

TOOLKIT

Compensation Plan Toolkit for Health Sciences Faculty

The purpose of this toolkit:

- To serve as a resource to departments, chairs, and others in their development of compensation plans.
- To effectively achieve institutional and departmental strategic goals, as well as the personal and professional goals of the faculty.
- To summarize approaches and experiences from published literature and work with six partner departments at the University of California, Davis School of Medicine.
- To support career flexibility and work-life integration by appropriately defining compensation criteria and incentives that mitigate unconscious biases.
- To address emerging needs and related scenario planning as changes in health care delivery, payments, and incentives occur.

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Meeting Basic Needs: A Check-List

Compensations plans serve many purposes; they reward and retain high performers, help attract new talent, and incentivize certain activities and behaviors while discouraging others.

An effective compensation plan must meet the basic needs of the faculty as well as the basic needs of the department or institution.⁹ Meeting the basic needs of each these stakeholder groups builds trust on both sides that goals and priorities of each are understood and considered, and that expectations for compensation will be fair.

To ensure that a compensation plan is built on the sound foundation of meeting basic needs, we have created the following checklist to serve as a reference as you develop criteria and metrics using the other resources in this toolkit.

Table 1 Checklist: Is Your Compensation Plan Meeting Basic Needs?			
	Need	Description	List elements In your plan
Faculty Needs	Security ⁹	Sufficient income to provide for personal security. Ensuring security builds trust.	
	Self-Esteem ⁹	Demonstrate respect for a faculty member's experience, skills, accomplishments, and stature.	
	Fairness ⁹	Demonstrate that processes are consistent, rational, and ethical, and that metrics are objective and understandable.	
	Flexibility to Achieve Personal and Professional Goals ^{1,2}	Criteria that reward a faculty member's role in the department, aligned with his/her academic series, and minimize an excessive need for "face-time."	
Organizational Needs	Maintain academic and organizational values ¹⁰	Ensure adequate attention to the academic mission and cultural values of the institution while recognizing different faculty roles, and that all contribute differently to a department's academic success.	
	Generate sufficient revenue to subsidize non-revenue generating academic activities ¹⁰	Recognize: 1) Clinical revenues drive most departmental activities, including teaching and research support; 2) Ensure fiscal responsibility.	
	Maintain sufficient flexibility in distribution of income to meet broad needs and unexpected circumstances ¹⁰	Ensure sufficient "wiggle room" to recognize contributions that may not neatly fit into established criteria or scoring systems within the plan. Support innovation and faculty needs.	
	Transparency regarding processes utilized by the chair and maintains trust among faculty ¹⁰	Use data regarding faculty performance for decision-making and to establish evaluation criteria. Ensure that faculty are well aware of data and criteria used.	

Guidelines for the Determination of Clinical Full Time Equivalent (cFTE) for Faculty Members

The following definitions for full-time clinical faculty (cFTE) work were created by the UCDHS Practice Management Board to:

- Standardize expectations across departments.
- Optimize physician productivity.
- Meet the community's need for access to healthcare providers.

Baseline Parameters:

cFTE is adjusted accordingly to accommodate assigned effort in the other missions, as defined by academic series, and local need. Baseline expectations for each academic series are listed as follows:

- MSP physicians: 100% time devoted to clinical effort
- Health Science Clinical Professor Series: 90% time devoted to clinical effort -10% time reserved for administrative and teaching responsibilities.
- Clinical X, In Residence, and Regular Series: Protected research time as defined by individual departments.

In general, reductions in clinical time must be either directly supported. (i.e. grant funding or paid administrative support (Medical Directorships) or granted by the Department Chair.

Time valuation given for patient care activities:

1. **Outpatient:** Generally each ½-day session = 10% or 0.1 cFTE/clinic
 - a. 44 weeks of clinic is equivalent to one year's worth of clinic
2. **Surgical and Procedural Work:** Generally each ½-day session = 10%. 0.1 cFTE/surgical or procedural ½ day
 - a. 44 weeks of effort is equivalent to one year' effort
3. **Shift Work (eg ED):** represents hospital work where effort is determined by physical presence and not necessarily patient load. Credit for clinical activity should be defined by Department Chair in consultation with the Executive Director of the PMB.
4. **Clinical Inpatient Service:** Each week (7 days) of assigned inpatient service is equal to 0.03 cFTE.
 - a. Depending on the demands of the clinical service a range of 0.02-0.04 cFTE/week is acceptable and should be defined by Department Chair in consultation with the Executive Director of the PMB.

5. **Consult services:** Each week (7 days) of assigned consultative service is equal to 0.015 cFTE.
 - a. Depending on the demands of the clinical service a range of 0.01-0.02 cFTE/week is acceptable and should be defined by Department Chair in consultation with the Executive Director of the PMB.

6. **Additional clinical time:**
 - a. Additional time can be counted as clinical time for activities such as: clinical conferencing (including CCS case conference), pathology review, radiology rounds, etc.
 - b. Determination of credit for additional clinical time will be at the discretion of the Chair in consultation with the Executive Director of the PMB.

7. **Time cannot be double counted:**
 - a. A procedure clinic performed while on inpatient service cannot be credited as having worked one and a half days during one calendar day, or two outpatient clinics while also covering a consult service cannot be counted as three clinic shifts worked.

Salary Components for University of California Health Sciences Faculty

There are two major forms of recognition/reward for faculty at academic health centers: compensation and academic advancement through professorial ranks.

Compensation and academic advancement are evaluated separately and use different criteria; however, they are linked since compensation often varies based on rank. An effective compensation plan should align with the academic reward process to allow appropriate balance to the incentives and rewards, and ensure organizational success in all academic missions.

Academic advancement at the University of California (UC) includes a unique system of merit advancement through a series of “steps” within each professorial rank, in addition to promotion. These steps are formally defined and uniformly applied across all 10 campuses of the UC system. Full descriptions of UC policies related to health science faculty compensation are available at the following links:

- University of California Health Sciences Compensation Plan: https://www.ucop.edu/academic-personnel-programs/_files/apm/apm-670.pdf
- University of California, Davis Health System implementation plan: <https://health.ucdavis.edu/media-resources/academic-personnel/documents/SOM%20Comp%20Plan%20Implementation%20Guidelines%202013%20-%20rev07.01.13FINAL.pdf>

Medical faculty compensation plans generally include a base salary and negotiated incentive component. UC faculty have several salary components which include components for the base salary and for incentives. The following is a brief summary of the the three standard salary components for UC health science faculty:

- X (base) salary: Consists of regular salary (as defined by academic rank and step) plus a differential ($X^1 = X$ Prime) determined by the base scale of the academic programmatic unit (APU) to which the faculty member belongs. An APU is defined by programmatic groups of faculty who have similar training as well as similar clinical, teaching and research responsibilities. The X salary component is determined by the approved rate of established system-wide salary scales for health science faculty according to a faculty member’s rank and step. Salary scales are available at: <https://www.ucop.edu/academic-personnel-programs/compensation/historic-academic-salary-scales/2014-academic-salary-scales.html>

Faculty in the tenured/tenure-track series receive funds from the state (19900 funds) to support their base salary. X^1 must be supported by other funds. Faculty in other academic series do not have state funds as salary support and must therefore have another salary source (clinical income, grants or other sources) to support their X and X^1 . The X and X^1 are the only salary components covered by the UC Retirement Plan for all academic series.

Increases in an individual faculty member’s base salary are determined by merit and promotion process for academic advancement, thus linking and aligning academic reward with compensation. Criteria for promotion and merit advancement are defined in the UC Academic Personnel Manual (APM). These criteria differ based on a faculty member’s academic series.

Links to the APM policies containing these criteria and the review process for each academic series are below:

- o Professor (aka Regular or Ladder-Rank series): http://www.ucop.edu/academic-personnel-programs/_files/apm/apm-220.pdf
 - o Professor In Residence series: http://www.ucop.edu/academic-personnel-programs/_files/apm/apm-270.pdf
 - o Professor of Clinical ____ series: http://www.ucop.edu/academic-personnel-programs/_files/apm/apm-275.pdf
 - o Health Science Clinical Professor series (HSCP): http://www.ucop.edu/academic-personnel-programs/_files/apm/apm-278.pdf
 - o Adjunct Professor series: http://www.ucop.edu/academic-personnel-programs/_files/apm/apm-280.pdf
- Y salary: This optional compensation is for salary beyond the base pay and represents additional negotiated compensation. Typically, this salary component is used to bring salary to a “market rate” for an academic in a specialty or discipline. There are no state funds provided for this salary component; therefore, a fund source must be identified for all faculty to cover this salary component. Department compensation plans are expected to define the criteria used for this negotiated compensation. The UC Health Sciences Compensation Plan, the governing document for department compensation plans, requires that the Chair shall consider total contribution of the faculty member, including teaching, research and professional, University, and public service in determining the Y salary component.
 - Z salary: This salary component is for an optional incentive/bonus payment beyond base (X+ X¹) or negotiated (Y) compensation. Department compensation plans are expected to define the manner in which faculty members within a department, division or APU may earn this incentive/bonus (aka Z payment). Z payments may be made for clinical or administrative service, unanticipated duties, extraordinary contributions, special circumstances, division of excess departmental or division revenue after payment of annual expenses, and payment for professional activities outside the operations of the department or school.

General Models for Compensation Plans

Table 2 lists several common models which can be used to define the criteria for the Y (negotiated) and Z (incentive/bonus) components of a departmental compensation plan.¹¹

The multi-factor productivity model has traditionally been the most common model at UCDHS; however, value-based models will likely become more important with changes in healthcare reform. Some form of productivity measure may still need to be considered, in addition to value.

Be aware that most compensation strategies incentivize and improve clinical and research productivity, but have been shown to have little effect on teaching, according to Akl et al.'s systematic review of publications of medical school faculty compensation plans.¹²

Bias that inhibits a flexible work-culture can exist in each of these models, even when objective criteria are used. Ensuring that metrics for incentivizing and rewarding organizational and team-based citizenship are included is important in promoting flexibility. Regardless of the model chosen.

Also, consider the following challenges in implementing productivity models which have been identified by Akl et al.:¹²

- Difficulties with assessment due to lack of timely and accurate billing data.
- Self-reporting of productivity which may require auditing for accuracy.
- Inability to fully consider team contributions causing them to be frequently left out.
- Little faculty control of factors that can influence their productivity, such as patient population, scheduling, staffing and other resources.

Table 2
General Models for Incentive Plans

Model	Definition	Advantages	Disadvantages
Clinical productivity based¹¹	Incentives are based on an individual's contribution to the clinical mission only, typically based on volume of services rendered.	• Clear objectives. • Simple execution. • Transparent (RVUs, # of studies, etc.).	• Undermines other values and missions. • Can create disruptive rivalry. • May distort practice patterns. • May drive performance through fear.
Multi-factor productivity based¹¹	Incentives are based on an individual's contributions to multiple missions (clinical, education, and/or research)	• Promotes traditional values if using traditional performance measures. • Potential for overall benefit (reputation, fiscal gain). • Rewards different talents.	• Difficult to measure subjective data. • Conflicting interests difficult to reconcile (1 hr teaching = ? clinical income).
Section-based¹¹	Incentives for collective performance are uniquely defined for each sub-unit or team in a department.	• Collective responsibility. • Enhances organizational performance.	• May increase "rich" vs. "poor" discrepancies. • Dilutes individual role. • Can't weed out non-performers.
Tailored individual¹¹	Unique incentives are defined for each individual to fit talents and career goals.	• Top-driven. • Highly flexible. • Links to strategic initiatives.	• Opaque decision-making. • Subjective; can be misused.
Chief-driven¹¹	Incentives are defined by the department chair to fit chair-defined goals.	• Top-driven. • Highly changeable. • Links to strategic initiatives.	• Opaque decision-making. • Subjective; can be misused.
Value-based	Incentives are defined by contributions to improving quality and lowering cost in delivery of clinical services care or other missions.	• Aligns with emerging payment methods for clinical services, and new health care delivery models such as accountable care organizations.	• Little existing experience to learn from.

Metrics of Performance

Most compensation plans use metrics to measure a faculty member's contributions, regardless of the general practice plan model used in the department.

Advantages: Metrics can quantify contributions, minimize ambiguity, and promote transparency and fairness. Metrics are easiest to apply to individual clinical performance since existing metrics associated with billing and revenue generation can be applied.

Challenges:

- Not all activities are easily measured: Non-clinical activities do not generate revenue or have an established value, particularly activities related to such as education, research, administration and university service.
- Establish your own metrics or scoring system: This includes the challenge of weighting each performance measure based on the department's own strategic priorities or those of their school or health system.
- There is a tendency to choose an easy or highly visible measure, even though this may not adequately represent the activity that the department wishes to incentivize or reward.¹³
- Achieving buy-in among faculty regarding the weights associated with metrics is ideal, but not always easy to achieve.

Benchmarks and score cards: Benchmarking performance against established external standards or internal standards, such as department peers, can be useful. "Score cards" or dashboards are often used. Performance measures can include clinical outcomes, including patient satisfaction, as well as productivity. Multiple measures giving a composite picture of performance are considered most effective, though profiling is not always to be reliable. Data from the electronic medical record may facilitate outcomes-based benchmarking.¹⁴⁻¹⁶ The Faculty Practice Solutions Center (FPSC) is a resource for information and comparative data unique to academic clinical, operational and financial performance that can be useful for benchmarking. A joint venture between the University Hospital Consortium and the Association of American Medical Colleges, the FPSC membership includes more than 90 faculty practices nationwide and includes the UC Davis Health System.

Examples of Metrics:

Table 3 Metrics for Clinical Productivity and Performance		
Metrics	Description	Examples and Comments
Relative Value Units (RVU)	Uses physician work RVUs developed for Medicare's physician fee schedule. ¹⁷	RVUs rank services using a common scale based on the resources required for each service, and accounts for time, technical skill and effort, mental skill and effort, and stress to provide a service.
Shifts-worked	Most commonly utilized in specialties such as anesthesiology or emergency medicine in which shift coverage for physician services is required, but where physicians only partially control number of patients or where productivity is constrained due to factors outside their control, such as surgical duration, operating room availability or staffing ratios.	• Usually defined as "clinical days worked", though some define a shift as a specific number of hours on duty.¹⁸ • On-call assignments may be considered separately from daytime shifts.¹⁸ • 20% of anesthesiology practices used a shift-only model, according to a published survey.¹⁸
Revenue/billable hours model	A faculty member must earn a pre-defined revenue goal or fulfill a pre-defined commitment to billable hours to cover the portion of his/her salary associated with clinical effort.	• May utilize either collected revenue or net revenue, based on preference of the department. • Can incentivize night/weekend call or coverage of extra duties. • Can successfully realign compensation to reward the most productive faculty.¹⁹
Clinical quality or value-based metrics	These metrics may provide balance to the quantitative measures listed above and/or to address the needs of accountable care organizations or other emerging delivery and payment models.	• Individual performance data from: patient satisfaction surveys; quality monitors (ie, complication rates); metrics associated with compliance, such as, completion of medical records or safety training. • Aligns with on-going professional performance evaluations required for maintaining medical staff privileges and hospital accreditation. • Emphasis by pay-for-performance programs and accountable care organizations may raise the importance of this component of compensation.

Table 4
Metrics for Non-Clinical Academic Performance

Metric	Description	Examples and Comments
RVU-equivalents	Uses department-developed RVU-equivalents for non-clinical activities to objectively value work and time associated with educational, research, administrative and other activities.	Educational value units (EVUs) created for core teaching activities with dollar units assigned. ²⁰
Salary credits	Salary credit equivalent to a percentage of salary is assigned for specified duties or accomplishments.	A well-developed model of this type has been described by the Department of Psychiatry and Behavioral Medicine at the University of California Davis Health System (UCDHS).^{21,22} • Administrative roles: Example: Salary credit for a vice chair is 15%, director of a training program receives 20%. • Does not address quality of contributions.
Point systems	Academic activities are assigned points or a range of points developed by the department.	• Points assigned to scholarly work (grants, papers, presentations), teaching, committee work, and citizenship (taking call on short notice, cooperation with other clinical units like the operating room). • Point systems vary in breadth as well as range of detail, according to a survey of academic orthopedic surgery practices,¹⁰ as well as our review at UCDHS.

Metrics for Organizational Citizenship and Team Contributions

Using the “right” metrics for organizational citizenship can positively influence team culture, as well as a culture of work flexibility. Surveys of the UC Davis School of Medicine faculty have shown that our faculty are reluctant to use the school’s career flexibility policies because of concern for burdening their team members, as well as fear of repercussions which includes the concern that the individual using the policies would be perceived as less committed to his/her career or to the team.^{1,2} Each of these reflect concerns regarding perceptions of others that can create stigmas with negative effects on a faculty member’s salary, academic advancement and/or career opportunities.⁴⁻⁹

Table 5 contains metrics for citizenship and team contributions derived from a published model designed to enhance overall awareness of contributions, and behaviors and caring related to group goals.²³ These metrics minimize the effects of unconscious biases related to the decreased visibility that a faculty member experiences when using flexible career policies, including leaves, alternate work schedules or alternate work sites.

Table 5 Methods and Metrics for Organizational Citizenship and Team Contributions*		
Methods to Raise Visibility of an Individual’s Contributions to Group or Team	Implementation: Examples and Metrics	Advantages
<u>Events:</u> Attendance and participation at “interaction rituals” that have symbolic meaning to the group regarding group membership and involvement.	Measure attendance and/or assign points for: • Department/division meetings for participation in group governance. • Teaching conferences to show commitment to educational mission. • Research retreat to show commitment to research mission. • Residency program graduation events to demonstrate support to trainees and colleagues for group educational efforts.	• Minimizes expectations of being “always available” and “ever present “ and the negative feelings that can result. • Workload, work schedule, and workplace become less relevant.
<u>Synchronized interactions:</u> Defining and attending events where group interactions should occur versus times when individual work can occur.	Measure attendance at and/or assign points for group-defined events such as: • Clinical teaching activities (rounds or case reviews) with house staff and other clinical team members. • Quality assurance conferences or rounds • Lab or committee meetings.	• Ensures availability for collaborative activities. • Allows uninterrupted individual time to complete “real work”. • Minimizes fragmented days and pressure to be “ever-present”.

Methods to Raise Visibility of an Individual's Contributions to Group or Team, Continued	Implementation: Examples and Metrics, Continued	Advantages, Continued
<u>Pro-active availability:</u> An individual's efforts to anticipate and integrate work, and initiate contact with co-workers.	• Examples: Recognize an individual's pro-active initiative, such as providing updates on projects appropriately (not excessively) to others, or identifying and leading resolution of issues by involving and communicating with others. • Metrics described in Table 4 may be useful to recognize these contributions.	Demonstrates commitment to group goals even without face-to-face interaction.
<u>Self-Presentation:</u> Enhancing visibility by volunteering to share activities publicly.	• Examples: Volunteering to give grand rounds or asking to have personal work projects placed on the agenda of team or department meetings for discussion. • Metric: Point system in Table 4, may be useful to recognize these contributions.	Communicates competence, hard work, and commitment to the group, particularly for those with reduced face-time.
<u>Conscientiousness and Helping:</u> Contributing extra effort to assist peers with their work.	• Examples: 1) Volunteering to cover colleagues for planned and unplanned absences; 2) Helping a colleague who has fallen behind in his/her work. • Metrics in Table 4 may be useful to recognize these contributions.	• Builds interpersonal relationships. • Demonstrates caring for group goals. • Enhances group motivation. • Triggers reciprocity.
<u>Voice:</u> Making constructive suggestions for change.	• Example: Contributing positively to the discussion at faculty meetings, committees and workgroups. • Metrics in Table 4 may be useful to recognize these contributions.	• Demonstrates caring for group goals. • Enhances group motivation. • Triggers reciprocity.
<u>Peace-making:</u> Working to resolve difficulties.	• Examples: 1) Suggesting and helping implement solutions; 2) Volunteering and contributing actively to committees to address issues; 3) Privately helping colleagues and others to resolve issues. • Metrics in Table 4 may be useful to recognize these contributions.	• Demonstrates caring for group goals. • Builds inter-personal relationships. • Enhances group motivation. • Triggers reciprocity

*Methods, examples, and advantages derived from Van Dyne et al.²³

The Minefield of Unintended Consequences

Misaligned Incentives

The business classic “The Folly of Rewarding A While Hoping for B” describes “fouled-up” reward structures and gives several examples from both academia and the medical profession in which the desired behavior or goal is not the one that is rewarded. The author lists four general factors for why this phenomenon is so prevalent.¹² Examine your plan closely to see if any of these are present:

- Excessive reliance on objective criteria: Simple quantifiable standards may be successful in highly predictable areas, but can cause goal displacement elsewhere.
- Over-emphasis on highly visible behavior: Counting publications is more visible and therefore easier to reward than other important behaviors also worthy of reward like teamwork and creativity.
- Hypocrisy: Rewarding and getting desired behaviors, even though claiming these are undesired.
- Emphasis on morality or equity rather than efficiency: A felt obligation to reward a noble effort or cause may prevent the ability to withhold reward for less than optimal performance.

Face-time Bias

Compensation Plans that are dependent on highly visible activities inevitably have some “face-time bias” that may affect the evaluation and reward process. Face-time bias is:

- A form of unconscious bias related to the amount of time one is passively observed in the workplace without need for interaction.
- Has a significant adverse effect on how an employee is perceived and evaluated at work.
- Composed of spontaneous trait inferences which occur when passively observing an individual in the workplace and leads to quick and lasting impressions that can affect performance appraisals. Expected face-time, i.e., being seen in the office during normal business hours, leads to inferences of the trait “responsible” and other synonymous descriptors. Extracurricular face-time, i.e., being seen in the office outside of normal business hours, leads to inferences of the trait “committed” and its synonyms. Reducing passive face-time may therefore lead to lower performance evaluations for remote workers.³

Team culture, peer pressure for performance, and availability can lead to face-time bias. A faculty member who uses a flexible work schedule, takes a family leave, or uses tools for distance work, inevitably reduces his or her face-time among the other team members. Even if the faculty member performs excellently in his/her assignments, other team members may be unaware since he/she is less visible. As detailed in previous publications, UCD School of Medicine faculty surveys showed that approximately 20-30% of men and women of all generations chose not to use flexibility policies due to concerns about burdening colleagues.^{1,2} Several articles in a special issue of the Journal of Social Issues described the stigma associated with use of career flexibility policies, and the negative effects that this can have to salary and careers of men and women.⁴⁻⁹ These important issues related to face-time, team culture, and stigmatization suggest that a negative perception regarding a faculty member’s organizational citizenship and commitment to the group can influence an individual’s use of flexibility policies and inhibit a culture of flexibility.

Sorting Effects

Be aware that faculty members are attracted to or retained in a department or school as a result of the activities or behaviors that are rewarded in a compensation plan. On the flip side, some faculty members inevitably are pushed out because they don't like the reward system and choose to leave. More than one of our partner departments have noted sorting effects – intended or not – in their current compensation plans which has led to some faculty separations, as well as the recruitment, retention, and advancement of faculty whose values resonate with compensation plan criteria and thus help achieve the department's strategic goals. Sorting effects can change the work culture of departments. For example, benchmarking against peers may create a more competitive culture that may not appeal to all. Departmental culture could potentially affect diversity as well since an individual's gender, race/ethnicity, and cultural background may or may not align with the work culture of a department.

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