The Cutting Edge

the Association of Academic Surgical Administrators

www.aasa1.org September 2013 Edition

President's Message:

The Company I Keep

Bess Wildman, President

Last week my kids started a new school. It has been a roller coaster of a week watching them cope with all the newness. The new school has a uniform, and there are different rules about homework and personal responsibilities. Obviously, neither one of them knew anyone in their class, or any of their teachers, or even where to go for various things. Even things as mundane as lunch rituals and pick up and drop off are different. I have to applaud the school; they have done a great job of orienting them to all of the traditions and norms. Each child was paired with a "Tiger Buddy" who reached out over the summer and talked about the new school. Several parents, teachers, and classmates of our children have reached out over the summer. Everyone has been supportive, kind, and welcoming to them. yet it has not been easy.

Despite fears and worry, my son has decided to make the most of it and has eagerly jumped in. In a particularly profound moment he offered that the new school gives him a chance to be the best of who he was at his old school and a chance to shed some less flattering aspects of his persona. I wish I had his insight and his adaptability. A mere five days and he is enjoying being the most experienced trumpet player in the class, is already playing Mine Craft with some of his new Nashville buddies, and is actively trying to fit into all of the new customs that are a part of his new school and class.

I don't know if it is the age, the gender or just the kid, but for my daughter, the transition has been much more challenging. It is heartbreaking to watch as my 13-year-old daughter Camilla grieves the loss of her friends and her school while struggling to navigate this change, figure out a new social network, ensure she does well in school, blend in, and keep up her connections back in Winston-Salem. We battle moments of acting out, tears, anger, and true fear of what is to come. I try to tell her all of the opportunities and good things about her new school and Nashville - but to her, all of that is unknown and uncertain.

(Continued on page 2)

The Company I Keep (Continued from page 1)

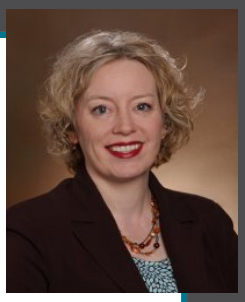
I recently had a conversation with our chief residents about their transition from trainee to faculty. This was not the first time I have been asked to help provide advice to trainees on the business side of their career choice. Normally, these conversations touch on negotiation of contract terms, understanding benefits, reasonable packages for research or clinical practice, and compensation expectations. This year's discussion was different; I had to pause. I realized that by the time they finished their fellowships, these young surgeons would be entering a workforce that looks different than the one that they have trained in. It will look different than the one I have worked in for the last 18 years, and I am not sure how to advise them.

As we shared our thoughts about how declining reimbursement, quality, health care reform, sequestration, etc. will impact their futures, I watched a glimmer of fear pass over each of their faces. In that second, the reality that despite their confidence with a scalpel, or teaching others, or their scientific understanding. they know their future is unclear. They are about to get a front row seat to healthcare reform. The worries of individuals stepping into a career in healthcare may be slightly more profound than who will sit next to them their first day at school. However, I realized that in many ways they were the same as Camilla. Their future is unknown and uncertain. And they too do not know how to be successful in a world where the rules, the expectations, and the culture are unknown.

These are the times we live in, and my daughter and our chiefs are not alone. There are thousands writing about change and ambiguity and pretty much every one particularly in our industry is experiencing it. The new rules, expectations, and cultures will be born out of efforts to eliminate waste, improve efficiency, and change to the economic model that has been the foundation of health care since the creation of Medicare. And as I read about so many of our organizations making cuts, I appreciate the loss that change brings. I am learning for my daughter, for our employees, and for me, it is difficult if not nearly impossible to process change in a way that we can see through it to envision the place beyond it. We have no map, no compass or clear understanding of the end point of our journey. But from reading the articles in this quarter's *Cutting Edge* and taking stock of the agenda for the National Meeting, I take comfort in the company I keep. Similar to my daughter, there is a network supporting us as we navigate change. And I for one will continue to lean on my AASA colleagues for insight, advice and support .

On a final note, as I finished typing this, I received an email from one of my daughter's teachers. In it she compliments Camilla on her graceful transition into the community, ease of making new friends, and early academic success. I hope this means that perhaps her future is becoming her present and she will be better for the change. Who knows, she might even thank me for moving us one day.

IT'S A TIGHT RACE FOR THE EGGS AND BACON!



Before I share the current new member competition I want to welcome all of the new AASA members who have recently joined. It has been a busy couple of months but I'm excited about the continued interest in our organization by new members. Please take a moment to welcome these new colleagues. You can find their contact information after you login online at www.aasa1.org. Go to Member Resources and then Directory Search to look them up.

And now on to the competition! As a reminder, the AASA Board has decided to engage all of the regions in a new member drive competition. Each region will get one point for a new member and an additional point if they are from a medical school not currently represent by our roster. The region with the most points by the fall annual meeting in October will be treated to a full breakfast, with bacon J at the Tuesday morning regional breakout session. Below are the current standings.

If you know of someone who would benefit from becoming a member of AASA please share with them how great this organization is and direct them to www.aasa1.org and the "join us" button at the top of the page. Hearing a personal testimony about the organization is an easy way to gain new members. If anyone has questions regarding membership please direct them to me at Stephanie.Farmer@UCDenver.edu.

AASA 2013 RECENT NEW MEMBERS

First Name	Last Name	University	Region
Bernardo	Huapaya	Cornell University	East
Brad	Insco	University of Colorado	West
Christopher	Wang	University of California - Davis	West
Dennis	Murtagh	Montefiore Medical Center	East
Diana	Barden	Virginia Commonwealth University	South
Gayle	Meadows	Virginia Commonwealth University	South
James	Henry	University of Pennsylvania	East
Jaskaran	Birak	University of California - Davis	West
Jessica	Kovac	Beth Israel Medical Center	East
Julia	Snow	University of Kentucky	South
Kent	Bliss	Vanderbilt University	South
Linda	Combs	University of Kentucky	South
Lisa	Lester	Stanford University	West
Marc	Cella	Harvard University	East
Mariah	Bowden	Oregon Health & Science University	West
Mary Beth	Camacho	Virginia Commonwealth University	South
Meryl	Gold	Columbia University	East
Michael	Panion	University of California - San Francisco	West
Nina	Luppino	Icahn School of Medicine	East
Robin	Main	University of Florida	South
S. Jean	Royal	The Ohio State University	Midwest
Thomas	Taddonio	University of Michigan	Midwest

Region	New Members	New Schools	Total Points
East	14	2	16
Midwest	9	1	10
South	14		14
West	10	1	11

Top Ten Reasons to Join Us in DC

Megan Berlinger and Nicole Buikema

As we prepare for this year's annual AASA conference in Washington, DC, below is our top 10 list you can anticipate. If you have not yet registered for the October 6-8th conference, you can register at:

http://www.aasa1.org/Annual-Conference-Registration.

10. Location: This year's conference is in our nation's capital. The Grand Hyatt is located near China Town, across the street from one of the Smithsonian Museums, and a short walk to the White House and National Mall.

9. Transportation: The Grand Hyatt is located at the Metro Center metro stop providing very convenient transportation. The Grand Hyatt is about a 20 minute metro ride on the blue line from the Reagan airport and less than $3. Sunday's events are three metro stops away from the Grand Hyatt on the red line. The program will contain directions for these events.

8. Social Opportunities: There are two options for evening social opportunities this year, one within the Grand Hyatt and another at a local restaurant each night. This provides a chance to unwind and get to know colleagues around the country after the conference.

7. Application: The conference provides examples and case studies that we can all return home with ideas and apply to our situations.

6. Professional Development: This year's Sunday lunch speaker will focus on professional development providing strategies for resiliency within a demanding surgical administration environment.

5. Poster presentations: This year's conference has the opportunity for participation in sharing research and best practices. A cocktail hour on Monday provides attendees to learn from these posters and for discussion.

4. Celia King Dinner: An annual tradition, the Celia King dinner is included in registration for all attendees. It is an opening night reception and sit down dinner that celebrates the history of AASA as well as the reason we are invested in careers in surgical administration. The Hamilton is the location for this year's dinner and is located within blocks of the Grand Hyatt.

You know we can "administrate", but did you know we can sing too?

My favorite networking opportunity has to be the hospitality suite at the end of each conference day. We get to come together in a casual setting and get to know each other a bit more and have some fun while at we are at it. Rumor has it that the karaoke machine will be back this year...maybe with some new songs.

-Benson Won

3. Partnership: We are partnering with the Surgical Chairs again this year for an invigorating discussion on Sunday around reform and out of the box strategies. All attendees will also receive access to American College of Surgeon convention center activities.
2. Connections: The AASA conference provides opportunity to connect with colleagues across the country. This is valuable in building your network to share best practices, commiserate, and have contacts for post conference questions the entire year.
1. Incredible Content: This year's conference focuses on updates within reform and current healthcare environment as well as strategies to help us each move surgery successfully into the future. To view the program agenda:
http://www.aasa1.org/2013Agenda.

We look forward to seeing you all in Washington, DC in October.

If you have not booked your hotel rooms yet, please do so soon as rooms are limited. The most convenient way to secure your reservation is by visiting the following website: https://www.tphousing.com/acs_aasa/. or call Travel Planners at 888.810.4455 between 9:00am - 7:00pm EST to make your reservation. Remember to indicate that your reservation is for the AASA block at the Grand Hyatt DC.

"cFTE, The Mystery Definition"

Stephanie Kearney, MBA, MHA

The definition for clinical FTE (cFTE) has been one of the recent elusive terms in academic healthcare. With looming changes in healthcare medical service payments and the forced redesign of physician compensation, cFTE is taking center stage.

cFTE has a wide variety of definitions ranging from core concepts such as clinical hours per week, funding, deductions, percentages, etc. However, in my search for the perfect cFTE definition I have found two definitions to be the most common.

1. Deduction Method – Starting with a 1.00 FTE, deductions are made to the total FTE based upon defined hospital leadership roles, academic leadership roles, grant effort, protected research time etc.

   For example, a Division Chief may be 0.80 clinical and 0.20 administrative for his/her role thus being a 0.80 cFTE.

2. Hours Worked – Based upon the physician's calendar or schedule, outline how all 10 half days are spent and for what activities.

   For example, a Division Chief reserves Wednesday AM for his/her chief duties thus being a 0.90 cFTE.

Although both definitions appear to be at polar ends of the definition spectrum, they are more closely related than one might think. In an ideal world a physician's schedule would accurately reflect the Deduction Method. However, we all know this not to be true especially for surgeons. From my experience, Division Chief's traditionally do not 'block' their schedules for their chief related duties. The necessary administrative duties are done before or after the work day as this is when their faculty are available as well. When this is the case, the Hours Worked definition can be punitive to faculty who are held to a wRVU target based upon their cFTE for compensation purposes. In these cases, the expected clinical generation of the chief is no different than their faculty members which are not the traditional expectation.

In my Department of Surgery, there is a Chief who holds two half days clinics and performs surgery all other days of the week including weekends. Although he shatters his wRVU University Health System Consortium (UHC) benchmark he has also been able to establish nationally recognized programs across three hospitals in his non clinical time. If the Chief

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Done Right... Centralization +/- Integration = Revitalization

Jeff Albers

Change in my work environment is a common theme at the dinner table in my house. Recently, I was discussing the difference between centralization of services and integration and how many health systems are moving in that direction. As I've learned at Northwestern, the drivers of successful centralization and/or integration have to be the end results– **a better patient experience and expanding market share via reputation and recognition in the industry**.

It's easy to see the advantages of bringing operations from each clinical practice under one management structure:

1. Most important, it's easier to maintain a consistent patient experience.
2. Shared resources can help retain internal talent by creating a clear development path for clinicians and management.
3. Safety and compliance policies can be better defined and implemented.
4. Done right, you can enable collaboration and idea sharing.

The difficulty and in some cases disadvantages comes when you acknowledge the feeling of loss-of-control and specialty knowledge. Those acknowledgements have to be met and mitigated by **creating a culture of collaboration and engagement** with internal communication. In addition, it's important to **maintain departmental expertise and influence within the clinical operation**. The physicians need to remain engaged and ultimately responsible for identifying clinical needs and creating a vision.

That same loss-of-control is also a defining point in the argument about integration of practice plans with hospitals, development/philanthropic arms, etc. Something we are all grappling with at Northwestern right now is that ambiguity in who is driving the decisions during the transition period. Is it the hospital? Is it the doctors? Eventually, when we **create a "culture of one,"** the control and ambiguity issues will diminish.

For now, the focus has to be on the positives of integration:

1. One decision-making structure enables proactive leadership, rather than reactive

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On Leadership

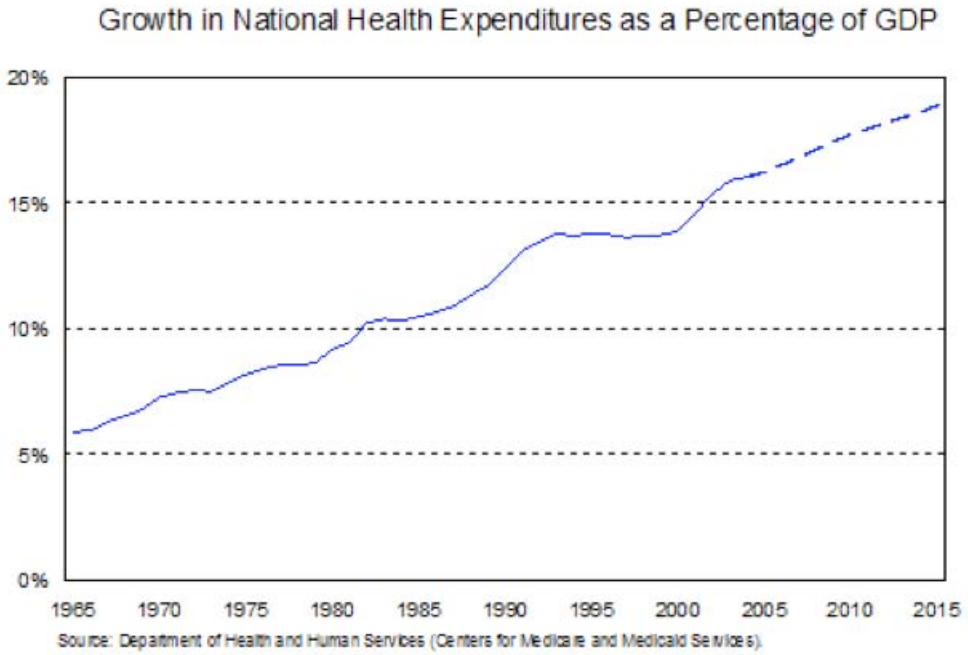
David Kaplan

We have all been hearing it for quite some time, there are big changes coming in healthcare. There are many that have been predicting cataclysmic events to occur including the end of our healthcare system as we know it. To some we should all run for the hills and jump in our bunkers for the pending Armageddon. The reality is that change has indeed arrived on all our doorsteps and evolution of our healthcare system will continue as the market forces take hold. These changes will indeed prove challenging for us all, but hardly worth running for a different career. In fact, I would argue the opposite, instead this is an amazing time to be working in healthcare, and especially in Surgery.

Never before have we experienced a time in the US Healthcare system that offered such wide reaching coverage to our citizens via the Affordable Care Act. At the same time we continue to see amazing technical and pharmaceutical advances in treatment of a vast array of diseases, disorders, and the ability heal in ways never seen before. This has placed many of our institutions in extremely high demand, so there is no shortage of work in many of our hospitals.

All these innovations and increased hospital census do of course come with challenges which include; how to ensure every patient has access to high quality care, increased costs of new treatment modalities. The continued rise in expenditures (see Table 1) with shrinking reimbursement is one of our largest obstacles to overcome, never has the need to do more with less been truer.

Table 1



The only way to successfully navigate our way through these challenges will be our fortitude as leaders and our ability to help our organizations succeed. To quote Sun Tzu, **The Art of War**, "A leader leads by example not force", speaks to the fact that there is nothing more powerful than a leader who can and does walk the walk. As leaders, we will be tested along with our Department Chairs. It is this critical relationship that for many of us will determine our future roles. For example, many of the traditional structures in academic medicine will be changing due to many reasons (See Table 2). These changes may cause many academic and/or clinical departments to cease to exist as we know them. Instead, many of our departments will be shifting into Institutes, Centers, or even service lines across health systems.

TABLE 2: DRIVERS OF CHANGE IN ACADEMIC MEDICINE

New science and technology, particularly genetics and information technology.
The rise of sophisticated consumers.
The feminization of medicine.
Globalization.
Emergent diseases.
The increasing gap between rich and poor.
The unimportance of distance.
The demand for more from health care by "big hungry buyers."
The spread of the Internet and digitalization.
Managerialism.
Increasing anxieties about security.
The expanding gap between what can be done and what can be afforded in health care.
The lack of agreement on where "health" begins and ends.
The aging of society.
The increasing accountability of all institutions.
The loss of respect for experts.
The rise of self-care.
The rise of ethical issues.
The 24/7 society.
The economic and political rise of India and China.

Awasthi, Shally, Beardmore, Jil, Clark, J, "The Future of Academic Medicine: Five Scenarios to 2025", July 2005, Milbank Memorial Fund.

Through this, as our organizations seek to fix these issues there will be chaos abound. There will be consolidations, mergers and acquisitions, cost cutting, layoffs, and right sizing. There will be political power plays, and musical chairs in leadership regardless of location, organizational size, or financial status. A true leader will filter this noise remain focused and will keep their team working to take care of our patients, which remains the primary reason we are all in this business. This will require constant communication and feedback to our faculty, management, and staff regarding their performance, and keeping them abreast of the key happenings in our respective departments. This will require us to take some time to personally thank our staff, and to find out what we can do to make their jobs

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5 Ways to Teach Physicians About Financial Management

Jeff Akers, CPA, Senior Consultant,

McKesson Business Performance Services

Akers specializes in financial, business advisory, and practice management services for medical practices. He provides strategic and financial analysis, performs practice reviews, prepares compensation plans, implements financial management best practices and internal controls, and prepares cash flow forecasting for medical groups. Prior to joining McKesson, Akers provided consulting services to physician groups for a national health care services organization and spent five years in public accounting specializing as an auditor of health care systems. He is a member of the American Institute of Certified Public Accountants. Akers holds a bachelor's of science degree in accounting as well as a master's degree in accounting from East Tennessee State University.

The delivery of high-quality care is the No. 1 priority for physicians—but quality should be supported by sound financial management. Here, Jeff Akers, CPA, a senior consultant with McKesson Revenue Management Solutions, shares strategies for helping physicians understand what is driving the bottom line.

Review basic financial reports and key metrics monthly

Three reports – the balance sheet, income statement, and cash flow forecast – can give physicians a clear, concise indication of the group's financial performance, Akers says. Keep it simple: What does cash flow for the organization look like? How is revenue trending? Are there any outliers in expenses? What is the forecast for cash flow based on volume and payment trends? The key is comparing current periods with prior years' performance and against budget to reveal variances and trends. Reviewing measures such as revenue per FTE, compensation package per FTE, and overhead as a percentage of total expense also will help physicians understand whether their practice's performance is in line with its business plan and how the practice compares with other practices nationally.

Share relevant benchmarks

Be sure to benchmark data that physicians consider important, Akers says. Physicians often want to know how their group is performing relative to other practices. Common productivity measures are work relative value units, cases, base units, procedures, and number of patients seen per hour.

Show physicians why accurate documentation matters

Although claim denials may end up in the business office, they often start in the physician's office because physicians have neglected to include required, proper documentation. First, define the problem by showing denials per physician, per procedure and/or patient, and per payer. Then, beginning with a service that is experiencing multiple denials, explain why the claims are often denied and the financial implications to the practice. "If you're not educating physicians on proper documentation and continuous coding changes, there is a

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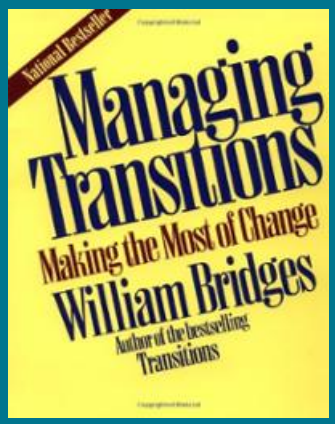
From My Bookshelf:

Managing Transitions

(De Capo Press, 3rd Edition, 2009)

by William Bridges

Shaun Hernandez



In this era of healthcare reform, we are reminded time and time again of the impending and significant changes that lie ahead. From hospital closures to an all-out paradigm shift in how we are incentivized to provide care, those closest to the action have made quite clear the fact that the future of healthcare will look very different from the present.

We are, in other words, in a period of transition. But what does this mean, really? What are its implications? And, as leaders, how do we manage it? In *Managing Transitions*, William Bridges answers these questions with a refreshing balance of theory and practicality.

Bridges begins by distinguishing between *change*—a "situational" phenomenon defined as a move from one discrete point to another—and *transition*, a "psychological" process involving the individuals affected by change. He describes three phases to the transition process:

- ***Ending, Losing, Letting Go*:** This first phase is critical in the transition, as a successful ending is requisite for a proper new beginning. Much of Bridges' discussion in this section details the leadership qualities necessary to shepherd people away from the old and toward the new.
- ***The Neutral Zone*:** Bridges describes this phase as "...a state of affairs in which neither the old ways nor the new ways work satisfactorily." To combat against the dissidence, productivity declines, and anxiety elicited during this time, he encourages managers to set clear goals to be met, optimize communication, and create a "Transition Monitoring Team" (TMT) composed of a cross-section of the organization to "take the pulse of the organization in transition."
- ***The New Beginning:*** Again differentiating the "situational" concept of a *start* with the "psychological" notion of a *beginning*, Bridges argues that in order to plan a successful beginning, managers must exercise patience, utilize communication, and demonstrate a clear vision among their team.

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Hospital/Physician Payment Arrangements: Strategic Investments

Mr. Matthew P Johnson &

Ms. Neelam Patel

Introduction

This article is the second in a series that describe the most common types of hospital/physician payment arrangements within an academic medical center (AMC). Specifically, it provides an in-depth exploration of the role that strategic investments play in departments of surgery.

Payment arrangements for strategic investments are often based on historical negotiations that predate current department and hospital leadership teams. These arrangements often lack a clearly documented methodology for determining payment amounts and are rarely linked to performance, service agreements, or actual department expenses. A formally defined framework is necessary to ensure transparency, strategic alignment, return on investment (ROI), and consistency with the goals and objectives of all stakeholders.

Payment Types

Strategic investments within an AMC can typically be classified into one of the two categories below.

Program Support

Departments may operate mission-critical programs or lead strategic initiatives that are not financially sustainable due to various market factors (e.g., volumes, reimbursement, care models). As a result, surgery departments often receive strategic investment funding from the hospital to offset the deficits incurred from providing these services. Program support payment arrangements are typically ongoing. However, departments may receive time-limited support from the hospital to assist with development costs for new programs. Transplantation is an example of a surgical program that often requires support through strategic investments for an initial development period and may receive ongoing support depending on volumes and degree of subspecialization. Recently, several clients have also reported seeking strategic support to sustain their cardiothoracic programs.

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Done Right (Continued from page 8)

response to market trends.

2. Preparing for the effective implementation of healthcare reform.
3. Creation of a coordinated vision with shared goals for multiple stakeholders.
4. Driving operational efficiencies and keeping the organization lean allows for nimble, swift action.

Back at the dinner table, these positives played out in a discussion with my wife. As Northwestern pushes forward from our US News and World Report #6 position in our goal to be the #1 academic medical center in the country, shared goals can help us implement big ideas. Right now, we're working to create a lung transplant center. In our non-integrated structure, the practice plan would have concocted the idea, gone to the hospital to convince it to provide funding to recruit a top physician and been responsible for meeting the objectives developed on one side of the team. Then, three years later, the hospital would have assessed the outcomes without being part of the process. Sound familiar? Now, we have the opportunity to create a shared goal, recruit and retain the talent we need to make it a reality, make quick decisions needed to advance the center and collaborate to give our patients the best possible experience.

Ultimately, there's a missed perception that centralization is happening because of integration. At Northwestern, centralization of some functions would have happened anyway because it's driven by a response to patient needs. Whether centralization happens first, or in tandem like it is for us, the driver of both changes has to be a better patient experience and enhancing the capabilities of the institution to become a market leader. If we do that, we will achieve big wins for all our stakeholders and will revitalize our organizations and our industry.

On Leadership (Continued from page 9)

easier. We might want to plan some employee recognition events, maybe even find a way to work in a holiday party of some sort to show appreciation. While we would all enjoy a raise, or bonus, sometimes it is not always about the money, but about recognition for all the great work our teams do throughout the year. As leaders we often get caught up in the day to day grind, and sometimes it is easy for us to get stuck in meetings and not see daylight, but we cannot lose sight of those that help us succeed, and that help our patients every single day!

Leadership in this changing healthcare landscape isn't easy, and will only get tougher, but I once again argue that this is one of the most exciting times in healthcare, one that will allow us to reinvent academic medicine and to establish ourselves as true leaders in this market.

5 Ways to Teach Physicians *(Continued from page 10)*

high likelihood that the practice is being denied payment," Akers says. Ideally, this monthly agenda item will become less time consuming over time due to improved documentation and fewer denials.

Connect the dots

Physicians should periodically view their practice through the lens of a business owner, keeping in mind that each decision has a bottom-line impact. Physician groups should have a decision framework in place that provides an efficient process for making business decisions. For example: Who has authority to decide? What are the bottom-line implications? Is there a downside/risk? How soon must the decision be made? Each decision should comply with the group's financial, strategic, and patient care objectives.

Keep it brief

Be respectful of a physician's limited time. During financial reviews, physicians should be able to immediately understand where the practice stands. Do not overcomplicate the presentation with details that will cloud key information. Instead, use dashboard tools to zero in on only those metrics physicians need to know; then, be available for subsequent outside discussion if further explanation is requested. "Physicians are busy. Often, their business meetings occur at the end of a long day. The last thing they want to do is sit in a two-hour accounting session," Akers says.

For more information on what impacts your practice's bottom line, contact us at 1-800-877-0132 or performanceinfo@mckesson.com.

ANYONE FOR GOLF?

One of the activities we will be offering this year is a Golf Tournament to be held on Saturday, October 5 starting at 11:30am. Please see the attached flyer for more details. If you have already registered for the conference and did not choose the Golf option, no problem, just let me know and we will get you signed up. If you have not registered for the conference, you still have time. Go to www.aasa1.org and click on Register now link on the menu. Don't forget to log in first to enjoy the $50 member discount. Choose the golf option if you are wanting to join us for a fun-filled day on the links.

Strategic Investment Continued from page 12)

Faculty Start-Up

Surgery departments often require hospital funding to cover the costs associated with new faculty members as they establish practices and build productivity. Payment arrangements related to faculty start-up are agreed to for a defined period of time; commonly, 3 to 4 years, with a step-down approach for hospital support over the length of the payment arrangement.

Payment Mechanism

Based on our experience with AMCs, the most effective methodology for determining program or faculty start-up support is based on a negotiated funding amount backed by a specific business plan. A standardized business plan template for program support and faculty start-up ensures that executive leadership teams and decision makers have the information required to appropriately assess potential strategic investments. Additionally, business plans should link support funding to the value of services provided and document the ROI for the teaching hospital through an agreed-upon set of metrics.

It is imperative that the assumptions driving the business plan incorporate specific financial data and include targets for productivity and performance. A description of the duties or services should also be documented so that the department and teaching hospital understand and agree to all commitments and expectations. The table below provides a high-level overview of business plan components and potential considerations.

Program support business plans should be mutually agreed to by the hospital and department and reviewed on an annual basis against department and program finances, hospital operational needs, and performance targets and adjusted accordingly. Faculty start-up business plans should have an agreed-upon approach to modify the business plan in the event that faculty performance exceeds targets (including possibly ending the start-up plan).

Conclusions

While many AMCs have improved the clarity and objectivity of strategic investments, the opportunity for greater transparency and alignment lies within a hospital/physician payment strategy that is grounded in business planning principles. The outcomes from a business plan methodology can provide surgery departments and their teaching hospital partners

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Strategic Investment Continued from page 15)

Business Plan Component	Potential Considerations
Objectives	Description of the duties or services provided. Description of how the position, service, or program benefits the department, School of Medicine (SOM), and hospital and furthers strategic objectives. Remediation plan, in the event that anticipated funding sources are unavailable or productivity does not achieve projected levels.
Funding Sources	Program/faculty patient care revenues. SOM financial contributions. Hospital financial contributions.
Funding Uses	Cost of faculty physicians, midlevel providers, support staff, etc. Non-personnel and indirect costs.
Projections	Faculty effort across missions. Productivity levels and performance.

with greater predictability in the levels of strategic investment. In addition, business plans link actual financial data to payment levels, which safeguards that department expenses related to program support or faculty start-up are accounted for. Ultimately, a business plan approach to strategic investment ensures that mission and strategic priorities are appropriately funded and served.

The final article in this series on hospital/physician payment arrangements will explore several methodologies for structuring clinical coverage arrangements.

* * * * * *

This article was submitted by Mr. Matthew P. Johnson, Manager, and Ms. Neelam Patel, Senior Consultant. To learn more about AMC funding arrangements, please contact Mr. Johnson at 206-689-2200 or *mpjohnson@ecgmc.com*.

About ECG Management Consultants, Inc.
ECG offers a broad range of strategic, financial, operational, and technology-related consulting services to healthcare providers. As an industry leader, ECG is particularly known for providing specialized expertise regarding the complexities of the academic healthcare enterprise, strategic and business planning, specialty program development, and hospital/physician relationships. ECG has offices in Boston, Dallas, San Diego, San Francisco, Seattle, St. Louis, and Washington, D.C. For more information, visit *www.ecgmc.com*.

Development of New Administrator Certification

Rebecca Napier

Many mature professional organizations have some form of training or certificate program available to their members. Completion of these certificate programs indicate a level of knowledge, competency, and professionalism. The AASA has grown significantly over the past 26 years, both in number and knowledge base, making an AASA Surgical Administrator Certificate Program a logical next step. We want to provide something more robust, specific, and academically driven for surgery administrators than other programs currently offered.

During our September 5th webinar, we will discuss the development of the AASA Surgical Administrator Certificate Program—an exciting new opportunity for our members. This is the beginning of further discussions regarding professional development and the role of an administrator that will occur at our annual conference. Particulars regarding the modality, curriculum, and other program details are just a few of the points for consideration and dialog. This is an opportunity for less experienced administrators to provide input on the areas they need more information on and for senior administrators to provide the content and mentorship needed for the program. Please join Rebecca Napier, Department of Surgery Administrator at the University of Kentucky as the host of the September 5th AASA Webinar, starting at 3 pm. You can register for the webinar at http://www.aasa1.org/Administrator101

"The AASA was *not* what I expected when I attended my first meeting in Philadelphia a few years back. Instead of a predictable program and somewhat stiff environment, I was welcomed into a warm, engaging group of individuals who exceeded my expectations in terms of organization, content and activities.

From getting to know my AASA 'buddy' to networking with administrators from around the country, to having fun at the Celia King Dinner (& late night karaoke!), the annual meeting is a whirlwind of stimulating conversation, exposure to new ideas and engrossing speakers, while truly connecting with friends and colleagues.

The AASA is *unique* - it is a highly professional yet laid-back organization that has evolved from a core group of dedicated and visionary surgical administrators; this group continues to grow, expand & innovate each year, while at the same time keeping the feel of the regional & annual meetings relaxed and welcoming. I am looking forward to attending my 4th AASA annual meeting in Washington, DC on October 6-8!"

- Kira Martin

CFTE the Mystery Definition (Continued from page 6)

can be both clinically productive and manage his division effectively should he be held to a higher standard? This question is one my department leadership is still striving to answering. However, as of today they are leaving towards no. For this reason, my Department will be adopting the Deduction Method for next year's compensation plan and wRVU expectations.

As we all search to better define cFTE in our respective institutions we can all be certain that our struggles are the same. Who knows what the perfect definition for cFTE is, but perhaps it will become more transparent in the future.

From My Book Shelf (Continued from page 11)

In his discussion of the theory behind each of these phases, Bridges weaves in practical advice, often in the form of case studies. The book thus functions as something of a workbook with which managers are able to measure and improve their transition-taming skillset.

Although Bridges' advice can at times feel both monotonous and trite (communication, trust, vision as the keys to a successful transition), I believe it is his elucidation of transition theory in conjunction with practical, real-world steps managers can take that delivers the greatest value to readers.

This is a quick read that sheds useful light on a timely subject. Overall, I believe it deserves a space on any healthcare manager's bookshelf.

Do you have ideas or suggestions on topics you would like to see in future editions of *The Cutting Edge*? Please let us know by contacting Bess Wildman at bess.wildman@vanderbilt.edu or Stephanie Schroeder at sschroed@med.umich.edu