MISSION-BASED HIRING IN ACADEMIC NEUROLOGY

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MISSION-BASED HIRING IN ACADEMIC NEUROLOGY

TALKING POINTS

- Running an academic department is like running a small business
- There is a disconnect between the hiring criteria and function of academic-department chairs
- Employees (faculty members) are happiest, most successful, and most loyal when doing what they like to do and what they feel they are good at
- Recent healthcare changes:
  - Have led to the demise of the “triple threat” (once rare, now impossible)
  - Place a premium on effective management and leadership skills at academic medical centers
- A mission-based approach to hiring:
  - Is a logical and more-effective approach to running a department regardless of recent healthcare changes
  - Is consistent with the ongoing changes in healthcare
  - Enables departments to excel in all four missions even with the demise of triple-threat faculty members

ACADEMIC MEDICINE: THE FOUR MISSIONS

- Education
  - Teaching
  - Curriculum development
- Research
  - Basic science
  - Clinical
  - Behavioral & social sciences
- Patient Care
- Leadership/Service
  - Management
  - Entrepreneurship

The 4-legged stool of academic medicine:

Leadership/Service is often omitted when referring to the 3-legged stool…

and called "administration" by those who do not have the leadership gene

MISSION-BASED HIRING

Can refer to one of two related concepts

- Mission-based faculty
  - System of organizing and hiring faculty members to ensure that the department excels in all four core missions of a medical school
  - Implemented at department level
- Mission-based management
  - System of management that incentivizes departments and faculty members to ensure that the institution excels in all four core missions of a medical school
  - Implemented at institutional level

"7 HABITS OF HIGHLY EFFECTIVE PEOPLE" & THE DEPARTMENT CHAIR

1. Be proactive
2. **Begin with the end in mind***
3. Put first things first
4. Think win/win
5. **Seek first to understand…then to be understood***
6. Synergize
7. Sharpen the saw

Stephen R. Covey. 1989, 2004

"7 HABITS OF HIGHLY EFFECTIVE PEOPLE" & THE DEPARTMENT CHAIR

1. Be proactive
2. Begin with the end in mind
   - *<u>Imagine</u> your perfect department. <u>Publicize</u> your vision. <u>Build</u> toward it.*
3. Put first things first
4. Think win/win
5. Seek first to understand…then to be understood
6. Synergize
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Stephen R. Covey. 1989, 2004

"THE E-MYTH REVISITED"

Short book debunking "entrepreneur myth" that small businesses are started by entrepreneurs

- Most businesses are started by technicians tired of having a boss
- Each of us has 3 business personalities
  - Technician – doing, working – lives in the present
  - Manager – order, planning, pragmatism – lives in the past
  - Entrepreneur – control, creativity, innovation – lives in the future
- Fatal Assumption: if you understand the technical work of a business, you understand a business that does that technical work
- In fact, the technical work of a business and a business that does that technical work are two totally different things
- Your business is nothing more than a…reflection of who you are
- The owner must delegate, but never abdicate, responsibility (in order for the business to stay true to the owner's vision)

Michael E. Gerber. 1995, 2001

THE TECHNICIAN VS. THE ENTREPRENEUR

The Entrepreneur "Begins with the End in Mind"

Technician Perspective

- What work has to be done?
- Focus on inside results: income
- Starts with the present, future is uncertain
- Envisions business in parts
- ***The future is modeled after the present-day world***

Entrepreneur Perspective

- How must the business work?
- Focus on outside results: customers and profits
- Starts with well-defined future, changes present to match vision
- Envisions business in its entirety
- ***The present-day world is modeled after the vision***

The "end in mind" = the owner's vision.

In academic medicine, the owner is the chair.

Michael E. Gerber. 1995, 2001

THE ACADEMIC MEDICINE DEPARTMENT AS A BUSINESS

- Chairing an academic department is like owning a business
- Chair (owner) must fully understand and balance effectively all 3 business personalities within self and department:
  - Technician – patient care, research, education
  - Manager – organization and functioning of faculty and staff
  - Entrepreneur – vision, mission, growth, extradepartment relations, customer responsiveness (awareness and adaptability)
- Unlike owners of many other businesses, the academic chair must continue to function as a technician, manager, and entrepreneur throughout her/his term as chair
- External (institutional) restrictions on management & growth vary among institutions; thus, appropriate balance of 3 business personalities varies among institutions

CHAIRS OF ACADEMIC DEPARTMENTS: DISCONNECT BETWEEN HIRING & FUNCTION

- Traditionally, medical schools choose the most outstanding technician to be chair
- Failure as manager or entrepreneur leads to chair failure with one of two results:
  - Replacement of chair
  - Medical school assumes many traditional chair responsibilities under centralized governance

"7 HABITS OF HIGHLY EFFECTIVE PEOPLE" & THE DEPARTMENT CHAIR

1. Be proactive
2. Begin with the end in mind
3. Put first things first
4. Think win/win
5. Seek first to understand…then to be understood
   - *Listen empathically. Diagnose before you prescribe. Demonstrate you understand needs & wants of others (faculty, Dean, hospital, learners, patients, funding agencies, donors, etc.)*
6. Synergize
7. Sharpen the saw

Stephen R. Covey. 1989, 2004

SEEK FIRST TO UNDERSTAND…

Why do faculty members choose a career in academic medicine?

- Impact
  - Local teaching
  - Regional & national presentations & committees
  - Publications
- Team
  - Camaraderie
  - Personal growth
- Creativity
  - Scientific inquiry
  - Paper writing
  - Lecture creation
  - Curriculum development
  - Leadership & management
- Altruism – caring for indigent patients
- Narrow subspecialist clinical interest

First seek to understand each of your faculty members' reasons for pursuing academic medicine.

We are all happiest, most successful, and most loyal when our job enables us to do what we like to do and what we feel we are good at.

THE DEMISE OF THE "TRIPLE THREAT"

Erosion of protected time, time efficiencies*, & extramural funding

- Changes in patient care
  - More time spent on documentation
  - Pressure to decrease hospital length of stay
  - Pressure to see more clinic patients
- Changes in education
  - Less emphasis on bedside teaching
  - More emphasis on curriculum development & evidence-based methods
- Changes in research
  - Less emphasis on clinical observations
  - More emphasis on randomized clinical trials
  - Decreased federal funding
- Changes in leadership
  - Increased need for management efficiencies and time to lead

In the past, it was easier to perform two activities concurrently, e.g.:
patient care + teaching
or
patient care + research

And, in reality, most academicians excel in only 1-2 areas anyway

ACADEMIC MEDICINE: TRADITIONAL MODEL

Impractical & less effective due to dependence on triple threats and lack of alignment with faculty strengths and interests

- Every faculty member must:
  - Be "triple threat," excelling in:
    - Education
    - Research
    - Patient Care
  - Publish or perish
  - Generate his or her own salary via grant or clinical income

Team sport analogy: Each team member plays every position

- Consequences
  - Faculty activities don't always match strengths or interests
  - Faculty satisfaction suffers
  - Department quality suffers
  - Education and administration get short shrift ("unfunded mandates")
  - No role for generalists in academic medicine
  - Chair spends less time up front and more time after the fact—policing, scolding, or covering for faculty

ACADEMIC MEDICINE: ALTERNATIVE MODEL

Focus on departmental success (beginning with the end in mind) naturally leads to mission-based hiring and assignments

- Every department must:
  - Be "quadruple threat," excelling in:
    - Education
    - Research
    - Patient Care
    - Leadership
  - Publish
  - Ensure faculty incentives align with pre-specified role(s)
- Each faculty member excels in 1-2 areas

Team sport analogy: Each team member plays different position

- Consequences
  - Faculty activities always match strengths and interests
  - Faculty satisfaction improves
  - Department quality improves
  - Equal support for all 4 legs of the academic stool
  - Important role for generalists in academic medicine
  - Chair spends more time up front—recruiting, assigning, and incentivizing faculty—and less time after the fact

ACADEMIC MEDICINE: ALTERNATIVE MODEL IMPLICATIONS

- More pressure on the chair, who must:
  - Devote time to—and be effective at—leadership (management and entrepreneurship)
  - Believe in philosophy of shared responsibilities
  - Recruit balanced faculty in terms of both subspecialty (e.g., epilepsy, stroke) and mission (e.g., education, research) expertise and interests
  - Place faculty in optimal positions to succeed
  - Ensure ***equitable*** (though not necessarily equal) compensation for all faculty members, despite their variable roles and activities

ACADEMIC MEDICINE: EXTERNAL PRESSURES

Changing healthcare landscape is <u>accelerating</u> the alternative model

- Shrinking NIH research funding
- Changing patient-care incentives and models
  - Affordable Care Act
  - Reimbursement based on <u>value</u> (= quality/cost)
  - Reimbursement based on <u>population health</u>
  - Patient-centric, interdisciplinary approach to healthcare delivery

ACADEMIC MEDICINE: EXTERNAL PRESSURE CONSEQUENCES

Changing healthcare landscape is <u>modifying</u> the alternative model

- Greater dependence on clinical revenues
- Compensation based on incentives/performance metrics
- Greater need for leaders with business & administrative skills
- Greater emphasis on institutional cross-subsidization
- Removal of some administrative responsibilities from chairs and departments, esp. clinical services and, recently, education
  - Multidisciplinary service lines or institutes
  - Centralization of core clinical services
  - Centralization of educational-resource distribution (EVUs, etc.)

HISTORY OF U.S. HEALTH CARE & MISSION-BASED MANAGEMENT

- Increased healthcare funding mid '60s to early '70s
  - 1965 – Medicare for Americans ≥ 65 yo
  - 1971 & 1972– Cancer & Heart Disease Acts increased research funding
  - 1972 – Medicare expanded to include disabled < 65 yo
  - ***Efficient management of academic centers/departments not prioritized***
- Decreased healthcare funding in the '80s & '90s
  - Lower reimbursement rates for physician services
  - New regulatory burdens
  - Greater cost-sharing by research sponsors
  - Increased demand for clinical productivity and revenue
  - Less time for education and research
  - ***To improve efficiencies, move from independent departments to centralized governance & mission-based management / budgeting***
- Decrease in NIH funding vs. inflation & GDP since 2003
  - ***Need for greater efficiencies in academic centers / departments***

WT Mallon. 2006:1-5.

DEFINING "FACULTY" IN ACADEMIC MEDICINE (1 of 2)

- Increased economic focus of academic medical centers has:
  - Changed faculty members' perceptions of their roles and priorities
  - Potential to marginalize academic pursuits (education, research)
  - Resulted in creation of large, integrated healthcare delivery systems via mergers, affiliations, or acquisitions of systems and physician practices
- Concurrently, medical school class sizes are increasing in response to projected physician shortage with aging population
- Medical schools must:
  - Decide if physicians in expanded clinical networks should have faculty appointments
  - Continue to attract faculty interested in academic medicine
  - Develop compensation plans and recognition systems deemed equitable among physicians with different titles, ranks, and roles

Block SM, Sonnino RE, Bellini L. 2015
commentary written by Deans of Faculty Affairs
from Wake Forest, Wayne State, and Penn

DEFINING "FACULTY" IN ACADEMIC MEDICINE (2 of 2)

- AAMC Group on Faculty Affairs survey in 2/2014 revealed lack of consensus regarding faculty appointments and titles
- Block, Sonnino, & Bellini propose a definition of "faculty" with "fundamental" and "variable" components to improve alignment with the 3 missions of education, research, & patient care
  - Fundamental – educational, scholarly, administrative activities
  - Variable – other activities based on local environment, e.g.,
    - Service to the institution or community
    - Mentoring
    - Innovation in, or contribution to, a clinical discipline
    - Participation in quality and safety initiatives
    - Clinical, academic, or administrative leadership
    - Development of and participation in unique clinical entities

In response to the current environment, many schools have created "faculty pathways" such as Clinician Scientist, Clinician Educator, & Clinician

MISSION-BASED DEPARTMENT ORGANIZATION

The University of Oklahoma Department of Neurology Model

- Utilize role-specific faculty evaluations
- Vary wRVU target expectations based on faculty role
  - % clinical FTE based on primary mission-based role
    - Clinicians 60-100%
    - Education & Medical Directors 40-60%
    - Researchers 0-40%
  - Annual 100% FTE wRVUs based on clinical type & 2014 FPSC* data
    - E&M adult neurologist 5105
    - E&M child neurologist 5534
    - EEG/EMU 7940
    - Critical care 6852
    - Neurointervention 9374
- Determine average dept $/wRVU for last 1-2 y
- Adjust target wRVUs based on financial calculations

**FPSC = UHC/AAMC Faculty Practice Solutions Center*

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THE END