GBAnalytic #17

Insights from the Faculty Effort Assignment Definitions Survey

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Faculty Effort Assignment Definitions Survey

Introduction

The Data and Benchmarking Committee of the AAMC Group on Business Affairs (GBA) designed the GBAnalytic #17 survey to better understand how institutions, departments, or work units define and assign faculty effort across missions. The survey specifically gathered information on how a 1.0 FTE faculty role is defined, whether effort is categorized by mission, and how institutions monitor or report faculty effort.

The following summary of findings offers a national snapshot of current practices and emerging trends that can support benchmarking and peer learning.

Methods and Definitions

The GBAnalytic #17 survey was distributed through Verint to all members of the GBA. As the survey was open to respondents at both the dean's office and departmental levels, multiple responses from a single institution were possible. To ensure consistency in responses, this survey was structured around four core mission areas that applied regardless of funding source and were defined as follows:

Teaching & Education includes teaching, grading, course preparation, developing new curricula, advising, or supervising students or residents (non-patient care), working with student or resident groups (non-patient care).

Research includes research, reviewing or preparing articles or books, attending or preparing for professional meetings or conferences, reviewing or writing proposals, seeking outside funding.

Clinical Service & Patient Care includes medical service including patient care with resident, fellows and medical students, counseling patients or families, and administrative tasks associated with clinical service.

Administration includes university, medical school, health system, faculty practice or department administrative duties, meetings, and committee work.

Results

Overall Participation

Overall, 74 surveys from 68 U.S. medical schools were included in this analysis. Of the 68 schools, 30 (44%) were public, 26 (38%) were private, and 12 (18%) submitted a completed survey without providing identifying information.

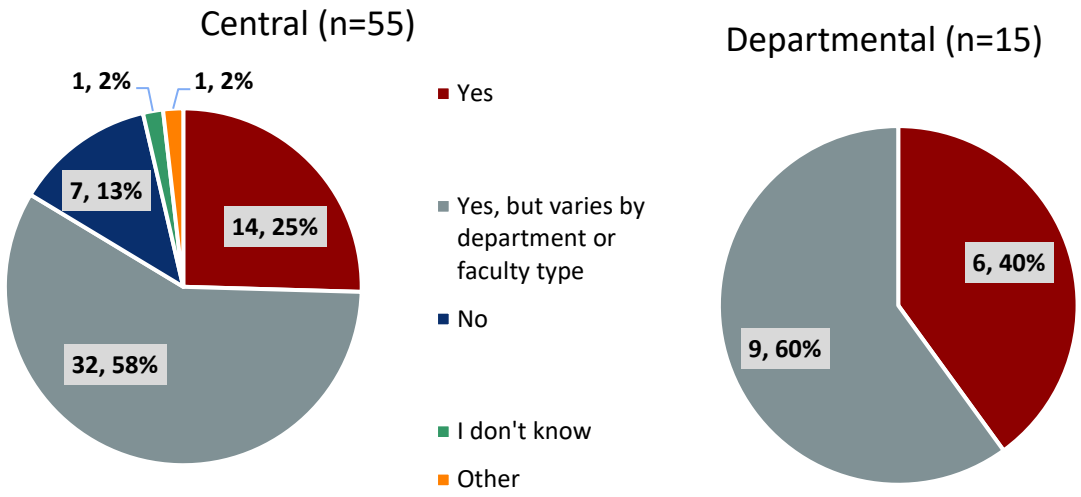
Participants were first asked to indicate their role and institutional location, which determined how subsequent results are organized. Of the 74 respondents, 55 (74%) identified as "Central Office (Dean's office, central administrative service, etc.)", 15 (20%) as "Department/Division", and 4 (6%) as "Other". No respondents selected "Academic Center/Institute".

The results below compare responses from those who identified as “Central” or “Departmental”. The four respondents who selected "Other" are excluded from the main analysis. Their responses are included in Appendix for reference.

Central and Departmental Responses

Q2: Defining 1.0 FTE

Among central respondents, 46 of 55 (84%) reported having a defined expectation of what constitutes a 1.0 FTE for faculty effort or productivity purposes, with most indicating this definition varied by department or faculty type. All 15 departmental respondents similarly reported having a defined 1.0 FTE expectation. Notably, 7 of 55 (13%) central respondents reported no defined expectation.



Figures 1 & 2. For faculty effort or productivity purposes, does your institution, department or work unit have a definition of what a 1.0 FTE faculty member is expected to work?

Central free-text responses for “Yes”:

- FTE is equal to 40 hrs per week, 2,080 hrs per year
- 27 or more hours per week teaching students and/or residents at the school or any of its affiliated institutions, and/or in research or clinical services activities within the institution
- 44 weeks

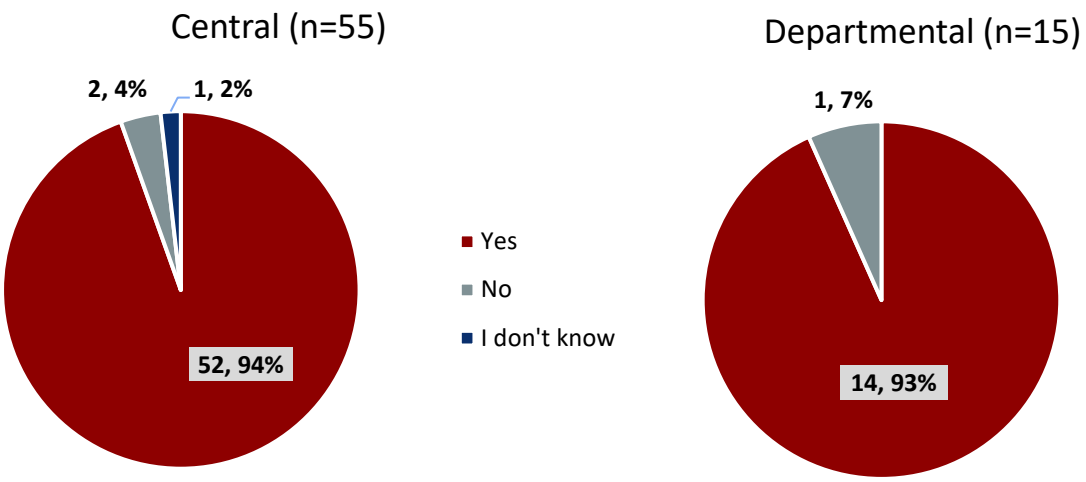
- 50 hours per week or 10 sessions per week for 46 weeks per year, APPs are 48 weeks per year; if faculty do more than 50 hours per week, they cannot be more than 1.0 FTE. Some specialties, like hospitalist and Emergency Medicine have shifts requirements
- Employees who are regularly scheduled to work 30 or more hours per week are considered full-time employees. Most full-time University employees work 37.5 hours per week
- Full-time is 37.5 hours per week
- We treat 1.0 FTE as a 40-hour week; the issue is defining clinical FTE, which can vary by department

Departmental free-text responses for "Yes":

- 40 hours per week
- The Department of Emergency Medicine has specified expectations for annual clinical hours per year for academic and community phenotypes
- Yes, we have a 1.0 doing 36 hours of patient facing time and 4 hours administrative

Q3: Categorizing Faculty Effort by Mission

Greater than 90% of both central and departmental groups indicated their institution, department, or work unit categorized faculty effort into mission categories.



Figures 3 & 4. Does your institution, department or work unit categorize faculty effort into mission categories (i.e., education, research, clinical, administration, or other)?

Q4: Faculty Effort Categorization by Mission Area

Among the 52 central respondents who answered "Yes" to Q3, 90% or more reported categorizing effort across all four missions: research, teaching, clinical, and administration.

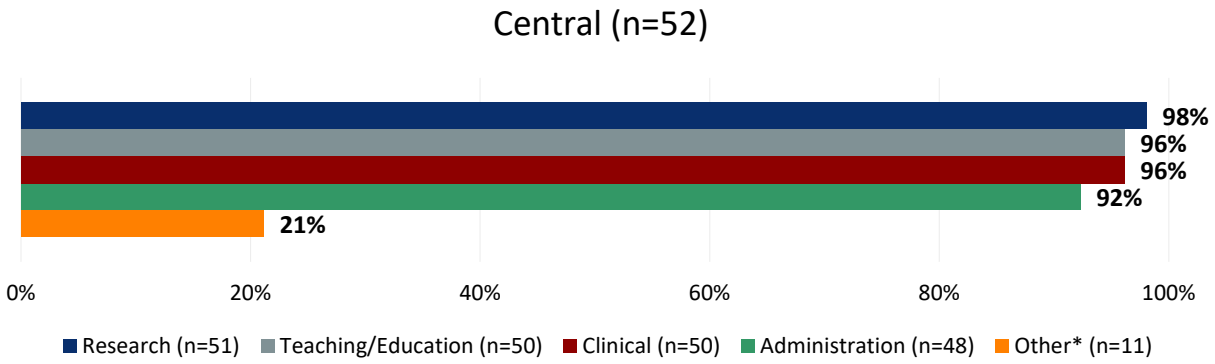


Figure 5. Faculty Effort Categorization by Mission Area (select all that apply).

*Other mission categories included: affiliate activities, citizenship, community or public service, contract labor for FTE purchased by external entitites, hospital specific administrative roles, services (broadly), and other strategic areas.

Among the 14 departmental respondents who answered "Yes" to Q3, 90% or more reported categorizing effort across research, clinical, and teaching missions, while a slightly lower proportion (86%) reported doing so for administration.

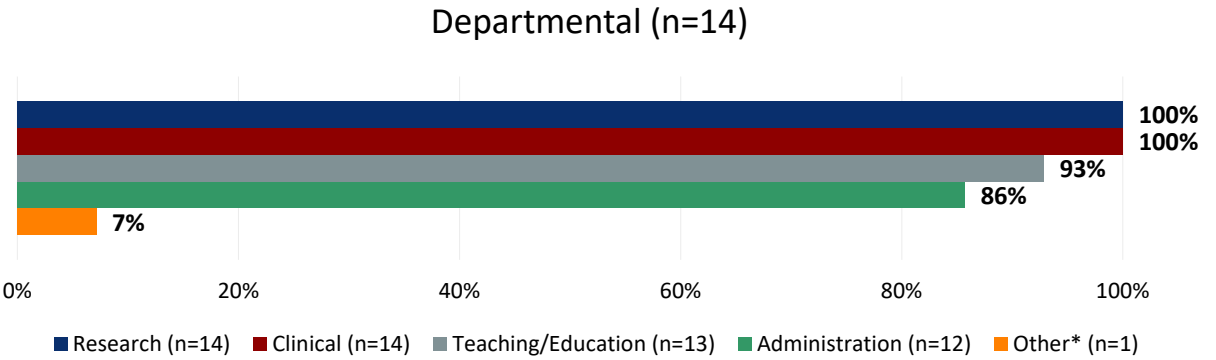


Figure 6. Faculty Effort Categorization by Mission Area (select all that apply).

*The other mission category identified was “community engagement and global health”.

Q5-7: Gathering, Monitoring, and Reporting Faculty FTE

Among central respondents, 48 of 55 (87%) confirmed they gather, monitor, and/or report faculty FTE across different missions, primarily through spreadsheets from departments, home-grown/web-based software, and mission-based salary funding.

For those reporting faculty FTE through methods other than mission-based salary funding, annual reporting was most common among central respondents (53%), followed by monthly or quarterly (21%), bi-annual (12%), and other methods (9%), the latter of which included bi-annual effort certification and monthly FTE reporting.

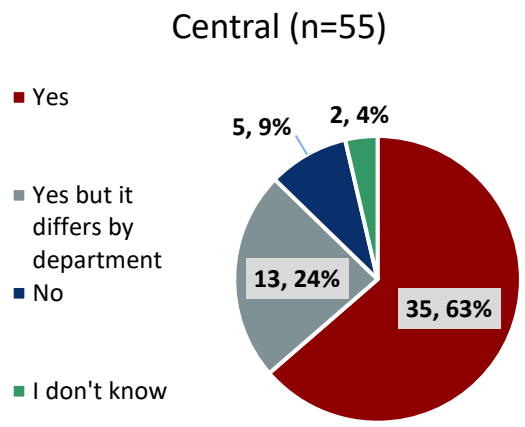


Figure 7. Does your institution report faculty FTE across different missions?

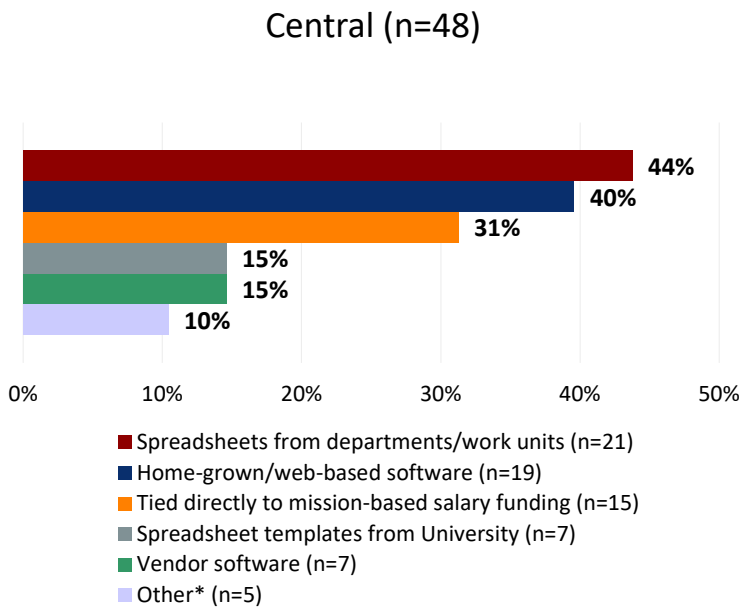


Figure 8. How does your institution gather, monitor, and report faculty FTE across missions? (select all that apply).

*Other methods for reporting include data uploads to a BI tool, pay codes costed by mission within an ERP system, payroll integration, and capture via Anaplan.

Among departmental respondents, all 15 confirmed they gather, monitor, and/or report faculty FTE across different missions, primarily through spreadsheets from departments, mission-based salary funding, and spreadsheet templates from the parent university.

For departmental respondents reporting faculty FTE through methods other than mission-based salary funding, monthly reporting was most common (36%), followed by bi-annual (29%), annual or quarterly (21%), and other (7%), the latter of which included real-time reporting as effort changes.

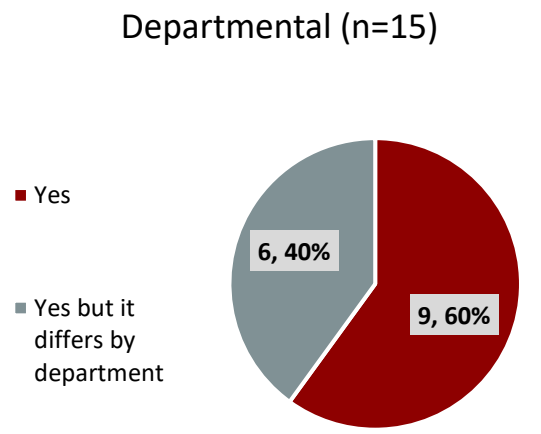


Figure 9. Does your institution report faculty FTE across missions?

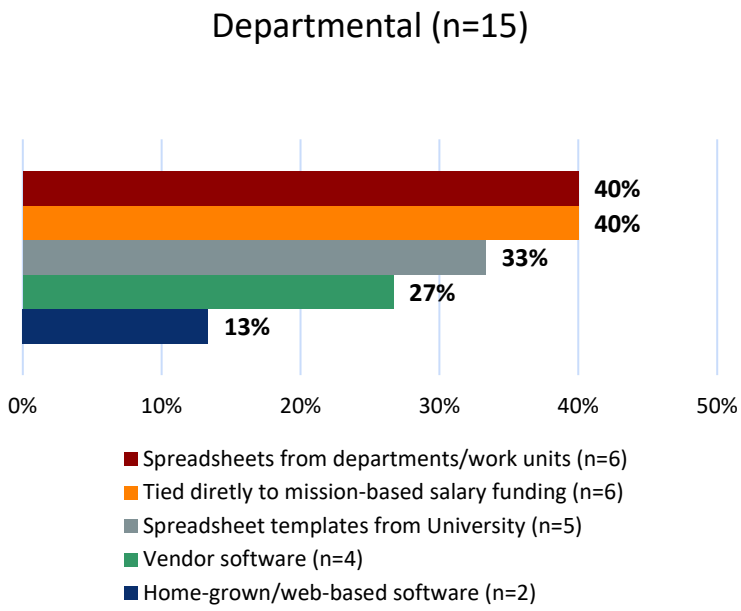


Figure 10. How does your institution gather, monitor, and report faculty FTE across missions? (select all that apply).

Takeaways from questions 5-7:

Both central and departmental respondents most commonly relied on department-level spreadsheets and mission-based salary funding to gather, monitor, and report faculty FTE across missions. Central respondents showed greater adoption of home-grown or web-based software compared to departmental respondents (40% vs. 13%). Reporting frequency also differed, with central respondents predominantly reporting annually (53%), while departmental respondents were more evenly distributed across intervals, with monthly reporting being most common (36%).

Questions 8-11 were visible only if a respondent selected "Clinical Service/Patient Care" on question 4 categorizing faculty effort into mission areas.

Q8-11: Clinical FTE Structure, Determination, and Standard Adjustments

For the central group, 42 (86%) respondents confirmed that regarding faculty effort and productivity, they have a standard structure for clinical FTE (cFTE), with a relatively equal distribution in how cFTE is determined.

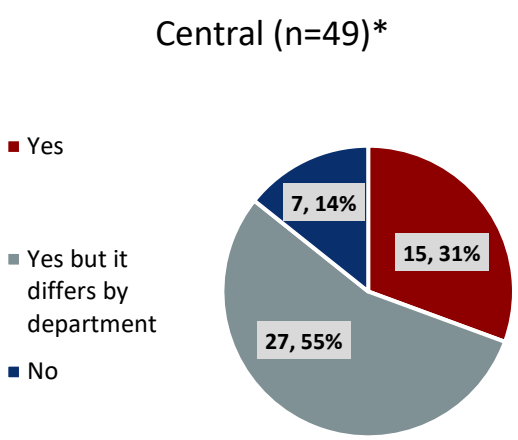


Figure 11. For faculty effort and productivity purposes, does your institution have a standard structure for cFTE, like sessions, hours, or funding? **Excludes one blank.*

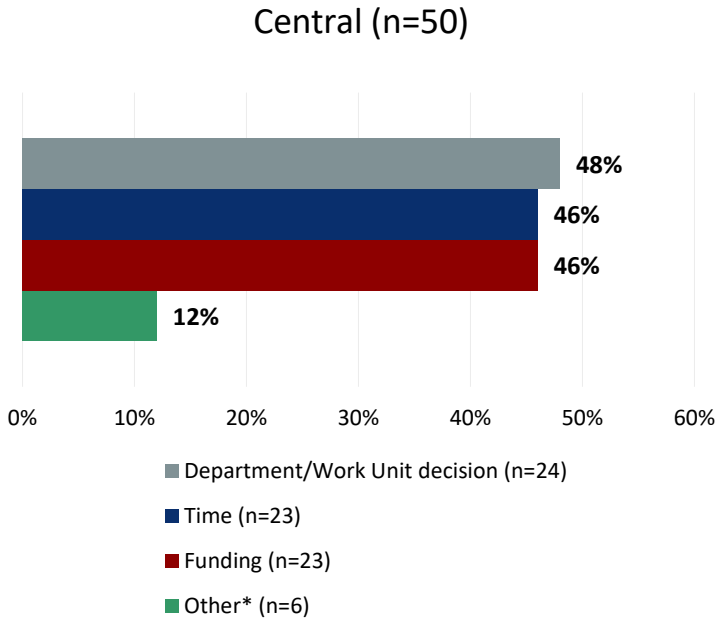


Figure 12. In general, how is cFTE determined (less research, education FTE)? Select all that apply.

*Other responses include:

- All faculty have an annual salary. The four hospital systems use different parameters for productivity metrics including research and clinical research but rank linked compensation program per department. These approaches are not uniform across 4 systems
- Based on agreement with clinical partner
- Defined as the remainder once admin, education, and research FTE have been set
- Funded research also affects the level of cFTE
- It can also be assigned to roles outside the cFTE, even if they are not directly funded.
- The Chair determines clinical effort but allows for research, administrative and education FTE

For faculty effort and productivity purposes, 31 (65%) central respondents indicated faculty's non-patient facing clinical time (e.g., case review, tumor boards, patient messages, patient phone calls) ***was included*** within their cFTE to determine productivity targets, 6 (12%) excluded it from cFTE, and 11 (23%) indicated it varies across departments.

For the departmental group, all 14 respondents confirmed that regarding faculty effort and productivity, they have a standard structure for clinical FTE (cFTE), with a staggered distribution for how cFTE is determined.

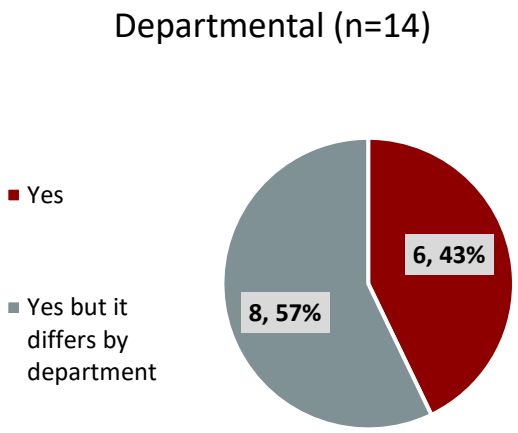


Figure 13. For faculty effort and productivity purposes, does your institution have a standard structure for cFTE, like sessions, hours, or funding?

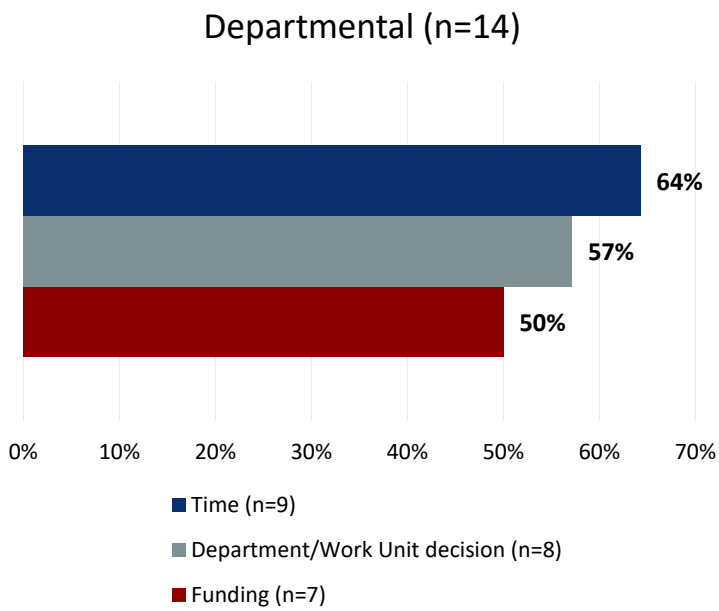
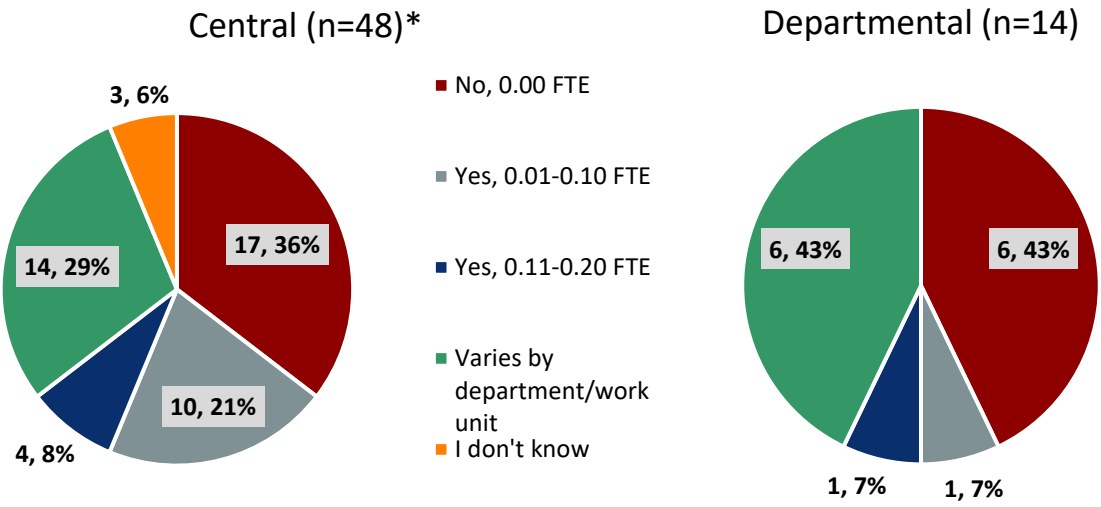


Figure 14. In general, how is cFTE determined (less research, education FTE)? Select all that apply.

For faculty effort and productivity purposes, 5 (36%) departmental respondents indicated faculty's non-patient facing clinical time (e.g., case review, tumor boards, patient messages, patient phone calls) ***was included*** within their cFTE to determine productivity targets, 6 (43%) excluded it from cFTE, and 3 (21%) indicated it varies across departments.

Question 11 asked whether institutions uniformly reduce cFTE from 1.0 for clinically focused faculty. Among central respondents, the most common response was no uniform reduction (36%), followed by variability by department or work unit (29%), and a combined 29% reporting a uniform reduction across the 0.01-0.10 and 0.11-0.20 FTE ranges. Departmental respondents similarly reported no uniform reduction (43%) or variability (43%), with a combined 14% reporting a uniform reduction.



Figures 15 & 16. Does your institution, department or work unit uniformly reduce the CFTE from 1.0 CFTE for faculty effort and clinical productivity purposes? **Excludes two blanks.*

Takeaways from questions 8-11:
Both central and departmental respondents largely confirmed having a standard structure for clinical FTE, with 86% and 100% respectively reporting a defined cFTE framework. The methods used to determine cFTE were relatively evenly distributed across department or work unit decision, time, and funding in both groups.

The most notable difference emerged in how non-patient facing clinical time is handled. Central respondents predominantly included it within cFTE (65%), while departmental respondents were more likely to exclude it (43%). In both groups, a uniform cFTE reduction from 1.0 was uncommon, with "no uniform reduction" being the most frequent response among central (36%) and departmental (43%) respondents, and variability by department or work unit also common (29% and 43%, respectively), suggesting that a standardized approach to clinical productivity expectations is inconsistent across institutions.

Question 12 was visible only if a respondent selected "Teaching/Education" on question 4 categorizing faculty effort into mission areas.

Q12: Education FTE Determination

For central respondents, the most commonly reported methods for determining education FTE were department or work unit decision and regulatory body guidelines, each selected by 54% of respondents.

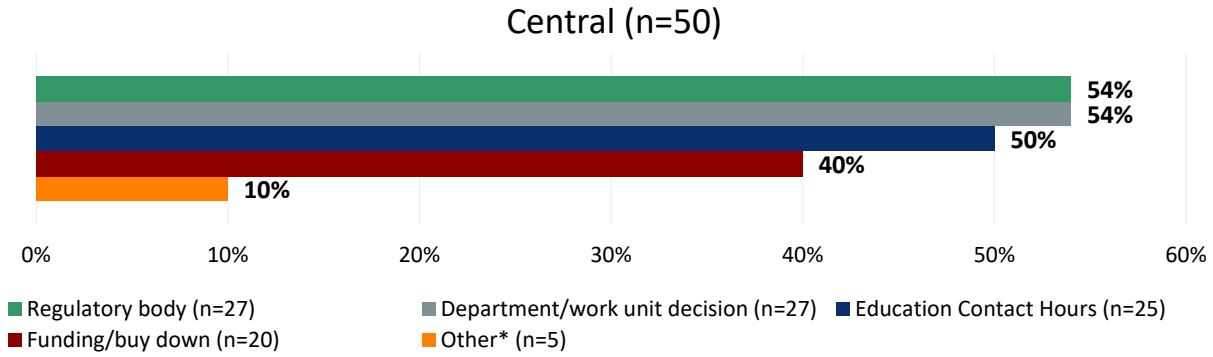


Figure 17. How is education FTE determined/calculated (less clinical and research FTE?) (select all that apply).

*Other methods included:

- Designated by Dean's office (Dean of Education)
- Defined by funding for education leadership roles... or all other 100% clinical faculty have an up to 10% teaching expectation built into faculty handbook/contract
- Through an "Education Cap" where FY25 = $200K & FY26 will = $250K
- We use an 80/20 model: academic and education is fulfilled in that time. This is in addition to buy downs for resident or clerkship direction

For departmental respondents, the most commonly reported methods for determining education FTE were funding or buy-down arrangements (77%), followed by department or work unit decision and regulatory body guidelines, each selected by 69% of respondents.

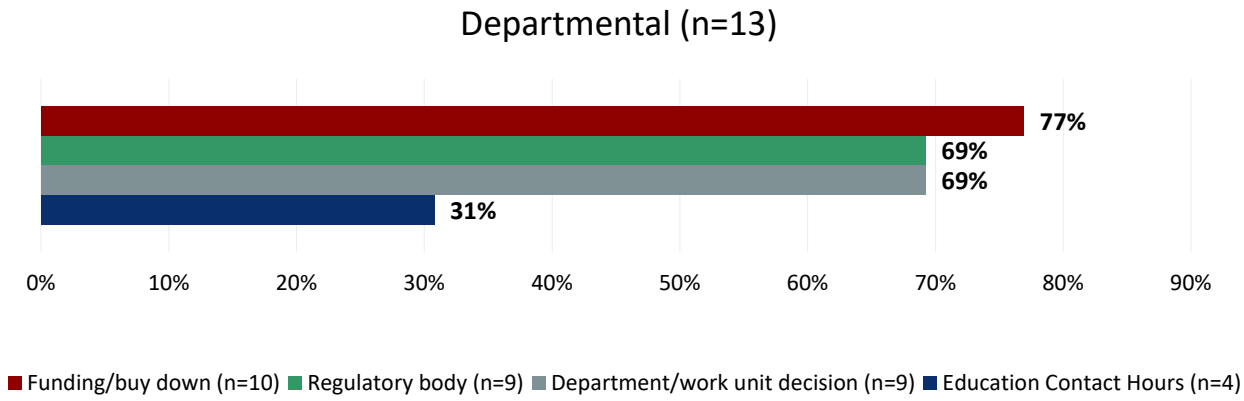


Figure 18. How is education FTE determined/calculated (less clinical and research FTE?) (select all that apply).

Takeaway from question 12:

Across both groups, department or work unit decision and regulatory body guidelines were among the most common methods for determining education FTE. Notably, funding or buy-down arrangements were more prevalent among departmental respondents (77%) than central respondents (40%).

The final survey question 13 was visible only if a respondent selected "Research" on question 4 categorizing faculty effort into mission areas.

Q13: Research FTE Determination

Among central respondents, the most commonly reported methods for determining research FTE were a defined letter of employment, startup package, or departmental resources (32 of 51, 63%), extramural salary including cost share and amounts above the NIH salary cap (28, 55%), and department or work unit decision (26, 51%).

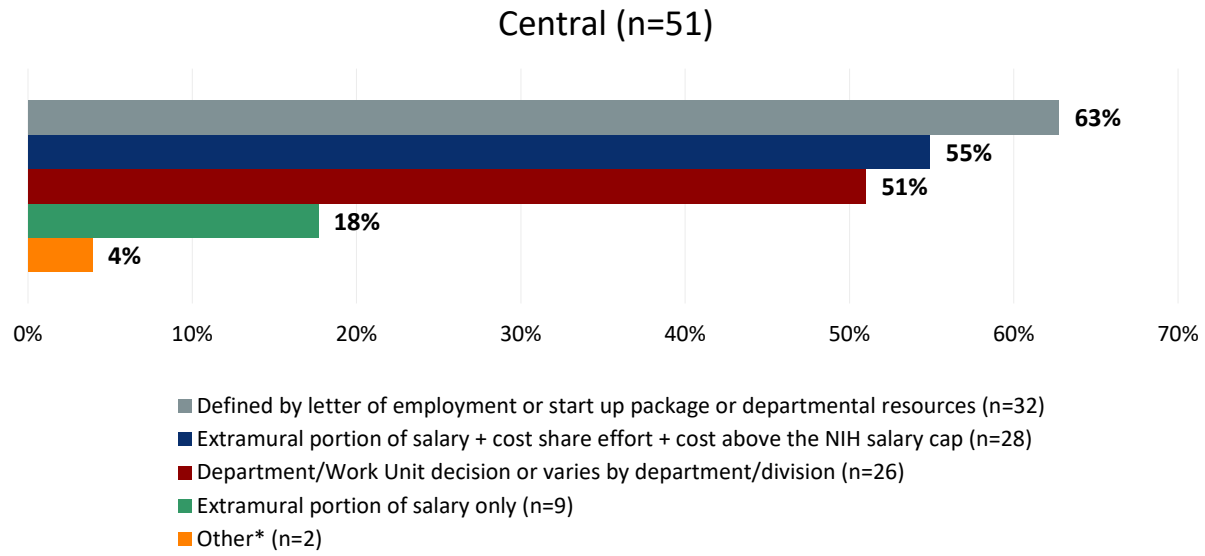


Figure 19. How is the research FTE determined/calculated (less clinical and education FTE)? (select all that apply).

*Other responses included:

- Letter of employment is a reference. It depends on if basic science or clinical, as it depends on the hospital system (e.g., one does annually, one parses for students or research).
- Time spent on unsponsored research.

Among departmental respondents, the most commonly reported methods were department or work unit decision (10 of 14, 71%), defined letter of employment, startup package, or departmental resources (9, 64%), and extramural salary including cost share and amounts above the NIH salary cap (6, 43%).

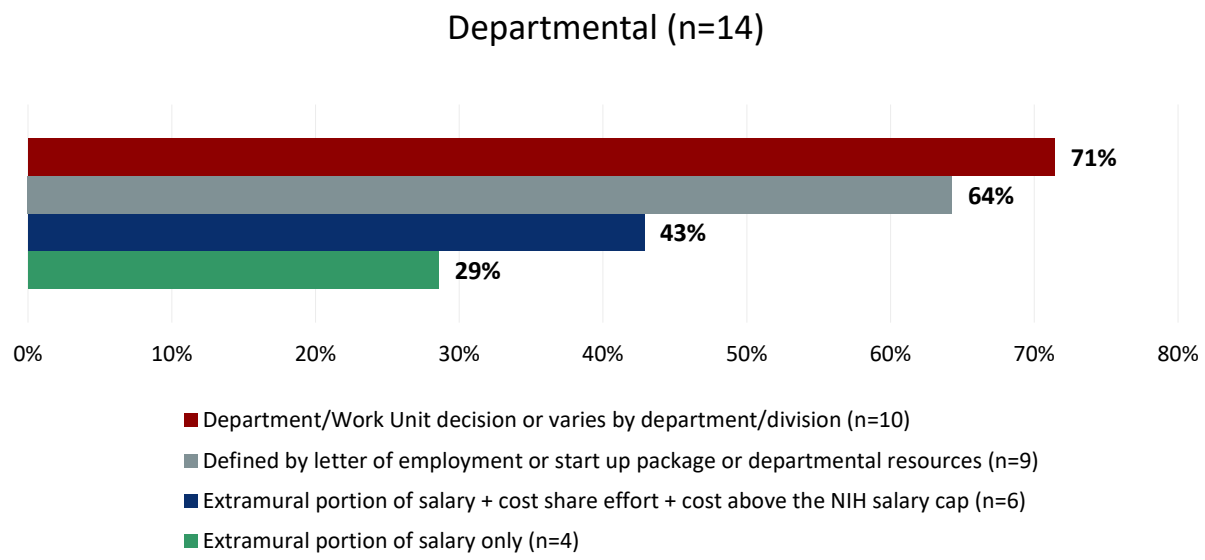


Figure 20. How is the research FTE determined/calculated (less clinical and education FTE)? (select all that apply).

Takeaway from question 13:
While both groups frequently cited letters of employment and extramural salary including cost share and amounts above the NIH salary cap as methods for determining research FTE, departmental respondents placed greater emphasis on department or work unit decision (71% vs. 51%). Central respondents showed a more distributed use of methods, with three approaches each selected by roughly half or more of respondents, suggesting greater methodological variation across central offices.

Conclusions

Across both central and departmental respondents, department or work unit decision-making was consistently among the most commonly cited methods for determining faculty effort across clinical (Q9), education (Q12), and research (Q13) missions, indicating that faculty effort allocation is largely decentralized in practice.

This decentralization was reflected in a recurring pattern of variability across multiple questions. From defining a 1.0 FTE (Q2) to gathering and reporting faculty effort (Q5) to determining clinical

productivity targets (Q11), a notable proportion of respondents, including central, indicated that practices differ across departments within their institutions.

Clinical FTE showed the least consistency, with the majority of both central and departmental respondents reporting either no uniform cFTE reduction from 1.0 (36% and 43%, respectively) or variability by department or work unit (29% and 43%, respectively).

These findings from 68 U.S. medical schools provide a useful national benchmark of current practices, though they should be interpreted in the context of the sample size.

Appendix

Of the four respondents who selected "Other" for question 1, one identified as "faculty practice finance," another as "practice plan leadership and departmental leadership," and two did not provide a response. All four reported a defined 1.0 FTE expectation that varies by department or faculty type.

All four confirmed their institution categorizes faculty effort into mission areas, selecting Clinical Service/Patient Care, Teaching/Education, Research, and Administration, with two additionally selecting "Other," one of whom specified "Strategic."

All four confirmed their institution gathers, monitors, and/or reports faculty FTE across missions, with two indicating this differs by department. For question 6, three respondents indicated they report faculty FTE via a university-provided spreadsheet template, two via department-level spreadsheets, and two indicated it was tied directly to mission-based salary funding. One respondent also reported using both home-grown/web-based software and vendor software. Regarding reporting frequency, three respondents selected "monthly" and one selected "annually."

All four indicated a standard cFTE structure that differs by department. cFTE was most commonly determined by department or work unit decision and time-based measures (each n=3), with two indicating funding-based buy-down. On question 10, one respondent included non-patient facing clinical time within cFTE, two excluded it, and one indicated it varied by department.

For question 11 on reducing cFTE from 1.0 for faculty effort and clinical productivity purposes, responses were mixed, with one reporting no reduction, one reporting a reduction of 0.21+ FTE, one indicating it varied by department, and one unsure.

For question 12 on how the education FTE is determined, all four cited department or work unit decision, three cited regulatory body requirements, and two cited funding or buy-down. For the final question 13 related how the research FTE is determined, all four reported using the extramural portion of salary including cost share and amounts above the NIH salary cap, three cited letter of employment or departmental resources, and two cited department or work unit decision.