

Guidance for Intent to Retire Notification: Clinician/ Clinical Faculty focus

Goal: The goal of “Intent to Retire Notification” is to provide adequate time for careful transition planning for the individual and the institution. In particular, it supports the ability to share skills and background knowledge and carefully transition patients, learners, and responsibilities with maximal efficiency.

Background:

Any turnover of faculty or clinicians is expensive and time consuming. It is not just the loss in momentum for patient care, educational expertise or research, but also includes the actual costs of new hires and new commitments for the institution. This is particularly true for retirement. Assuring a robust transition process reduces the high cost of turnover due to lack of continuity in research or education and lack of attention to transfer of patients and referral networks. A clear transition plan and expectations for the retiring leader also assures that new leaders, interim leaders, faculty or clinicians have the information and support for an optimal start that enhances their success and promotes retention. Planning ahead for retirement positively affects the retiring faculty, their colleagues, the community, and other ventures. This approach emphasizes a culture of respect and consideration of our faculty and providers that enhances retention and recruitment for the future.

In the case of retirement, which is a very thoughtful process on the part of the individual, more notification time from the practitioner than the minimum of 90 (APP) or 120 days (4 months) is expected: a 1 year notification is recommended. A concern of faculty, particularly in leadership, is assuring that the period of time prior to retirement be effective (avoid “lame duck” syndrome). Institutional leaders are concerned leaders may lose focus (short timer syndrome). This may be addressed by discussing and developing clear expectations between the institutional leadership and the aspiring retiree for the transition period (see sample expectations for key roles as samples). It should be noted that immediate health or other personal needs that require rapid transition to retirement are recognized as exceptions to this guidance.

Guidance: Intent to Retire Notification

Level of Leadership (examples)	Expectation for intent to retire notification
Department Chair (clinical); Large Program/ Centers	1 year prior to planned retirement minimum
Division Chief/ Ambulatory Physician Leader/ Large clinical site Residency/ Fellowship Program Directors	1 year prior to planned retirement
Clinically based physicians/ practitioners	1 year prior to planned retirement is preferred .

Addendums: Sample Expectations for Chairs, Division Chiefs, Program Directors (GME), Ambulatory Chiefs in transition that could be used to foster discussion to clarify expectations during a transition to retirement.

Sample Expectations for Transition: Department Chair (Clinical)

The department chair is a member of the senior leadership of both the UMass Chan Medical School and UMass Memorial Health Care, Inc. and was appointed by both. The chair articulates the vision and mission of the department and works collaboratively with other institutional leaders and colleagues to ensure alignment of departmental and institutional vision and goals. She/he is responsible for the comprehensive leadership, management and stewardship of his/her department's missions related to clinical care, education, and research, as outlined in the "Expectations of a Chair". The department chair oversees all aspects of clinical care - quality, staffing levels, regulatory compliance, etc and promotes advances in clinical practice. The chair supports the vision for the educational programs and research scholarship of the department and oversees the research enterprise, all educational and training activities, and faculty academic affairs. The chair provides leadership in community engagement, advocacy, and philanthropic activities. The chair develops the clinical and academic budgets for his/her department, monitors budgetary performance and institutes corrective measures, when needed. She/he is responsible for maintaining standards of excellence in these missions and for allocating departmental resources so as to achieve the objectives of both the clinical and the academic enterprises until such time that they are relieved of these duties by the Dean and CEO.

During the transitional period to retirement, the Chair is expected to continue all of the above responsibilities and implement the established departmental strategic plan but would not develop or implement new strategic plans. A key aspect of the transition period is to identify and train interim leadership to assume leadership and management of all missions of the department. Besides ensuring high quality clinical care, scholarship, and teaching, this includes faculty academic development, recruitment for key clinical positions, and budgetary oversight. These responsibilities may be assumed by one or more individuals if interim leadership is needed.

Sample Expectations for transition: Division Chief

Background: Division Chiefs serve a specific subspecialty, focus area, or program. They report to the Departmental Chair and are responsible for assuring both the development of their Divisional area and the faculty within. They often have fellowship programs to oversee as well as clinical and research initiatives. As such, this is a key leadership role within a Department and within the institution which is integrated within the ongoing strategic planning and future directions of the institution. The timing of a transition should be tailored to the needs of a Fellowship if it exists. The expectation is that the transitioning/retiring Chief will provide financial, strategic, network, educational, and research background and other intelligence to the incoming Chief and maintain the status and stability of the Division in the interval. **The optimal approach is to review the Division Chief responsibilities unique to the position with the Departmental Chair and identify the key functions to fulfill until transition and those that are important to maintain, document, and transfer information to the incoming leadership.**

Examples of key clinical and administrative responsibilities to consider:

ADMINISTRATIVE FUNCTIONS:

- Oversight of budget and finances
- Status of any philanthropic efforts
- Oversight of operational issues
- Oversight of personnel – attendings, residents, nurses, administrative staff
- Responsibility for faculty, including clinical educators and clinical researchers
- Status of scholarship, education, innovation and collaboration with other divisions

CLINICAL RESPONSIBILITIES:

- Clinical practice development, relationship with Ambulatory Physician Leader
- Programs for strategic growth of outpatient services
- Service to the community (i.e., underserved or underinsured patients)
- Safety and Quality initiatives
- Compliance issues within the division.

MENTORSHIP AND EDUCATION:

- Ongoing mentorship and development needs of faculty
- Present faculty development plans in progress
- Status and needs of education across the learning continuum
- Fellowship training issues and needs to comply with ACGME if relevant
- Residency training issues and needs to comply with ACGME and RRC

RESEARCH ISSUES:

- Research oversight and needs of researchers and staff

SAMPLE EXPECTATIONS for transition: AMBULATORY PHYSICIAN LEADER (APL)

Background: The APL has overall responsibility and authority for the clinical practice within their ambulatory specialty. The APL works as a fully integrated team with the Clinical manager and administrative clinic manager to create a patient-centered, staff friendly, high quality clinical environment. The APL works with clinic managers, senior vice president and department chair to establish clinic specific goals related to: volume, financial performance, patient access, patient satisfaction, quality, productivity and financial stewardship. APL and clinic managers will receive regular feedback on their progress and will be given the authority to shift resources and make appropriate changes aimed at improving overall clinic performance within guidelines established by the Senior Vice President and Department Chair. **The optimal approach is to review the APL responsibilities unique to the position with the Departmental Chair and identify the key functions to fulfill until transition and those that are important to maintain, document, and transfer information to the incoming leadership.**

Examples of key clinical and administrative responsibilities to consider:

ADMINISTRATIVE FUNCTIONS

- Maintain strategic plan, tactics and goals for clinic in collaboration with the clinic managers.
- Oversee and manage associated medical center budgets if applicable.
- Ongoing evaluation of staff, managers with Senior Vice President and share status with incoming leadership
- Address staff, physician and patient complaints and feedback in collaboration with clinic managers and share effective mechanisms that have been developed to address these.
- Assure that the clinic and its staff meet all applicable regulatory requirements (EL4U).
- Meet regularly with clinic manager and be available to meet with all clinic staff on an as needed basis.
- Meet regularly with all providers and staff to hear and address concerns about clinic operations.

CLINICAL RESPONSIBILITIES:

- Effectively communicate strategic plans and tactical goals and metrics for the clinic to the physicians and other providers on a regular basis.
- Monitor and improve quality of care and patient satisfaction.
- Work to improve scheduling, access, patient flow and clinic volume.
- Improve financial performance and efficiency of the clinic
- Improve teamwork and morale within clinic, fostering integration and communication among different levels of staff
- Improve use of electronic medical records, billing and other information technology to meet “meaningful use” and other regulatory standards and enhance provider efficiency.

SAMPLE EXPECTATIONS for transition: PROGRAM DIRECTOR/ ACGME accredited residency/fellowship

Background: UMass Chan Medical School is the sponsor of all ACGME-accredited programs with the clinical experience in UMMMHS. The program director of an ACGME-accredited residency or fellowship program is responsible for oversight of the day-to-day operations of the program as well as compliance with regulatory functions. As such, this is a key leadership position within individual departments and continuity of residency/fellowship operations is of utmost importance when a program director steps down or leaves the institution. **Timing of and communication about the transition should be part of the transition discussion with the Chair and the Vice Dean for Graduate Medical Education.** In general, the ideal time to make the announcement is after the Match list is submitted in February and before Match Day in mid-March. The expectation is that the current program director will share their program files with the in-coming program director.

Examples of key responsibilities to consider:

1. Compliance with regulatory updates (annual process)
 - a. ACGME WebADS annual update
 - b. NRMP
 - c. ERAS
 - d. GME Track
 - e. Specialty Board (ABIM, ABA etc)
 - f. Annual Program Evaluation with action plans
2. Orientation for new residents or fellows
3. Recruitment of new residents or fellows
4. Program oversight: (this should generally be done on an annual basis with updates as needed)
 - a. Review Curriculum
 - b. Review goals and objectives
 - c. Review evaluation system
 - d. Review procedure logs
 - e. Review policies and procedures including compliance with same
5. Appoint and oversee the Clinical Competency Committee
 - a. Recognizing residents requiring remediation and ensuring development of improvement plans
6. Appoint and oversee Program Evaluation Committee
7. Continue to support resident/fellow scholarship and quality improvement initiatives