Creating an Effective Compensation Plan for Academic Medical Faculty: A Toolkit for Departments and Chairs

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**Why was this toolkit created?**

The purpose of this toolkit is to serve as a resource to departments and chairs in their development of compensation plans that most effectively achieve institutional and departmental strategic goals, as well as the personal and professional goals of their faculty. We summarize approaches to compensation and incentives and related experiences, published literature and work with six partner departments at the University of California Davis School of Medicine that included structured interviews and review of their compensation plans. So that departments can make the most informed, outcomes-based decisions regarding the optimal design of their own plans.

An additional goal of this project is to support career flexibility and work-life integration by appropriately defining compensation criteria and incentives that mitigate unconscious biases. Our school standardized its flexibility policies across all departments in 2004[1](http://www.ucdmc.ucdavis.edu/academicpersonnel/academicleaves/pdfs/Family-Friendly-policies.pdf). But like most medical schools, our policies have not achieved their full potential to enhance flexibility, or increase faculty satisfaction and productivity. This project received funding from an Innovation Award for Medical School Faculty Career Flexibility from the Alfred P. Sloan Foundation and the American Council on Education. The project’s goal is increase flexibility in our school by addressing unconscious biases. A recent survey of our faculty revealed the faculty’s considerable reluctance to use UC DHS’ policies due to a variety of barriers and biases that can stigmatize those using flexibility policies and which have been shown by others to lead to depressed earnings and limited career opportunities.4-9 Since compensation plans can powerfully communicate organizational values and priorities, they can greatly influence faculty behavior. It is our strong belief that addressing flexibility within the context of the compensation plan will grow a culture of flexibility, enhance team-based citizenship, increase faculty satisfaction, and support existing incentives and recognition of performance in clinical care, research and education.

Lastly, we hope that this toolkit helps to address emerging needs and related scenario planning as changes in health care delivery, payments, and incentives occur. It is difficult to fully anticipate the future, but better understanding of existing models and their advantages and disadvantages may help departments re-design these models and create new ones that better address the challenges as they arise. This toolkit is intended to become a living document that is updated regularly to share experiences from which all can benefit.

**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.

Smithson and Koster purport that 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>
<thead>
<tr>
<th>Need</th>
<th>Description</th>
<th>List elements in your plan that meet this basic need</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Faculty Needs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Security⁹</td>
<td>Sufficient income to provide for personal safety and basic economic needs (pay bills, repay loans, housing). Ensuring security builds trust.</td>
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<tr>
<td>Self-Esteem⁹</td>
<td>Demonstrate respect and value for a faculty member’s education, experience, skills, accomplishments, contributions, and stature in the local community and the broader medical/scientific community.</td>
<td></td>
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<tr>
<td>Fairness⁹</td>
<td>Demonstrate that processes are consistent, rational, and ethical, and that measures of performance are objective and understandable. Includes information-based evaluation of faculty accomplishments and performance metrics for salary adjustment.</td>
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<tr>
<td>Flexibility to Achieve Personal and Professional Goals¹²</td>
<td>Criteria that allow reward for a faculty member’s role within the department that is aligned with his/her academic series, and that minimize need for “face time”</td>
<td></td>
</tr>
<tr>
<td><strong>Organizational Needs</strong></td>
<td></td>
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<tr>
<td>Maintain academic and organizational values¹⁰</td>
<td>Ensure adequate attention to the academic mission and accultural to the values of the institution while recognizing that faculty members fulfill different roles and that all contribute in different ways to academic success of the department.</td>
<td></td>
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<tr>
<td>Generate sufficient revenue to subsidize non-revenue generating academic activities¹⁰</td>
<td>Recognize: 1) Clinical revenues drive most activities of the department and ensure that sufficient funds are available for teaching and research support, and for appropriate university or community service activities. 2) Ensure fiscal responsibilities so that expenses don’t exceed revenue.</td>
<td></td>
</tr>
<tr>
<td>Maintain sufficient flexibility in distribution of income to meet broad needs and unexpected circumstances.¹⁰</td>
<td>Ensure sufficient “wiggle room” to recognize contributions that may not neatly fit into established criteria or numerical point or scoring systems within the compensation plan. Support innovation and faculty needs.</td>
<td></td>
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<tr>
<td>Transparency regarding processes utilized by the chair and maintain trust among faculty.¹⁰</td>
<td>Use information and data regarding faculty achievements and performance for decision-making and established criteria for evaluating or weighting these accomplishments, and ensure that faculty are well aware of information, data and criteria used.</td>
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</table>
Guidelines for the Determination of Clinical Full Time Equivalent (CFTE) for Faculty Members

In 2013-14, the UC Davis Health System Practice Management Board provided the following definitions for full-time clinical faculty (cFTE) work in order to create better standardization of expectations across departments, and to ensure optimal physician productivity and availability to meet access needs in our community, and address needs for patient access to physicians. We also recognize that few faculty members are assigned 100% clinical duties, since an academic medical center such as ours requires that faculty spend time and effort in the research and teaching missions as well as time for community service. The intent is that cFTE is adjusted accordingly, to accommodate appropriate effort in the other missions, as defined by academic series, and local need.

Baseline Parameters:

- MSP physicians - 100% time devoted to clinical effort
- HSCP 90% time devoted to clinical effort - 10% time reserved for administrative and teaching responsibilities.
- Clin X 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’s 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.
A Synopsis of Salary Components for University of California Health Science Faculty

Compensation is one of the two major methods of recognition and reward for faculty at academic health centers. Academic advancement via promotion through professorial ranks is the other major method of recognition and reward. In addition to promotion from one rank to the next, academic advancement at the University of California (UC) includes a unique system of merit advancement through a series of “steps” within each professorial rank. These steps are formally defined and uniformly applied across all 10 campuses of the UC system. Though compensation and academic advancement typically have separate criteria and review processes at all medical schools, these are often linked in some way since compensation often varies based on rank. An effective compensation plan should include some alignment with the academic reward process to allow appropriate balance to the incentives and rewards, and ensure organizational success in all academic missions.

Full descriptions of UC policies related to health science faculty compensation are available at the following links:


Medical faculty compensation plans generally include a base salary and 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 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’) determined by the base scale of the academic personnel 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 which address a faculty member’s rank and step. Salary scales are available at: [http://www.ucop.edu/academic-personnel/compensation/2013-academic-salary-scales.html](http://www.ucop.edu/academic-personnel/compensation/2013-academic-salary-scales.html)

Faculty in the tenured/tenure-track series receive funds from the state (19900 funds) to support their base salary. X’ 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’. The X and X’ 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:

- Professor (aka Regular or Ladder-Rank series): [http://www.ucop.edu/academic-personnel/_files/apm/apm-220.pdf](http://www.ucop.edu/academic-personnel/_files/apm/apm-220.pdf)
- Professor in Residence series: [http://www.ucop.edu/academic-personnel/_files/apm/apm-270.pdf](http://www.ucop.edu/academic-personnel/_files/apm/apm-270.pdf)
- Professor of Clinical ___ series: [http://www.ucop.edu/academic-personnel/_files/apm/apm-275.pdf](http://www.ucop.edu/academic-personnel/_files/apm/apm-275.pdf)
- Health Science Clinical Professor series: [http://www.ucop.edu/academic-personnel/_files/apm/apm-278.pdf](http://www.ucop.edu/academic-personnel/_files/apm/apm-278.pdf)
- Adjunct Professor series: [http://www.ucop.edu/academic-personnel/_files/apm/apm-280.pdf](http://www.ucop.edu/academic-personnel/_files/apm/apm-280.pdf)

- **Y salary**: This optional university additional compensation is for salary beyond the base pay and represents negotiated additional 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 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.

- **Z salary**: This salary component is for optional incentive/bonus payment beyond base (X) or incentive (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. 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. 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. It is uncertain as to whether a component of productivity will also need to be considered in compensation, as part of or in addition to measuring value.

When choosing your model, 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. 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.:  
- 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>
<thead>
<tr>
<th>Model</th>
<th>Definition</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
</table>
| **Clinical productivity based**<sup>11</sup> | 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 based**<sup>11</sup> | 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-based**<sup>11</sup> | 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 individual**<sup>11</sup> | 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-driven**<sup>11</sup> | 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. |
Measuring Performance

General Concepts for Performance Metrics

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

Advantages to using metrics: 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 to metrics: 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. Departments therefore need to establish their own metrics or scoring system, which includes the challenge of weighting each performance measure based on the department’s own strategic priorities or those of their school or health system. A pitfall in creating metrics is the 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. Achieving buy-in by the faculty members regarding the appropriateness of these weighted scores is also needed, though not always easy to achieve.

Benchmarks and score cards: Benchmarking performance against established external standards or internal standards, including comparison to peers within the department, and providing this information to faculty in the form of “score cards” or other feedback may be useful. Performance measures for both clinical outcomes, including patient satisfaction, as well as productivity have been reported. Multiple measures giving a composite picture of performance are considered most effective, though profiling generally has not been found to be reliable. Data from the electronic medical record may facilitate outcomes-based benchmarking. The Faculty Practice Solutions Center (FPSC) ([https://www.facultypractice.org/cps/rde/xchg/fpsc/hs.xsl/home.htm](https://www.facultypractice.org/cps/rde/xchg/fpsc/hs.xsl/home.htm)) 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.

Metrics for Individual Productivity and Performance

Metrics for individual productivity performance are listed in Tables 3 and 4. These may be used singly or in combination.
<table>
<thead>
<tr>
<th>Metrics</th>
<th>Description</th>
<th>Examples and Comments</th>
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<tbody>
<tr>
<td>Relative Value Units (RVU)</td>
<td>Uses physician work RVUs developed for Medicare’s physician fee schedule.17</td>
<td>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 (ref Nati Health Policy Forum). Example: An intermediate office visit = 1.42 RVUs, colonoscopy = 3.69 RVUs, total hip replacement = 21.61 RVUs.</td>
</tr>
<tr>
<td>Shifts-worked</td>
<td>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.</td>
<td>• Usually defined as “clinical days worked”, according to a 2005 survey of 138 academic anesthesiology practices, though some defined a shift as specific number of hours on duty. 18  • On-call assignments were frequently considered separately from daytime shifts or other performance measures. 18  • 20% of the practices surveyed used a shift-only model. 18</td>
</tr>
<tr>
<td>Revenue/billable hours model:</td>
<td>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.</td>
<td>• May utilize either collected revenue or net revenue (collected revenue minus expenses associated with faculty benefits and shared overhead), based on preference of the department.  • Can be used to incentivize night/weekend call or coverage of extra duties since these activities provide opportunities to earn extra billable hours or collected revenue.  • Has been shown to successfully realign compensation to reward the most productive faculty. Other academic missions were not adversely affected and in fact improved, though the incentive was only clinically-based. 19</td>
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<tr>
<td>Clinical quality or value-based metrics</td>
<td>Quality and value metrics may be added to a plan to 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.</td>
<td>• Individual performance data from: patient satisfaction surveys; quality monitors such as rates of infection or other complications, or clinical correlation data for pathologists and radiologist; metrics associated with compliance with institutional policy obligations such as completion of medical records or safety training.  • Pay for performance programs and accountable care organizations may make this component of compensation increasingly important.  • Aligns with on-going professional performance evaluations required for maintaining medical staff privileges and hospital accreditation.</td>
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Table 4  
**Metrics for Non-Clinical Academic Performance**

<table>
<thead>
<tr>
<th>Metric</th>
<th>Description</th>
<th>Examples and Comments</th>
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</thead>
<tbody>
<tr>
<td>RVU-equivalents</td>
<td>Uses unique department-developed RVU-equivalents for non-clinical activities to create an objective measure for valuing work and time associated with educational, research, administrative and other activities.</td>
<td>Educational value units (EVUs) created for core teaching activities with dollar units assigned.</td>
</tr>
</tbody>
</table>
| 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).  
  - Administrative roles: Salary credit for a vice chair is 15%, director of a training program receives 20% credit, and directors of a medical student clerkship and fourth-year elective receives 25% and 10% respectively.  
  - Academic accomplishments also receive credits: 4% for first author in a peer review publication, and 3% for a co-author.  
  - In their published report on their salary plan, the authors note that addressing quality of contributions is a limitation; however, this system has been successful in incentivizing academic performance since documented increases in number of grants and total grant funding have occurred, as well as in the number of publications. |
| Point systems       | Academic activities are assigned points or a range of points developed by the department.                                                                                                                 | Points are typically given for scholarly work (grants, papers, presentations), teaching, committee work, and citizenship (taking call on short notice, cooperation with department and 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, as well as our study at UCDHS. |
**Metrics for Organizational Citizenship and Team Contributions**

Citizenship and contributions to a team, department, school, medical center or health system can be more difficult to quantify or measure than clinical and academic productivity. Attendance at key events can be a simple, easy to implement metric, but isn’t usually sufficient to address all aspects of citizenship or the quality of the time spent and contribution to the key activities.

Defining and monitoring 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 model created by Van Dyne et al. that is designed to enhance overall awareness of others’ needs in the group, caring about group goals, and behaviors related to organizational citizenship.\(^23\) These metrics are specifically designed to minimize the effects of face-time bias and other unconscious biases related to the decreased visibility that a faculty member experiences when using flexible career policies, such as distance work, telehealth practice, flexible work schedules, and leaves.

<table>
<thead>
<tr>
<th>Methods to Raise Visibility of an Individual’s Contributions to Group or Team</th>
<th>Implementation: Examples and Metrics</th>
<th>Advantages</th>
</tr>
</thead>
</table>
| **Events:** 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 and/or division faculty meetings for participation in group governance.  
- Teaching conferences to participate and show commitment to educational mission.  
- Research retreat to show commitment to research mission.  
- Residency program graduation events to demonstrate support and commitment 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. |
| **Synchronized interactions:** Defining and attending events where group interactions should occur versus times | Measure attendance at and/or assign points for group-defined events such as::  
- Clinical teaching activities such as rounds or case signout with housestaff and other clinical team members.  
- Quality assurance conferences or rounds | • Assures adequate time and availability for group collaborative activities.  
• Ensures uninterrupted individual cognitive |
when individual work can occur.

- Lab or committee meetings.

activity to complete “real work”.
- Minimizes pressure to be “ever-present”
- Eliminates fragmented days.

### Methods to Raise Visibility of an Individual’s Contributions to Group or Team, Continued

<table>
<thead>
<tr>
<th>Implementation: Examples and Metrics, Continued</th>
<th>Advantages, Continued</th>
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| Pro-active availability:
An individual’s efforts to anticipate and integrate work, and initiate contact with co-workers. | Examples: Document and recognize an individual’s pro-active initiative, such as providing updates on projects and assignments appropriately (not excessively) to others, or identifying and leading resolution of issues by involving and communicating with others.  
- Metrics described in Table 4 (RVU-equivalents, point system or salary credits) may be useful to recognize these contributions. | Demonstrates commitment to group goals even without face-to-face interaction. |

| Self-Presentation:
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, as described 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. |

| Conscientiousness and Helping:
Contributing extra effort to assist peers with their work. | Examples: 1) Volunteering to cover colleagues for planned and unplanned absences; 2) Assumeing responsibilities for a colleague who has fallen behind in his/her work.  
- Metrics described in Table 4 (RVU-equivalents, point system or salary credits) may be useful to recognize these contributions. | Builds interpersonal relationships.  
- Demonstrates caring for group goals.  
- Enhances group motivation.  
- Triggers reciprocity. |

| Voice:
Making constructive suggestions for change. | Example: Contributing positively to the discussion at faculty or division meetings, committees and workgroups.  
- Metrics described in Table 4 (RVU-equivalents, point system or salary credits) may be useful to recognize these contributions. | Demonstrates caring for group goals.  
- Enhances group motivation.  
- Triggers reciprocity. |

| Peace-making:
Working to resolve difficulties. | Examples: 1) Suggesting solutions and offering to help implement them; 2) Volunteering to be on committees and workgroups to address issues and contributing actively to the groups work; | Demonstrates caring for group goals.  
- Builds inter-personal relationships.  
- Enhances group |
3) Private conversations with colleagues and others to help resolve issues.
- Metrics described in Table 4 (RVU-equivalents, point system or salary credits) may be useful to recognize these contributions.

<table>
<thead>
<tr>
<th></th>
<th>Motivation</th>
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<td>Triggers reciprocity</td>
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*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

If your compensation plan criteria are highly dependent on highly visible activities, bias associated with “face-time” 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. Face-time bias has been shown to have a significant adverse effect on how an employee is perceived and evaluated at work. Passive face time may be important to spontaneous trait inferences that lead to quick and lasting impressions that can affect performance appraisals. Elsbach et al. has shown that 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

Even if face-time bias is not an overt emphasis in the salary structure, our work with partner departments in our medical school highlighted an emphasis on team culture, peer pressure for performance, and availability, all of which can be influenced by face-time. 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. This may strongly influence whether a faculty member is perceived by colleagues as a strong, participatory, and available team member. 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, our 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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