STATE UNIVERSITY OF NEW YORK – STONY BROOK
SCHOOL OF MEDICINE
STRATEGIC PLAN

Submitted by the
Resource Allocation and Academic Planning Committee
Commissioned by the
Executive Committee of the Faculty Senate

Summer, 2001

Preamble

The RAAP Committee of the Faculty Senate (membership indicated below) was commissioned by the Executive Committee and by the Dean of the Medical School to recommend a strategic plan with respect to the resource allocation and future development of the medical school activities at Stony Brook. The RAAP Committee met with the key leaders of academic and clinical Departments, Operation and Financial Officers, appropriate Dean's Office personnel directing educational and research missions, and the Dean himself. The committee reviewed financial reports, space allocation and physical plant status reports, teaching and educational plans, research and development dossiers, and other collateral materials. The committee was granted broad and unlimited access to any and all data relative to this charge.

The RAAP Committee Members met monthly to review and deliberate over the key areas identified in this recommended plan. Initial broad-reaching and idealistic thinking has been moderated toward realism in the modern era of medical education, research, and the health care marketplace. This proposal has been reviewed broadly, and represents an intensely collaborative effort. Each RAAP committee member has had equal access, and equal participation in the summary formulation presented below.

The authors of this proposal wish to indicate their realization that no plan is perfect, nor that any plan might be implemented in its totality without interval review and revision. On the other hand, the committee members suggest that during the developmental phase for this recommendation, that a quite realistic appraisal of the current status at Stony Brook has been accomplished. The following strategic plan is recommended in view of the perceived challenges facing our medical center.

For the reviewer of these materials, the major areas are simply divided into an assessment of present status, and thereafter, generalized recommendations for future development. The charge to the RAAP Committee was to NOT be highly specific numerically, financially, or otherwise, but rather to present a broad reaching conceptual scope.

STRATEGIC PLAN

The focus of this strategic plan is for the School of Medicine (SOM). It is obvious that for this plan to succeed, it must be consonant with the needs of the Hospital, our University and the Community, both local and global.

The SOM at Stony Brook trains students to be physicians, and assists in the training of other health professionals (Dental and Medical Students, Nurses, Health Technologists, Managers, and Biomedical Scientists), delivers health care at its designated hospital and other facilities, and provides the soil for generation of new information and ideas so that the quality of health care delivered today is the best that it can be. It is recognized that with the advancement of knowledge the quality of health care will be better and continue to improve with time. The SOM will achieve these goals only if it performs its functions of education, research and service in an exemplary manner. We also believe that a unique aspect of a "University based Academic Medical School" such as the SOM at Stony Brook is that all of its functions should act in concert to advance the generation of new knowledge.

I. Teaching

Our goal is to educate medical students in the broad aspects of bio-medical sciences, and to prepare them with the necessary technical, social and emotional skills to be beginning practitioners. Hence, they will be well prepared to follow any path in the furtherance of their individually chosen medical careers. Students are to be exposed to the full spectrum of career paths so that they are able to make informed career choices. Furthermore, the SOM will make it a high priority to educate students in such a fashion that lifelong self-education is fostered, and thus assure that the quality of health-care delivered continually improves.

The SOM's educational program is designed to prepare students to train to be MD Practitioners, some of whom will function as generalists and others as specialists, and to be "Academic Physicians." The educational process will prepare some students to train to be MD's and MD's/PhD's engaged in both basic and clinical investigative work in academia and industry to assure that the practice of medicine will continue to improve. It is also expected that the SOM will train PhD biomedical scientists for careers in academia and industry, again to ensure the highest quality health care in the future. Furthermore, the SOM will control the training of residents (GME) to assure competence at the highest level of practice. In addition, the SOM will foster professional competence by the established practitioner as the School will develop programs to continue the training of practicing physicians and other health professionals.

To this end the SOM by the authority of its executive, and with significant input from the Faculty Senate will develop and implement a "Professional Code of Conduct" which will be binding on all members, including students, of our medical community.

Many of our faculty believe that our teaching efforts, though satisfactory, have not employed the modern modalities of communication and interactive methodologies that are now available. It has only to be mentioned that attendance at lectures, particularly during the first two years of

school is less than satisfactory. Furthermore, there are those who believe the structure of our medical curriculum should be reevaluated to determine if it fulfills all of our educational goals. It is not the function of this committee to make specific recommendations for change in the curriculum but rather to set in motion a process to appropriately evaluate the curriculum. It is suggested that the Faculty Senate with the full and enthusiastic support of its Curriculum Committee, and the Dean of the SOM, empower a special task force to examine our current curriculum. The task force, after sufficient preliminary work identifying problems and posing appropriate questions, should organize a retreat of faculty with the goal of formulating workable solutions. These are to be presented to the Faculty Senate through its Curriculum Committee, and the Dean of the SOM for implementation. Implicit in this proposal is that the Dean of the SOM earmark substantial additional funds particularly for modern interactive communication techniques and devices**.** In all proposed changes the SOM must ensure that in all programs there is enrollment of, and educational support for, qualified students from under represented minority groups.

Many of our faculty believe that there are insufficient structural incentives, at the departmental and interdepartmental levels, for our faculty engaged in teaching to choose to develop into superior medical school teachers. The precise structural changes affecting faculty that would be helpful in the development of the teaching functions are not obvious, but when formulated must not be wasteful of the scarce financial resources available, and must not do damage to the academic, clinical and research roles of an academic medical school. To this end it is proposed that the Dean of the SOM, with the advice of the Chairs of the Departments and Directors of the Institutes, suggests a broad range of options, to be considered by the faculty through its Faculty Senate. After meaningful deliberation of the faculty and it recommendations, the Dean should implement a few specific changes affecting faculty to further our teaching goals. Furthermore, to ensure accountability, the changes that are implemented, should be reviewed to determine if they achieved the goals set and at what cost.

RECOMMENDATIONS:

1. Develop and implement a **"Professional Code of Conduct."**
2. Name and empower a **"Curriculum Special Task Force"** to develop new educational programs and technologies.
3. Name and empower a **"Teaching Faculty Special Task Force"** to develop new programs and support structures for these faculty.

II. Clinical Academic Development

Many of our faculty believe that there has been a significant turnover of clinical faculty to the detriment of both the clinical and research functions of our medical school. Along with many other possible and rational reasons for the faculty turnover, the perceived lack of support for selected faculty to pursue academic careers has led to the loss of too many SOM faculty with an interest and a successful record of academic accomplishment. Many of our clinical faculty believe that even though there have been many high priority problems at the SOM that have consumed resources and energy, there has been insufficient commitment on the part of the Chairs and the School to the academic mission of the Clinical Departments. Whether these

beliefs by some of the faculty are substantially correct or not, it is proposed that the Dean of the SOM give a clear directive to specific Clinical Departments that an important function for them is to develop a significant clinical research-academic presence that must in time, be recognized as such nationally. The SOM must identify resources that must be used by the Departments to hire new or redirect existing faculty to this function. To ensure accountability, Departments, after an appropriate interval (no more than 5 years), must be reviewed by an outside review team, in the traditional academic manner taking into account the academic mission of the department. The submitted report to the Dean is to be shared, en toto, with the faculty. If this goal, of an increased academic presence in selected clinical departments, is not met, then it represents the foundation for critical review of the Chairperson, with possible dismissal when incorporated into the context of a more integrated assessment.

Many of our clinical faculty believe that there are insufficient structural incentives at the departmental level to ensure that chosen, and gifted faculty in research and academic pursuits, be allowed to develop academic careers along traditional pathways. For a faculty member to be able to pursue medical-research, the School (Department) must provide protected time with salary. To this end it is proposed that it be acknowledged by the SOM (Department and Institutes) that all faculty members do not have the same job description, and some faculty members will be designated to be given compensated time to pursue defined research goals. These selected few will be expected to generate funds to support their academic and research pursuits. If funds are not generated, it is mandatory that these faculty have a change in their job description, and others chosen to pursue academic and research pursuits**.**

RECOMMENDATIONS:

1. Dean to prioritize (AND FUND) recruitment of academic clinicians.
2. Chairs to prioritize (AND FUND) clinical academic development.
3. Establishment of criteria to evaluate departmental academic development
4. 3 – 5 year scheduled clinical department review – external.
5. Discipline and /or dismissal of Chairs not meeting criteria for academic clinical program development.
6. Designation of clinical research faculty.

III. Basic Academic Development

A mission of the School is to promote, nurture and conduct biomedical research. As fruits of both non disease-, and disease-directed research are well established, the SOM must be a special place that is supportive of both (basic and applied), bench, clinical, public health and health-delivery related research. The success of this mission will ensure that ideas and technologies of today are translated into better health care for tomorrow, and that new ideas continue to develop to render better the health care of the future.

To fulfill its mission of biomedical research and academic pursuits, it is necessary that the structure of the SOM be supportive of this goal. In the past the SOM adopted a traditional structure based on Departments and within Departments, Divisions, but always allowing for interdepartmental integrative research. It is obvious that the SOM in recent years has been supportive of the "goal-oriented, Institute" approach to a new SOM organization. One has only

to think of the new Cancer Institute, and Institute of Molecular Cardiology to appreciate the new structures that are being put in place. These changes, however, have taken place without detailed discussions with the faculty about the intended, and as best as can be approached, the unintended consequences of such changes. Procedures for choosing Institute Directors, review of Institutes to assure quality, duties of faculty re: Departments and Institutes, and role of Institute faculty in clinical care and teaching have not been discussed and made public. It is suggested that the Dean of SOM with the participation of knowledgeable faculty members, and the Faculty Senate consider the implications of the recent structural changes and formulate some general procedures in the expectation of maximizing the value of these changes.

RECOMMENDATIONS:

1. To develop a formal review process to initiate and monitor new structural initiatives (e.g. – centers, institutes, etc.)

IV CPMP Faculty Practice Plan

In brief, the faculty practice plan (CPMP) represents the full time clinical faculty through a Board consisting of elected members from each Department, many of whom are departmental Chairs, and serve as Presidents of their respective Professional Corporations. Numbering 18, these PC's act independently to operate practices and budget clinical revenue separately, but may coordinate their activities through the Board. An Executive Committee consisting of the President, Vice-President, Secretary/Treasurer and a Director provide business leadership. The Board has commissioned several groups and committees to facilitate strategic initiatives, including but not limited to the issues of practice development, faculty recruitment and retention, managed care contracting, and IPA development. None of these functions are defined in the Union contract which mandates that CPMP exist.

It is beyond the scope of the present document to provide a critical review of the CPMP practice plan. The faculty, however, has brought to light concerns regarding the operation of the plan, with specific issues in managed care contracting, credentialing, billing, collections, practice development, etc. In some clinical departments, these operations may have resulted in significant financial and personnel losses.

A central focus has been that the great independence afforded the Department Chairs and PC Presidents, may actually be obstructive with respect to key business decisions in the maturing marketplace. This is most evident in the managed care contracting operations, where 18 PC presidents have independent veto authority. While the plan is working toward a single signatory authority concept, it does not presently exist. A key element toward that goal, is the ability to equitably distribute funds across "winners" and "losers" in a contract negotiation. No agreed upon mechanism clearly exists in this regard. Indeed, there appears to be no central authority directing such activity.

Another focus has been the relationship of the CPMP Plan to University Hospital, and the health care marketplace in Suffolk County. The plan has focused upon the potential advantage of conjoined enterprises, contracts, and the like with University Hospital, but there has been limited

success. This issue is beyond the scope of this document, but serves to characterize the lack of an over-arching leadership.

A final critical concern is the matter of academic faculty recruitment/retention and compensation/incentivization. The RAAP Committee has reviewed materials indicating a $20 - $30 million dollar annual expenditure in the faculty recruitment, as this process necessitates enhanced salary and collateral materials to effectuate recruitment versus retention. Clinical faculty satisfaction at the medical center is abysmally low, scoring less that the 10th percentile in national surveys. A critical element is related to salary (and bonus), which varies greatly across departments within the plan, and according to independent philosophies. Recruitment packages, particularly with respect to "protected time" and "academic pursuits," are often compromised by the PC presidents for the realities of fiscal departmental performance. The "taxation" base is significant. Faculty are generally concerned that their performance is gauged solely by their revenue generation ability. The academic faculty feel strongly that little emphasis on key academic missions has been placed within the recruitment/retention process of clinical practitioners.

RECOMMENDATIONS

1. Restructure the business functionality to a single signature authority (e.g. CEO), and from the independent PC to a single PC or MSO structure.
2. Initiate a strategic planning process, with emphasis upon faculty recruitment and retention, faculty compensation and incentive plans, and faculty practice systems.
3. Reorganize MSO business functions, and enhance information systems to streamline financial performance and reduce clinical revenue taxation.
4. Solidify a practice group mission and vision partner with University Hospital (e.g. PHO).
5. Re-emphasize academic mission and support for clinical faculty. This may require re-negotiation of the clinical taxation structure.

V Structures

The academic and clinical environments at University Medical Centers in this decade (and millenium) have undergone, and are undergoing, a significant paradigm shift. The classical academic departmental structure under a single chairmanship acquiring and allocating all physical and faculty resources toward development of a prioritized mission is giving way to multi-disciplinary, inter-departmental approaches. The advantages of a "center" or "institute" level programmatic approach is a paradigmatic precedent in evolution. A recent and typical example at Stony Brook is the formation of biologists, molecular biologists, cell biophysics and electrophysiologists to the same lab bench with clinical cardiothoracic surgeons and cardiologists, focusing upon clinically relevant problems within the Institute for Molecular Cardiology. Such interdepartmental and translational problem solving could never be effectuated within the confines of a single departmentally focused, classical academic paradigm.

The faculty and staff interviewed by the RAAP Committee for this purpose have repeatedly emphasized the overall weakness of the clinical faculty in their research and academic pursuits.

There are clearly islands of strength within the medical center, which should be acknowledged. Nevertheless, it is recognized that for key strategic initiatives, an overarching, interdisciplinary approach has not been accomplished in any structural component within the clinical arena. There exists no template for integration of multiple clinical disciplines (e.g. – surgical, medical, radiological, etc.), nor for integration of the basic science disciplines within the clinical arena.

A further concern, voiced predominantly by the basic science disciplines, is that the present organization of the clinical departments, and indeed the practice plan, emphasizes clinical practice success and de-incentivizes academic pursuits. Clearly, the changing health care and managed care marketplace places extreme selection pressure upon the PC presidents for fiduciary performance. To that end, key recruitments generally follow clinical performance guidelines, rather than consider optimizing academic clinical outcomes, particularly toward research and teaching initiatives.

Finally, it is apparent that the clinical departmental chairs, through their independence as PC presidents, and through the independence afforded by the organization of the practice plan as noted above, are able (and do) exercise prerogatives beyond the scope of the leadership of the Dean particularly with respect to the recruitment/retention process. For example, it is more cost efficient to recruit a junior faculty in a fiscally ailing department than to focus upon the academic value and prestige that a more senior recruitment may bring to the medical center, and to the hospital, albeit at a higher cost to that department. An interdisciplinary recruitment would obviate such a concern.

The committee clearly realizes that financial resources are not unlimited and that any planning process must be clear in its priorities. Consequently, the Dean, with the advice of the various Chairs must identify the areas for academic development and indicate which areas will not grow, or largely provide clinical care without a research or academic direction.

RECOMMENDATIONS

1. Formulate a “Center of Excellence,” or “Institute” mechanism for key clinical and academic initiatives.
2. Organize and define a matrix management reporting mechanism for leaders identified to pursue such key initiatives. Such reporting should be to the Dean, and to the CEO equally, emphasizing the impact within the medical center of such key initiative to the academic mission and the clinical operational performance at the hospital level.
3. Identify and allocate funding sources within the institution for the leadership of such centers of excellence to develop programs through recruitment/retention, and to allocate resources particularly to secure the interdisciplinary academic mission.
4. Identify and allocate funding sources with the institution that would facilitate incentive alignment of clinicians, basic researchers, and the hospital toward development of quality outcomes, and best/efficient practice within the key initiative structure.
5. Nominate academic faculty with joint appointments through the Dean’s office and within the hospital organization, to spearhead the development of the top strategic initiatives.

6. Commit to the allocation of space, faculty, and resources to the above appointees to support the key initiative development.
7. Define the scope, size, support, and extent of program development at the outset, to better align goals within key strategic initiative.
8. Define and organize the interaction of the clinical arm with the local private practice community. An attitude of inclusion, and a mechanism to incentivize best practice behaviors, needs to be facilitated.
9. Define internal/external programmatic review processes, as well as comparable academic and clinical chair review processes toward achieving key strategic initiatives.

VI Key Strategic Initiatives

An advisory committee to the Dean should be established to recommend key strategic initiatives that incentivize collaboration among basic and clinical disciplines, and that optimize the opportunities of the center/institute approach. Fulfillment of academic, teaching, clinical and financial missions should be considered.

RAAP COMMITTEE MEMBERSHIP

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