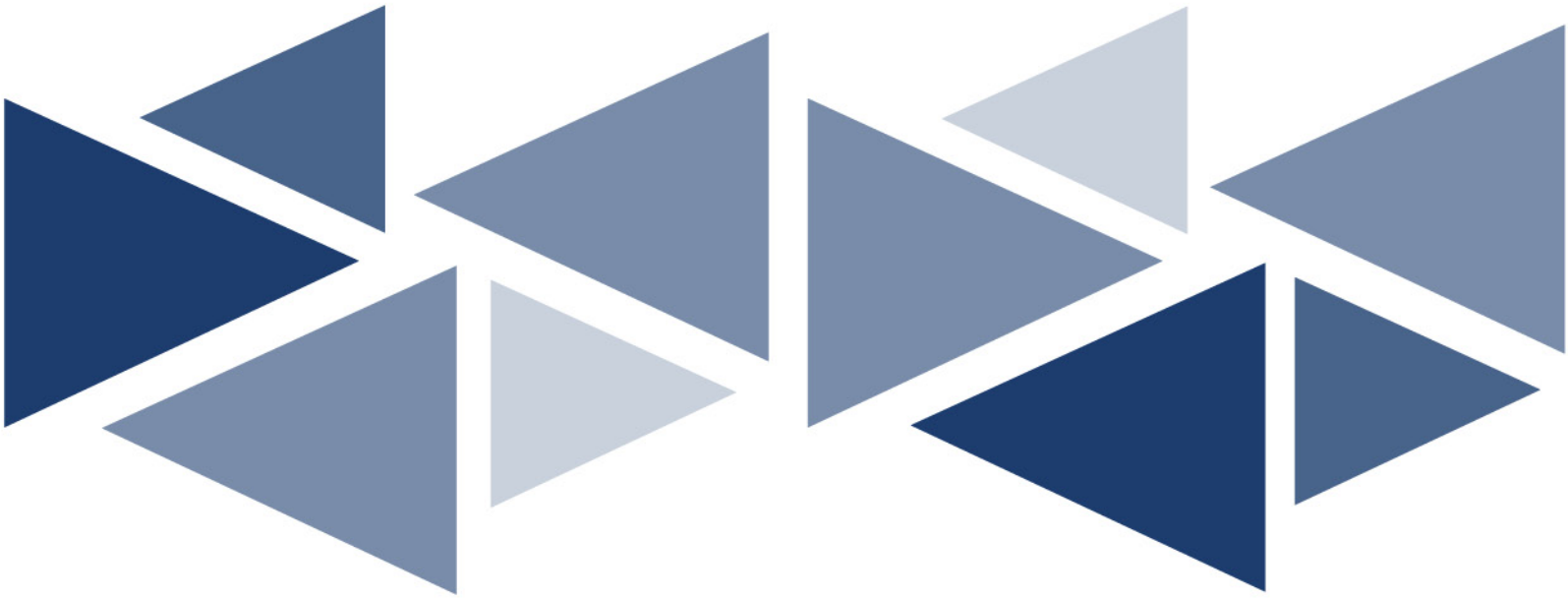
Funds Flow Deep Dive

Notes from the World Café Discussion at the 2023 Principal Business Officers' Meeting

AAMC Group on Business Affairs (GBA)



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AAMC Group on Business Affairs (GBA)
September 20-21, 2023
Westin Bayshore, Vancouver
Vancouver, BC, Canada

This document was created by the Group on Business Affairs and is intended to provide a summary of the World Café discussion at the 2023 Principal Business Officers' Meeting around funds flow. All content reflects the views of the meeting participants who participated in the World Café discussion and does not reflect the official position or policy of the AAMC unless clearly specified. This document should not be cited as an official AAMC publication.

For questions, please contact GBA@aamc.org

September 2023

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Notes from the World Café Discussion at the 2023 PBO Meeting

Background

The AAMC Group on Business Affairs (GBA) Principal Business Officer (PBO) meeting was held September 20-21, 2023, in Vancouver, Canada. The PBOs, who are the senior finance and administrative leader at AAMC member medical schools, convene annually. PBOs are permitted to bring one colleague to the conference. There were 81 attendees at the 2023 conference from 53 schools.

The first day of the conference focused on funds flow in transition. The first session featured two schools and their funds flow models; what keeps the PBOs up at night as it relates to funds flow in the current environment; where are there sources of concern, opportunity or both; and how do schools balance their research and education missions given additional pressures on payment mixes.

Following the formal presentations, there was a World Café deep dive where PBOs responded to three different questions and scenarios. Each table was assigned one of three questions. There was a moderator and note taker at each table. After 30 minutes, participants rotated to a different table. Below are high level notes from these discussions.

Notes from the Discussion

Question 1

Acknowledging the pressures on health systems, what is a reasonable approach to have a portion of the hospital margin support medical school needs? How do we make the case for what we need now, not necessarily what we have needed and received in the past?

- ***How do we align incentives to achieve common goals (without settling for a basic wRVU support model)?***
- ***How can we work with the health system to address the inefficiency and associated costs of care delivery in an AMC?***
- ***How can we develop a shared culture of sunsetting historical deals in favor of utilizing resources for progress or growth?***

Overall alignment:

- Shared mission, but keep your own identity
- Follow and align your strategic plan
    - Know that it's ok to say no
    - Hires should align with strategy, not opportunity
    - Communication is key
- Alignment of research priorities and areas of synergy
- Develop agreed core principles

- How do we grow together? Show what a holistic approach requires and the impact on the hospital or the overall health system
- Agree on deliverables
- Align specific financial goals such that faculty are incentivized to help create revenue or reduce expenses to realize improvements in margin, which is then shared.

Data

- Demonstrate, via data, the value proposition of being an academic medical center that's associated with a medical school
- Integrated data and shared data governance
- Leverage rankings for key areas for collaboration
- Agree on metrics to define and demonstrate value

Environment and Culture

- Aware of financial markets and where there can be cost reductions and savings
- Buy-in from the hospital to invest in the academic mission
- Halo effect of robust research, which can bolster reputation and brand enhancement
- Value proposition and make the case in the investment
- Aligned leadership and governance to make it sustaining – what are the core principles?
- Academic pay does not equal clinical subspecialty pay – how do you engage clinicians?
- Mission(s) are important – what will resonate with the health system?

Question 2

What are ways to rethink the academic medicine tradition in which all faculty participate in multiple missions?

- ***How could we address the increasing need for predominantly or even solely clinical faculty? What problems would that solve?***
- ***What are the pros and cons of moving away from multi-mission faculty?***
- ***What is the importance of faculty spending effort on activities that aren't funded by external operating revenue or extramural funding sources (clinical/professional fee revenue, sponsored awards, contracts, student fees, state support)? Can you catalog why you pay faculty for this institutionally funded effort?***
- ***If you have a cFTE formula, does it include some of these institutionally funded efforts? If not, why not?***

Community providers – many different approaches

- Increase in the state
- Not required to participate in all of the missions if not at main campus
- Hired by the health system but not considered faculty

- Purchasing practices in the community and eligible to be faculty even if at the community hospital
- Debate over whether to call community health providers 'adjunct' (part-time) or 'affiliate' – there was push back
- Heavy investment in cFTEs in the community to be more engaged in education and research. If they don't feel integrated into the department, it may not be successful

Other considerations

- UGME funding models – new model investing in educators; departments can subsidize
- Classic model – research track; clinical track (more growth opportunity); tenure track; looking at shifting to a community model. Triple threat is no longer an efficient model, unlike focusing on solely clinical, education and research
- Clinical mission makes a margin – the more clinicians you hire, the more funding for education and research
- Public school system – therefore, a commitment to the community to provide the same level of access to care
- Need to be clear on expectations and transparent – why are profits subsidizing other missions? Show how everyone benefits.
- Educating partner hospital and health systems around the different cost of FTE, clinicians versus academics.
- Growth and sustainability of the research portfolio requires a clinical balance
- School should be the triple threat – not the individual -it's not realistic for individuals to achieve the triple threat. Research and education are more attainable in some cases. Centers of Excellence have research and clinical leads but not education and, in some cases, basic science departments are being converted into centers of excellence. This promotes thinking and working in a team environment.
- Should every school pursue a research mission?
- Do all physicians have to be faculty?

Recruitment and Employment Considerations

- Academic tenure track
- One paycheck versus two paychecks from the practice plan plus the university
- To be considered a 'researcher' – you need to have 20% of your time dedicated to research; however, many are moving away from research
- Titles: Clinical assistant professor versus clinical associate professor
- Hard to recruit researchers without a strong clinical presence. Larger research organizations are out of balance and need to grow clinicians. It's rare to be a triple threat (strong in education, research, clinical)
- Also competing with private practice and other health systems
- Competing with other schools who want to grow their research portfolio and get higher research rankings

- How to define an FTE – is it 40 hours or total hours worked? There's tension around this and if you take on an additional 10%, do you just work more or do you deduct from 40 hours
    - Departments define FTEs differently
- Challenges – faculty without enough cFTE who need to be paid; if you have a cFTE formula, does it include institutional funded effort?
- Pros/cons of multi-mission faculty
    - Pros: can't have unfunded research, more efficient
    - Cons: less translational
- Clinical educator faculty
    - Easier to hire than those with time for research too
    - Positive – better patient satisfaction scores
    - Could yield better research when you hire researchers in clinical departments
    - Often clinician educators or staff physicians are paid more but feel second class; yet have the highest patient satisfaction.
- Different models:
    - Create staff position for satellite sites. Work as community providers. Negative – 2 tiers of faculty
    - Dialogue around researcher salaries versus clinical providers versus community physicians. Still salary inequity issue perception
    - Engage with community physicians – encourage operating with residents/fellows on campus to reignite the flame
    - Fear that the interest in engaging in education mission is declining
    - Clinical educator track – issues with time for this commitment being stolen by clinical duties. Protected time not really protected
- As RVUs decrease with age/physical ability, engaging faculty through director and admin roles to subsidize compensation.
- More affordable to recruit residents who train within the same system. Coaches for residents – career versus job. Long-term versus more short-term. How to educate the younger generation.
- How to incentivize/recruit/retain new faculty. Set up incentive plans for all roles. Centralized compensation with targets. Rewards and penalties realized. Caps on how much you can earn

How do you also ensure research success?

- Compensation plan supports performance
- Defining research for your organization
- Collaboration between clinical and basic science departments
- Allow a time period of unfunded research to be grown
- Don't push lower productive faculty to be educators
- K awards versus time back to clinical
- Ask the hard questions – set goals and evaluate K awards
- Support (needs to be well resourced) for clinical science

Question 3
You are 5 months into your fiscal year and your operating budget plan is on target to meet the balanced budget goal. You receive a call from your dean communicating that university executive leadership will reduce your transfer for the remaining 7 months by 25%. How do you approach this operating budget reduction?

- ***What are some assumptions for achieving this reduction?***
- ***Where can you consider new revenue sources to make up this gap?***
- ***Where can you possibly cut to make up this gap?***

Understand the purpose of revenue and purpose of your expenses

- Efficiency of resources – review. What is committed?
  - Productivity of faculty (basic science departments)
  - Accountability
  - Off campus
  - Furlough staff
  - Different tracking tools
  - Salary shifts
  - Overhead
  - Compensation plan that caps at levels
  - Engagement
  - Reserves – what's available
  - Staff vacancies
  - Pay cuts
  - Benefit reductions
  - New revenue sources
  - Encourage group practice think, not departmental
  - Adaption of start-up utilization
  - Office space, especially if faculty aren't present
  - Show integrated financial statements – transparency

Consider temporary adjustments

- Hospital partnerships (increase funds flow, increase gap)
- Use state reserves
- Use other reserves
- Personnel (always suffers)
- Unfunded research
- More clinical work for physician scientists
- Programmatic review
- Outsourcing
- Ideas to the community (idea generator)
- Rework commitments

- Leadership compensation (temporary reduction)
- Scholarship
- Perks
- Phased in faculty compensation
- Space subletting
- Staff effort (grant funding) = Indirect Costs
- More transparency
- Delay of projects
- Hiring freezes, then have committee review and slowly reintroduce vacant positions
- Can practice plan assist?
- Administrative supplements
- Review incentive plan and rules of engagement
- Have departments consider solutions
- Line of credit
- Release/cancel leases or re-negotiate payments
- Stop overtime
- Review recharge rates
- Renegotiate support services
- Food at meetings
- Cut in incentives
- Partner with other simulation centers

No reserves?

- Voluntary furloughs
- Is additional endowment distribution feasible
- What clinical services might we need to stop funding
- Reprioritize the mission – what is needed?
- Reduce the number of residents
- Start a masters program
- Increase enrollment
- Create new clinical partnerships/purchase a hospital
- Shared services
- Early retirement incentives

Key points

- Communication is key – departments, faculty and staff need to know
- Hiring freezes delay the inevitable – people do 2 or 3 jobs, burnout, then leave. Consider other alternatives
- Needs to be across the board and everyone treated equally
- Charge a committee to review aspects of the budget in order to get buy-in

- Not just a finance problem but a leadership program

Consider an "Operational Efficiencies" initiative

- Red, yellow, green buckets
- Not going to fix everything in six months but this can drive long-term monitoring and enhancements
- Defining what is "core" – leadership agreement that it has to be funded fully – everything else has to be reconsidered; needs to be thoughtful on how to be sustainable