# BUDGET & PAYROLL

The Coordinator, Program Director, or GME office can control the budget and payroll system for residency programs. Regardless, there are many factors that weigh in managing both systems expeditiously. Since this is a Program Coordinator Handbook we try to look at these systems from the Program Coordinator point of view.

## Payroll

There have been many ways payroll systems are monitored today, more than likely your system is automated, but some manual monitoring may be necessary in some instances. Most programs have payroll systems that are automated and can be reviewed from the Coordinators' preliminary input to the final approval by the Program Director or Director of Medical Education (DME). Automated systems make payroll easier and less cumbersome. Most residents are salaried positions and have budgeted salaries, which are monitored monthly in actual budget reports. An additional task in handling the payroll is the monitoring of duty hours, which can be integrated into the newer systems.

Payroll basically consists of making sure that the resident has been in the hospital and working in a supervised environment. Whether he/she are there for one to four hours or a full eight hours can be determined by time cards, swiping systems, or just a roll call in the morning at grand rounds attendance. However, the monitoring of attendance of your residents usually is approved by the Program Director or DME in accordance to guidelines with accreditation and auditing agencies.

Vacation time for most residents is three to four weeks. Residents will also incur conference time, sick time or personal time away as well. When this occurs, a system of accountability must be maintained with the Program Director, the Coordinator, and the Chief Resident. Guidelines must be maintained and fair for all residents when it comes to time away from training and completing the residency program. In addition, there are leave of absences that are a required benefit for all residents or employees of the facility. These benefits are a requirement of State and Federal laws or codes. These statutes cannot be violated otherwise consequences to the facility and the program could be detrimental.

Residents taking extended time away from the program for paternity, maternity, military, medical, personal, and educational leaves MUST be approved by the Program Director before the leave is initiated and communicated to your Human Resource Department and Graduate Medical Education office. There should be an agreement of understanding between the Resident and Program Director that if the leave is for an extended time (longer than the four week vacation), then the Resident will make up the time or extend his or her residency training. Some

programs will allow for the Program Director to grant reduced training time to accommodate some extenuating circumstances.

Communication is a large part of making sure attendance and time away from the program are documented accurately through payroll systems. Any time should be approved by the Chief Resident or Program Director and acknowledged by the Program Coordinator in the payroll system for accurate control of salaries paid to Residents.

**Budget**

The budgeting process usually takes a year for planning, revising, implementing, and utilization. Most budgets are formulated by past cost analysis and expenditures. Budgeting systems are set up within each facility and distributed to the Director of Medical Education or the Program Director after careful review and reflection of past expenditures. The accounts are distributed with expected costs for the coming year. The cost must be reviewed by the Program Director and Program Coordinator to determine if the cost was below or above what should be allotted for the account. In most cases, the cost is too low and should be increased.

Some costs will be integrated with other accounts for consolidation of monies to pay the costs incurred by all programs within an organization. But, most organizations distribute budget cost to each individual program and a separate cost to Medical Education is necessary to cover impending accreditation reviews, program access to database learning tools, graduation, orientation, etc. It is the Coordinators responsibility to monitor, in most cases, how these funds are utilized within the department and for each account.

After many meetings, the Program Director with the help of the Coordinator, will decide if the amount allotted is enough to benefit the program for the coming year. If not, then back to the drawing table until a more beneficial resolution to necessary funding is developed.

Capital items are another separate budgeting arena and should also be determined at least one year in advance of the current budget year. Capital items or equipment is the cost of an item that exceeds usually $1,000.00 or more (depending on what you facility has determined as the “capital amount”). These items usually always require a signature from the Program Director, Director of Medical Education, Vice President or higher. Capital items must be made through a search in the form of quotes, market comparisons, long- and short-run costs, maintenance, training, depreciation, utilization, functionality, etc. Nevertheless, these items are also necessary for training programs to run smoothly and efficiently. Even though these “big ticket” items take some planning, they can be the difference in marketing a program to top graduates from medical schools around the world.

Once a budget has been approved for the coming year the Coordinator will be responsible for the funds to be directed to the correct budget accounts. This may take on the shape of an Excel spreadsheet or more automated budget accounting methods, but must be maintained for the next round of the budgeting cycle. Financial accountability has been a source of considerable frustration for Program Directors as well as policy makers. Policymakers and payors are concerned that there is no mechanism for monitoring or ensuring that society is receiving value for the funds expended. Faculty and Program Directors suspect at best, and are certain at worst, that some of the monies distributed to institutions for the direct costs of graduate medical education are used for other purposes. Documentation of at least 75% of the funds received would allow flexibility in institutional use for 25% of the funds distributed on the per-resident payment basis.

## References

Rich, EC et al. (2002) Medicare financing of Graduate Medical Education: intractable problems, elusive solutions. Journal of General Internal Medicine, 17, 283-292.