

# A SHARED COMMITMENT TO FAIR PAY

Recommendations for Attaining and Sustaining  
Compensation Equity in Academic Medicine

2026



# A SHARED COMMITMENT TO FAIR PAY

Recommendations for Attaining and Sustaining  
Compensation Equity in Academic Medicine

2026

Valerie M. Dandar, MA • Amy S. Gottlieb, MD • Diana M. Lautenberger, MA  
Mallory E. Lee, MA • Anja M. Paardekooper, Drs

## CONTRIBUTORS

### AAMC Project Leads

Diana M. Lautenberger, MA  
Valerie M. Dandar, MA  
Mallory E. Lee, MA

### The AAMC Compensation Equity Advisory Committee

The AAMC Compensation Equity Advisory Committee included representatives from various AAMC bodies (the Council of Faculty and Academic Societies; Council of Deans; Chief Medical Officers' Group; Group on Business Affairs; Group on Faculty Affairs; Group on Collaboration, Engagement, and Community; and Group on Faculty Practice), AAHCI senior administrative and fiscal officers, and subject matter experts on compensation equity among faculty in academic medicine.

Chair: Amy S. Gottlieb, MD  
Co-Chair: Anja Paardekooper, Drs

Nita Ahuja, MD, MBA  
Julie Byerley, MD, MPH  
Tina Cheng, MD, MPH  
Errol Crook, MD  
Kevin Eide, MBA, MDiv  
Lawrence Furnstahl  
Cathy Garzio, MBA  
Reshma Jagsi, MD, DPhil  
Melina Kibbe, MD  
Christina Mangurian, MD, MAS  
Bryan Pyles, MBA  
Eve Rittenberg, MD  
Lisa Rotenstein, MD, MBA  
Chris Senkowski, MD  
Maria Soto-Greene, MD, MS-HPed  
Joann Strobbe, MEd

### Acknowledgments

We would like to extend a special thanks to Dr. Amy Gottlieb for her leadership and significant contributions to the Compensation Equity Summit and the writing of these recommendations. We also thank the following people for authoring the case studies included in this report: Joe Kerschner, MD, Nita Ahuja, MD, MBA, FACS, Cathy Garzio, MBA, Kevin Eide, MBA, MDiv, and Tina Cheng, MD, MPH. Lastly, we thank Carolyn Brayko, PhD, and Amy Smith, PhD, for their contributions to this manuscript.

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, clinical care, biomedical research, and community collaborations. Its members are all 162 U.S. medical schools accredited by the [Liaison Committee on Medical Education](#); 13 Canadian medical schools accredited by the [Committee on Accreditation of Canadian Medical Schools](#); nearly 500 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 210,000 full-time faculty members, 99,000 medical students, 162,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Through the Alliance of Academic Health Centers International, AAMC membership reaches more than 60 international academic health centers throughout five regional offices across the globe. Learn more at [aamc.org](#).

Suggested citation: Dandar VM, Gottlieb AS, Lautenberger DM, Lee ME, Paardekooper AM. *A Shared Commitment to Fair Pay: Recommendations for Attaining and Sustaining Compensation Equity in Academic Medicine*. AAMC; 2026.

© 2026 AAMC. May not be reproduced or distributed without prior written permission. To request permission, please visit [aamc.org/reproductions](#).

# CONTENTS

## INTRODUCTION iv

- Compensation Equity Evidence and Background 1
- The AAMC Compensation Equity Summit 1
- Using These Recommendations 2

## RECOMMENDATIONS 4

### Section 1: Establishing Leadership Commitment, Building Consensus, and Ensuring Accountability for Pay Equity 5

- Establishing Leadership Commitment* 5
- Creating a Governance Structure That Ensures Accountability* 5
- Creating a Compensation Philosophy That Builds Consensus for Equitable Compensation* 6

### Section 2: Creating Compensation Models and Administrative Processes to Support Pay Equity 7

- Preparing to Assess Your Current Compensation Plan(s)* 7
- Ensuring an Equitable Compensation Model* 7
- Communicating the Institution's Faculty Compensation Plan* 9
- Conducting Ongoing Pay Equity Studies* 9
- Developing Advanced Data Collection and Reporting Capabilities* 11

### Section 3: Creating Funding Structures to Achieve Pay Equity 12

- Approaches to Funding Equity Adjustments and Nonclinical Work* 12
- Budgeting for Pay Equity Adjustments* 12
- Funding Compensation for Nonclinical and Nonbillable Clinical Activities* 13

## TAKE ACTION 14

- What Does Success in Compensation Equity Look Like? 15
- A Call to Action: Pay Equity Remains the Smart Thing to Do 16

## CASE STUDIES 17

- Case Study 1: The Role of Leadership and Building Consensus for Pay Equity Success 18
- Case Study 2: Compensation Philosophy and Governance at Medical College of Wisconsin 20
- Case Study 3: Redesigning a Departmental Incentive Program and Base Scale With Data and Transparency 22
- Case Study 4: Tools for Measuring Faculty Effort to Ensure Compensation Transparency, Accountability, and Equity 25
- Case Study 5: Overhauling the Compensation Model at Yale Department of Surgery 27

## REFERENCES 30

## APPENDIX. Case Study 4: Tools for Measuring Faculty Effort 31

- Figure 1. The Pediatric Activity Calculator; an example spreadsheet for an individual. 31
- Figure 2. The Research Activity Calculator; an example spreadsheet for a faculty member. 32
- Figure 3. Division faculty salaries; an example spreadsheet. 33



# INTRODUCTION

## Compensation Equity Evidence and Background

Fair pay is critical to recruiting, engaging, and retaining talented employees and is, thus, a key component of organizational success.<sup>1</sup> Unfortunately, academic medicine has been slow to achieve compensation equity among faculty despite effective levers having been identified for addressing this issue.<sup>2-4</sup> Between 2019 and 2022, the AAMC released a series of three reports that detailed the considerable pay inequities within the profession and encouraged institutions to review their own compensation practices and outcomes.<sup>5-7</sup> These reports provided data that characterize the current state of compensation equity in academic medicine to help generate conversations about local action at the institutional level; however, many organizations continue to struggle with addressing the root causes of these inequities. The AAMC acknowledges that achieving sustainable pay equity is a complex task, so this publication was created for institutions of all sizes and with varying experience with pay equity practices so that any reader can leverage these actionable strategies.

This publication focuses on fair pay as a key business practice and critical strategy for successful workforce recruitment and retention. It optimizes how to recognize, reward, and compensate faculty more equitably by refining existing systems and processes (e.g., productivity models based on the relative value unit [RVU], which has many well-described limitations<sup>8-14</sup>). It is important to note that the terms “fair” and “equitable,” as they relate to pay and compensation, are used interchangeably throughout to stress the principles of equal pay for equal work.

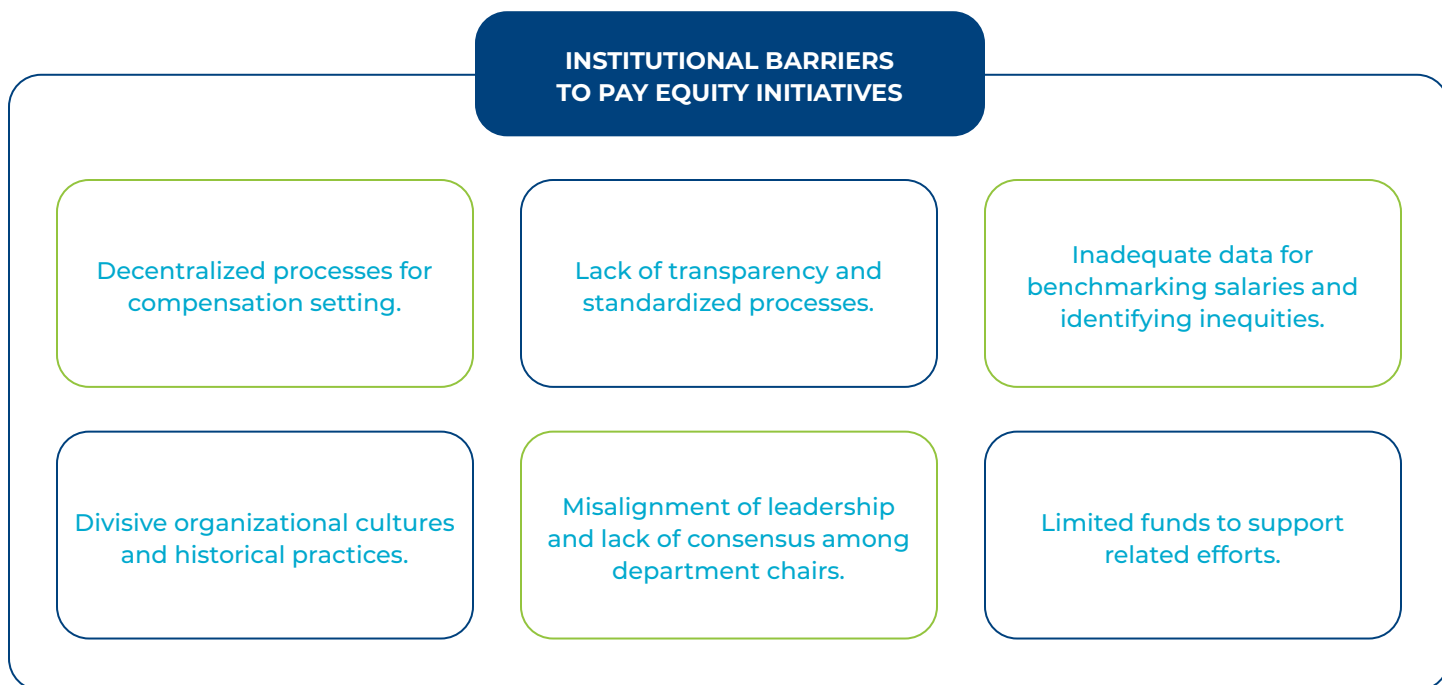
The AAMC hosted its first national Compensation Equity Summit to provide a forum for academic medical leaders to share concrete strategies for supporting fair pay. The summit’s findings and conclusions are the foundation for the expert-informed recommendations outlined here.

## The AAMC Compensation Equity Summit

The summit sought to expand upon prior explorations of compensation equity by directly engaging the experiences and expertise of key institutional leaders with responsibility for or significant influence over the compensation strategies and policies within their organizations. In particular, the summit aimed to identify and address system-based challenges that limit opportunities to close pay gaps among academic medical faculty. The summit was held May 8, 2025, and engaged 143 individuals from 70 academic medical institutions and professional societies, including senior leaders such as medical school deans, practice plan executives, department chairs, chief financial officers, faculty affairs deans, and human resources officers. Participants also included nationally recognized experts in pay equity, the AAMC Compensation Equity Advisory Committee, and invited speakers from executive leadership within academic medicine. The summit featured six sessions on key elements of compensation equity:



Members of the Compensation Equity Advisory Committee and invited speakers described complexities and challenges existing within each of these domains and, based on their own experiences at their institutions, presented tangible and promising ways of tackling them. They also acknowledged the well-intentioned efforts that have failed. In addition, participants were asked to discuss institutional barriers they've encountered when trying to establish pay equity initiatives; common responses included:

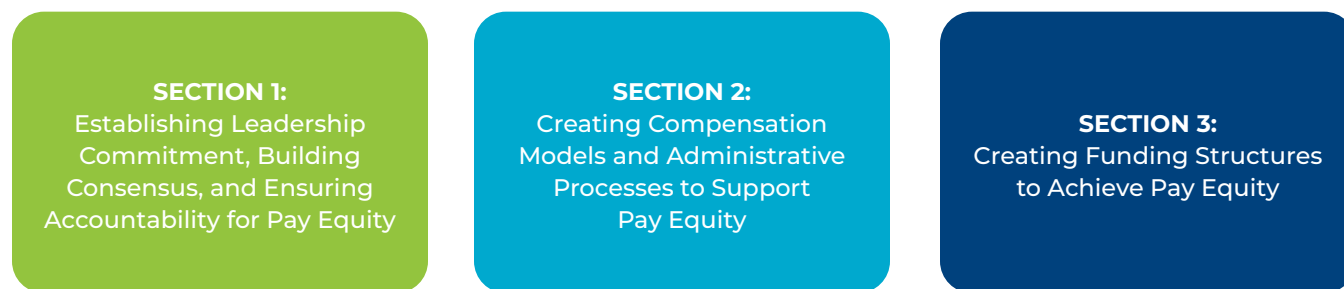


## Using These Recommendations

This monograph represents a synthesis of key themes that emerged from the Compensation Equity Summit, as well as from numerous discussions over the past year with leaders who are responsible for determining compensation in academic medicine and with pay equity experts. The recommendations that follow serve as a critical resource for anyone who has responsibility for or influence over compensation strategy or operations and who seeks to pay their faculty fairly and equitably. Recommended strategies vary in complexity and scope to align with the wide range of institutional structures and leadership roles that exist across academic medicine.

As with previous AAMC research in this area, this monograph provides recommendations only for faculty compensation and recognizes that pay inequities may also exist for other employees in the academic medicine enterprise. Additionally, while this document is primarily written from the perspective of leadership teams within the dean's office of a medical school, most recommendations are relevant for department chairs and practice plan executives, as well as leaders at institutions where health system partners play a significant role in faculty compensation. In their entirety, these recommendations are written as a roadmap, beginning with considerations for institutions that are without any pay equity infrastructure and cascading to strategies for organizations that are looking to fine-tune their sophisticated processes. Each section of this monograph could also serve as a stand-alone resource for leaders looking to bolster their efforts in a particular area.

Recommendations are organized into three sections, each describing strategies and relevant operations to establish, implement, and sustain compensation equity efforts:



We conclude the recommendations with success indicators, gleaned from both the literature and summit participants, so that readers may know what success looks like when leading compensation equity efforts. Lastly, a series of case studies follows these recommendations, showcasing institutions and departments that have leveraged promising and innovative approaches to achieve compensation equity.



# RECOMMENDATIONS

# Section 1: Establishing Leadership Commitment, Building Consensus, and Ensuring Accountability for Pay Equity

Prior to launching any pay equity initiative, medical school deans and other leaders should identify compensation equity as an institutional priority and evaluate the organization's readiness for change. This endeavor entails recognizing and understanding existing microcultures within the institution that could positively impact or detract from sustainable change.

## Establishing Leadership Commitment

- Create an official charge at the highest level of organizational leadership to assess, enhance, and monitor compensation equity on an ongoing basis.
- Form collaborations, as appropriate, with the health system CEO, university leaders, and physician practice plan executives when initiating this work so that all leaders agree that compensation equity is critical to recruiting, engaging, and retaining talented academic medical faculty.
- Establish a compensation committee comprising leaders who represent the dean's office, health system, faculty practice plan, human resources, and the academic departments. Creating a unified, representative, cross-institutional committee allows for consistency in policy application, reduces redundancy of this work across departments or units, and provides a central strategy to ensure practices across the organization are adhering to the overall compensation philosophy.
- Dedicate time for deans to meet with department chairs and division chiefs about their commitment to advancing compensation equity as a key component of the institution's recruitment and retention strategy and to remind department leaders that they are responsible for achieving pay equity among their faculty members.
  - Establish clear expectations for department leaders, including regularly reviewing pay equity study results, addressing inequities, and looking for opportunities to improve compensation methodologies.
  - Institutions might also consider incorporating pay equity metrics as a component of annual reviews for department chairs.
- Work with the institution's communications staff to craft regular messages to the faculty and academic medicine community that both clarify the rationale for undertaking compensation equity initiatives and provide progress updates.
  - Consider issuing a joint statement about the shared commitment of the school of medicine, university, practice plan, and health system to prioritize compensation equity and provide an expected timeline of the initiatives.
  - Continue to communicate the institution's commitment to pursuing compensation equity, even when faced with operational, financial, or cultural challenges.

## Creating a Governance Structure That Ensures Accountability

After the compensation committee has been formed, leadership should empower the committee to:

- Create a public charter for the committee.
- Identify where the committee will reside within the existing organizational structure (e.g., the dean's office or faculty affairs office).

- Invite legal, compliance, and faculty representatives to join the committee for certain activities or initiatives.
- Draft a compensation philosophy (refer to the following list) or review and enhance an existing philosophy as needed. The compensation committee should ensure ongoing alignment between the compensation plan(s) and philosophy.
- Determine a compensation methodology and benchmarking standards (refer to Section 2), and identify funding sources to address inequities (refer to Section 3).
- Facilitate conversations among institutional leaders about the degree to which compensation plans might be standardized centrally or determined at the department level.
  - For institutions that ultimately allow compensation plans to vary by department, chairs should receive guidance from the compensation committee on designing and implementing fair pay practices that consistently compensate faculty for similar work across departments.

### **Creating a Compensation Philosophy That Builds Consensus for Equitable Compensation**

Charge your compensation committee to establish an institutional compensation philosophy with clear guiding principles for developing compensation plans (regardless of whether compensation plans are centralized or determined at the department level). Once drafted, it is important for leaders to approve of the philosophy and embrace its ongoing use when reviewing and determining compensation.

A comprehensive philosophy for equitable compensation:

- Aligns compensation with the institution's vision, mission, strategy, and core values.
- Is flexible enough to withstand leadership transitions without jeopardizing pay equity.
- Is transparent and comprehensible for faculty, and can easily be explained to faculty.
- Clearly articulates the benchmarks used to set compensation, such as data from the AAMC or Medical Group Management Association. Department chairs and division chiefs should be engaged in identifying the most accurate, relevant, and up-to-date sources for benchmarking across specialties.
- Defines the types of metrics accounted for within the components of pay.
- Explicitly rewards nonbillable, nonclinical work, such as teaching, mentoring, research and scholarship, community service, quality improvement efforts, and leadership roles that benefit the organization.
- Seeks to limit individual negotiations in compensation setting and instead use uniform standards and processes for reviewing offers that exceed predetermined amounts.

## Section 2: Creating Compensation Models and Administrative Processes to Support Pay Equity

After an institution establishes a governance structure and compensation philosophy, the compensation committee should review existing compensation model(s) and practices, including processes for assessing compensation equity. The objective is to integrate fair pay practices into regular business and workforce operations instead of treating them as optional, ad hoc efforts.

### Preparing to Assess Your Current Compensation Plan(s)

Charge the compensation committee (or other relevant group) with directing a review of existing compensation methodologies:

- Examine findings from any previous salary equity studies.
- Identify and catalog current compensation plans across the institution.
- Document market benchmarks that are used throughout the institution for compensation setting.

Determine whether the institution would benefit from having external partners assist in evaluating compensation models or conducting salary equity studies:

- Using an external partner – an impartial party – can build trust with faculty and leaders. It is critical that consultants have experience with and a deep understanding of the complex cultures and structures that exist within academic medicine, especially implicit drivers of clinical compensation methodology, mission-aligned elements of faculty productivity, and funds flow.
- Evaluate opportunities to partner with experts from the broader university community (e.g., biostatisticians, industrial psychologists) or an affiliated health system (e.g., human resources professionals like compensation analysts).

### Ensuring an Equitable Compensation Model

Reviewing institutional compensation plans sets the stage for aligning pay practices with organizational values, strategies, and operational goals. The following recommendations are based on typical components of physician compensation.

#### Base Salary

Consider implementing a formula in which base pay is determined by specialty, rank, and years in rank, and the amount is not negotiated except in unique situations. In unique situations, identify a process of accountability; for example, determine whether the compensation committee or dean for faculty affairs should review a base salary when it is set above or below what is dictated by specialty, rank, and years in rank.

#### Productivity-Based Incentive Payments

When developing or revising a compensation plan to facilitate pay equity, leaders should consider that mission-aligned productivity encompasses more than clinical activity and that the RVU is a metric with well-described limitations.<sup>8-14</sup> Moreover, it is critical for leaders to understand that activities deemed eligible for incentive pay may signal to faculty the priorities of the institution and what is rewarded. Additionally, while incentive pay in medicine has historically been determined by individual productivity, institutions can benefit from considering team-based approaches for quantifying and allotting compensation in this domain.

#### Nonbillable Clinical Work and Nonclinical Work

The sections below outline considerations for assessing nonbillable clinical work and nonclinical work.

### Identifying, Quantifying, and Recognizing Nonbillable Clinical Work

- Collaborate with leaders, physicians, and others who determine compensation to identify which nonbillable clinical activities could be readily quantified. Account for time spent on these specific activities when assessing traditional clinical volume targets, like number of visits or RVUs generated. Alternatively, create a system of credits derived from these activities that faculty can accrue and use for nonfunded effort. Examples of nonbillable clinical activities include time spent:
  - Responding to patient messages.
  - Coordinating with other members of the care team.
  - Reviewing patient panel data to close preventive care gaps.
  - Participating in quality improvement activities or forms of care delivery that may be time-consuming but improve patient experience (e.g., working at multidisciplinary clinics for patients with cancer).
- Generate and disseminate a list of nonbillable clinical activities eligible for productivity-based compensation:
  - Identify approaches to standardize, measure, and report nonbillable clinical work.
  - Determine how to collect this data without overburdening clinicians and administrators.
  - Leverage preexisting data already available within the electronic health record (EHR) for nonbillable clinical activities. For example, some EHRs can produce information on time spent charting and answering patient messages, and the number of messages managed by a physician relative to their patient load.
  - Provide these metrics alongside other productivity data for leaders to review during the process of compensation setting, as well as in reports for faculty so they can understand how their performance and compensation are calculated.
- Create billing templates and educate providers about time-based billing for clinical encounters.

### Identifying, Quantifying, and Recognizing Nonclinical Work

- Identify which nonclinical activities are often “invisible” to those setting compensation but are mission-aligned and can be easily quantified.
- The compensation committee or department leadership should establish clear and transparent standards for determining which activities are considered baseline expectations of employment or of an academic appointment versus those which should be eligible for incentive pay.
- Create a standardized list of activities that include teaching and educational activities (e.g., developing presentations and lectures for trainees, writing learner evaluations and letters of nomination or recommendation); research and scholarship (e.g., identifying and writing grants; drafting and submitting manuscripts; presenting at scientific, educational, or professional meetings); mentorship of learners and faculty; and serving as a member of institutional, regional, and national committees.
- To identify any critical omissions in the list of nonclinical activities, survey the faculty to ensure the list is comprehensive before implementing reward structures.
- Identify approaches to measuring and reporting nonclinical work. On an annual basis, quantify faculty time that has been dedicated to nonclinical activities. Consider developing a simple point system or a standardized data collection tool to measure and track these incentive-eligible activities across the department or school.
- Provide these metrics alongside other productivity data for leaders to review during the process of compensation setting, as well as in feedback to faculty about their performance and how their compensation is calculated.
- Commit to ongoing dialogue with compensation decision-makers and others about how efforts to identify, quantify, and recognize nonclinical activities are positively impacting assessments of individual and organizational performance and contribute minimally to additional administrative burden.

### Compensating Leadership Roles

- Identify leadership roles across all levels of the institution (e.g., associate dean, assistant dean, vice chair, division chief, residency program director, fellowship director, clerkship director).
- Compile a list of responsibilities for these leadership roles and identify the current structures for compensating this work.
- Consider creating standardized job descriptions and pay structures for similar leadership roles within departments (e.g., a fixed dollar amount or percentage FTE for vice chair roles).
- Consider stipends for institutional leadership roles (e.g., vice dean, associate dean):
  - Define the minimum level of expected effort for each role.
  - Establish a transparent process for awarding stipend amounts based on scope of responsibility.
  - Establish a minimum stipend for each role based on AAMC total compensation benchmarks for dean's suite positions, and consider adjusting upward if a specialty necessitates it.

### Recruitment and Retention Packages

- Standardize the approach for determining sign-on compensation (e.g., signing bonuses, housing support, relocation support), start-up packages (e.g., office and lab space, administrative and academic support), and retention commitments (e.g., pay increases, academic and organizational promotions, seed funding, space allocations).
- Design processes for reviewing recruitment and retention packages to ensure outliers are identified and discussed before offers are made. Determine whether the compensation committee or another entity (i.e., the faculty affairs or human resources department) will review new faculty offers to ensure compensation equity.

### Communicating the Institution's Faculty Compensation Plan

- Make compensation plans easily available online for faculty, including descriptions of the process for determining and allocating incentive payments.
- Meet annually with university leaders, clinical partners (i.e., practice plan, hospital or health system leaders), faculty council, organizations for women in medicine and science, and other established faculty groups to provide education and information about the compensation plan.
- Incorporate the institution's compensation philosophy in materials that describe the compensation plan.
- Include compensation equity initiatives in recruitment materials for new leaders, clearly communicating the expectation of contributing to these efforts.

### Conducting Ongoing Pay Equity Studies

Some institutions have been conducting pay equity evaluations for many years, while others may be initiating a pay equity study for the first time. The following recommendations support a broad array of experiences in this sphere and include how to enhance established processes, create advanced compensation analytics, and facilitate improved communication with department leaders and faculty.

- Conduct annual or biannual compensation equity studies.
  - Create a compensation equity review committee (either as a subcommittee of the compensation committee or a separate entity) that includes compensation professionals and an administrative support team, as this review committee will be responsible for overseeing study design, data collection, data analysis, and results dissemination. Consider how many faculty members should be included to represent the institutional landscape, and include a senior administrator as a sponsor or strategic partner. Identify review committee members who will lead the interpretation and dissemination of study results.

- Identify senior leaders who will ensure the equity study is completed, meet with departmental stakeholders to discuss the results, oversee the process of departmental action plans to address inequities, and ensure equity adjustments are funded, as applicable.
- Leverage existing promising practices for compensation regression methodologies.
- Based on regression analyses, identify outliers within each department or division who are below and above target benchmarks for total compensation or base compensation identified by the compensation committee (refer to above). Make sure to identify which components of pay are included in total compensation metrics (e.g., incentive compensation, leadership stipends).
- Refine study methodology over time to improve precision and accuracy.
  - Consider adding additional variables into the compensation equity analysis, such as tenure status or length of time at the institution, as well as stratifying the analysis to study different faculty subgroups (e.g., clinician-educators).
  - For institutions that have been conducting pay equity studies, consider expanding efforts by assessing wage compression (when pay for new hires exceeds that of employees who have been at the institution for longer in the same role) and comparing actual pay to predicted salaries using a set of predictor variables.
- Share compensation equity study data with department chairs and administrators and divisional leadership (as appropriate).
  - Provide data on compensation outliers (i.e., high and low earners).
  - Hold department leaders accountable for providing oral or written justifications for any outliers.
  - Develop and implement action plans for addressing outliers: Correct compensation for those below the benchmark and determine future approaches (if any) for faculty members who are above benchmarks; for example, request that department chairs provide a rationale to the compensation committee when seeking annual increases (especially substantial amounts) for those who are already earning significantly above benchmarks or beyond a predetermined threshold, and secure the dean’s approval for adjusting those salaries.
- Communicate with faculty about launching the compensation equity study and when the findings are available. While working in partnership with institutional legal counsel:
  - Create a communications plan to announce that the institution is undertaking a study on faculty compensation equity.
  - Establish a regular cadence for sharing updates.
  - Publish a report of the aggregate findings, including a description of the steps the institution and departments will take to address inequities.
  - Share market data and the benchmarks used in the study, and illustrate how the institution aligns with them.
  - Present the study results through multiple communication channels (i.e., virtual or in-person town halls, faculty senate meetings, departmental meetings, grand rounds, etc.).

## Developing Advanced Data Collection and Reporting Capabilities

- Incorporate faculty compensation and productivity data into existing faculty databases or a data warehouse. Depending on the structure of an institution's data systems and accessibility of particular data points, centralizing information into a data warehouse or data lake may not be possible; however, if an institution has the ability to easily link and store data, designate one location where the data can be easily accessed for creating on-demand reports and dashboards, as well as for conducting yearly pay equity studies. Consider storing the following in this system:
  - Employee data provided to human resources (i.e., personal-level demographics, hiring data, etc.).
  - Academic appointment data (i.e., rank, time spent in rank, tenure status).
  - Productivity data (i.e., research, clinical, and other productivity metrics determined by the institution).
  - Compensation data (i.e., current and historical data for the individual and external compensation benchmarks used in determining pay).
- Create a data dashboard for each faculty member that shows their compensation, benchmarking statistics, productivity metrics, research funding, etc.
  - Consider distributing to all faculty a deidentified compensation chart that shows the departmental or institutional distribution of faculty compensation ranges based on degree type and years spent in rank.
  - Develop an activity calculator for each faculty member that measures clinical and nonclinical activities.
  - Develop a compensation calculator that faculty can use to see how their own compensation is determined.

## Section 3: Creating Funding Structures to Achieve Pay Equity

To address compensation inequities, institutions should consider allocating designated funding to close the compensation gaps identified in pay equity studies.

### Approaches to Funding Equity Adjustments and Nonclinical Work

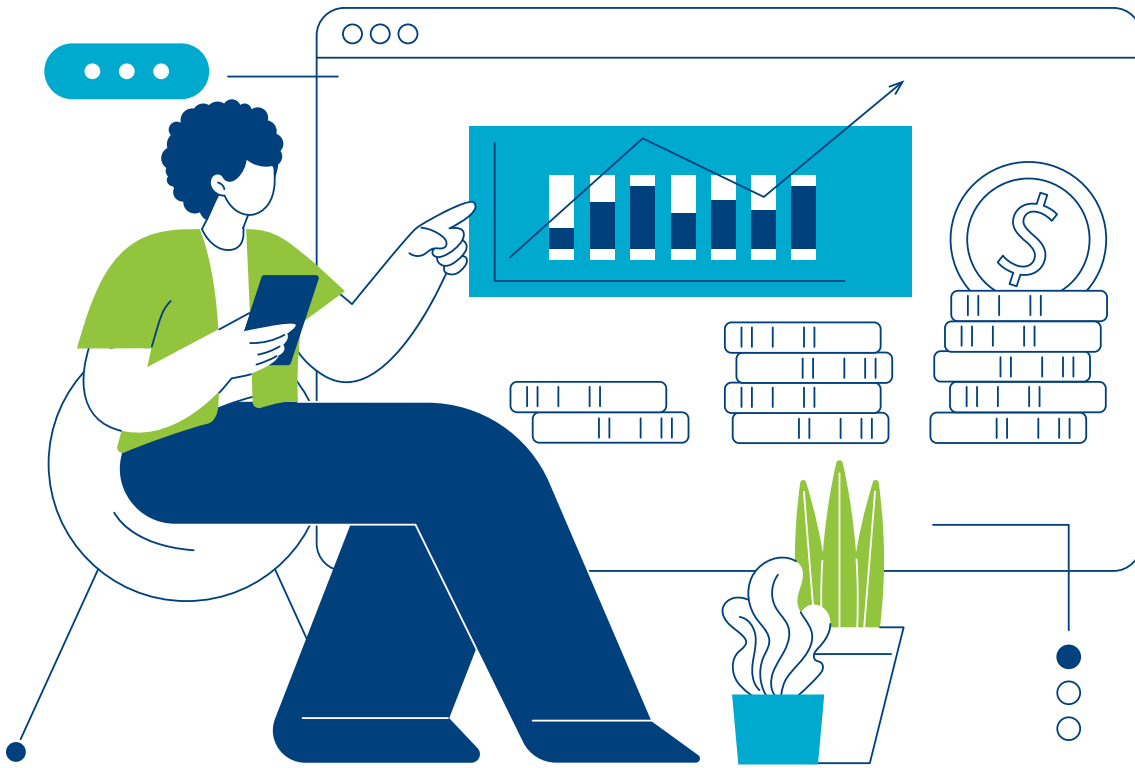
There are various strategies that institutions can employ to identify funds for salary initiatives, depending on how decisions on resource allocation are made within the organization. Funding may be sourced at different levels, including the school, department, or health system, or at multiple levels at the same time. When determining the most suitable approach, institutions should carefully consider their mission, current and projected financial statuses, local and national markets, budgeting structure (including the delegated budget authority), existing compensation plans, and the model for funds flow. These factors will inform which funding strategy and process will best support the institution's efforts to close compensation gaps and equitably compensate faculty for nonclinical and nonbillable mission-aligned work.

### Budgeting for Pay Equity Adjustments

- Convene the institution's compensation committee on an annual or biannual basis, according to the institution's established schedule, to evaluate faculty compensation. This evaluation should include both internal and external equity concerns. Following this review, the committee provides a report on their assessment of compensation gaps in the institution, including a clear explanation of the methodology used to arrive at the conclusions.
- While the compensation committee may make recommendations based on pay equity analyses, the institution's most senior leadership (e.g., the dean and principal business officer) should ultimately determine how to address these compensation gaps within the organization's broader financial framework. Below are four independent recommendations that institutions may consider for funding equity adjustments.
  - Create a dedicated line item in the annual budget, either at the institutional level or departmental level, to fund pay equity reviews, if using external partners, and pay equity adjustments.
  - Create a funding pool specifically for equity adjustments by allocating a percentage of the annual budget available for compensation increases related to salary equity adjustment.
  - Identify equity adjustment funding as part of an institution's annual assessment on clinical revenue or margin (if applicable). This approach links the availability of funds for equity adjustments to the financial performance of the institution.
  - For larger clinical affiliates, an assessment could be implemented as a percentage that is charged on all fee-for-service revenue.

## Funding Compensation for Nonclinical and Nonbillable Clinical Activities

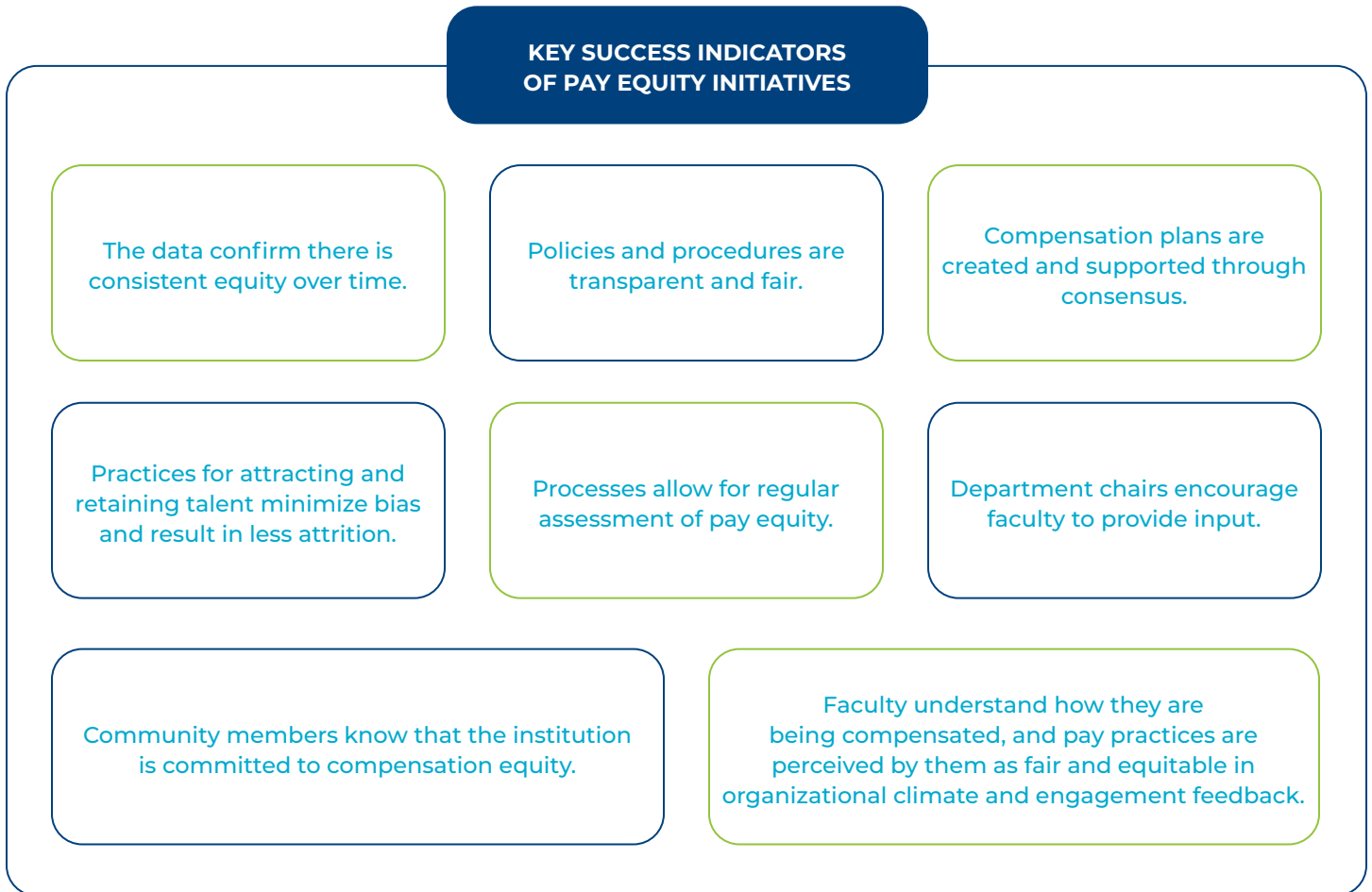
- Designate an annual pool of funds at the departmental level specifically to support nonclinical and nonbillable clinical activities. Institutions may choose to incorporate this dedicated amount within each department's annual budget to ensure consistent and reliable support for these mission-aligned efforts.
- Maximize all available resources by utilizing division-level funding in the creation and maintenance of the department's funding pool. Additionally, departments may consider establishing a general fund aimed at providing targeted support to divisions that have traditionally operated with lower financial margins.
- Review the financial performance and position of each department on a routine basis in alignment with the institution's compensation philosophy. Through this ongoing analysis, departments with lower (clinical) margins can be identified, allowing finance leadership to partner with departmental leaders to develop methods for resourcing compensation for nonclinical and nonbillable, mission-driven work.
- Consider offering rewards other than cash for mission-aligned activities. Possible alternatives include dedicated clinical FTE (cFTE) relief and increased scheduling flexibility, which provide meaningful recognition and support for faculty members engaged in these important efforts.
- Monitor and regularly evaluate institutional processes for funding nonclinical and nonbillable, mission-aligned activities across all departments, ensuring that these strategies remain in alignment with the institution's established compensation philosophy.



TAKE ACTION

## What Does Success in Compensation Equity Look Like?

At the start of any pay equity initiative, it is essential to articulate what a successful initiative will look like so the institution's compensation philosophy, methodology, and assessment will align with that vision. During the AAMC's Compensation Equity Summit, attendees were asked how institutions will know if their pay equity efforts are succeeding; the following outcomes were identified as key indicators. Institutions may use these indicators to guide their processes and initiatives, with the understanding that it takes time to first establish pay equity efforts then sustain them:



## A Call to Action: Pay Equity Remains the Smart Thing to Do

Given the strong evidence that fair pay is a key component of organizational success, academic medical institutions cannot afford to ignore this issue. Medicine is becoming more representative of varying backgrounds; today, for example, over half of graduating medical students are women,<sup>15</sup> and the next generation of junior faculty – regardless of identity – are keenly attuned to the accessibility of opportunities and growth in the workplace, including fair pay. Pay equity stands to benefit everyone, and as people from different backgrounds with differing viewpoints work to advance academic medicine, compensation equity will be essential to maintaining and engaging a full and productive workforce. Regardless of workforce composition and organizational structure, investing today in pay equity strategies and infrastructure positively impacts future organizational risk mitigation and faculty recruitment and retention for all institutions.

By implementing even one of the following recommendations from this monograph, institutions can take action toward creating sustainable compensation equity.

- Establish a strong and transparent leadership commitment to compensation equity.
- Create a rigorous governance structure that ensures accountability for leaders who determine, review, offer, or negotiate compensation.
- Create a compensation philosophy that fosters equitable compensation practices through consensus.
- Assess and refine compensation plans regularly to sustain equity.
- Identify, quantify, and recognize nonclinical and nonbillable clinical work.
- Establish a transparent structure for compensating leadership roles.
- Standardize the process for reviewing and approving recruitment and retention packages.
- Conduct recurring studies on faculty salary equity and disseminate the results.
- Communicate regularly with employees about the institution's compensation philosophy and model(s), and provide robust and easily accessible information on how compensation is determined.
- Partner with department and health system leaders to craft sustainable models to supply and allocate funds for pay equity adjustments.
- Identify a source that will fund compensation for nonclinical and nonbillable clinical activities.
- Commit to long-term, ongoing improvements regarding governance processes, compensation models, and pay equity study methodologies, as well as opportunities to communicate with faculty.

## Next Up: Case Studies on Taking Action for Sustained Compensation Equity

To illustrate the previously discussed recommendations, the next section presents five case studies detailing successful efforts in supporting sustained compensation equity. These efforts can be easily adapted by institutions and departments alike.



# CASE STUDIES

# Case Study 1: The Role of Leadership and Building Consensus for Pay Equity Success

## Joe Kerschner, MD

Senior Partner at Chartis; previously Dean of the School of Medicine, Provost, and Executive Vice President at Medical College of Wisconsin

### Institution Background

The Medical College of Wisconsin (MCW) is a large school of medicine in the upper Midwest, with over 2,000 faculty. It is a private, not-for-profit, research-intensive medical school that is consistently in the upper one-third of medical schools in the National Institutes of Health ranking, with close affiliation with our hospital partners. The faculty report to the dean of the school of medicine, who is responsible for the clinical, research, education, and community engagement missions of the school. The dean reports to the president of MCW.

While our institution had already started its journey of ensuring compensation equity when I took on the dean role in the medical school 15 years ago, there was still much to be done. The major consideration was that, despite initial efforts, there was still skepticism around the process and the level of transparency (or lack thereof) provided to faculty around compensation. In addition, there was also concern about the heterogeneity of the process across departmental units; therefore, an important step in moving our compensation equity efforts forward was building consensus for this work. To do this, there were several critical strategies we employed to ensure there was shared commitment, trust, and engagement around our efforts.

### Getting Started, Building the Team, and Communicating Our Vision

From the outset, institutional leadership articulated the clear importance of compensation equity for MCW, including having an uncompromising “We will do this” approach. We also frequently articulated that this was a top institutional priority. This meant setting up structures, expectations, and operations that would move forward, even if there were difficult financial considerations for the institution or a particular department. This had to be communicated clearly at senior leader meetings, in budget guidelines, and in performance reviews of departmental leaders to illustrate clearly that pay equity work wasn’t going to drop off our priority list if budgets or time were tight.

We intentionally built an internal team of experts, provided accurate data and analysis, and created solutions when issues were uncovered. This initiative took some investment to get off the ground but proved to be well worth it. The alternative of relying on bringing in a consultant every few years to undertake compensation equity work does not generally provide real-time or contemporary solutions that fit your unique institution. In my opinion, this work cannot succeed without internal experts, and those we had at our institution were incredible and deserve much of the credit for this success. That being said, external consultants may be helpful in developing strategy, providing best practices for these efforts, and – in the absence of an analytics team – performing data analysis.

Results from the internal data analyses must be supported, and departmental leaders should be given clear instructions about their responsibilities for fixing any problems that may be uncovered in their units. Again, this is not a matter of “if you can afford it.” It can be helpful, as we did, to centralize any adjustments in compensation that might be needed.

### Building Consensus Through Data-Driven Action

Building consensus is critical, and most departmental leaders will understand that and perform accordingly if this work is strongly emphasized by senior administration. This is especially true if data are clearly presented and reviewed in a transparent fashion. It is also critical to enlist parts of the organization that are champions of compensation equity. Our institution has a center that was specifically created to support the advancement of women in science and medicine, and the leader of this center was always brought into these conversations and was a powerful influence across the institution. Along with our center director, individual conversations with chairs were held to ensure their understanding and seek their input. The importance of pay equity was also tied to annual reviews, so institutional, “all-leaders”

meetings had this topic as an ongoing agenda item to collectively clarify questions and seek input from leaders. With these tactics, there was clear communication of the importance of this work and several avenues provided to allow for discussion, refinement, and incorporation of it into the operations and organizational culture.

Transparency of data is the other key component of our success. It is important to ensure there is transparency both in sharing the results of compensation equity studies and in discussions about the findings. Our last step was to share much of that data directly with each faculty member. There was some pushback around this consideration, as it requires considerably more effort from leaders to meet with faculty regarding their salaries. While time is precious, this is well-invested time and important for engagement, well-being, and overall development of both leaders and faculty members.

One benefit of implementing compensation equity initiatives in this fashion is that leaders over time come to understand that this is a priority of the institution, and they will likely not want to modify budgets or have their budgeting priorities called into question in the future. As such, with a steadfast approach, the “problem” areas — and the need for modifications — lessen over time.

Most of our institutions have equity, well-being, belonging, or other similar core values. I believe that unless your institution can truly demonstrate commitment to pay equity, almost any other efforts around the institution’s values will have very little impact. Without a clear commitment to compensation equity, faculty will rightfully question how much emphasis or investment the institution is making in these areas — the foundation of your institutional values.



# Case Study 2: Compensation Philosophy and Governance at Medical College of Wisconsin

**Kevin Eide, MBA, MDiv**

Vice President of Financial Planning and Data Analytics at Medical College of Wisconsin

## Institution Background

Our journey toward a transparent, equity-driven compensation system began more than a decade ago, when our organization made a commitment to address pay equity, not just by clearly articulating a compensation philosophy, but also by using rigorous measurement, salary benchmarking, and communication practices that would engage and empower all faculty in the process. With support from the president, dean, and board of trustees, initial efforts sought to first define why structured compensation governance mattered. This was not done just as an academic exercise, but as a strategic imperative to ensure market competitiveness, internal consistency, and, above all, pay equity.

## A Cross-Institutional Committee to Support Success From the Beginning

In the first year, we established the Institutional Compensation Committee (ICC), charged with designing and overseeing the new framework. Reporting directly to the president, the ICC's charter spelled out both its own responsibilities and those of department chairs, setting clear expectations from the beginning. Representing a cross section of the institution, the committee included leaders from research, education and clinical affairs, the CFO, audit leadership, the chief people officer, legal counsel in an advisory role, and various other institutional leaders, as well as staff from the compensation team who would manage the day-to-day operations. This mix of mission leaders and operational experts ensured that every decision reflected Medical College of Wisconsin's (MCW) tripartite mandate of research, teaching, and patient care.

Over the next 18 months, our compensation team drafted detailed white papers and business rules to define how each faculty role should be matched against national compensation benchmarks. We created a data warehouse to pull together demographics gathered from human resources, financial records, clinical productivity metrics, and research funding. Faculty roles were aligned with various specialty codes to reconcile external surveys with internal job definitions. Rather than outsource the entire effort, we relied on internal expertise for most of the heavy lifting, with about 90% of the whole process completed internally. We involved an external consultant only to provide impartial validation of methodology and to reassure chairs that the benchmarks reflected industry best practices.

## Turning Principles Into Practice

Once data integration and benchmarking protocols were in place, we started to design the governance structure and necessary operational and compliance processes. Each year, the compliance and audit department independently extracts compensation, labor, benchmark, and productivity data, then applies multitiered regression analyses modeled on Office of Federal Contract Compliance Programs standards to detect inequities. Department chairs review flagged cases, offering any needed context to explain discrepancies in the data. Any unresolved issues circle back to the ICC for final deliberation. As a result of these layered checks, we now see only single-digit escalations annually — clear evidence that governance and transparency work in tandem to safeguard compensation equity and fairness.

## Establishing Compensation Practices as a Regular Process

Over time, we wove compensation governance into our operational fabric. During budget planning, each department chair receives a custom report comparing current salaries and productivity data to both national and internal benchmarks. All new and open faculty positions display fair market value ranges, triggering mandatory ICC review for any offer above the 75<sup>th</sup> percentile. In fall 2025, each faculty member received a compensation statement detailing their pay components and personal benchmark and the department-average market rate. New chairs and administrators meet with the compensation team as part of their onboarding, ensuring that governance processes become second nature rather than afterthoughts. These operationalized checks and balances are applied to new faculty hires, existing

faculty promotions, and retention arrangements, ensuring efforts toward compensation equity are continuous and not just done in isolated cases.

Although the ICC was chartered within the first year of our compensation equity work, embedding compensation governance into our institutional culture took several years of ongoing socialization, continuous education, and iterative refinement. What began as a project to establish fair market value evolved into a strategic advantage: Our commitment to “equal work for equal pay” is a recruitment and retention tool. Chairs and senior leaders regularly champion the system, helping to bolster confidence in MCW amid a national narrative that academic medicine has much room for improvement in this area.

## Lessons Learned

Several lessons emerged from our experience. First, leadership alignment is essential: Without early and visible sponsorship from the president, dean, and board, efforts to reimagine pay structures would have stalled, because we would not have had buy-in from the rest of the faculty. Second, data integrity must be central — departments need clear guidance and shared responsibility for maintaining clean, consistent records. Third, transparency around benchmarking methodology builds trust and redirects one-off requests from department leaders seeking to offer higher salaries to recruit specific individuals. Finally, solid governance rules built off the institution’s compensation philosophy and principles protect institutional credibility, such as requiring a committee to review compensation or salary requests that exceed a set benchmark (e.g., the 75<sup>th</sup> percentile, per the fair market value rule).

Looking ahead, we plan to refine this framework even further. Efforts are underway to incorporate additional specialty-specific data sources for roles that remain hard to benchmark. Our progress to date is also informing our next steps, as our efforts have resulted in fewer incidences of identified compensation inequities, allowing MCW to schedule audit reviews every *other* year. We have now refined our processes and approach enough that we can take care of slight adjustments or complicated cases. But it was all the work around leadership commitment, data integrity, transparent benchmarks, and continual education and collaboration with faculty and leaders that got us to where we are today.



# Case Study 3: Redesigning a Departmental Incentive Program and Base Scale With Data and Transparency

## Cathy Garzio, MBA

Executive Vice Provost and Chief Operating Officer of Weill Cornell Medicine; previously Vice Chair and Director of Finance and Administration for the Department of Medicine of Stanford University School of Medicine

### Institution Background

Stanford University School of Medicine (Stanford) is a research-intensive, private medical school located in Palo Alto, California. The department of medicine is the largest department with a consolidated budget of approximately \$600 million and is composed of 700 faculty, of which roughly two-thirds are clinical faculty and the remainder are basic scientists and physician-scientists. The compensation structure at Stanford must consider the high cost of Bay Area living and the pressure of competing with two other large, local private systems and an academic medical center nearby.

In 2016, the chair of medicine asked departmental leaders to work collectively to redesign the department's incentive compensation system. Our clearly stated goals were to create a compensation methodology that was:

1. Transparent, formulaic, and easy to explain to faculty at all levels.
2. Adaptable if environmental circumstances were to change (useful during the coronavirus pandemic).
3. Equitable in terms of allowing scientists and educators to share in the clinical success.

As a group of about 30 people, we met weekly for 10 weeks to discuss the process and objectives and did not model any numbers until we were about eight weeks into the discussion. The plan was intended to adhere to identified principles and had buy-in from the divisional leadership before we modeled and assessed impact.

### Redesigning a Formulaic Incentive Program

Our efforts resulted in a formulaic incentive program that included a department and division tax structure for funding academic investments, building reserves, and assuring equity and team incentives that could reward educators and scientists with a “share” of the clinical surplus. A department tax of 23% of work RVUs (wRVU) revenue primarily funded mission investments (e.g., research and teaching) and new programs that served the whole department. The division tax, ranging from 25%-30%, also came from wRVU revenue and mostly funded the faculty metric incentive (explained below) and some division overhead. Additionally, we agreed to make sure that no faculty member fell off a compensation “cliff” because of the new incentive plan. Using internally derived compensation data, we developed forecasts under the new model. Any faculty member who suffered a loss of greater than 10% solely due to the new plan (versus a change in activity) was provided with a path to transition over the next three years.

Additionally, a divisional metric incentive allowed faculty to earn up to 20% of their base salary via predetermined criteria. Typically, these criteria focused on clinical productivity, grants or publications, citizenship, leadership participation, or other predetermined criteria. Each division chief was required to establish criteria at the beginning of the fiscal year and to have it approved by the department vice chair prior to implementation. Because the metric incentive allowed division chiefs to reward strong performance in any mission and benefit from best practices across the department, there was little resistance in moving to a more mathematical approach. Moreover, the principles-based approach used to create the new incentive plan facilitated openness and trust among leaders in considering a new way of establishing the base salary.

### The Impact of Creating a Base Salary Scale

After a year of implementing the new incentive plan, we decided to create a base salary scale to set initial and future

faculty salaries and to also completely remove individual negotiations of base salary from the equation. This was a radical idea in our department, where division chiefs traditionally had significant control over negotiation and setting increases. The base salary scale took into account a faculty member's medical specialty, rank, and years in rank, with 10 steps in each scale for assistant and associate professors and 22 steps for professors. We set the first step for "Assistant," "Associate," and "Professor" using the AAMC median for the specialty and assumed a 5% increase at academic promotion to the next rank. The scale steps were mathematically defined by goal compensation end points. At the start of this process, if an individual was over the scale step amount, they received a modest 2% increase until their base compensation caught up with the scale.

For many faculty members, regardless of gender, the initial year of setting the scale created large increases in salary. Because each clinical faculty member had an individual profit and loss (P&L), their total compensation was not harmed and often increased because the base salary increased while the incentive amount decreased. Overall, we found that most of our faculty still achieved healthy incentives, in the 15%-30% of total compensation range, with some considerably higher. Individual P&Ls existed prior to implementing this revised compensation plan, but the incentive did not previously include either a "team" or "metric" component.

After we revised our approach to setting base salary, our overall goal was to achieve a "total compensation" target of the 75<sup>th</sup> percentile per the AAMC's benchmark amount for that specific specialty. In doing so, we changed the conversation from being one that primarily was about size of incentive to one about total compensation. This was important, too, as faculty members had their individual bottom lines assessed for the team bonus. As long as we kept total compensation moving towards or above the target, there was satisfaction with the model.

For basic scientists embedded in clinical divisions, we created a basic science scale using AAMC benchmarks and applied the exact same approach as for the clinical divisions. Over time, we developed a separate scale for bioinformaticists and biostatisticians, as this market had considerable competitive pressure.

### Success Found in Iterating the Scale Over Time

Over the years, this approach to the salary scale was iterated based on feedback from faculty, division chiefs and administrators, Stanford faculty compensation team, and others as well as by our commitment to transparency in listening and learning along the way. We also initiated an annual meeting to walk faculty through the base scale and incentive plan formulas, the full scale with numbers by each specialty (while respecting the privacy of individuals), and the progress made toward achieving our target of the 75<sup>th</sup> percentile of the AAMC compensation for a given specialty. We have also improved our approach over the years by meeting individually with faculty, so the vice chair could answer all questions.

### Lessons Learned

The primary lessons we learned from this work were the importance of commitment to radical transparency and adherence to predetermined principles for compensation. Overall, compensation decisions that are data-driven, formulaic, and guided by a set of principles are the most successful and make it much easier to explain and manage the process. After seeing this success, other departments at Stanford adapted the department of medicine's compensation methodology. To our knowledge, Stanford did not experience a competitive disadvantage due to the new approach to faculty pay, even when telling job candidates that base salaries would not be negotiated.

There are a few elements specific to Stanford's department of medicine that are noteworthy: Neither our salary scale nor our incentive plan had any gating function, and there was no wRVU threshold or other metric to meet or exceed before an incentive was earned or a scale increase was given. With a P&L approach and a team bonus, we could keep most salaries competitive. It's also important to note that Stanford Medicine has closely aligned its health system and medical school; it has one of the oldest wRVU-based funds flow models in the country, and most faculty members are accustomed to a relatively standardized approach to compensation. As a research-intensive school that also wants to reward its clinicians, our scientists understand and appreciate this model that allows them a share of the clinical surplus.

We are most proud of how the salary scale allowed us to achieve greater compensation equity, although we continued to work on supplemental compensation for leadership roles across the school and health system. Our compensation equity work drove us to make other pay-related decisions that improved the organization as well, such as term limits for certain leadership roles, a database and approval process for administrative supplements, a database and review of packages offered to new science recruits, and decisions about open calls for internal leadership roles. Adopting a scale based on rank and specialty for base compensation started in the department of medicine and was eventually adapted by the entire school with support of the vice dean. This entire process made fairness, transparency, and trust core values of the department and ultimately led to improvements in the organization overall.



# Case Study 4: Tools for Measuring Faculty Effort to Ensure Compensation Transparency, Accountability, and Equity

**Tina L. Cheng, MD, MPH**

Professor and Chair of Pediatrics at the University of Cincinnati College of Medicine, Director of the Cincinnati Children's Research Foundation, Chief Medical Officer for Cincinnati Children's Hospital Medical Center; previously Pediatrician-in-Chief and Co-Director for Johns Hopkins Children's Center

## Institution Background

This case study is based on my experience as a pediatrics department chair at two private, nonprofit institutions: Johns Hopkins, a research-intensive medical school located in Baltimore, Maryland, and Cincinnati Children's, a free-standing children's hospital serving as the department of pediatrics for the University of Cincinnati (UC) College of Medicine in Cincinnati, Ohio. During my tenures, Johns Hopkins and Cincinnati Children's had pediatric departments with 220 faculty and 870 faculty (plus an additional 150 clinical MD, DO, PsyD, and DMD staff members) in 19 divisions and 38 divisions, respectively. About half of the total full-time employees were in basic science and clinical research with both departments consistently ranking among the top children's hospital or department of pediatrics in NIH funding. The faculty at Johns Hopkins report to the dean of the school of medicine, who is responsible for the clinical, research, and education missions. At Cincinnati Children's, the faculty report to the CEO of the hospital and the dean of UC College of Medicine, who reports to the university president.

## Keeping Track of Activity and Funding Effort

Many faculty members wonder how clinical responsibilities are distributed among their colleagues. Some faculty members appear to balance numerous research grants alongside many clinical duties, while others have substantial "protected time" without research funding or administrative roles. When I became the department chair at Johns Hopkins and then Cincinnati Children's, I set out to create tools that would enable us to track faculty effort more accurately and equitably. My goal was to foster greater transparency, accountability, and fairness in how work and funding were allocated across the department. To achieve this goal, we developed two tools:

- The **Pediatric Activity Calculator (PAC)** for faculty to track their own activities and the associated funding sources with more granularity than formal effort reporting (Appendix Figure 1).
- The **Research Activity Calculator (RAC)** to track effort and funding sources for the faculty members' research teams and associated laboratory or research costs (Appendix Figure 2). A division-level RAC was also tabulated.

The expectation is that the PAC calculation should total 90%-100%, reflecting time spent on clinical work, funded educational roles, administrative duties, and externally supported research. The RAC calculation demonstrates funding coverage from research grants or contracts and other sources (e.g., specific business plans, endowment) for all research staff and expenses per institutional expectations.

Both the PAC and RAC are maintained and updated regularly to reflect changes in individual effort. Division directors use these tools to monitor activity and guide discussions during faculty evaluations. Individual PAC and RAC data and division summary sheets (Appendix Figure 3) are reviewed annually during both budget meetings and division chair meetings. The tools were developed collaboratively with division leaders to account for variations in clinical work across divisions. For example, inpatient service expectations vary depending on the size and intensity of the division's clinical activities. Benchmark data for full-time clinical service requirements by subspecialty have recently been collected by the Association of Medical School Pediatric Department Chairs and the Association of Academic Administrators in Pediatrics. Over the past decade, the PAC and RAC have been successfully implemented in two pediatric departments at two different institutions.

## Implementing a New Tool for Faculty

When the system was first introduced, many faculty members were surprised to learn how little they understood about the sources of their own salaries. While some expressed concerns about the increased oversight, many appreciated the increased transparency and the resulting fairness in workload. Although there was initial concern about potential faculty stress in attention to individual effort, the system became widely accepted over time.

Each division maintains spreadsheets that compile PAC and RAC data alongside compensation benchmarks, salary data, and faculty evaluation ratings (Appendix Figure 3). Faculty are listed by academic rank and years in rank, and their salaries are compared against established benchmarks. These comprehensive overviews allow division leaders to identify and address inequities and make informed decisions regarding effort allocation and salary adjustments.

With the implementation of these tools, it has become easier to track and adjust individual faculty effort in a standardized way. Division directors are now better equipped to hold faculty accountable for their time and contributions. Similarly, department chairs and administrators can ensure that each division aligns faculty activities with available funding and department priorities.

*With gratitude to Sally May, Vice President of Finance and Administration, and Rashmi Hegde, PhD, Professor and Vice Chair of Pediatrics, Cincinnati Children's Hospital Medical Center and University of Cincinnati College of Medicine.*



# Case Study 5: Overhauling the Compensation Model at Yale Department of Surgery

## Nita Ahuja, MD, MBA, FACS

Dean of the University of Wisconsin School of Medicine and Public Health, Robert Turell Distinguished Chair in Medical Leadership, and Vice Chancellor for Medical Affairs at University of Wisconsin–Madison; previously Chair of the Department of Surgery at Yale School of Medicine

### Institution Background

When I became chair of surgery at Yale School of Medicine, the department comprised 161 faculty members across 11 divisions and five residency programs, operating in six or seven affiliated hospitals. Annually, the department generated more than 700,000 work RVUs and managed a \$17 million research portfolio. At that time, the department faced a challenge familiar to many institutions: an intricate patchwork of more than thirty distinct compensation plans spread across its academic unit and a separate health system. There was mistrust among faculty because of opaque incentive structures that varied greatly by specialty, physical location, and rank, and could not always be easily explainable. Leaders and faculty agreed that redesigning the compensation structure and coming up with a transparent plan to pay for it were essential to restoring fairness and trust.

From the outset, I was committed to ensuring that any new model we developed would remain anchored in widely recognized, specialty-specific benchmarks that accounted for seniority and rank. Our steering committee, which was composed of division chiefs, a vice chair, and senior administrators, was also committed to simplicity, clarity, and fairness rather than elaborate formulas that individuals might try to “gamify.” We enlisted an external consultant to organize data and frame possibilities, but it was our own leaders who worked with the faculty, testing assumptions in small-group meetings, town halls, and one-on-one discussions.

Over the course of 12 months, four key changes transformed our department’s pay structure:

1. **A formal acknowledgment of protected time for scholarship and teaching was established**, which replaced the previous “hand wave” approach. Using the AAMC’s regional benchmarks as guidelines, procedural clinical faculty secured 20% of research time and research-track clinicians secured 50%, which we funded by creating a deliberate delta between the RVUs generated and the base-salary expenditure.
2. **The committee calibrated how much a faculty member’s salary should rise when promoted from assistant to associate professor**, moderating six-figure jumps in certain subspecialties, to maintain financial balance.
3. **A modest compensation goal was introduced**: 90% of salary was guaranteed, while the remaining 10% hinged on mission-driven activities, including attendance at grand rounds, teaching, and completion of an annual review outlining professional goals, among other academic work. Rather than demand individual RVU targets, division chiefs distributed this “at-risk” component across their teams, adjusting thresholds to account for specialty-specific productivity variations.
4. **A diminishing return scaling factor, based on wRVU, was designed**: As productivity increased, the incentive growth tapered. This approach encouraged faculty to continue to prioritize teamwork while still driving clinical productivity, which was key to the model’s financial sustainability. By supplementing compensation with a wRVU bonus, we were able to narrow the gap between productivity and compensation percentiles, allowing us to maintain market-competitive salary ranges and retain top talent.

Underlying the entire framework were guiding principles that proved critical to its success. The algorithm corrected historic compensation inequities that might otherwise have been viewed as subjective, punitive, or too politically fraught for the steering committee to act upon directly. By returning consistently to these principles, the committee could make difficult decisions while keeping the “why” front and center.

## Leveraging Partnerships to Fund Adjustments

Developing a strategic partnership with the health system was essential for this effort to succeed. A central funding challenge we had was with specialties whose downstream value was invisible to pure RVU metrics, such as pediatric cardiac surgery or breast surgery where faculty do more ancillary and long-term, patient-focused work. Rather than attempt a unilateral adjustment, we paced negotiations with the health system: first, to show that overall departmental productivity was rising; then, to present targeted subsidy requests for those undervalued specialties. These sequential conversations avoided overwhelming hospital leadership and ensured alignment at each stage of implementation.

We wouldn't have been able to address these compensation inequities without rigorous financial modeling and scenario planning. My finance team and I began by taking stock of the department's financial surpluses that had been built up over the years by conservative spending. Those reserves became the critical buffer for a rollout that, on paper, threatened to undercut revenue. To test the waters, we conducted a “shadow period” in which we modeled the new compensation rules against the existing funds flow, confirming that first-year losses could range as high as 3% on a budget of roughly \$160-\$180 million. Armed with those projections, we carved out a multimillion-dollar pool from reserves to absorb shortfalls, even as we tightened incentive payouts to limit risk. These results helped us to replenish reserves while continually adjusting forecasts against shifting clinical volumes, ensuring that reserve draw-downs never exceeded planned thresholds. Throughout this process, maintaining a close partnership with the CFO was critical; we reviewed rolling three-year projections and calibrated subsidy levels for mission-critical activities like protected research time.

We ended Year 1 of the new plan net-neutral, driven by a higher-than-anticipated increase in clinical productivity, and by mid-Year 2, sustained productivity gains put us back into the positive. Minor salary adjustments, such as small increases for undercompensated faculty and slight decreases for a handful of outliers, proved manageable. One of the most important results from this process was that no one chose to leave under the new structure.

Within two years, we had a unified, transparent model that rewarded scholarship, teaching, and clinical excellence. In department surveys, faculty reported being compensated more fairly and receiving clearer expectations for career development. A retrospective audit also revealed a larger-than-expected rise in women's median salaries, underscoring the plan's power to address subtle pay inequities that prior calculators had missed. While requiring complex management and administrative oversight, administrators appreciated now having only one compensation plan, freeing staff to focus on faculty support rather than managing one-off requests. Equally important, the investment of significant effort did not end once the compensation plan was finalized. Implementing the plan, communicating expectations, and reinforcing consistency with faculty remain ongoing work within the department.

Notably, this was only the first phase. A research-specific compensation plan was implemented in a second phase, which is not described at length here, but was equally critical to ensuring fairness for the nonclinical faculty.

## Lessons Learned

Reflecting on this journey, culture and communication were paramount. One of the most critical aspects of success was ensuring that the plan was communicated to faculty clearly, consistently, and openly. There can be no secrets — faculty compare notes, numbers, and conversations — so aligned messaging and transparency were essential to maintaining trust. Continuous dialogue through cabinet meetings, peer-to-peer mentoring among division chiefs, and frequent educational sessions built consensus and revealed compensation inequities early. Investing in robust forecasting and being willing to subsidize mission-critical activities gave the plan staying power. Equally important, as chair, I had to own every step of the process, with all adjustments passing through my office until I could confidently say the department was stronger, fairer, and more unified.

Yale's experience offers a blueprint for other academic medical centers wrestling with compensation complexity at the department level. By centering our philosophy, simplifying incentives, and leveraging clinical partners for funding, institutions can align faculty motivations with organizational missions. Even amid the uncertainty of clinical volumes and funding streams, a principled, data-driven, and transparent approach can transform a complex academic health system into a sustainable model — one that retains talent; rewards a wide variety of contributions; and ultimately benefits patients, learners, and the academic enterprise alike.

*With gratitude to Ms. Claudia Chujoy, Associate Director of Administration, and Ms. Cecelia Smith, Chief of Staff and Communications Officer, Yale School of Medicine Department of Surgery.*



## REFERENCES

1. Bohnet I, Chilazi S. *Make Work Fair: Data-Driven Design for Real Results*. Harper Business; 2025.
2. Gottlieb AS, ed. *Closing the Gender Pay Gap in Medicine: A Roadmap for Healthcare Organizations and the Women Physicians Who Work for Them*. Springer; 2021. doi:[10.1007/978-3-030-51031-2](https://doi.org/10.1007/978-3-030-51031-2)
3. Gottlieb AS, Jagsi R. Closing the gender pay gap in medicine. *N Engl J Med*. 2021;385(27):2501-2504. doi:[10.1056/NEJMp2114955](https://doi.org/10.1056/NEJMp2114955)
4. Gottlieb AS, Dandar VM, Lautenberger DM, Best C, Jagsi R. Equal pay for equal work in the dean suite: addressing occupational gender segregation and compensation inequities among medical school leadership. *Acad Med*. 2023;98(3):296-299. doi:[10.1097/ACM.0000000000005087](https://doi.org/10.1097/ACM.0000000000005087)
5. Dandar VM, Lautenberger DM, Garrison GE. *Promising Practices for Understanding and Addressing Salary Equity at U.S. Medical Schools*. AAMC; 2019. <https://store.aamc.org/promising-practices-for-understanding-and-addressing-faculty-salary-equity-at-u-s-medical-schools.html>
6. Dandar VM, Lautenberger DM. *Exploring Faculty Salary Equity at U.S. Medical Schools by Gender and Race/Ethnicity*. AAMC; 2021. <https://store.aamc.org/exploring-faculty-salary-equity-at-u-s-medical-schools-by-gender-and-race-ethnicity.html>
7. Dandar VM, Lautenberger DM. *Exploring Salary Equity Among Medical School Leadership*. AAMC; 2022. <https://store.aamc.org/leadership-compensation-equity-report-exploring-salary-equity-among-medical-school-leadership.html>
8. Urwin JW, Emanuel EJ. The relative value scale update committee: time for an update. *JAMA*. 2019;322(12):1137-1138. doi:[10.1001/jama.2019.14591](https://doi.org/10.1001/jama.2019.14591)
9. U.S. Government Accountability Office (GAO). *Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy*. GAO; 2015. <https://www.gao.gov/assets/d15434.pdf>
10. Chan DC, Huynh J, Studdert DM. Accuracy of valuations of surgical procedures in the Medicare fee schedule. *N Engl J Med*. 2019;380(16):1546-1554. doi:[10.1056/NEJMsal807379](https://doi.org/10.1056/NEJMsal807379)
11. Nurok M, Gewertz B. Relative value units and the measurement of physician performance. *JAMA*. 2019;322(12):1139-1140. doi:[10.1001/jama.2019.11163](https://doi.org/10.1001/jama.2019.11163)
12. Benoit MF, Ma JF, Upperman BA. Comparison of 2015 Medicare relative value units for gender-specific procedures: gynecologic and gynecologic-oncologic versus urologic CPT coding. Has time healed gender-worth? *Gynecol Oncol*. 2017;144(2):336-342. doi:[10.1016/j.ygyno.2016.12.006](https://doi.org/10.1016/j.ygyno.2016.12.006)
13. Oshinowo TO, Rallo MS, Schirmer CM, Chambless LB. Gender differences in Medicare practice and payments to neurosurgeons. *JAMA Surg*. 2024;159(1):35-42. doi:[10.1001/jamasurg.2023.4988](https://doi.org/10.1001/jamasurg.2023.4988)
14. Raber I, Al Rifai M, McCarthy CP, et al. Gender differences in Medicare payments among cardiologists. *JAMA Cardiol*. 2021;6(12):1432-1439. doi:[10.1001/jamacardio.2021.3385](https://doi.org/10.1001/jamacardio.2021.3385)
15. Lautenberger DM, Dandar VM. *The State of Women in Academic Medicine 2023-2024: Progressing Toward Equity*. AAMC; 2024. <https://www.aamc.org/data-reports/data/state-women-academic-medicine-2023-2024-progressing-toward-equity>

# APPENDIX. Case Study 4: Tools for Measuring Faculty Effort

Figure 1. The Pediatric Activity Calculator; an example spreadsheet for an individual.

PAC (Pediatric Activity Calculator)									
Fiscal Year	2025	<i>The purpose of this form is to calculate expected effort for a fiscal year.</i>							
As of Date:	12/31/24								
Division:	Division ABC								
Name:	Dr. X								
FTE:	1.00								
100% Research Faculty?	No								
<b>Externally Funded Research Effort (Include Cost Share)</b>									
	<b>Funding Source</b>	<b>Fund</b>	<b>Dept ID</b>	<b>Project ID</b>	<b>Start Date</b>	<b>End Date</b>	<b>%</b>	<b>Adjusted %</b>	<b>Notes</b>
NIH Grant # 123456	Grant	90000	572004	307052	1/1/20	1/1/25	25.00%	12.50%	
Grant #9876	Grant		34554	22456	7/1/22	6/30/26	15.00%	15.00%	
<b>Total Externally Funded Research Effort (Include Cost Share)</b>								<b>27.50%</b>	
<b>Internal Awards/Start-up Effort</b>									
	<b>Funding Source</b>	<b>Fund</b>	<b>Dept ID</b>	<b>Project ID</b>	<b>Start Date</b>	<b>End Date</b>	<b>%</b>	<b>Adjusted %</b>	<b>Notes</b>
Recruitment Start-Up	HF Business Plan	53181	572004	143565	8/1/21	11/30/25	5.00%	5.00%	
<b>Total Internal Awards/Start-up Effort</b>								<b>5.00%</b>	
<b>Teaching Effort (protected time for a specific role related to teaching faculty)</b>									
	<b>Funding Source</b>	<b>Fund</b>	<b>Dept ID</b>	<b>Project ID</b>	<b>Start Date</b>	<b>End Date</b>	<b>%</b>	<b>Adjusted %</b>	<b>Notes</b>
<b>Total Teaching Effort</b>								<b>0.00%</b>	
<b>Administrative Effort (protected time for clearly defined leadership role) - refer to instructions</b>									
	<b>Funding Source</b>	<b>Fund</b>	<b>Dept ID</b>	<b>Project ID</b>	<b>Start Date</b>	<b>End Date</b>	<b>%</b>	<b>Adjusted %</b>	<b>Notes</b>
<b>Total Administrative Effort</b>								<b>0.00%</b>	
<b>Clinical Contractual Effort (activity billed outside CCHMC)</b>									
	<b>Funding Source</b>	<b>Fund</b>	<b>Dept ID</b>	<b>Project ID</b>	<b>Start Date</b>	<b>End Date</b>	<b>%</b>	<b>Adjusted %</b>	<b>Notes</b>
<b>Total Clinical Contractual Effort</b>								<b>0.00%</b>	
<b>Clinical Effort Generating wRVU's Through CCHMC</b>									
	<b>1.0 cFTE Definition</b>	<b>Current Activity</b>	<b>%</b>						<b>Notes</b>
Outpatient Clinical Sessions (All Subspecialties)	8	2.50	31.25%						
Outpatient Procedural Sessions (All Subspecialties)	8		0.00%						
Inpatient Service (Any specialty not specifically named)	45	13.00	28.89%						
Other Clinical Activity	TBD		0.00%						
<b>Total Clinical Effort Generating wRVUs Through CCHMC</b>			<b>60.14%</b>						
<b>1.0 cFTE wRVU Benchmark</b>							<b>3,368</b>		
<b>wRVU Benchmark Based on CFTE</b>							<b>2,025</b>		
<b>Total</b>								<b>92.64%</b>	
<b>List any pending externally funded awards below:</b>									
	<b>Expected Allocation %</b>								
R01 Application for XYZ	15.00%								
<i>Please use the space below to explain how the remaining unallocated FTE will be used for the duration of the fiscal year.</i>									



**Figure 3. Division faculty salaries; an example spreadsheet.**

Rank	Benchmark Salary	Name	FTE	Gender	Degree	Years @ Rank	Expected Percentile Range	Salary	Percentile Rank
Professor	AAAP <sup>1</sup> Speciality	Faculty 1 MD	1.00	M	MD	16.0	50-100		60.7%
Professor		Faculty 2	1.00	M	MD	7.5	40-80		53.4%
Professor		Faculty 3	1.00	M	MD	5.4	35-75		34.1%
Professor	AAMC <sup>2</sup> PhD	Faculty 4 PhD	1.00	F	PhD	11.5	50-100		60.5%
Professor		Faculty 5	1.00	M	PhD	8.3	40-85		48.6%
Associate Professor	AAAP <sup>1</sup> Specialty	Faculty 1 MD	0.70	F	MD	7.0	40-80		52.8%
Associate Professor		Faculty 2	1.00	M	MD	5.4	35-75		50.0%
Associate Professor		Faculty 3	1.00	F	MD	3.4	30-70		46.6%

Last FY PAC <sup>3</sup> %	Current PAC %	Last FY RAC <sup>4</sup> %	Current RAC %	Division Director Evaluation
				Meets Expectations
				Meets Expectations
				Meets Expectations
				Exceeds Expectations
				Meets Expectations
				Meets Expectations
				Meets Expectations
				Exceeds Expectations

<sup>1</sup>AAAP: Association of Administrators in Pediatrics

<sup>2</sup>AAMC: Association of American Medical Colleges

<sup>3</sup>PAC: Pediatric Activity Calculator

<sup>4</sup>RAC: Research Activity Calculator

