Building Successful Triple-Threat Teams in Academic Health Systems

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On the vanguard of healthcare.
In some academic health systems the mechanisms to recognize and reward faculty have not progressed to accommodate the variation in roles, contributions and professional interests of team members – particularly those clinically-focused faculty whose contributions are largely to take care of patients.

The number of physician faculty in medical school clinical departments is increasing rapidly as academic medical centers evolve into academic health systems by building extended clinical networks. No longer is each individual faculty member expected to be a “triple threat,” making significant research, education and clinical contributions. Instead, most clinical departments now recruit faculty playing more targeted roles intended to make the department, division or program collectively a “triple threat” when working as a team. Yet, in some academic health systems (AHSs) the mechanisms to recognize and reward faculty have not progressed to accommodate the variation in roles, contributions and professional interests of team members – particularly those clinically-focused faculty whose contributions are largely to care for patients.

Academic systems risk significant faculty dissatisfaction and turnover if they do not recognize the changing nature of the faculty complement they are hiring today and for the future. This dynamic is amplified given the broader industry trend of high levels of physician burnout, a “hidden epidemic” that is increasingly top-of-mind for many AHSs. In this context, many AHSs are exploring new models for evaluating and recognizing the unique contributions made by each faculty member. Our work advising multiple AHSs and insights gleaned from interviews with academic health system leadership suggest that many institutions are actively grappling with the best options to manage and support their changing faculty workforce. Given the continued increase in clinical capacity and capabilities required at most AHSs, it is essential that each organization understand and address the needs of all faculty members if they are to build and maintain an engaged, satisfied and productive professional workforce.
The Growing Care of Clinically-Focused Faculty

Material growth in the number of medical schools and students over the past decade has led to a significant increase in the number of faculty. Yet, the magnitude of faculty growth within clinical departments has far exceeded growth within basic science departments – and has also outpaced growth of both the number of accredited medical schools and enrolled medical students (see Figure 1).
This growth in the number of clinical department faculty is driven by the need for increased clinical activity, not by requirements for educational capacity or research growth. More specifically, AHSs are growing clinical faculty capacity to:

**Grow patient volumes and revenues** to maintain the strong financial performance needed to invest in both the clinical and academic enterprises, particularly in an era of flat or declining reimbursement and rising labor, drug and supply costs.

**Gain critical mass in subspecialty programs** to achieve superior outcomes and economies of scale based on experience and efficient utilization of specialized equipment, staff, information technologies and other resources dedicated to these programs.

**Provide more timely access** to the large numbers of patients seeking care at academic medical centers.

**Develop services at owned and affiliated hospitals, and ambulatory sites across the region** to enable patients to get care closer to home and secure referrals for patients needing those services best provided at the core academic medical center.

**Build primary care networks** to secure access to sufficient populations to remain essential to payors and transition to population-based reimbursement approaches; provide medical students, residents and other health professionals with clinical experience delivering basic medical services; and study new ways to provide more effective healthcare for populations and specific patients.

Most of the clinically oriented faculty required to support this growth will have limited opportunity to make meaningful scholarly contributions using traditional definitions such as conducting funded research, publishing numerous peer-reviewed articles, and providing significant teaching to medical students, residents and fellows. In most cases, these newly hired faculty are expected to carry a full clinical load, making it unlikely that they have the time to successfully obtain grant funding or conduct extensive scholarship activities. Moreover, access to extramural funding overall is challenged, with intense competition for increasingly constrained budgets.

**FOR EXAMPLE**

The percent of NIH grant applications that receive funding has declined from greater than 30 percent to 19 percent; and less than 12 percent of the approximately 166,700 faculty nationally were Principal Investigators (PI) on an NIH grant in 2016. At one leading research-intensive AHS, only about 540, or 20 percent, of the medical school’s approximate 2,700 faculty are PIs on an NIH grant.
In this context, increasing numbers of medical schools no longer provide “protected time” to all faculty members. Instead, they opt to reserve protected time for a subset of faculty with the strongest prospects for gaining extramural funding or making some other important academic contribution with that protected time. Further, there is already sufficient faculty capacity to teach medical students, residents and other health professionals in most specialties, so that newly added faculty effort dedicated to education is unnecessary. This situation raises the question of what it means to be a faculty member for those new recruits spending almost all of their time in clinical practice and having little opportunity or expectation to conduct research or teach.

Limitations of Traditional Faculty Recognition and Reward Systems

The traditional definitions of scholarship that inform faculty evaluation and advancement have not kept pace with this growing cadre of clinically oriented faculty at many AHSs. For example, one research-intensive medical school’s website historically showed the mean and median numbers of peer-reviewed publications, which was always well into the double digits for those faculty who were promoted to assistant, associate and full professor. Additionally, most AHSs are now managing clinical effort and output expectations much more aggressively than they have historically, as external pressures increase the need to optimize physician workforce productivity and overall enterprise clinical performance. These expectations constrain time protected or otherwise available for scholarship.

EXAMPLE  LIMITED OPTIONS FOR CLINICAL FACULTY PROMOTION

At one AMC with almost 1,200 faculty in the clinical track, well over 800 were Instructors or Assistant Professors. Some of these were new faculty members whose titles were appropriate given their career status, but many others had been Assistant Professors for long periods, creating growing frustration with their inability to advance. Most of these Assistant Professors were making important contributions to the organization, by providing unique and needed patient services, leading quality improvement initiatives or serving in leadership roles. On average, 70 percent of their effort was patient care based on their reported effort. However, the medical school’s promotion criteria, which focused heavily on peer-reviewed publications, did not recognize some of the alternative ways that faculty could contribute to the academy. As a result, Assistant Professor was the “terminal rank” for many highly experienced faculty. This problem was exacerbated by compensation models in many departments that were closely aligned with rank.
Daniel Pink’s research on intrinsic motivation in the workplace says that most people, particularly professionals, are driven by the desire for autonomy, mastery and purpose in their work. In most AHSs, promotion into higher level ranks is a driver of performance as it symbolizes peer and organizational recognition of a faculty member’s mastery of their field, in addition to indicating status within the organization. Promotion might also provide faculty members with greater autonomy at many AHSs. If progression defined by academic rank is a key part of the culture, and clinically-oriented faculty are unlikely to get promoted, there is a high risk that they will feel undervalued and some will become dissatisfied or leave.

In addition, some AHSs base a meaningful portion of faculty compensation on an individual’s academic rank such that promotion also brings tangible economic rewards for faculty – and those more clinically-oriented faculty not achieving academic advancement may be disadvantaged. While tying significant compensation to academic rank risks dissatisfaction and turnover among busy clinicians, some AHSs may experience other shortcomings when they introduce more clinically-oriented compensation models based primarily on individual clinical production. In particular, this option risks insufficient attention to scholarly and team contributions.

The dynamics described above are increasingly identified as challenges at AHSs, yet many organizations still struggle to balance different organizational objectives and values in their faculty and physician rewards and recognition systems. The criticality to overcome these challenges is clear. As authors studying this issue at Johns Hopkins warned, “Academic medicine does not only require good scientists and researchers, but good clinicians, who contribute immensely to clinical medicine and the translation of laboratory research into clinical practice. Unless we recognize those who spend most of their time looking after patients, we will lose them to the private sector and end up with a glut of researchers and no one to teach clinical skills and bedside medicine to the coming generation.”
Emerging Models to More Effectively Recognize Clinical Faculty Contributions

To adequately engage and motivate this growing cadre of clinically-focused faculty, some AHSs are exploring new ways to recognize the unique contributions made by each faculty member. The factors that motivate individuals will vary, but typically include a combination of opportunities to pursue their areas of interest by providing them with time and other support for these endeavors, regular title advancement as a form of peer recognition, public recognition of their contributions and economic reward through compensation.

For most AHSs, moving to a pure clinical productivity-based system of reward and recognition, akin to private practice, is culturally incongruous and is therefore insufficient; most faculty, even those who are clinically focused, are opting to practice within an AHS environment at least in part because they wish to contribute to medical advancement – even if in less traditional ways than a “triple threat” model. Some faculty value the prestige of working in an AHS, which provides them a legacy and greater sense of purpose. Accordingly, AHSs are increasingly acknowledging contributions to the tri-partite mission that go far beyond extramural funding or publication in peer-reviewed journals. Examples of areas for recognition may include:

**CLINICAL EXCELLENCE**
that meaningfully enhances the organization’s overall reputation, draws large numbers of referrals and enables recruitment of additional faculty to build sustainable and differentiated programs.

**REGIONAL AND NATIONAL LEADERSHIP**
in quality improvement and administrative roles.

**MAKING SIGNIFICANT CONTRIBUTIONS**
to translating research findings into clinical application by helping to design clinical trials and/or enrolling patients in clinical trials.

**COMMUNICATING NEW HEALTH IMPROVEMENT FINDINGS**
through social media tools, which reach large numbers of peers and patients, rather than through traditional scholarly publications and conferences, which reach a relatively small (but important) audience.
Along with a broadened perspective celebrating a more expansive definition of faculty contributions, some AHSs are applying structural approaches to more effectively engage and recognize their clinically-oriented faculty. Some of these approaches are being pursued by modifying the more traditional, university-informed frame around faculty promotion and tenure, while other models are taking these issues outside of that setting to allow for more flexibility.

**1.** Create alternative, non-faculty, organizational models to accommodate physicians whose primary role is patient care.

**2.** Create different titles that distinguish between academic contribution and clinical contribution.

**3.** Broaden the definition of academic contribution to reflect greater diversity in the roles and contributions made by individual faculty members.

**4.** Tie compensation primarily to economic contribution and secondarily to academic rank such that clinically productive junior faculty can earn as much or more than senior faculty that are more academically oriented.

Numerous academic health systems employ physicians who do not have faculty appointments, particularly to staff off-campus primary care practice sites, off-campus ambulatory centers and affiliated community hospitals. Examples include Penn Medicine, Duke, UPMC and Johns Hopkins. This approach removes the constraint of an academically-anchored compensation and promotion system – yet it can also create unintended competition between faculty and non-faculty specialists in the same discipline if they are managed as different groups practicing in the same geography. In addition, some AHSs have experienced tension between faculty and non-faculty due to different compensation models and lack of mutual respect. In a few academic health systems, greater coordination and integration of faculty and employed clinicians in the same specialty has occurred over time after going through an initial phase of tension due to competition and mixing physicians with different professional aspirations. In other cases, AHSs have taken approaches to employing more complementary non-faculty specialists to avoid these competitive factors. For example, an AHS might employ non-faculty general OB/GYNs while all Maternal Fetal Medicine specialists remain in traditional faculty roles.
Several AHSs have begun using this approach by creating formal mechanisms to recognize clinical excellence; for example, a faculty member may remain an Assistant Professor while identified as a Master Clinician in recognition of their clinical prowess and contribution. However, the use of this approach to date is limited and fairly binary, with only a small number of physicians recognized for clinical excellence and all others remaining in traditional recognition models.

**EXAMPLES INCLUDE**

Some of the teaching hospitals affiliated with Harvard have separated academic titles from clinical titles. Physicians at Dana Farber can be Physicians, Senior Physicians or Institute Physicians regardless of their Harvard Medical School academic appointment and title.

Other research-intensive AHSs have created mechanisms supplemental to faculty titles, such as:

- **Johns Hopkins** created the Miller-Coulson Academy of Clinical Excellence which has established a definition of clinical excellence and metrics to identify clinicians who might be eligible for membership. The Academy was established in 2008 at Johns Hopkins Bayview. It has now spread to other Johns Hopkins facilities but remains small, with fewer than 70 physician members identified on their website.

- In 2013, **Penn Medicine** elected its inaugural class of 22 faculty members into its newly established Academy of Master Clinicians.

- In 2017, the **Columbia University** Vagelos College of Physicians and Surgeons inducted its inaugural class of 119 faculty members into the new Academy of Clinical Excellence. The role of the Academy is to define, recognize and perpetuate excellence in clinical care by faculty, trainees and students.

- The **University of Michigan**’s Department of Medicine has a similar initiative called the Clinical Excellence Society that welcomed its inaugural class of 23 faculty members in 2013.

Create different titles that distinguish between academic contribution and clinical contribution.
Active clinicians can contribute to the tri-partite mission in different ways, many of which differ from the typical academic definitions of success. For example, a physician who leads a clinical program that successfully attracts referrals and advances the organization’s reputation, might not meet traditional academic promotion standards but is making an important contribution to the organization. One approach is to create additional faculty tracks and to create alternative pathways within tracks, particularly the tracks used by clinically-oriented faculty.

EXAMPLES INCLUDE

**Stanford** has a Tenure Track, a Physician Scientist Track and a Clinician Educator Track. The Clinician Educator Track typically attracts physicians who are 80-100 percent clinical with compensation similar to community physicians; in addition, physicians in this track have only a medical school appointment since the track is not recognized by the University. Clinician Educators are salaried employees of Stanford University, classified as exempt staff, and are, in general, subject to and expected to comply with the University’s applicable policies and procedures. Still, many of their responsibilities, which focus on clinical care and clinical teaching (and may involve an administrative role or scholarly activities), are similar to those held by members of the Professoriate. Therefore, as a result of their academic credentials and multifaceted contributions to the School’s educational mission, Clinician Educators are regarded colloquially as faculty and are referred to as such in everyday usage.

**Emory** has created a Medical Educator and Service Track (MEST) for faculty who plan to devote most of their time to patient care or teaching, with only limited participation in scholarship. Promotions for MEST faculty are based on achieving local and regional educational or service contributions. Limited scholarship is required and there is an unlimited time for promotion.⁶

**University of Michigan** has retained a single Clinical Track but created new pathways within the track in 2017 to better reflect the different ways clinical faculty can contribute. For example, recognized contributions might include gaining regional, national or international recognition for quality leadership, administrative leadership, clinical teaching or clinical trial participation.
Strategically Redefining the Roles of Medical School Faculty to Benefit the Overall Institution

Our interviews with leaders from academic health systems suggest that many are still finding their way through these issues – as organizations test one, or several, of the above models to see what approach best addresses the needs of their diverse faculty. For most, a concern remains that chairs, senior faculty and medical school leaders may be steeped in traditional definitions of success, making it hard for them to recognize broader definitions of the ways individuals “contribute to the academy” and making it difficult to mentor faculty pursuing different definitions of success.

Still, with physician faculty burnout as a core concern for most health systems and increasing requirements to optimize performance across the tri-partite mission, AHSs are prudent to begin exploring and crafting new solutions to best fit their culture and history while supporting goals for continued growth and sustainability. Academic health system leaders need to recognize the shifting nature of their faculty workforce and the tension that changing roles can create. Ignoring the problem risks making things worse even though the solutions require change.
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Sources


3 Chartis Primary Research.


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