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Impressions from the Annual Meeting of Principal Business Officers of the GBA
Austin, TX, September 8-10, 2011

The AAMC's Annual Meeting of Principal Business Officers (PBO) was held in Austin Texas on September 8 to 10. Members of the Group on Business Affairs, these are the executive administrative leaders of member institutions (135 at last count) whose primary responsibility is the highest level of overall management of the business of academic medicine. Their areas of accountability are broad and comprehensive, including but definitely not limited to: finance and general accounting; clinical and research administration; human resources management for faculty and staff; communications and information technology; infrastructure and physical operations; space and resource allocation; and of course strategic planning for all of the above. They are advisors to Deans, Chancellors, and Chief Executive Officers.

When they convene, the PBOs are most likely to want to share and learn about what issues are current, and what their peers are up to. What's working, what's not, where are the next roadblocks, who has found ways to navigate around them? It is a lively meeting, with passionate conversations and deeply engaged participants.

It's important for us as human resources professionals to pay as much attention as we can to the issues that are of concern to our PBOs. First, they are in most cases our bosses! Second, they should be able (and willing) to rely on us to help with the planning and communications strategies that will affect our faculty, staff, post docs and students. What I have observed as I attend these meetings is that there is truly no area of responsibility owned by this group that does not touch on or feel the touch of the people who make the institution "go". In fact, almost every conversation – formal or informal – comes around to human resources concerns at some point in the discussion.

Following is a brief summary of the plenary presentation and even more brief comments on the other presentations at this year's meeting. I listened and took notes through the filter of the human resources issues, and with the intention of providing information about the topics that are currently of concern to our administrative leaders; it is my hope that these notes might help you help your PBO, through planning, staffing, communication, or program development.

The Plenary Session of September 8 was presented by ***Dr. Kenneth I. Shine, Executive Vice Chancellor for Health Affairs for the University of Texas System***. His topic was a discussion of whether there is now a fundamental shift occurring in the economic model for our institutions, or will things will go back to "normal"? The underlying question in this presentation was, "... what should PBOs be advising deans about future strategic directions?"

Dr. Shine believes that this new direction is not a bump in the road, but rather a sea change in the ways in which we will be expected to provide clinical care and educate doctors. His thoughts were presented as four main themes that illustrate a "now versus soon" view of the economics of academic medicine and clinical care in particular.

First, we are likely to move from process centered care to outcome centered care. In this model, even compensation would be tied to critical clinical outcomes. Outcomes will be measured in terms of their cost effectiveness, and their efficiency within an entire system, not in terms of number of cases, cost of individual tests, or one off treatment plans.

Second is what Dr. Shine referred to as a move to "consumerism". Clinical models will be patient centered rather than doctor centered. There may be one physician leading a team comprised of nurse practitioners, physician assistants, and other clinical personnel assigned to one patient. More treatment will be virtual, with phone and electronic communications replacing face to face consultations. There may even be some penalties when outcomes are unsatisfactory to those monitoring their success. From the HR standpoint, this might mean more training for faculty in managing and participating teams, more flexible and creative means of determining compensation, and hard work in helping breaking down existing silos and territorial blocks. The third expectation is that there will be a shift of focus from treatment to prevention. Most chronic medical problems are the result of behaviors that are unwise or unacceptable. New alliances will be formed and preventive care may indeed come not from the medical center, but the psychology or sociology department. This will require more participation from public health professionals, and perhaps partnerships with those institutions. Medical education will have to include teaching our students more about prevention and group health strategies along with the individual disease treatments they currently learn. Insurers already know that over time, prevention within population groups is more cost effective than treatment of individual symptoms related to common diseases.

The fourth point is related to the second -- "bundling" costs for some continuum of care with a team approach means that one fee may be split between several professionals, including surgeons, anesthesiologists, and nursing staff. The current model is "piecework" – each professional department bills and is paid individually. And costs for care may be structured in the future so that there is not as big a piece of the pie for each team member. This can mean that some team participants will vie for position in the group cost – one believing she deserves to be paid first, most, soonest, etc. Again, there are many inherent HR issues here.

What are the biggest challenges related to these changes? Our current environments are "viscous" – slow to flow, and hard to see through. We'll need to work on the "transparency" that is a plea from nearly every employee engagement survey ever conducted. Public health and medicine will need to become more aligned than ever before – perhaps even partners where it makes sense in urban or environmentally disease prone environments. Territorial wars may follow, and research funding will be more competitive than ever, with scarce funds going to innovators rather than "name brand" institutions.

With an increased focus on performance outcomes and efficiencies, there will be a real need for strategic thinking in HR about performance appraisal, compensation evaluation, and leadership

training at a level we haven't yet experienced. Consolidation of functions and institutional alliances present HR issues that will come to the forefront – assuming they're not there now. Where does this predictive discussion lead us? The most pressing need, according to Dr. Shine, is a galvanization of the imaginations of staff and faculty in helping to address the challenges to status quo, including new economic models, acceptable performance standards, and pending regulatory changes. Do we wait until funders, insurers and regulators tell us what the future will be or do we create it? Are our leaders prepared to deal with the pressures in a more aggressive way or will it be business as usual until a damaging crisis occurs? Can we break ourselves out of the model we have and build new ones?

We can – but only with the cooperation, enthusiasm and willingness of the current folk. This is truly a significant challenge for administrative officers and human resources leaders as well.

Another presenter at the meeting was ***Dr. Arnold Milstein, Professor of Medicine, General Internal Medicine, Stanford University School of Medicine***. Dr. Milstein is the ***Director of Stanford University's Clinical Excellence Research Center***. He discussed Stanford's new ambulatory care ICU and the potential for designing other new models of clinical care to address productivity in response to the current climate of cuts to health care costs.

A panel of administrative leaders presented information on their experiences and plans for developing physician networks. They were: ***Brian David, Vice Chair for Finance and Administration, Department of Medicine, and Martha Hooven, Vice Dean for Administration, both from Columbia University College of Physicians and Surgeons, along with Shawn Sheffield, Assistant Vice Chancellor for Resource Strategy and Planning at the University of California, San Diego School of Medicine.***

This group presentation and panel discussion stressed the need for administrators to be firm and consistent in messages about purchases and acquisitions. "Tell versus sell" was a strong theme; if a decision has been made, statements should follow that clearly and directly lay out the outcomes and projections for new partnerships and mergers.

An important point of discussion was that the high cost of medical education is high and rising. Yet it is almost impossible to pass the cost along to students whose debt burden on graduation is staggering. Most schools pay med ed by internalizing the expense (merging the budget for education within administrative overhead costs.)

Making the curriculum relevant in the changing environment of research and clinical care may mean that curriculum reform or redesign is required. The panel strongly recommends involving the faculty from the earliest stages of this process.

Medical education innovation was the subject of a talk by ***Timothy Brown, Associate Chief Financial Officer of the Indiana University School of Medicine*** and ***Jim Erickson, Executive Director of Financial Affairs from Johns Hopkins University School of Medicine***. Their key point was that it is vital to engage the faculty immediately in any efforts at curriculum change and design. They stressed that human resources concerns such as the stress of administrative and

academic realignment and/or political or cultural roadblocks to be navigated were of primary import in ensuring the success of their programs in innovation.

One of the most popular sessions was presented by ***Sally Rockey, Deputy Director for Extramural Research at the National Institutes of Health***. Dr. Rockey talked about the impact of the biomedical workforce on costs and recruiting. She said that a relatively small percentage of schools receive a large percentage of NIH funding. Of note for human resources is the fact that there are changes in the works relative to the potential for limitations on grant amounts for those with support for more than one active grant. Also, she discussed the new regulations concerning gifts to researchers from industry, significant changes in the requirements on reporting conflicts of interest, and the drop in allowable outside financial interest from $10,000 to $5,000, beginning in 2013.

Another point of interest from Dr. Rockey: a new patent law was passed in early September that may change the concept of who owns intellectual property. The past concept was ownership by the "first to discover". With the new law, the ownership accrues to the "first to file". There may be some tortoise and hare issues here – a faculty member who might be buried in work doesn't file and another scientist who is quicker off the mark may win rights to intellectual property. These are complex issues which may be of indirect HR impact. We all would do well to seek out the advice of our finance and research support leaders to better understand near and longer term implications (if any) of these impending changes for our own institutions.

Finally, the last official presentation of the meeting was titled, "Medical School Chair and Department Administrator Accountability". Presenters were ***J. Scott Gibson, Executive Vice Dean for Administration at Duke University School of Medicine***, and ***John F. Manning, Associate Vice Chancellor for Health Affairs/Chief Administrative Officer/Senior Associate Dean for Operations and Administration at Vanderbilt University School of Medicine***. This presentation focused on the use of scorecards, metrics, and evaluative tools to compensate and promote academic and administrative leaders within departments at two different schools. Metrics, Mr. Gibson said, create a lot of noise in the system. People look at them, dissect them, and comment on their relevance and merit. But they do create a platform for discourse about effectiveness and efficiency, both for the faculty and for the administrator. It is important for everyone who has a stake in this to be part of the planning and part of the analysis, too.
Dr. Manning talked about organizational goals as being the drivers for individual goals and objectives. Vanderbilt names these "Pillar Goals", and they drive the expectations for all departments. To make it easier for individual planning, there are about 17 published goals or objectives from which the person chooses 5 to 8 annually. All are tied to the Pillar Goals, and all have some measurable assessment.

Discussion was lively, and many PBOs were extremely interested in whether or not behavioral changes and improved outcomes in performance were realized. What was the answer? Yes. No. They were and they weren't, and as with all such programs, time will tell.
One of the most important outcomes of a meeting like this is that there are opportunities for participants to share stories. This kind of experiential learning is valuable both as a planning tool and a pressure release valve. One fine example of these "dialogue streams" was discussion of the creation of different faculty tracks that might reward clinicians and researchers who are non-

teaching in the classical sense, whose contributions are crucial, but who might currently feel undervalued within traditional tenure track appointment systems. Some working models and suggestions included such things as creating separate clinical and research tracks that are non-tenured but "benefitted." Perhaps non-tenure track faculty might be paid more or be given longer-term contracts. Others are thinking about creating an "educator" track. Community based docs are external to the academic tracks but need to feel like part of the faculty system in any case.

There were many more moments like this on topics that were acknowledged to be "keeping us awake at night." Time to vent, time to share, time to reflect, and time to review—these are the goals of meetings like this one.
If you would like more information, you might start with a conversation with your own PBO, or his associate, or her assistant. These are challenging and fascinating times for our work and our workplaces. Stay in touch, in every way you can!

Comments or questions?
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