

## UVM DOM CAREER DEVELOPMENT TOOLKIT

The DOM Career Development 'Toolkit' consists of a collection of supplemental documents prepared by the DOM Faculty Development Committee to assist faculty in understanding and navigating the academic medical system.

Subject
<a href="#">Effort percentages: What is expected of you and how to get there</a>
<a href="#">Productivity metrics and what they mean</a>
<a href="#">Should I take on a new task?</a>
<a href="#">How can I be more efficient?</a>

## **“PERCENTAGES”**

What you do will naturally follow what you are paid to do. Although this is self-evident, many faculty do not know or understand how their effort is supposed to be distributed. This can lead to confusion and discontent. All jobs have different ‘work weeks,’ but the percentages of what you spend your time doing should come close to what your offer letter or Annual Review form list. If you don’t know these, find them out (your unit administrator or division chief should have access to these). Knowing these numbers is critical for two reasons. First, you need to know how to plan your work life – these percentages give you a good idea what the expectations are from your division and department. Second, you need to know when your expectations don’t match these numbers.

### **X% of what?**

There are many ways faculty expectations can be out of sync with effort distribution, and hence many solutions to this problem:

- 1) Do you know exactly what is expected of you in each of these categories? If you’re doing more than you need or want to, you need to cut back. This gets to the heart of the “[Should I?/Shouldn’t I?](#)” dilemma many (especially junior) faculty face when asked to take on new responsibilities within the division, department, hospital, or university.
- 2) Are you operating efficiently? If your clinical time seems to spill over into your other activities, perhaps you need guidance on how to navigate the system better, get things done quicker, or schedule you clinics more efficiently. For more on improving **efficiency** click [here](#).
- 3) Lastly, are the numbers not what you want? This is a tough issue, but one that needs to be recognized in order to be addressed effectively. Effort distribution reflects both the missions (e.g. teach medical students, provide outstanding care) and the imperatives (e.g. clinics have to be staffed, surgeries need to be performed) of the division or department, and the financial reality of academic medicine.

The important thing to understand in this process is that effort is largely dictated by the needs of a division/department and the salary sources available, clinical activity being the main source of salary dollars for most individuals. Thus, any changes to a faculty member’s effort needs to not only address the missions of the division/department but *also* be supported by alternate sources of salary (e.g. 0.2 FTE to run the Medicine AI clerkship, 0.4 FTE – or “4.8 months” effort – on an NIH grant, or 0.1 FTE to direct Respiratory Care).

Unfortunately, doing something and doing it well do not translate into salary support under most circumstances. You will need to be strategic and upfront about your plans to support any activity you wish to pursue outside of your current effort distribution. Talk to your mentor and your Division chief – discuss what you want to do and how this not only fills a need in the division, department, or institution, but also how your effort in this pursuit would be covered by ‘external’ (e.g. Foundation or NIH) or ‘internal’ (e.g. the hospital or COM) salary dollars. There are often some discretionary funds within a division

or department that can be used to help support salary if the need for what you plan to do is critical within the division or department, and if the funds exist. Typically, however, you need to find these sources or, more often, make a plan of how you will secure them. *A plan is not sufficient to cover your salary*, but it is critical if you want to get the needed coverage.

Things you'll want to consider:

- 1) **Be concrete (and realistic) about the time commitment:** When a faculty member wants to do something new or different, they will often be overly optimistic about the time commitment associated with the activity. This is the path to a nervous breakdown. Before you get too far in the planning process, figure out exactly how much time the activity will take. If someone is in charge of the activity (e.g. a course director), nail down exactly what the time expectation will be. Ask others who have done the activity before what the time requirement was. Plan conservatively – overestimate the time requirement up front and then you can work backwards as you understand the task better and become more adept and/or efficient. Knowing how much time a new responsibility will take is critical for two reasons: 1) You must avoid over commitment (see [Should I/Shouldn't I](#)), and 2) Your planned effort must match your identified salary coverage for the activity.
- 2) **Don't harm the clinical mission:** The phrase 'No margin, no mission' is a grossly reductionist view of what we do in academic medicine, but it is in fact true. At the end of the day, the clinical activities of a division or department must meet both the financial needs of the group and the clinical needs of the population we serve. If your clinical group has to run flat-out to keep up with the clinical needs, it may not be a good time to propose cutting your clinical time by 40%. If, as part of a strategic plan, salary coverage can be found for that reduction and contribute to a business plan for a new hire, this may be one way to address the issue. Before you get too far down this road, however, talk to your mentor and your division chief.
- 3) **Have a business plan:** Believe it or not, everything you do has one or more business plans associated with it, whether it's clinic, research, or administrative work. At the end of the day (or fiscal year) the value gained from doing something has to be balanced against the associated costs, and most importantly from your perspective, your effort and that of others involved in your proposed activity has to be covered. Whether this is through associated additional clinical productivity (RVUs; see [Metrics](#)), COM teaching funds (FTARS; see [Metrics](#)), University teaching funds (see [IBB](#)), grants, or funds from other sources. If you want to make a convincing case for your proposed activity (and associated change in effort), you need to have a plan for how the finances will work. Sometimes this is straightforward: you are asked to direct a course in the medical school and it comes with 0.3 FTE salary coverage (which you have determined will cover the amount of time you will need to invest). Sometimes it is complex: you want to start a new clinic which you will direct. This has a lot of moving parts to it: space, staff support, and your salary, to name a few. How will you cover these? Can you identify a time that your current clinic space is underutilized? ('free' space and staff support). How much *additional* revenue

will the clinic produce? (RVUs that are otherwise being 'left on the table'). Are there other funds available to support it? (e.g. foundation commitments, philanthropic support). Is your new clinic a priority that UVMCC will pledge to support? If so, get a commitment in writing. Once you have crafted a business plan for your proposed activity talk to your mentor and then to your division chief and/or business manager.

- 4) **Make your case:** Just because you see the imperative for what you want to do, don't assume everyone else will. Having a business plan is a great help, but it's not always sufficient to warrant a significant change in your effort. What will you gain in your career development with this new effort? How will the division, DOM, COM, UVMCC, or University benefit from your new effort? How does this advance the missions of the DOM? Make a compelling case and be prepared to answer questions. Expect some skepticism - everyone has great ideas, why is yours different? Be prepared to go back to the drawing board and re-craft your plan. Be persistent but *responsive* in your revised proposal - if you can't figure out how to address the issues raised, your plan may just not work, at least at the moment. Shelve it and come back later.
- 5) **Don't make a deal you can't live with:** You really want to be Clinic Director, but there's only 5% effort available to cover this activity and the way want to do it, it's a 10% job. Something's gotta give. Your options are: 1) Make a convincing case as to why it's a 10% job and the benefits that this effort will bring the group; 2) Downsize your expectations for the position - but be explicit about what they are when you do so; or 3) Don't do it - maybe someone else can handle the task with only 5% effort, or maybe it's impossible, either way you don't want to be on the hook for the 'unfunded mandate' that it would be if you took the job and performed it to your level of expectations.
- 6) **Lastly, get credit for what you do:** We all do things that we receive no quantifiable benefit from; Academic Medicine is populated with altruists even among the cynics. This doesn't mean that you should routinely perform tasks for which you receive no 'credit'. Most things we do actually do count for something, it's just a matter of understanding how to properly capture them. This ranges from understanding how to properly bill for clinical services (RVUs), if that is part of your job, to making sure that your teaching in the COM is captured by the DOM (FTARS). If what you are doing receives neither RVUs nor FTARS, then it should be advancing your career, and in this case should be captured in your CV. This includes mentoring, committee service, publishing, presenting at conferences, teaching medical students, residents, fellows, undergraduate and graduate students. Any effort that results in 'credit' for someone else but not you (e.g. supervising an undergraduate student in your lab, taking on pharmacy or EMT students for a clinical shadowing rotation), should prompt you to ask why you are doing this. If someone else is charging a student for an experience you are providing that is *outside of your expected effort*, the principle of Incentive-Based Budgeting ([IBB](#)) mandates that you (through your division or the DOM) should receive credit for a portion of that charge. This means that you need to pay close attention to activities of this sort and discuss them with your chief before taking them on. If you doing things beyond your expected effort that yield no RVUs, FTARS, or IBB benefit, and do

not lead to your career development as captured in your CV, you most likely should not be doing them.

## THE METRICS OF OUR LIVES

We do not make widgets - the upside of this is, well, that we don't make widgets; the downside of this is that we have a hard time quantifying just what it is we do in all its many dimensions.

**RVUs:** The 'Relative Value Unit' (RVU), or more accurately, the work RVU (wRVU) is what physicians produce instead of widgets. Although specifically developed for use by CMS (Medicare) to replace the "usual, customary and reasonable" fee structure, the RVU has become a universally applied metric of physician work. The long and sordid history of how the RVU developed is detailed [here](#) (AMA), and a good explanation of how they work can be found [here](#) (ACRO). Briefly, the RVU was developed in the early 1990's by researchers at Harvard as part of the Resource-Based Relative Value Scale (RBRVS), and is a metric used to capture the amount of resource utilization required to perform a particular medical service. This includes the "relative level of time, skill, training and intensity" to provide a given service. All billable physician services are reported as CPT ("Current Procedural Terminology") codes, e.g. 99244 "Level 4 Office Consult," and wRVUs, in theory, provide a way to translate CPT codes into an amount of 'work' performed.

In the case of Medicare's use of the RVU for payment, there are additional components that go into a final determination of resource use, including Practice Expense and Malpractice components of the total RVU. Each component of the RVU is adjusted by a geographical factor (Geographic Practice Cost Index or GPCI) corresponding to the RVU component (W, PE, or M) to take into account regional variation in costs of practice. The final, adjusted, combined RVU is then multiplied by a Conversion Factor (CF), set by CMS, which converts the RVU into an actual dollar amount for payment from Medicare.

In practice, RVUs are determined for all services provided by a physician (not just those delivered to Medicare beneficiaries) as a way to determine 'clinical productivity.' Thus, 'RVU targets' are a way to specify an expected amount of clinical work over a given period of time. Although 'quality' metrics are also being developed and implemented on both the national and local levels with the stated goal of emphasizing 'quality over quantity of care,' the primacy of the RVU has not faded.

Anyone with clinical responsibilities at UVM should be aware of not only their RVU targets for the fiscal year, but also how those RVUs are to be generated - e.g. how many patients do you need to see in a clinic to hit your target? This isn't so much to get you moving on the treadmill, but so you can understand how you can navigate your responsibilities. Providers also need to be aware of clinical activities that do not generate RVUs - generally, anything that you do not attach a billing code to. The time you spend on the phone with a patient? The hours you dedicate to arranging for DME, prescriptions, home oxygen, etc.? The meticulous note writing? Zero RVUs. Should you skip these activities? No, of course not, but it's important to understand why it often seems like you're working flat-out but running in place in the current healthcare system. The other reason to know this is to help avoid wasting your time and effort on things you *shouldn't* be doing: Those curbside consults you do for your colleagues? You receive only the liability.

**FTARS:** All faculty are expected to contribute to the educational mission of the COM, and faculty productivity is incentivized across all missions within the academic medical center. The College of Medicine developed the Faculty Teaching, Accountability and Rewards System (FTARS) in 1996 as a mission-based productivity system used to allocate general fund revenue to departments in proportion to their teaching, research and associated administrative activities. The allocation formula is updated annually and has traditionally used a variety of teaching, research and administrative drivers. Recently, an effort has been undertaken to revise the FTARS system (see [FTARS Committee report](#)).

**IBB:** The principle of Incentive-Based Budgeting should be somewhat intuitive for faculty in an academic medical center. As described in the [UVM IBB Final Report](#), IBB is “a management tool that will empower our academic leaders to develop and manage their resources strategically, efficiently, and effectively as the academic units continue to elevate the quality and reputation of academic programs in order to meet the needs of our students. IBB links strategy with resources at the appropriate level.” Simply put, IBB mandates that academic units (e.g. the COM) and in turn their departments (e.g. the DOM) are responsible for covering the expenditures associated with their activities, while revenues derived from these activities will go to that unit or department. Although cost-shifting in the forms of subsidies and ‘taxes’ continue to exist under IBB, these mechanisms become the exceptions and not the rule. The DOM runs under the principle of IBB on both sides of the academic medical center (UVM and UVMMC), paying rent for the clinic spaces, offices, parking, and labs we use. We pay for our portion of all ancillary services associated with our efforts at both UVMMC and the COM. It is critical to realize that nothing is ‘free’ under this system. However, any reduction in our expenses results in a greater ‘margin’ (net revenue) for us. Thus, opportunities for the DOM to increase its activities (especially those without associated revenues) depends heavily on the balance of revenues and expenses under IBB.

**Other academic ‘metrics’:** Publications, presentations, grants, mentees... What are the metrics for promotion? (Coming Soon)

## SHOULD I?/SHOULDN'T I? AND LEARNING TO SAY "NO."

Faculty members face this quandary on a daily basis related to administrative responsibilities, teaching, clinical service, community service, and the list goes on. Particularly as junior faculty, the question of whether to add commitments and then which ones is not only difficult but critically important. Can you fulfill all your obligations and add a new one? Where is the dividing line between being a 'good citizen' and sacrificing yourself for the team?

As a junior faculty member you have a variety of opportunities available to you. In addition to the defined clinical, teaching, and or research obligations specific to your promotion track, every faculty member is encouraged to participate in divisional and departmental committees, teaching, mentoring and other activities, and similarly at the hospital, College of Medicine, University, and national/international levels. On top of that, there are the other facets of working in an academic medical center that, although not necessarily required by your track, may be open (and possibly desirable) to you, such as research, teaching, clinical, or administrative responsibilities. Do you want to be the PI for that new study? What about that inter-division collaboration your colleague suggested? Should you take on a new lecture for the med students? It sounds like a lot of fun to develop the new curriculum for the fellows. Maybe you *would* be perfect for the directorship of the clinic... There are some days when the options and obligations seem overwhelming.

Keeping a clear vision of what you hope your life and career will be like in 5-10 years (and beyond!) can help guide how you pursue the opportunities presented to you. Will this activity help you meet people that will be resources for you in the future? Will it provide opportunities to develop new skills? Will it help build the reputation you are hoping to create? Will it move you closer to promotion? If the answer to these questions is yes, then whatever it is may be a worthwhile endeavor. The other component to keep in mind is: will this commitment stretch you too thin? Even if this seems like a great opportunity, the need to fulfill your clinical obligations and other commitments may make it impossible to take on a new task.

Saying no can be awkward or uncomfortable and many of us have not had a lot of practice doing it. Part of our training whether as MDs or PhDs was learning how to deal with heavy workloads and committing to long hours. However, if done indefinitely it will almost undoubtedly lead to burnout. So, we need to say "NO!" from time to time. Here are some tips from the Faculty Development Committee:

1. Be clear and honest with yourself and others- Be thoughtful about whether you can truly take on this new responsibility- if you feel you cannot, be clear and explain honestly why you are declining the opportunity.
2. Are there others who may find this to be their perfect opportunity? Consider referring or recommending a colleague whose interests and goals are more closely aligned with the committee or project.
3. Don't consider it a personal failure or fear missing an opportunity. You are making a choice to ensure that your current work does not suffer because you are overextended, and may allow you time for that next opportunity that really aligns with those goals you set for yourself.



## HOW CAN I BE MORE EFFICIENT?

One of the hardest things to learn as an academician is how to manage a work environment full of competing priorities and ever-changing systems. Whether one is seeing patients in clinic or preparing a lecture for students, time constraints always loom large. One way to address these constraints is through increasing your efficiency in accomplishing your tasks - sometimes by getting better and faster at what you are doing (e.g. using dot phrases in PRISM), and sometimes by rearranging how you do them (e.g. consolidating two half-day clinics to one whole-day to free up some contiguous time one day a week for lecture preparation). Here are some tips from the Faculty Development Committee to improve efficiency across the many tasks you may face. If you have any suggestions for Efficiency Tips, please send them to the [Committee](#) for inclusion on our list!

### Clinic:

- 1) When deciding on the days you want to do clinics, consider having a day set aside for scholarly work or preparing for lectures. Half days are just not adequate to get the work done. Also consider working away from the clinic on that day (such as your research lab or library).
- 2) Be very careful with scheduling patients and the time you want to allot new patients or established patient visits. Keep in mind that besides the time it takes for the face-to-face encounter, an almost equal amount of time is needed to complete the notes, make follow up calls and close the encounter.
- 3) Use smartphrases or smarttext in your clinic encounter notes. You would need to create your own template to fit your style and meet the billing requirements. Having your own smartphrases can make you very efficient.
- 4) Consider having residents or students in your clinic as they may help ease the clinic load.
- 5) Have a good balance of inpatient vs outpatient responsibilities. This allows a change in your routine and a new teaching environment can be invigorating.
- 6) Take the help of your clinical nurses and staff to make patient calls. If non-urgent, you can simply type a letter to be sent to the patient. This saves enormous time and effort.
- 7) Try to complete your patient encounter notes the same day or within 24 hours. Procrastinating just increases the time you spend to complete the encounter as you need to recreate the story. If needed, you can place addendums to your signed and closed patient encounters.

### Administrative:

- 1) Enroll in committees only if you have the time and enthusiasm to serve in the committee.

### Teaching:

- 1) Consider using canned PowerPoint slides from your colleagues and focus on the major teaching points only. Students, residents and fellows have access to a lot of information and not everything needs to be covered in a talk.

Scholarly work:

- 1) While single-authored publications are possible, try to have co-authors as it pushes everyone to meet the deadlines and complete the assigned research work in a timely manner.