word of mouth. In addition, advertising faculty and other professional positions in diverse venues guarantees a broader audience of candidates. When it comes to faculty, especially at higher levels, personal contact by colleagues in the field may be an especially effective recruitment tool.

Search Committee

Diversity in search composition is extremely important. Search committee members from different backgrounds, with different perspectives and expertise, are important for identifying excellent candidates. Some institutions or departments may have committee composition requirements, such as a chairperson, administrative staff, service line-affiliate representative, or advocates for diversity and inclusion. Forming an effective search committee is critical to the recruitment process, but it is also important to provide search committees with communication tools, a detailed process, and training in human resources or pre-employment practices, interviewing techniques and protocols, and unconscious bias awareness. At times, the search process needs to remain confidential. Remind the committee of the importance of confidentiality for the protection of the candidates, especially if these candidates are employed at other institutions.

Committees should be given enough time to review applications thoroughly. Applications, resumes, and CVs should be reviewed with carefully drafted criteria that is applied consistently for all individuals. It is important to communicate with both those not selected and those selected. Remember that searches and recruitment are another form of marketing the institution—a candidate's bad experience or a lack of transparency in the hiring process may become a

representation of the department or institution as a whole.

Members should evaluate candidates based on set criteria. Interview protocols are often encouraged and offer the ability to ask the same questions to applicants, therefore providing the same evaluation criteria. However, a holistic approach to applicant review may offer an opportunity to identify additional strengths and qualities that may broaden the impact of potential hires.

While on campus, applicants should be given information that highlights the importance of not only the position but also the institution and the department. Visits and meetings should include key stakeholders and must engage and excite candidates about the prospects of employment. Remember, active communication with candidates throughout every step of the process is important—it speaks highly of the organization and its commitment, and keeps all parties engaged.

Letter of Offer, Contracts, and Start-Up Funds

Letters of offer or contracts are often accompanied by important aspects of faculty employment. Institutions usually have letter templates that include all of this information. Administrators are often involved in the determination of salary and compensation sources, start-up funds, laboratory and office space, equipment requests, moving expenses, and general financial-related topics. It is important to note that salary structures and packages are often complex and require administrator involvement not only for funding source identification but for sustainability as well.

ONBOARDING

After an effective search and successful recruitment comes one of the most important aspects of new employment. Onboarding is more than a checklist and certainly more than new employee orientation. It is part of talent management and development, ensuring proper integration into the organization's culture. Formalized onboarding procedures shortens the time to productivity and maximizes the new employee's impact. Effective onboarding programs will inform the new faculty member about the structure, performance, mission, vision, values, challenges, and expectations of the institution.

Organizations that engage in a formal onboarding program are more effective than those that do not. According to the Society for Human Resource Management, onboarding has four distinct levels: compliance, which teaches new employees basic policies and rules; clarifications, which ensures new employees understand their role; culture, which provides employees a sense of organizational norms; and connection, which helps employees form personal relationships and information networks.

At some teaching hospitals, an onboarding program provides a focused and comprehensive process that may include a series of activities during the faculty member's first year. Onboarding activities include determining the critical factors that are needed to ensure the success of the new faculty members. Most onboarding programs use a team approach with representatives from the practice plan, hospital, division, and marketing. The group attempts to determine how the new members relate to current programs and what efforts will be needed if new programs will be developed. For example, the group could develop targeted marketing plans to help the faculty member connect with referring physicians and patients.

Internal communication is equally important and often overlooked during the new employee's initial work time. The team normally develops a checklist to ensure the small details, such as stationery, business cards, and lab coats, are not missed. The goal is to provide the newcomer with a great start toward success. Another feature is to assist with networking by providing opportunities for discussions about common interests, with the goal of creating synergistic effects for the participants and the overall organization.

MENTORING AND FACULTY DEVELOPMENT

The evidence is strong that faculty development programs along with mentoring programs increase retention, productivity, and promotion for academic medicine faculty. As such, great strides have been made in the area of mentorship of faculty in academic medicine, especially in combination with professional and faculty development initiatives.

Mentorship has grown as a tool for all faculty in academia and is often considered a crucial part of faculty success. In general, studies have found that new employees who are successfully mentored by current employees are twice as likely to remain with their organization as employees who are not mentored. Academic medicine has successfully broadened mentoring approaches and intensity. Mentors provide leadership and guidance, but they should also provide prospective counseling, education, and monitoring of career progress. Among many benefits, a seasoned mentor enhances the likelihood

of critical introductions to prospective collaborators along with socialization into institutional and organizational structures, culture, and climate. Moreover, mentors can help new and junior faculty navigate the critical requirements for establishing a clinical practice or starting a research program. It is important for departments to have formal mentoring programs. Successful mentoring programs include the establishment of goals, regular meetings, and relationship building. Common mentoring programs involve one-to-one mentoring mostly intended for new faculty, as well as forms of peer mentoring.

Successful faculty development programs set clear program goals and content, and provide mentoring and coaching, a conducive environment, and a sustaining network. Faculty development includes support for activities such as finding research funding, writing academic articles, participating in conferences and professional associations, attending leadership and management trainings, as well as other types of curricula. This emphasis on professional development often aims to recognize great educators and increase publications and healthy funding portfolios for researchers.

The structure of mentoring and faculty or professional development programs depends on the institution, departmental or divisional focus, faculty needs, organization structure, and resources available.

DIVERSITY AND INCLUSION

AAMC defines diversity as a core value that embodies inclusiveness, mutual respect, and multiple perspectives and serves as a catalyst for change that results in health equity. In this context, administrators and faculty are mindful of all aspects of human differences, such as socioeconomic status, race, ethnicity, language, nationality, sex, gender identity, sexual orientation, religion, geography, disability and age. AAMC also defines inclusion as a core element for successfully achieving diversity. Inclusion is achieved by nurturing the climate and culture of the institution through professional development, education, policy, and practice. The objective is to create a climate that fosters belonging, respect, and value for all and encourages engagement and connection throughout the institution and community. Diversity and inclusion are important for many reasons, but especially in medicine because there is a great underrepresentation of minority groups as considered in AAMC's definition of diversity. This underrepresentation in the medical profession is relative to the demographic statistics in the general population.

Search and recruitment practices and models have surfaced that emphasize diverse search committee composition, unconscious bias training, the creation of structured interview processes, fostering awareness that bias may be presented in recommendation letters, and that cultural differences can adversely affect first impressions. In addition, studies have revealed that the recruitment and hiring of faculty in areas that also contained a diversity requirement resulted in the most reliable recruitment of underrepresented in medicine (UIM) faculty. Specifically adding this criterion in the job description, such as "experience working with diverse groups of students, populations, faculty, etc.," can increase the likelihood of a UIM being hired. Moreover, as academic medical centers expand their searches for UIM faculty, they may find competitive candidates in existing staff positions and alternative faculty tracks within their own institution.

Recruitment resources and efforts will be ineffectual if there is no systemic effort or intention to nurture and retain UIM talent. Retention practices in the academic medicine literature have often been linked to faculty development programs that integrated professional skill development and academic career advising.

Mentorship programs have been continuously growing and are expected to enhance productivity and promotion while addressing numerous barriers disproportionately experienced by UIM faculty, such as competing demands and lack of institutional support.

UIM faculty do not have enough faculty development programs. It identified several characteristics that successful faculty development programs use: effective and frequent mentoring; focused instruction on clinical, teaching, and research skills; regular networking opportunities; reduced administrative or clinical expectations to facilitate scholarly activities that lead to promotion and tenure; access to institutional seed money for pilot projects; and giving promotional weight to institutional service and community service.

Mentoring and faculty development programs have offered an opportunity for institutions and departments to address and encourage diversity and increased participation of UIM faculty in academic medicine. Administrators of internal medicine have an important role in these initiatives and have an opportunity to be at the forefront of activities within their departments, divisions, or centers.

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10 INTRODUCTION TO HUMAN RESOURCES MANAGEMENT (STAFF)

Human capital is an institution's largest investment. Many organizations spend as much as 90% of their budgets on people. With this level of financial commitment, expertly managing the vast world of human resources (HR) must be a priority.

RECRUITMENT, ORIENTATION, AND ONBOARDING

When opening a new staff recruitment or hiring a replacement, managers should take the time to review and assess the current organizational structure and the reliable strengths of existing staff to identify current needs. Job responsibilities and organizational demands change over time. The hiring of a new team member provides an opportunity to consider or formalize reassignments of duties, adjust operational practices, or consider new titles and reporting roles.

Interviews are an opportunity to ask qualified candidates pertinent questions about their skills and to provide information about the work environment, position responsibilities, and expectations.

Interviewing best practices:

- Each candidate should be interviewed by the same person(s)/panel and be asked the same questions. Make notes about the candidate's responses. Collect notes from each interviewer for the recruitment file.
- Describe the job and how it fits into the department. Explain the role of the department within the university.
- Review the job description with the candidate and identify the relative importance of various job responsibilities.
- If possible, show the candidate the work setting and any challenges of the physical space.
- Ask each candidate if they can perform the essential functions of the position with or without a reasonable accommodation.
- Explain the expectations for quality of work, punctuality, attendance, work schedule, working conditions, and so on.
- Review topics such as overtime, flex-time, vacation scheduling (peak workloads), required union dues, and so on.
- Review the salary range and benefits package for the position.

Effective organizations do not end the hiring process with an accepted offer; bringing a new employee on board begins the day the offer is presented. "Once taken for granted, the process of hiring, welcoming, orienting and engaging new employees into a company culture today is collectively referred to as 'onboarding'" (1). A successful onboarding endeavor can help lead to a successful employee. Regularly following up with a prospective employee before the start date helps thwart any counteroffers and creates a welcoming climate.

Employee orientation should include information beyond that provided at institutional program or HR benefits meetings. Managers must be actively engaged in not only traditional orientation checklist items and the basics of what the job and role is all about but also the cultural and political elements of the institution—how things get done. It is imperative to explain all aspects of the workplace to new employees to ensure that they are on an immediate trajectory toward successful performance.

ENGAGING EMPLOYEES

The majority of managers and supervisors are not trained HR professionals. Managers and supervisors should be coached to consistently address the following topics:

- **Clear work expectations.** Do employees know exactly what is expected of them? When they walk in the door every day, can they measure their progress against well-defined goals? If they cannot, they may never feel a sense of achievement in their role. If expectations are unclear, employees will inevitably face frustration and will be open for other opportunities that provide clear expectations of where their contributions will be measured and recognized.
- **Materials and equipment.** Do employees have access to the right tools to support their skills, experience, and talents? Employees need the right tools and equipment to perform their jobs at an optimum level.
- **Appropriately matched job descriptions with skill sets.** Are the employees working in the right roles? Just because an individual is gifted in a particular

area does not mean he or she has a full array of talents for every role. Talent can be very specialized and narrow, and knowing each employee's boundaries and limitations is very important.

» **Appreciation and acknowledgement of work.** Do valued employees know that someone at work, preferably their manager or supervisor, cares about them? If they do not, the institution will not retain them. The employee-manager relationship is critical in turning talent into lasting performance and excellence. In addition, ongoing dialogue and solid communication must be maintained with the most productive employees. Many managers give their greatest degree of attention to employees who are falling behind. Talented, productive people crave time and attention from their managers and will leave the institution if they have a weak relationship (or no relationship) with their manager.

» **Commitment to quality.** Do high-performing employees work with other productive employees? When assembling teams, managers and supervisors should consider a number of variables to promote a high level of commitment and performance. Team members rely on both technical expertise and positive interpersonal skill to support their accomplishments and growth toward excellence.

» **Opportunities to learn and grow.** Does the institution create an environment that encourages employees to drive toward innovation for more productive results? Talented employees need to be "stretched" in just the right ways to fully engage them. Great managers always ask what skills and knowledge need to accompany talent to result in the greatest outcome for each person and help identify resources to meet those needs.

RECLASSIFYING POSITIONS

Jobs and roles evolve with the ever-changing needs and goals of the institution. Therefore, it is fitting to periodically conduct a job analysis to whether a position needs to be reclassified. Reclassification may result in a change to a position's job level or salary grade depending on the company's compensation structure. While most managers request reclassifications with the intent of moving position levels higher, a position's changing role may result in a lower job level or grade. A useful guide is to conduct a formal review of the position when at least 20% of the responsibilities and duties have changed. A job analysis of this nature is a data-gathering process used to identify the tasks, duties, responsibilities, and accountabilities that comprise the job while maintaining equity with others working in similar roles.

INTERNAL EQUITY ASSESSMENTS AND ADJUSTMENTS

It is prudent to routinely compare employee salaries to proactively address pay inequities. Looking within a particular job classification, managers should consider current compensation structure and years applicable of experience for all incumbents. Additional adjustments can be considered for pertinent educational background, certifications, and performance reviews. As with all compensation plan updates, the process and criteria should be transparent to all members of staff.

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11 NEW SUPERVISORS TOP 10

Individuals who take on a supervisory role will need specialized mentoring and training. Supervisors are responsible for overseeing employees, day-to-day work, and long-term performance while accomplishing their own work. Supervisors may be responsible for establishing schedules, completing projects, addressing performance management, conducting review and hiring, and training and coaching staff. This hapter covers ome common concerns that should be addressed based on local structure and environment.

COMMON NEW SUPERVISOR CONCERNS

1. What is my role as a supervisor within the larger human resources structure of the organization. What is my area of authority and responsibility and how do I obtain training to fulfill these duties?

2. Where can I find an overview of the different job classes at the institution (e.g., faculty, graduate students, post docs, overtime eligible or exempt, union and nonunion employees)?

3. How do I access job descriptions for the employees in my unit? How do I determine previously established performance expectations?

4. Where do I obtain an overview of the hiring process?

5. What is the compensation and benefits structure for each job class?

6. What is the process for performance management and position reviews?

7. How does one access union contract information?

8. What are the institutional policies to address grievances, whistleblowers, or retaliation?

9. What recognition programs are in place?

10. What are the pertinent institutional, state, county, or city regulations that need to be addressed in the HR management process?

LABOR LAW FUNDAMENTALS FOR HR MANAGERS AND SUPERVISORS

Over the years, various legal regulations have been enacted in the employment arena to provide protection to both employees and employers. Every aspect of employment is affected by these regulations: recruitment, on-the-job activities, promotion, and termination. This chapter highlights some of the most prominent items of federal legislation for the workplace and how to remain compliant with their requirements.

FAIR LABOR STANDARDS ACT

The Fair Labor Standards Act (FLSA) was enacted in 1938 to protect covered employees by establishing a federal minimum wage, identifying overtime requirements (including the federal overtime rate of 1.5 times the regular compensation rate), identifying exempt and nonexempt jobs, providing protection and regulations for working children, and establishing recordkeeping requirements for payroll.

Effective July 24, 2009, the federal minimum wage was set at $7.25 an hour. Some states have a state minimum wage that may be higher than the federal minimum wage; in these instances, the higher rate is the legal minimum (1).

As with the minimum wage, some states have a higher overtime premium (as well as corresponding overtime regulations) than the federal rate of 1.5 times. Again, in those instances the state premium (and regulations) should be considered the legal mandate. FLSA requires overtime payment in some nonstandard situations, which include, but are not limited to, the following (2):

- Waiting time, where an employee is asked to wait for their next task, should be considered working time and count toward the total work hours of the week, including overtime if warranted
- On-call time, when an employee is required to stay on the premises in the event that work arises (even if it does not), must be compensated.
- Rest and meal periods vary in compensability. Although these breaks are not required by FLSA, the law does mandate when they should be compensated. In general, a rest period less than 20 minutes should be compensated. Meal periods exceeding 30 minutes do not have to be

compensated unless that employee is required to work through the meal period.
- Nonexempt employees attending lectures, training programs, and meetings may be entitled to compensation and overtime pay if the event is held within regular business hours, is involuntary, and is job related.

FLSA identifies certain professions that are considered exempt from the aforementioned overtime regulations. The exempt professions mostly seen in the health care industry are classified as executive, professional, administrative, and information technology.

FLSA has wage requirements for exempt employees. Current minimum salary requirements are mandated by federal guidelines. Additionally, in all exempt roles, the job requires a significant amount (usually no less than 80%) of independent discretion and decision making. The tasks performed by these exempt individuals are also usually not routine in nature (3).

FAMILY MEDICAL LEAVE ACT

In 1993, Congress passed the Family Medical Leave Act (FMLA) to provide eligible employees job protection for up to 12 weeks during a 12-month period of unpaid leave for qualifying events. FMLA is applicable only to employers with at least 50 employees in a 75-mile radius of the worksite. Eligible employees must have worked at least 12 months for the employer and at least 1,250 hours for that employer in the previous 12-month period. The qualifying events protected under FMLA are:

- The birth of a son or daughter to the employee for whom the employee is the primary caregiver.
- The placement of a son or daughter to the employee (for adoption or foster care) for which the employee is the primary caregiver.
- The employee's own serious health condition that affects his or her ability to perform work functions (required form available at http://www.dol.gov/esa/whd/forms/WH-380-E.pdf).
- The care of the employee's spouse, son, daughter, or parent due to the family member's serious health.
- The care of a military family member's serious health condition, when the family member serves in the regular Armed Forces, National Guard, or Reserves and if the condition was incurred in the line of duty on active duty (required form available at http://www.dol.gov/esa/whd/forms/WH-385.pdf).
- Exigency for military family leave (required form available at http://www.dol.gov/esa/whd/forms/WH-384.pdf).

Barring any complications that arise, generally items such as routine dental appointments, non-migraine headaches, the common cold, the flu, stomachaches, and other minor sicknesses in themselves do not meet the definition of a serious health condition. Likewise, being advised by a health care provider to use over-the-counter remedies and any other like remedies that are available to the public without a health care provider consult does not in itself meet the definition of continuing treatment.

Accurately administering the FMLA process is very time sensitive. When an employee requests (or the employer identifies) a potential FMLA-qualifying leave for the first time during the applicable 12-month period, the employer must notify the employee of FMLA eligibility status within five business days via the Notice of Eligibility and Rights & Responsibilities (http://www.dol.gov/esa/whd/forms/WH-381.pdf) form. If the employee is not eligible for FMLA leave, the notice must state at least one reason why the employee is ineligible. It is not necessary to provide additional confirmation of eligibility during the applicable 12-month period if the employee's status remains unchanged.

Next, the Designation Notice (http://www.dol.gov/esa/whd/forms/WH-382.pdf) must be provided by employers in writing within five business days after obtaining sufficient information to know whether a given absence is FMLA-qualifying. This letter can be provided to the employee immediately with the notice of eligibility if all FMLA information is received and approved. If leave is granted, the designation notice must include any "fitness-for-duty" certification that may be required by the employer before the employee can return to work. It also must specifically inform the employee of the amount of leave—hours, days, or weeks—that will be deducted from the 12-week FMLA allowance. If this breakdown is unknown at the time the leave is granted (e.g., when the amount of leave is unforeseeable or sporadic), the employer must provide such information on an employee's request, but the employer need not provide such breakdowns more often than every 30 days.

FMLA benefits can be used several ways. Employees may take the entire time all at once, as a reduced schedule, or as intermittent leave (none of which are to exceed 480 hours in the 12-month period since the leave began). During any leave under FMLA, employees must be entitled to the same benefits and rights as if they were not on leave; all health care plan options must continue to be available to

the employee. Additionally, when employees return from the leave, they must be reinstated to the same position as before the leave with the same overall duties, compensation, benefits, terms, and conditions of employment. If their job has been filled during their absence out of job necessity, a similar position must be made available. If they are unable to perform their essential job functions on return from the leave, then they are no longer entitled to the benefits provided in FMLA (4).

AMERICANS WITH DISABILITIES ACT

The Americans with Disabilities Act was passed in 1990 and added qualified persons with disabilities as a protected class. Three main provisions provided by the act are:

1. All facilities should be accessible to the disabled.

2. Reasonable accommodation should be made to qualified individuals with disabilities.

3. Instances where reasonable accommodations are not made must result from undue hardship to the employer, meaning such an accommodation would create an excessive burden for the employer (5).

AGE DISCRIMINATION IN EMPLOYMENT ACT

Passed in 1967, the Age Discrimination in Employment Act provides that for employers with more than 20 employees, individuals over the age of 40 shall not be discriminated against in any activity including, but not limited to, hiring, promotions, benefits, compensation, and termination. Exceptions are made in some cases, including but not limited to situations where a bona fide occupational qualification exists or termination or corrective action for just cause was taken (6).

THE CIVIL RIGHTS ACT OF 1964—TITLE VII

The best known portion of the Civil Rights Act of 1964, Title VII established protected classes of individuals as well as discriminatory unlawful employment practices. The protected classes identified in Title VII are race, color, religion, national origin, and sex. Except for bona fide occupational qualifications, it is unlawful to discriminate in any employment practice (hiring, promotion, termination without cause, etc.) based on these characteristics. Individuals who are not legally authorized to work as regulated by the Department of Homeland Security (most commonly identified by an I-9 form, http://www.uscis.gov/files/form/I-9_IFR_02-02-09.pdf) are not protected by Title VII. As amended by the Equal Employment Opportunity Act of 1972, Title VII applies to all employers who employ 15 or more individuals. The act created the Equal Employment Opportunity Commission to enforce the law as well as to investigate any complaints of discrimination in the workplace based on the above protected classes (7).

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION

Created as a result of the Occupational Safety and Health Act of 1970, the purpose of the Occupational Safety and Health Administration (OSHA) is to enforce the guidelines set by the act. These guidelines, intended to protect workers in the place of employment, include, but are not limited to:

- Employees must be provided a workplace that is safe and free from hazards.
- Employers must abide by and comply with all regulations set forth by the act.
- Employees must abide by and comply with all regulations set forth by the act in their individual behavior and actions.

As a result of workplace injuries, each state has set its own legislation regarding workers' compensation. These individual laws may vary, but the overall goal of each law is to provide benefits and compensation to employees who are injured or die as a result of working on the job (and within the safety constraints provided for their protection). Benefits may include, but are not limited to, medical and rehabilitation cost coverage for the injury as well as survivor benefits in the case of death. Compensation varies, but in most states the compensation paid to employees who are unable to work due to a workplace injury is a formulaic value based on the job performed as well as the seriousness of the injury (8).

RECORDKEEPING AND RETENTION

In all circumstances it is important to keep accurate, thorough, and current records in employment decisions. These records can provide sound justification against employee claims of unlawful employment practices. Each state has its own retention guidelines that should be followed if they are more stringent than the federal guidelines.

Legislation Related to Retention Guidelines		
Legislation	**Applicable Records**	**Federal Retention Period**
Fair Labor Standards Act	Records pertaining to compensation calculation and exemption status	Two years
	Records of eligibility for children to work	Three years or until termination
Family Medical Leave Act	Any items pertaining to the leave including job information (for verifying job restoration), description of leave policy, record of leave dates and hours used, items pertaining to the leave request, and certification of eligibility	Three years
Americans with Disabilities Act	Individual employee's compensation and benefit records, employment actions, and requests for reasonable accommodations	One year
Age Discrimination in Employment Act	Records of employment actions, employment test results, training records, as well as temporary employee records	One year
	Employee benefit plans	90 days
	Compensation and job records	One year after plan ends and three years while plan is current
Title VII	Records of all employment practices	One year
	Records related to discrimination claims	Until charge is resolved (however, a recommended best practice is seven years)
Occupational Safety and Health Act	Records of safety and health training	Three years
	Illness and injury logs	Five years
	Exam records for exposure to toxic substances, blood-borne pathogens, and hazardous materials	30 years

Although it is convenient to keep all of these documents in an employee's personnel file, this practice is not always appropriate or legally sound. Specifically, documents that pertain to an employee's health status and medical condition must not be retained in the personnel file. For example, any documentation relative to an employee's FMLA leave must be housed in a separate file maintained in a separate, secure, and confidential location.

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12 INDIVIDUAL PERFORMANCE MANAGEMENT

The most effective way to manage performance is simple to state but not easy to do—have a constant conversation with employees about performance and development. This section will walk through effective ways to accomplish this endeavor, including best practices and practical tools to manage and document feedback, performance, and development issues.

DEFINING PERFORMANCE

> "Employees' job performance is a result of their behavioral attributes and the environment in which they work. Behavioral attributes include expertise, adaptability, rate of improvement, commitment, and effort employees expend. The work environment represents the culture, systems, and policies. It also includes the degree of supportive management, tools, and training that individuals receive. Employees' performance can be fairly assessed only when the manager accounts for all these environmental factors". (1)

This definition is beneficial because it encompasses behavioral and environmental factors. Both are critical and have a major impact on day-to-day performance output.

Managers should ask:

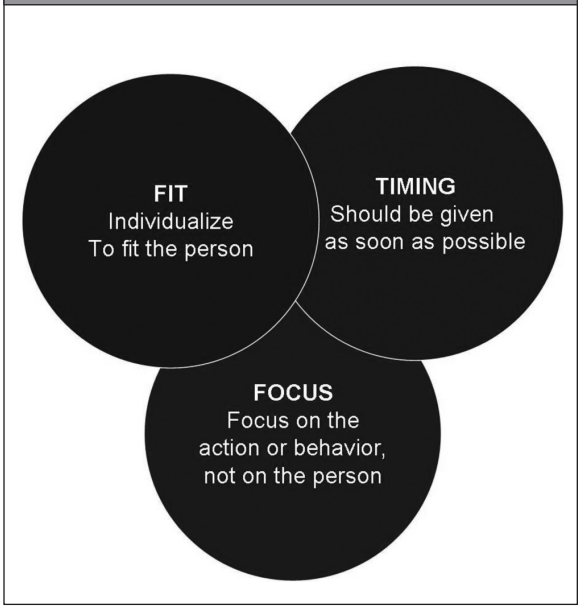
- How can I provide meaningful feedback and truly manage performance if I am not evaluating the entire picture?
- What if I am not taking ownership for my influence on the employee's performance?
- What if training efforts miss the mark or are "sink or swim" oriented?
- What if the employee honestly cannot articulate what I expect?

ONE-ON-ONE MEETINGS

When done properly and regularly, one-on-one meetings open consistent communication between a manager and employee about performance and development. Maintaining these meetings can prove difficult with a busy schedule; however, the minimum recommendation is to hold one-on-one meetings no less than quarterly. For practical purposes, include the annual performance evaluation as one of these quarterly one-on-one meetings. These meetings are all about the employee—focused time with the manager dedicated to discussing and documenting performance, development, and future goals.

Providing frequent and honest feedback to each employee that touches all areas of performance is the ultimate key to success.

Diagram of Feedback



PROVIDING CONSTRUCTIVE FEEDBACK

How does an effective manager provide meaningful feedback that positively affects employee performance? The overarching rule regarding feedback is that it must always be constructive, practical, and useful. Employees need to hear feedback that will help them succeed. Feedback should be individualized to fit the employee's learning style and temperament. Additionally, feedback must be timely; do not wait a week to approach a situation that needs immediate mediation. Feedback should be focused on actions, not personality. In summary, three elements—fit, timing, and focus—are all integral to providing constructive feedback.

BEST PRACTICES

Supervisors are encouraged to hold individual meetings with staff on a regular basis. Meetings should occur in a private location and at a time that minimizes interruptions.

- Prepare. Plan what to say and how to say it. Make a list of accomplishments, areas of improvement, and possible solutions.
- Ask and expect the employee to prepare, encouraging active participation.
- Establish a nonthreatening tone and maintain it throughout the meetings.
- Actively listen to the employee's ideas, concerns, and goals.
- Provide timely recognition, motivation, and encouragement.
- Work to keep the mission and direction of the institution in front of the employee as it relates to his or her role.
- Give honest and objective feedback (including timely examples of strengths and areas to develop).
- Set and regularly adjust goals, deadlines, projects, and overall performance expectations.
- Make sure that all parties understand what needs to be done. Keep expectations clear. Agree on specifics and commit to follow-up dates.
- Never wait to discuss performance issues and concerns.
- Describe the working environment. How do each of you characterize the group's morale?
- Are there any specific issues or problems that have been identified since the previous meeting?
- With regard to your own development, what improvements would the employee like to make over the next six to 12 months?
- What challenges the employee? What motivates the employee?
- Call an urgent meeting as necessary to provide feedback.
- Make notes to follow up in the next meeting.

Documentation

Create a simple format that facilitates your ability to take pertinent notes and share them with the employee shortly after each one-on-one meeting. Include in your documentation matrix:

- Quarterly update: Training, updates to development plan, follow-up from prior quarter.
- Feedback: Accomplishments for the quarter, positive and critical feedback.
- Discussion items: Work or personal issues, career development, feedback for specific workgroups.

Conversation Flow in One-to-One Meetings

You Tell Me…	I Tell You…
Step 1 What Went Well	Step 3 What Went Well
Step 2 What Went Wrong	Step 4 What Needs Improvement (that you did not mention)

- Suggestions for improvements to division, laboratory, or other work area.
- Action items: Confirm assignments and timelines for completion for both supervisor and employee.

WHAT ABOUT PERFORMANCE MANAGEMENT?

Many managers believe performance management is solely issuing warnings and firing employees, but this mind-set is misguided. Effective performance management involves many positive opportunities to provide feedback, praise, recognition, and encouragement to reach stretch goals. Timely feedback as well as providing employees with the opportunity to provide feedback to supervisors or other leadership team members helps identify issues early and may help improve outcomes. There should never be any surprises when it comes to an employee's performance. Every employee should be able to answer the question, "What does your manager honestly think of your performance?" One-on-one meetings are the foundation of every employee's ability to answer this question.

DEVELOPMENT PLANS

Development plans should be created during the one-on-one meeting process. A development plan documents the learning activities the employee plans to accomplish during the next six to 18 months to further develop skills required to successfully achieve job standards and further career development (2). Skills

identified for professional development should relate to job assignments and career aspirations, both current and future. This process is also key for succession planning efforts, as noted in the "Introduction to Human Resources (Staff)" chapter. Ideally, the development plan facilitates discussions between the manager and the employee about skill development in support of current expected behaviors, job results, career objectives, and goals.

Although employees may initially react negatively to development plans, these plans are not intended to be constant reminders of what they do not do well. The plans are also not intended to be used as a veiled corrective action plan. The introduction of development plans can be met with resistance but perseverance, and appropriately managing this process will lead to effective results.

PERFORMANCE EVALUATIONS

The common practice of writing annual or semiannual performance evaluations should also be viewed as part of the overall process of individual performance management. Most institutions have a system of performance evaluation that includes a form or evaluation tool. While some tools facilitate performance management better than others, the goal of evaluations is "to strike a balance between providing the employee with an in-depth assessment and set out a plan to facilitate future growth" (1). Regardless of the form used, cover both aspects when evaluating employees.

ANALYZING PERFORMANCE PROBLEMS

Up to this point, a foundation for effective performance management has been established by having a constant conversation with each employee about performance and development. Despite the quarterly one-on-one meetings, development plans, and unbiased evaluations, some employees will still perform below expectations.

To analyze a performance problem, start by identifying the nature of the performance discrepancy (3). Get to the root of the gap between what is expected and what is being produced. For example, a coworker complains about an employee's attitude, but what does that mean? What is the actual discrepancy? Is the employee 20% behind on a measurable quota? Is the employee not showing up to work on time? Is the employee missing informational meetings necessary to do his job? Drilling below the surface (and observing things firsthand) helps identify the actual discrepancy between the expectations of performance and the tangible output.

Once the nature of its problem has been identified, the importance of the discrepancy can be considered (3). Why is the discrepancy important? What would happen if the discrepancy were left alone? Could doing something to resolve the discrepancy have any worthwhile result? Decide if the discrepancy is worth pursuing at this stage.

If a performance discrepancy exists and is considered important, determine whether it is due to a genuine skill deficiency. Perhaps the employee needs more skill practice or needs to hear more consistent and constructive feedback from the manager. Ask. Hold open and honest conversations during one-on-one meetings. Consider sending the employee to a formal training program or assigning a trusted coworker to serve as a mentor. To document and build accountability, any and all of these steps may be included as part of a development plan or even more formally documented via a performance improvement plan.

Sometimes the employee exhibits a discrepancy in performance, but no amount of training is going to close the gap. Ask questions to determine the obstacles preventing the desired performance (3).

- What obstacles are preventing this employee from performing?
- Does the employee know what is expected of him?
- Does the employee know when to do what is expected?
- Are there conflicting demands on this employee's time?
- Does the employee lack the authority, time, or tools?
- Are there restrictive policies that ought to be changed?
- Can potential interference be reduced (e.g., improving lighting, modifying work location)?

Managers who are frustrated by poorly performing employees often do not stop to consider that legitimate obstacles to performance may be beyond the employee's control. Good managers take the time during one-on-one meetings to try to get to the root cause to help an employee perform in a successful manner.

Last, most people want to do a good job. Managers should try to be objective, examine responses for unconscious biases, and rely on available data.

We work in institutions that have innumerable policies and procedures, corrective action processes, and documentation requirements. Attempts to help an employee correct any performance discrepancies must be well documented. Employees need to know that there are negative consequences for consistently not performing to expectations. These consequences generally amount to a corrective action process with varying steps to document the expectations, gaps in performance, and time frames required for correction. Consult the institution's human resources representative to move forward with the formal process.

While the focus in this section has been on more quantifiable performance deficiencies and gaps, respond immediately whenever behavioral issues occur (e.g., inappropriately touching another employee, yelling in the hallway, breach of confidentiality). Have a reasonable expectation of professionalism and courtesy. If an employee's behavior does not meet these standards (sometimes formally written in the institution's work rules or policies), immediate corrective action or termination must occur.

PERFORMANCE IMPROVEMENT PLAN

A performance improvement plan (PIP) is a good place to start when serious performance or behavioral deficiencies persist and have not been corrected via verbal discussion in the one-on-one meetings. Depending on institutional policies, this plan is generally not a "formal" step of corrective action; however, it is a critical early step in positively managing performance. It also forces the manager to create concise performance documentation that details the manager's expectations as well as the employee's deficiencies and puts due dates and accountability on key deliverables.

FORMAL WRITTEN AND FINAL WRITTEN WARNINGS

Most organizations have a formal process of corrective action and prescriptive tools to use. Learn and follow the formal process within the institution. In general, at least two formal corrective action steps should occur prior to termination—written and final written warnings. If prior counseling processes have occurred (i.e., file notes from one-on-one meetings, development plans, evaluations, or PIPs), the formal corrective action documents must reference these conversations and counseling processes to create flow and continuity. The institution undoubtedly requires the use of a form at this stage.

TERMINATION

One of the most unpleasant aspects of management is terminating an employee. However, if significant progress through the individual performance management process has not occurred, and if an employee is not suitable for another position within the institution, termination is appropriate (1). Countless managers do not want to go through the emotions associated with firing someone, but the result of this apprehension is the reduction of institutional output, teamwork, and perhaps quality.

Best Practices

- As with all formal steps of corrective action, include an appropriate witness in a termination meeting. Most often the witness will be from human resources, but the witness could also be a manager or an appropriate colleague.
- Never say anything that would be regrettable if quoted in a future lawsuit:
  - Never generally agree with the employee.
  - Do not discuss how good they were as an employee.
  - Do not say "how much you regret this action" or "how sorry you are to do this."
  - Never state "my boss (or human resources) is making me do this." Own the termination situation.
- No matter how serious an employee's negative reaction is, maintain empathy but resist the natural inclination to comfort someone.
- Keep the meeting and interaction as brief as possible while allowing the employee appropriate time to react and respond.
- Never allow the discussion to move into the realm of negotiation. The decision to terminate has been made and is not up for debate.
- If there are any concerns about personal safety or the safety of others due to an employee's reaction, alert security staff prior to the meeting.

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13 INTERNATIONAL VISAS: COMMON QUESTIONS AND ANSWERS

WHAT IS A VISA?

A visa is a stamp on a passport obtained at a US consulate or embassy that allows an international visitor (such as a student, researcher, or faculty member) to enter the United States legally. Once individuals secure a visa and are admitted by an immigration officer at the port of entry, they gain a temporary status to remain in the United States. Please note that a visa is different from status. A visa stamp in itself does not guarantee entry unless an individual has satisfied an immigration officer at the port of entry of his or her intent and purpose of visit. Once an individual is admitted, then a person can remain in the United States in valid status as long as his or her visa allows. While the Department of State controls visa issuance, the Department of Homeland Security controls the inspection and admission of international visitors.

HOW MANY DIFFERENT TYPES OF VISAS ARE THERE? WHAT ARE THE MOST COMMON TYPES FOR EDUCATIONAL INSTITUTIONS?

Best practice is to start the visa process by contacting your institutional office responsible for oversight of academic personnel or staff who require visa sponsorship.

The most common nonimmigrant visas at educational institutions are F-1 visas; M-1 visas; J-1 visas for students, scholars, and physicians; TN visas, derived from the North American Free Trade Agreement with Canada and Mexico; H-1B visas for the specialty occupation category of employment; and O-1 visas of employment for extraordinary ability in the sciences, arts, education, business, or athletics. In addition, institutions may also sponsor an individual for a permanent resident or immigrant visa, commonly referred to as a "green card."

For a complete list of visa types, please visit the Department of Homeland Security website at www.dhs.gov and the Department of State website at www.travel.state.gov.

WHAT IS THE GENERAL APPLICATION PROCESS AND HOW LONG DOES IT TAKE FOR AN INTERNATIONAL VISITOR TO OBTAIN A VISA?

While the US consulate or embassy in each country has different requirements, the general visa application process begins by obtaining an appropriate immigration document from a US educational institution or employer. After completing the visa application, candidates should make an appointment with the US consulate nearest to their place of residence. Locator information for US consulates can be obtained from www.travel.state.gov. It is highly recommended that an individual applying for a US visa check the website of individual consulates or embassies for details on specific country requirements, such as documents, letters, etc. Applicants must allow ample time for visa processing in the event that a security and background check is required.

WHAT ARE THE RESPONSIBILITIES OF THE INSTITUTION AND THE INTERNATIONAL VISITOR IN THIS PROCESS?

Sponsoring institutions must adhere to immigration and labor regulatory requirements for each visa category. Violating these requirements may result in penalties and in some cases, the loss of ability to continue a program. Institutions should seek legal counsel to ensure compliance. It is always the responsibility of international visitors to maintain their status at all times. They need to ensure they have valid passports, retain proper immigration documents, and adhere to the rules and regulations that govern their stay in the United States.

DOES THE INTERNATIONAL VISITOR'S ROLE AT THE INSTITUTION AFFECT THE TYPE OF VISA THAT SHOULD BE REQUESTED?

Each role must be thoroughly examined before a decision is made to bring an international visitor to either study or work. In the case of a student, an educational institution must be certified by Department of Homeland Security Student Exchange Visitor Program to bring international students on campus. Each admitting office must establish an admission process to evaluate credentials, language

proficiency, and financial resources available for the duration of the program. Once the admission criteria and other requirements are met, an immigration document to obtain a visa may be issued according to the regulations set forth by the Department of Homeland Security. Each employment option for faculty, researchers, and staff must be examined on the basis of institutional policy, requirements of the position, qualification of the individual, and regulations that govern the category of visa. Adequate steps must be taken to conduct routine internal audits to ensure compliance with immigration and labor regulations.

AFTER INTERNATIONAL VISITORS ARRIVE ON CAMPUS, WHAT IS THEIR EMPLOYMENT STATUS?

It depends on the category (visa) in which an international visitor was admitted to the United States. For example, if he or she was admitted on an H-1B visa, then the regulations that govern H-1B visas will apply. Please consult with your international office and legal counsel to confirm eligibility and review specific requirements for each visa type.

ARE THERE ANY SPECIAL REPORTING REQUIREMENTS WHILE AN INTERNATIONAL VISITOR IS AT THE INSTITUTION?

The reporting depends on the requirements of the visa category. If an international visitor is in J-1 or F-1 status, the Department of Homeland Security requires reporting about the presence of that individual on campus. In addition, there are several event-based reporting requirements—such as registration, program validation (for J-1), change in address, change in program objectives, and financials—that an institution must comply with to retain certification and designation. In general, all international visitors in any nonimmigrant category—other than students—are required by law to notify the Department of Homeland Security of any address change within ten days. Employers must be vigilant in submitting amended employment petitions to USCIS if the original terms of employment change substantially (for H-1B and O-1). Please consult with your international office and legal counsel confirm eligibility and to review specific requirements for each visa type.

WHAT PROCESS IS REQUIRED TO TRANSFER AN INTERNATIONAL VISITOR FROM ONE INSTITUTION TO ANOTHER?

Each visa category requires a different process. Proper advice should be sought before the hire to ensure that a transfer or change of employer is possible. Regulatory issues should be considered, depending on how long an international visitor has been in the United States with a particular immigration status. Institutional collaboration and legal advice will greatly help in this process.

WHAT OPTIONS ARE AVAILABLE TO RENEW OR EXTEND A VISA?

Depending on the immigration status, it is possible to extend an individual's stay in the United States. However, a visa has to be renewed outside the United States, in the country from which the visa originated. It is possible to renew a visa in a different country, such as Canada. However, this process is risky and any uncertainty can be avoided by completing the process in the individual's home country.

WHERE CAN I FIND ADDITIONAL REFERENCE INFORMATION ABOUT IMMIGRATION AND VISAS?

The following websites provide detailed information about immigration, visas, and US government regulations:

- www.uscis.gov.
- www.ice.gov.
- www.cbp.gov.
- www.travel.state.gov.
- www.nafsa.org.

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14 DIVISION STRATEGIC PLANNING: A MODEL TO COMMUNICATE AND FUND YOUR SUCCESS

The practice of sound strategic planning is key to the success of departments and divisions of internal medicine—and the individuals who lead these diverse and complex organizations. Successful strategic planning broadly engages stakeholders, builds on extensive preparation, and addresses relevant topics. Given all the competing priorities that exist in a department of medicine, what are the expected benefits of allocating time and effort to the strategic planning process?

- Participation in planning and preparation activities allows for increased faculty and staff engagement.
- Engagement builds positive culture and promotes an attitude of continuous improvement.
- The resulting plan identifies shared priorities and aligns those priorities with financial commitments.
- The resulting plan identifies actions needed to succeed and steps required to meet long-term goals.
- The resulting plan serves as a means of communicating agreed-on goals that will help division members and others understand where your division is headed.

Administrators and faculty leaders may choose from a number of strategic planning tools, and this overview presents a proven model employed by the Duke University's Department of Medicine. The Duke approach employs two common model review tools: SWOT analysis and gap analysis. A SWOT analysis is a tool to help organizations assess issues within and outside of that organization. The purpose is to identify the organization's strengths and weaknesses as well as external opportunities or threats from competition. This information can then be used to guide strategic decision-making. Planning leaders should build in time to educate participants about the chosen planning tools and the utility and limitations of each. Participants also need to understand the expected timeline, scope of review, initial assumptions, and anticipated outcomes of the process. A division that engages in its initial formal strategic planning process should plan to build in periodic timeline reviews and communicate updates to faculty and staff throughout the process.

PLANNING AND PREPARATION

Committing effort to planning and preparation helps leadership refine the planning process and sets expectations for active participation from the outset. Stakeholders from both within and outside the division should be surveyed for perceived needs. Survey results should be scrutinized to identify gaps between the perceptions of respondents and those of the process leader. Survey results also may obligate process leaders to adjust expected scope or to add focus group activities to elicit clarity about survey data.

Time should be allotted to assessing the external environment. Are there organizations you would like to emulate? Have you contacted those organizations to discuss how they attained success? When interviewing members of the successful organization, ask them to share any mistakes they made during their process, in hopes that your organization might be able to avoid the same issues. Is the organization able to elucidate and share their experiences with eliminating unexpected barriers identified during the process?

Upon completion of the preparation and model review phases, leadership should create a strategic plan score card. The score card summarizes the agreed-on goals, intended completion dates, and anticipated costs for implementation of the strategic plan.

GETTING STARTED

Before launching public sessions, administrators and faculty leaders will benefit from developing an outline for internal reference. This outline will help confirm

SWOT Analysis Results for a Single Program			
Strengths	**Weaknesses**	**Opportunities**	**Threats**
Well-defined program	Staff turnover	Market volume is growing	Senior faculty member retiring
Excellent clinical research infrastructure	Practice location	Brand name provides recognition	New physicians coming to the market
State-of-the-art technology	Ability to change	Outreach with network faculty	Potential change in reimbursement

SWOT Analysis Results for Mission Area			
Strengths	**Weaknesses**	**Opportunities**	**Threats**
Medical student, resident, and fellow clinical training			
» Clinical strengths of the faculty » Recent increase in clinical educators to the faculty » Access to the surgical endoscopic simulator	» Relatively junior faculty and less experience as teachers » Clinical demands on the faculty with productivity goals » Lack of IT expertise to develop interactive teaching modalities	» Recruit top trainees to our field » Chance for more faculty to be engaged in rewarding educational experiences	» Division's priority on fellow training means less opportunities for students » Movement of faculty to locations away from main facilities.
Medical student and resident research training			
» Varied research experiences from bench to outcomes	» Funding for trainee research	» Recruit top trainees to our field	» Training falls to limited number of faculty (for residents) with limited support
Fellow research training			
» Varied research experiences in the division from bench to outcomes	» Limited number of senior mentors in the division and particularly in basic science	» Collaborations with other divisions and departments within the university.	» Limited number of applications for research and field competition among top programs

the scope and breadth of the division's activities to be reviewed. Most session participants will also find that a basic outline will encourage additional discussion and identification of activities that were not included in the initial outline.

The leadership group could conduct a focused session of their own to ensure that all participants understand the goals of strategic planning and how to engage in the SWOT or gap analysis discussions. The initial review of the clinical mission should include:

- Describe current clinical mission activities: clinical service lines, outpatient and inpatient clinical activities, existing affiliations with other health care entities, practice locations, current clinical productivity, and other current operating environment aspects.
- Describe your planned future state and where you want to be in your clinical mission in the next five years.
- Develop goals for your clinical mission. Describe how they support the future state of your clinical activities.
- Complete a SWOT analysis focused on your clinical mission. Include an overview of strengths, weaknesses, opportunities, and threats. Incorporate local, regional, and national impacts as necessary.
- Complete a gap analysis to compare your current operating state with your desired future state. Include the actions needed to achieve your stated goals.

Gap Analysis Results for Division—Specific Mission Area			
Division of Geriatrics	**Gap Analysis**		
Mission Requirement	**Current State**	**Desired State**	**Gap/Action**
Recruit additional bone specialist	Bone health program losing market share to competition	Recognized local leader in bone health clinical programs	Complete recruitment for additional bone health specialist

Gap Analysis Results for Division—Combined Mission Areas			
Requirement	**Current State**	**Desired State**	**Gap/Action**
1. Improve the division's finance	Managing expenses - administrative staffing reduced by 40% in past 5 years, identifying non-personnel cost reductions opportunities. Reallocating resources to meet divisional needs. Margin has improved but division is still deficit.	Demonstrate appropriate expense and productivity management. Collaborate with hospital to develop revised funds flow model.	Meetings have been scheduled with senior leadership to discuss. Closer integration with health system and hospital.
2. Improve divisional clinical productivity	Outpatient clinic redesign and workflow optimization.	See more new patients, revised patient flow, better patient and employee satisfaction	Completed phase I of the redesign pilot. Planning to have fully implemented program running by July 1, 2011.
3. Improve divisional reporting	Various reports are used to monitor productivity, compliance, and finances—often inaccurate or misleading.	Standard set of reports that are accurate and can be distributed on a timely and consistent basis,	Working with Medicine and physician practice plan to identify reports needed for reporting

» Develop an action plan that includes prioritizing your "future actions" and listing them in chronological order for completion. A number of the items in your plan will be tactical (i.e., short-term, micro, process-oriented steps that together help achieve your goals for this mission area) versus the long-term, macro goals of your plan.

MODEL REVIEW

The model review period allows all participants to become better educated about the current state of the division and to identify mutually agreed-on goals. Multiple sessions will be necessary to comprehensively analyze the clinical, teaching, research, and administrative activities of the division. Plan leaders should build in time during each session or at a launch event to explain model review tools. By using multiple review tools and engaging faculty and staff at all levels, leadership will elicit the different perspectives and diverse input necessary to develop a robust plan. Careful consideration should be given to session facilitation, group size, and composition of session participants.

Barriers to Implementation and Success

Leadership should ensure that faculty and staff are asked to participate in relevant review activities. Inadequate or inappropriate engagement of faculty and staff during planning or review periods will impede the implementation phase, so consider several communication platforms, make participation easy (e.g., keep surveys short), be clear about expectations and support for participation, and consider a kickoff event to generate enthusiasm. Ongoing communication in multiple formats about steps, goals, and progress is necessary to ensure successful implementation.

Administrative and faculty leaders should consistently demonstrate their commitment to and support for the value of strategic planning. Leaders should support broad participation in the process. By ensuring participation through protected effort to prepare for and attend planning sessions, leadership is highlighting the expected value of the results. Completion of the plan may be difficult if the model review process outcomes are unexpected or if the necessary changes are extensive. Leadership should model acceptance and support for change. Planning for the future

Strategic Plan Score Card					
October 2012 Update Division of Geriatrics	**Strategic Plan Score Card**				
	Initiative Lead	**Projected Implementation Date**	**Approved Funding**	**Current State**	**Next Action**
Clinical Mission					
Recruit additional bone specialist	Dr. Jones	6/30/2013	$175,000	Search initiated, reviewing candidates	Finalists to be reviewed by January 15, 2013
Initiative #2 title					
Initiative #3 title					
Research Mission					
Initiative #1 title					
Initiative #2 title					
Education Mission					
Initiative #1 title					
Initiative #2 title					
Community Service Mission					
Initiative #1 title					
Initiative #2 title					

should be an ongoing priority of your leadership focus. Concurrently, leaders should also demonstrate a commitment to excellence in all areas of plan performance—patient access, research compliance, productivity, expense management, and so on—without reservation or preference.

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APPENDIX

COVER PAGE

PUBLISH DATE: MONTH YEAR

DEPARTMENT OF INTERNAL MEDICINE STRATEGIC PLANNING TEMPLATE

This is where you provide the abstract of your strategic plan. This text should be the summary that you would be comfortable displaying on your website and distributing to current and future faculty, trainees, and staff. It should include your strategic planning purpose, an abstraction of your strategic goals, and closing text about the impact your Division intends to make for the Department, School, or other University entities.

TABLE OF CONTENTS

The table of contents should be set up to automatically update based upon the length of your document. If you add additional headers for a new section, copy a header from a current section and then click the body of the table of contents to update it.

CONTENTS

INTRODUCTION

Discuss the Division's history and importance. Describe divisional leadership, national and international reputation of your faculty, national rankings, and significant achievements accomplished by your division in all mission areas.

PLAN ASSUMPTIONS

The planning assumptions describe the current environment and serve as a backdrop for the division's strategic plan. They form the precepts for this plan.

- Example: The division will meet its operating budget during this five-year period of time.

PLAN VISION

This short statement describes the purpose of your plan and how you intend to communicate it and execute the planned actions.

PLAN GOALS

To ensure success, the vision needs to be translated into actionable, overarching goals. These goals should be mission based. The overarching goals you come up with should be included here and listed as part of your plan abstract:

- Goal number 1
  - Description of goal number 1
- Goal number 2
  - Description of goal number 2
- Goal number 3
  - Description of goal number 3

In each of the following sections of this plan, you will include mission specific goals and objectives specific to that mission area. Those goals and objectives, referred to as "future action" are focused on achieving the purpose of these overarching goals and are organized by priority in that section for completion. The future actions will be composed of primarily tactical plans that support the completion of your plan goals.

DIVISION MISSION STATEMENT

Include your division's mission statement. The division of XXXX is …….. Our mission is as follows: (Sample Administrative Services mission)

> The mission of all administrators in the department of medicine is to develop, perform, and provide administrative services that are recognized for their high quality and value by those we serve. These services exist to support our faculty, staff, and trainees in their pursuit of our education, research, clinical care, and community service missions.
>
> In providing our administrative leadership, services, and solutions, department of medicine administrators strive to conduct business with the highest degree of efficiency and effectiveness. These efforts are based on achieving our overarching goal of continuous improvement in the quality and value of our work for those we support and serve.

CLINICAL MISSION

Describe your current clinical mission activities, including a discussion of your clinical service lines, outpatient and inpatient clinical activities (to include the number of sessions, lab blocks, months of service, etc.), existing affiliations with other health care entities, practice locations, current clinical productivity, and other current operating environment aspects.

Describe your planned future state and where you want to be in your clinical mission in the next five years.

Develop your goals for your clinical mission and describe how they support the future state of your clinical activities.

Complete a SWOT analysis focused on your clinical mission. It should include a discussion of your strengths, weaknesses, opportunities, and threats. This review should incorporate local, regional, and national impacts as necessary.

Complete a Gap Analysis to compare your current operating state with your desired future state. This Gap Analysis should reflect action needed to achieve your stated goals.

Develop your action plan which includes prioritizing your "future actions" and listing them in chronological order for completion. A number of the items in your plan will be tactical (i.e. short term, micro, process-oriented steps that together help achieve your goals for this mission area) versus the long term, macro goals of your plan.

RESEARCH MISSION

Describe your current research mission activities. This should include a discussion of your current research portfolio (to include the number of awards by funding agency and by type of award), significant research programs, research collaborations (both internal and external), the division's research environment (specialized equipment, facilities, customized space, etc.), use of (or provision of) core resources and specialized laboratories here on campus, and other current operating environment aspects.

Describe your planned future state and where you want to be in your research mission in the next five years.

Develop your goals for your research mission and describe how they support the future state of your research activities.

Complete a SWOT analysis focused on your research mission. This should include a discussion of your strengths, weaknesses, opportunities, and threats. This review should incorporate local, regional, and national impacts as necessary.

Complete a Gap Analysis to compare your current operating state with your desired future state. This Gap Analysis should reflect action needed to achieve your stated goals.

Develop your action plan which includes prioritizing your "future actions" and listing them in chronological order for completion. A number of the items in your plan will be tactical (i.e. short term, micro, process-oriented steps that together help achieve your goals for this mission area) versus the long term, macro goals of your plan.

EDUCATION MISSION

Describe your current education mission activities. This should include a discussion of your faculty members' current education activities to include clinical conference, research seminars, fellow's conference, CME activities, GME and UME educational contributions, and other current operating environment aspects.

Describe your planned future state and where you want to be in your education mission in the next five years.

Develop your goals for your education mission and describe how they support the future state of your education activities.

Complete a SWOT analysis focused on your education mission. It should include a discussion of your strengths, weaknesses, opportunities, and threats. This review should incorporate local, regional, and national impacts as necessary.

Complete a Gap Analysis to compare your current operating state with your desired future state. This Gap Analysis should reflect action needed to achieve your stated goals.

Develop your action plan which includes prioritizing your "future actions" and listing them in chronological order for completion. A number of the items in your plan will be tactical (i.e. short term, micro, process-oriented steps that together help achieve your goals for this mission area) versus the long term, macro goals of your plan.

COMMUNITY SERVICE MISSION

Describe your current community service mission activities. It should include a discussion of your current community service activities to include participation in clinical and research community based activities locally, participation in institutional initiatives, and other community service activities your faculty, staff, and trainees participate in.

Describe your planned future state and where you want to be in your community service mission in the next five years.

Develop your goals for your community service mission and describe how they support the future state of your community service activities.

Complete a SWOT analysis focused on your community service mission. This should include a discussion of your strengths, weaknesses, opportunities, and threats. This review should incorporate local, regional, and national impacts as necessary.

Complete a Gap Analysis to compare your current operating state with your desired future state. This Gap Analysis should reflect action needed to achieve your stated goals.

Develop your action plan which includes prioritizing your "future actions" and listing them in chronological order for completion. A number of the items in your plan will be tactical (i.e. short term, micro, process-oriented steps that together help achieve your goals for this mission area) versus the long term, macro goals of your plan.

FACULTY DEVELOPMENT

Our faculty members are the most important element of the department. Their individual success is paramount to the corporate success of the division and department. Briefly describe the current faculty by summarizing their contributions to the division.

Complete a SWOT analysis focused on your current faculty. It should include a discussion of your strengths, weaknesses, opportunities, and threats. This review should build off the SWOT analyses completed for each of the four primary mission areas.

Develop your action plan which includes prioritizing your "future actions" and listing them in chronological order for completion. A number of the items in your plan will be tactical (i.e. short term, micro, process-oriented steps that together help achieve your goals for this mission area) versus the long term, macro goals of your plan.

PHILANTHROPIC DEVELOPMENT

Philanthropic development efforts are an important part of how we fund and provide durable support for our mission activities. Describe your division's activities in this regard.

Develop your action plan which includes prioritizing your "future actions" and listing them in chronological order for completion. A number of the items in your plan will be tactical (i.e. short term, micro, process-oriented steps that together help achieve your goals for this mission area) versus the long term, macro goals of your plan.

DIVISION LEADERSHIP

Faculty and staff leadership are vital to the successful development and implementation of this strategic plan. Describe current leadership for all mission areas and functional responsibilities. Additionally, detail how leadership will communicate and execute the approved strategic plan.

ADMINISTRATIVE INFRASTRUCTURE

The division's administrative leadership and infrastructure are critical to supporting the division's current activities and the goals of this strategic plan. Detail the current activities of the administrative infrastructure in support of the division's mission areas and functional responsibilities. This should also include a listing of all administrative employees, their titles, and roles in the division.

Complete a Gap Analysis of your current administrative staff. This Gap Analysis should reflect action needed to achieve your stated goals.

STRATEGIC FINANCIAL PLAN

Include summary revenue and investment calculations to meet the goals of your plan. These summary estimates will be evaluated and reviewed prior to finalization of your strategic plan. Approved goals will then have detailed financial plans developed and included in the final planning document. These financial plans (planned revenues and investment) will be included in the strategic plan scorecard at plan completion.

IMPLEMENTATION TIMELINE AND EXECUTION SUMMARY

Summarize your future action plans by primary goal area. They should be prioritized for completion and will be finalized when your plan is approved. These should include any tactical steps you have identified in your future actions in order to maintain a detailed summary of your execution activity. After the plan has been approved, this summary will be used to monitor implementation and execution progress.

STRATEGIC PLAN SCORECARD

The strategic plan scorecard will be developed after your plan has been reviewed and approved by department leadership. Your scorecard will reference the major items in your implementation timeline and will serve to track your progress and account for both the investment and the return on your plan.

15 CREATING A BRAND FOR YOUR DIVISION

When we think of marketing and branding, why don't we think of their divisions or departments the same way that we think of everyday products? When we think of coffee, we think of Starbucks; when we think of French fries, we think of McDonald's. These companies are just two that surround us every day with effective marketing and branding. The goal of this article is to explain the differences between marketing and branding; share the 10 steps for implementing an effective marketing plan; and describe how to use technology and social media to achieve your division's or department's marketing and branding goals.

MARKETING VERSUS BRANDING

What is the difference between marketing and branding? The Tronvig Group describes marketing as actively promoting a product or service, whereas branding is the expression of the essential truth or value of an organization, product, or service. Marketing can be thought of as a pushing tactical approach and branding as a pulling strategic approach (1). These two concepts form the backbone of every kind of advertising today. When you see a billboard or commercial dedicated to a product, the company is aiming to market that product to you. When companies use branding, they are creating a way of life with that product, pulling you toward it. The goal of branding is to establish a bond between you and a specific brand-name product. For instance, people often refer to all painkillers as Tylenol, rather than acetaminophen or ibuprofen.

Is it possible to use marketing and branding to push a product on customers or, in health care, our patients? As the Division Administrator for Nephrology at University of Florida Health System, one of my first actions was to discuss with the division chief his vision and strategic plan. The goal was to grow business, improve patient access, and provide high-quality care but when I joined there was no marketing for the division. How could we let everyone know that we offer outstanding care? To create an effective marketing and branding campaign, we set up a strategic plan and initiative using 10 steps.

GETTING STARTED

Step 1: Analyze the Situation

Define your product or service and communicate to your customers its intrinsic benefit or value. In the division's case, highlighting its world-renowned faculty who specialize in dozens of highly complex areas was a key point of the strategy.

Step 2: Conduct a Marketing Overview

Establish your target audience. We wanted to market to the physicians who send us patient referrals, such as family practitioners, urologists, and other private practice nephrologists.

Step 3: Complete a Competitive Review

Determine how high to set the bar. Two types of goals can be set: quantitative or qualitative. With a quantitative goal, set a measurable target to reach. With a qualitative goal, reach the goal of bringing increased value, such as improving image or visibility. For the division, I took a combination approach: I wanted to increase patient referrals (quantitative) and I wanted to improve our visibility locally and nationally (qualitative).

Step 4: Describe the Product or Service

Define the brand for your product or service. Create a clear and concise message. Highlight three or four key points that emphasize what the direct benefits are to your patients.

Step 5: Conduct a SWOT Analysis

Determine the strengths, weaknesses, opportunities, and threats (SWOT) of your organization and your competition. A well considered, planned, and executed SWOT analysis avoids duplication of efforts.

Step 6: Determine Goals and Objectives

Start by establishing a marketing budget. Set aside a specific dollar amount, either per quarter or per year, adequate to achieve your goal. You need to make the best marketing decisions possible to maximize the return on your investment. Evaluate marketing decisions, such as advertising in the phone directory or conducting a public relations program. Track each initiative and evaluate what worked and what did not.

Step 7: Identify Strategies: Positioning, Product, Distribution, and Promotion

The strategy could include advertising, public relations, direct marketing, promotions, and events. Select the strategies that work best for what you wish to achieve. Look into traditional media, such as newspaper ads, TV, and billboards. Explore nontraditional options, such as sponsorships, ad specialties, shows/events, electronic media, and the Internet. Be creative. Do not rule anything out.

Step 8: Utilize the Marketing Budget

Determine tactics and list specific action steps needed to achieve each strategy, including deadlines.

Step 9: Establish Timing

Establish a specific timetable for each tactic in your strategic plan. Implementing a tactic at the wrong time could result in failing to meet your marketing objective.

Step 10: Conduct an Evaluation

Measure the results of marketing efforts on an ongoing basis, using devices like ad codes, call-in logs, and reply cards (if the budget allows). Evaluate at the end of the year to see if the results matched your stated goals (2).

APPROACH

For the division, we did not have the money to start a huge ad campaign or to run TV commercials, but we could create an online presence unlike any other at University of Florida Health System. The goal of the strategic plan was to get our product and services out to patients, referring physicians, future fellows, and potential faculty through a website and social media.

Social Media

When I asked my division chief for permission to create a social media campaign, his reply was, "Why in the world would you want to do that?" but he agreed. Our division's marketing team developed a social media enterprise. Our marketing team set up a Google Hit Search. We sent a list of key words to Google to guarantee that our website would be featured on the first page of the search. The goal of your website should be to entice patients, faculty, colleagues, and future fellows and faculty with useful information about the program. Once we established our new website, we then expanded to all of the available social media outlets. You can find University of Florida Nephrology on Facebook, Twitter, LinkedIn, Instagram, and Pinterest. We post information about our division on each of these sites every day.

Insignia

The next marketing piece I implemented was more challenging. During my time in the military, I was around rank insignia and patches that everyone proudly displayed on their uniforms. My goal was to draw from that military tradition and create a patch that all of my faculty could display proudly on their white coats. It was not easy convincing the faculty to put a patch on their coats, but once we did we immediately saw a greater camaraderie among faculty, mid-levels, and fellows.

Collateral

The final marketing strategy implemented was a first from any division at University of Florida Health System. I took a look at how many guests and candidates came through our doors each year. Between visiting professors, guest speakers for grand rounds, faculty candidates, fellowship candidates, and guests, we had approximately 80 visitors every year. I created a gift bag filled with nephrology-branded swag that we created ourselves: T-shirts, water bottles, pens, markers, lanyards, and information about our outstanding program and amazing city. Now these candidates or guests take a little piece of marketing with them. Whenever they wear the shirt out—even if it's just to the gym—these individuals are the division's marketing outlet.

RESULTS

What did these marketing initiatives accomplish? For fiscal year 2013, nephrology moved up four spots in the national rankings; we finished in first place in the department of internal medicine financially; our new patients increased by 26%; in 2014, we matched all four of our nephrology fellowship spots after interviewing only 12 candidates, and moved up nine more spots in the national rankings to put our division in 25th place in the nation and second in the state of Florida. We are an ever-growing division: we hired two new faculty members this year, and my chief and I have set forth an aggressive plan with six new expansion initiatives that we hope will take our division to the next level. Our great team has done an outstanding job; however, there is still a tremendous amount that can be done at many levels.

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