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Academic Medical Center Governance: A Study Focused on the University of Mississippi Medical Center

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ACADEMIC MEDICAL CENTER GOVERNANCE: A STUDY FOCUSED ON THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

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ABSTRACT

Academic Medical Centers (AMCs) face many challenges, which can lead to financial constraints. For AMCs to remain sustainable in today's healthcare system, the literature presents a compelling case for expansion to mitigate their financial burdens. Expansion often requires quick decision-making, and as a result, scholars repeatedly discuss the importance of AMC governance being both nimble and efficient. The University of Mississippi Medical Center (UMMC) substantially impacts Mississippians, and the institution must remain a thriving center for education, research, and healthcare for the state. Given the importance of efficient and nimble governance in the institution's sustainability, this Dissertation in Practice (DiP) aims to explore the perceptions of the Institutions of Higher Learning Board of Trustees and the University of Mississippi Medical Center senior leadership regarding the efficacy of the current governance structure.

LIST OF TERMS AND DEFINITIONS

Academic Medical Center (AMC)- consists of a medical school, has a relationship with a teaching hospital, and serves the tripartite mission of education, research, and clinical care (Joint Commission International, 2021).

Academic medical center governance- policies, procedures, and organizational structure involved in overseeing and regulating academic medical centers.

American Medical Association (AMA)- is a Professional organization for physicians.

Association of American Medical Colleges (AAMC)- is an organization that serves academic medicine and consists of medical school members in both the United States and Canada.

Blue Cross Blue Shield of Mississippi (BCBSMS)- Private healthcare insurance provider.

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Healthcare is a massive and complex industry. In 2019, it comprised 17.7% of the nation's GDP (Centers for Medicare and Medicaid Services, 2020), and with an aging population, this number will continue to rise. Because of the demands and strains placed on a system this large, healthcare is ever-changing.

One significant change is the consolidation of healthcare facilities into healthcare systems. Small, individualized hospitals are rapidly merging into large healthcare organizations. Size offers protection against the widespread reduction in reimbursement for healthcare services. Academic Medical Centers' (AMCs) triple mission of education, research, and clinical care plays a vital role in the nation's complex healthcare system. In this Dissertation in Practice (DiP), academic health and academic medical centers are used interchangeably. The Joint Commission International's (2021) definition of AMCs and the Association of Academic Health Center's (2021) definition of AHCs are fundamentally aligned. Both organizations have a medical school, engage in a relationship with a teaching hospital, and serve the tripartite mission of education, research, and clinical care.

Academic medical centers (AMCs) are not immune to the nation's growing healthcare crisis pressures. The Association of American Medical Colleges presents AMCs with four options. Three involve growth into a healthcare system, while the fourth option is to "shrink into isolation" (Enders & Conroy, 2014**,** p.5). Current

recommendations for medical centers to expand into healthcare systems are not new. Inglehart's (1995) assessment nearly 30 years ago, asserted the need for change. The author discussed the growing trend of AMCs expanding to build partnerships with local providers and expanding their primary care capacity (Inglehart, 1995).

Many of the challenges facing AMCs today are the same that were present over two decades ago. In 1995, Inglehart articulated the need for AMCs to recognize the increased cost of operating as specialty care institutions. The cost of delivering specialized interventions and the reimbursement for that care has been a significant concern for AMCs, specifically the University of Mississippi Medical Center. In 2022, disputes concerning reimbursement and cost of treatment resulted in a nine-month stalemate that left 750,000 Blue Cross Blue Shield (BCBS) employees out of network with the state's only academic medical center, the University of Mississippi Medical Center (Vance, 2022).

This public dispute centered around reimbursement. Senior leadership at UMMC publicly stated they were underpaid by BCBS compared to other academic medical centers (LeMaster, 2022). However, BCBS refuted these statements claiming UMMCs statements were "misleading" and inaccurate (LeMaster, 2022).

Eventually, this led to the involvement of Mississippi Insurance Commissioner, Mike Chaney. In October 2022, Chaney stated, "Both parties are wrong. The university is asking for too much money. Blue Cross Blue Shield can give more" (Vance, 2022). This debate lasted nearly one year, and in late 2022 BCBS of Mississippi and UMMC reached

an agreement (Vance, 2022). Regardless of who was responsible for the fallout, reimbursement is a contentious topic for Mississippi's academic medical center.

It is not easy to overstate or express the impact AMCs have on society. Academic Medical Centers educate the next generation of healthcare providers, perform valuable research to advance modern medicine, and offer medical services to the community, often providing services to underserved and vulnerable populations. Given the significant challenges facing AMCs, it is clear they must be able to adapt in order to remain sustainable. Adapting to today's tumultuous healthcare environment requires nimbleness and efficiency.

The literature has repeatedly discussed the importance of AMCs to expand (Chair et al., 2018; Enders & Conroy, 2014; Inglehart, 1995). UMMC has experienced recent expansions, including partnering with multiple community hospitals throughout the state and building a new children's hospital. UMMC continues to look for growth opportunities. Currently, UMMC is seeking public support to open a burn center. However, this has resulted in competition with Baptist Medical Center for state funding (Bose, 2023).

UMMC provides invaluable services to the citizens of Mississippi. UMMC is the only level-one trauma center in Mississippi. Level one is the highest designation; these centers must meet stringent requirements to ensure the institution can offer high-quality, 24-hour access to care for the most complex traumatic injuries. It is also home to the state's only Children's Hospital, sickle cell anemia program, and bone marrow transplant unit (UMMC, 2023b). It provides valuable research, trains the next generation of

healthcare providers, and offers high-quality and specialized healthcare services to vulnerable populations, including underinsured and uninsured individuals. For UMMC to meet the growing demands of one of the unhealthiest states in the nation, the governance structure must be as efficient as possible. I believe that efficacy precedes efficiency, and both efficacy and efficiency begin with a proper governance structure.

The governance structure at UMMC is somewhat nuanced. UMMC is affiliated with the University of Mississippi and is considered a nonprofit public institution. The Vice Chancellor for Health Affairs at the medical center works with the Chancellor of the University of Mississippi, who reports to Mississippi's Institutions of Higher Learning (IHL) Board of Trustees concerning the University. Besides UMMC, the IHL Board of Trustees is also responsible for overseeing seven other public institutions of higher learning in Mississippi. IHL Board of Trustees is considered a constitutional governing board appointed by the governor (Mississippi Institutions of Higher Learning, 2023).

Statement of the Problem of Practice

This study explores the perceptions of Mississippi Institutions of Higher Learning Board of Trustees (hereafter IHL) and University of Mississippi Medical Center (hereafter UMMC) senior leadership regarding the efficacy of the current governance structure. By exploring the perceptions of leadership, this study seeks to answer three research questions:

1. Is the current governance structure of UMMC effectively meeting the needs of the institution?

2. Is the governance structure supportive of and responsive to the UMMC mission?
3. What are the perceptions of UMMC leadership and the IHL Board of Trustees concerning the current governance?

Positionality

Considering positionality is critical to the production of high-quality research. Describing one's personal experiences and position on the research topic promotes transparency (Qin, 2016). It allows the researcher to consider how their lived experiences or relationship with the topic could influence the study. Everyone's position on a topic is unique to that individual. My background in healthcare and the medical center has led me to explore the perceptions of the IHL board members and UMMC leadership regarding the efficacy of the current governance structure. Below I will outline my relationship with this research.

Personal Background

Mississippi Healthcare has played a significant role in my life. I have lived in Mississippi my entire life, and each of my immediate family members is in a healthcare profession. My parents were registered nurses; my wife is a physician assistant, and my brother is a physician. On a final, personal note, my father-in-law is the current Chancellor of the University of Mississippi.

Educational and Professional Background

I attended UMMC beginning in 2013, received a Doctorate of Physical Therapy in 2016, and remained employed as an outpatient physical therapist at the medical center. In 2022, I transitioned out of the clinical setting and into academia, and I am currently an assistant professor at the School of Health-Related Professions with the Physical Therapy Department.

In the last ten years of being affiliated with UMMC, I have become keenly aware of the challenges the medical center faces. As with many healthcare organizations, budget is a significant concern at UMMC. At times it was difficult for my department to hire therapists because UMMC struggled to provide competitive salaries. Traditionally, private institutions offer higher financial incentives. Therefore, I have heard the administration describe working at UMMC as a calling instead of a job. Also, given the bureaucracy involved in an extensive system, I have witnessed first-hand the glacier pace of modest reforms. However, even with these challenges, it is a rewarding workplace.

During my time at UMMC, I have seen the significant need for its services. UMMC provides highly specialized care to the sickest and most vulnerable populations. During the pandemic, it provided invaluable services to the community. For example, UMMC produced in-house COVID-19 testing when testing was in short supply, developed community testing facilities, and provided critical care to some of the sickest patients in the state (Cummins, 2022). Several community organizations partnered with and looked to UMMC for recommendations and suggestions during this time.

As an outpatient physical therapist, I regularly treated patients with little or no insurance who would have otherwise had no viable healthcare option. Mississippi has a high population of underinsured individuals, and the care UMMC offers is invaluable to many patients.

Conceptual Framework

A conceptual framework serves many purposes for the researcher. Robyn Smyth stated, "a conceptual framework has potential usefulness as a tool to scaffold research and, therefore, to assist a researcher to make meaning of subsequent findings" (Smyth, 2004). The conceptual framework is "a network, or 'a plane,' of interlinked concepts that together provide a comprehensive understanding of a phenomenon" (Jabareen, 2009). My conceptual framework has two elements: literature surrounding the governance of academic medical centers and the criteria for assessing the "nimbleness" and "systemness" of academic medical center governance, set forth by Chari et al. (2018).

Academic Medical Center Governance Structure

Potential for excellence begins with a proper governance structure. AMCs face many challenges, and their governing structures and processes must be effectively aligned and able to meet the healthcare system's demands (Chari et al., 2018). Although no two medical centers are the same, the literature clarifies that academic medical centers and their governance structure should possess some commonalities. Scholars have frequently emphasized the need to grow and expand academic medical centers (Chari et al., 2018; Enders & Conroy, 2014; Inglehart, 1995; Pellegrini, 2019). Enders and Conroy

(2014) discussed this at length, and Chari et al. (2018) used growth and expansion to explain the need for nimbleness in governance. Inglehart (1995) recognized the need for change almost thirty years ago. The challenges and constraints confronting AMCs create an environment with severe budgetary concerns. The previously mentioned literature has discussed the challenges and potential solutions for academic medical centers and has helped to frame interview questions for this study.

Nimbleness and Systemness

The other key aspect of this conceptual framework is the research provided by Chari et al. (2018). Chari et al. (2018) conducted a literature review and 23 interviews to identify critical academic medical center governance aspects. Furthermore, they develop criteria by which to evaluate the system (Chari et al., 2018). They identified alternative options by applying these criteria and assessing the University of California (UC) governance structure. Their study aided UC in adopting one of these alternative options in hopes of streamlining its governance structure.

The seven criteria identified by Chari et al. (2018) will play a significant role in creating questions for this study. The criteria for assessing a medical center's governance system include the following:

- Timeliness and efficiency in decision making
- Ability to provide strategic guidance,
- Ability to take advantage of system-level efficiencies
- Ability to maintain alignment across the triple mission
- Responsiveness to local conditions

- Expertise among board members in clinical care
- The feasibility of making a change (Chari et al., 2018)

The following literature review provides further explanation of their study.

Literature Review

In 2014, Enders and Conroy predicted that academic medical centers would completely transform in the coming decade. Whether or not the change has been this dramatic is debatable; nevertheless, AMCs exist in a dynamic environment. They must be adaptable to maintain relevance and fulfill their triple mission. The ability of medical centers to be nimble is a priority (Chari et al., 2018). Expansion and growth are vital to the sustainability of academic medical centers (Enders & Conroy, 2014), and it often involves collaborating with or acquiring new healthcare facilities. These expansions require efficient and sprightly decision-making. Therefore, AMCs governance structures must promote efficacy in the decision-making process. Governance structures allow for growth and help to ensure the sustainability of AMCs in today's increasingly challenging healthcare environment (Chari et al., 2018).

The differences within academic medical centers lead to heterogeneity of complex governance structures (Pellegrini et al., 2019). Governing boards come in all shapes and sizes, and preferred governance and leadership models differ among academic medical center members. As previously mentioned, UMMC is affiliated with the University of Mississippi, and the board of trustees oversees seven other public universities. The University of Alabama Birmingham is structured similarly to UMMC. The University of Alabama Birmingham medical center is affiliated with the University of Alabama and

therefore shares a Board of Trustees. This board is only responsible for the three higher education institutions within the University of Alabama System. However, some AMCs, such as the University of California, are considered multi-AMC systems and consist of several medical centers sharing one board. Other academic medical centers operate independently and have their own board. This literature review expounds upon academic medical centers' complexities and challenges, including the financial burdens and the need for an effective governance structure.

Financial Challenges Facing Academic Medical Centers

Financial constraints are arguably the most significant challenges surrounding academic medical centers. Reduction in reimbursement for healthcare services is a chronic problem, and financial challenges have plagued AMCs for decades. Over 20 years ago, Inglehart (1999) discussed the difficulties academic medical centers were confronting due to decreases in federal funding, particularly concerning the Balanced Budget Act of 1997. Similar difficulties remain today. Federal subsidization comprises a relatively small portion of academic medical centers' funding. The Association of American Medical Colleges, Liaison Committee on Medical Education (2021) reported that only 14% of medical centers' revenue is from federal grants and contracts. Instead, clinical services are responsible for providing the majority of financial support. The hospital and practice plan categories provided sixty-three percent of all revenue for 142 fully accredited medical schools, according to research conducted by the Association of American Medical Colleges, Liaison Committee on Medical Education (2021).

Academic medical centers receiving most of their funding through clinical enterprises is concerning for some. Lockwood (2014) expressed concerns that academic medicine is a bubble about to burst. To prevent the bubble from bursting, Lockwood (2014) suggested that the tripartite mission of academic medical centers should be self-sustaining.

Medicare and Medicaid comprise a large percentage of academic medical centers' payor sources for clinical services. In 2019, the Medicare Payment Advisory Commission reported Medicare profit margins for hospitals at a dismal -9.9%, projected to decline to -11% if payment rates were not increased (Medicare Payment Advisory Committee, 2019). Trouble is on the horizon with reimbursement rates for clinical care declining and hospital services providing the primary support for many AMCs.

Colenda et al. (2020) discussed medical centers' financial stresses and described debt as AMCs Achilles' heel. The authors also outlined the importance of liquidity for AMCs, given the COVID-19 pandemic (Colenda et al., 2020). They urged leadership to seek increased funding from federal programs and to pay close attention to the organization's financial performance (Colenda et al., 2020). Loans can be a necessity when considering multimillion-dollar projects. However, since debt plays such a vital role in the vulnerability of AMCs, leadership needs to be diligent in decisions regarding debt issuance (Colenda et al., 2020).

The financial challenges confronting academic medical centers are multifactorial. Using data from The Centers for Medicare and Medicaid Services and summary statistics from 3,552 hospitals, Koenig et al. (2003) estimated that in 2002 the mission-related cost

for all teaching hospitals was $27 billion, and inpatient cost per case at AHCs was almost double the all-hospital average (i.e., $8,817 vs. $4,928).

McCormick and Pruthi (2016) discussed factors that complicate academic health centers (AHCs) abilities to thrive in today's healthcare market. One issue identified by McCormick and Pruthi (2016) was AHCs patient mix. Academic health centers treated underinsured and uninsured patients disproportionately compared to other healthcare organizations, resulting in significant budget deficits (McCormick & Pruthi, 2016; Stimpson et al., 2014). Also, AHCs often treat the most complex cases involving severe traumas or complicated diseases (McCormick & Pruthi, 2016).

Research conducted by Szekendi et at. (2015b) supported McCormick and Pruthi's claims. Szekendi et al. (2015b) utilized a comprehensive database to analyze 28,291 frequently admitted patients' demographics – social and clinical characteristics. Drawing from an analysis of over 180,000 hospital admissions, they concluded, "patients who are frequently admitted to US academic medical centers are likely to have multiple complex chronic conditions and may have behavioral comorbidities that meditate their health behaviors, resulting in acute episodes requiring hospitalization" (Szekendi et al. 2015b). These complex conditions required AHCs to employ subspecialized physicians and maintain cutting-edge equipment, increasing academic health centers' costs (McCormick & Pruthi, 2016).

Johnston (2019) discussed decreases in federal funding and contemplated whether AMCs have become too large. Academic medical centers have grown into massive operations, and most AMCs' annual revenues exceed $500 million (Johnston, as cited by

Association of American Medical Colleges, Liaison Committee on Medical Education). Johnston (2019) suggested that AMCs should focus on solutions to enhance value and reduce reliance on fee-for-service medicine. The magnitude of AMCs limits nimbleness and hinders their ability to adapt rapidly to meet the needs of society (McCormick & Pruthi, 2016; Johnston, 2019).

According to Johnston (2019), small and nimble AMCs are better positioned to offer value to society than large organizations that tend to resist change. Frequently discussed in the literature is Johnston's call for nimbleness surrounding AMCs. Despite this, it is still rarely suggested that AMCs should be smaller.

Shared Governance

Shared governance has played a prominent role in developing higher education in the United States. Elements of shared governance can be traced back to the beginnings of higher education in America. The lay oversight boards in the founding of America's oldest college, Harvard, is a prime example of shared governance (Pusser & Loss, 2018). In today's higher education climate, shared governance has become difficult to define, and varying definitions can be found throughout the literature (McClellan & Hutchens, 2021). However, there are some common themes regarding what shared governance is. Expertise from members involved in decision making is repeated frequently in the literature. Shared governance allows shareholders with expertise relative to the topic to be involved in the decision-making (McClellan & Hutchens, 2021). McClellan and Hutchens (2021) state, "Shared governance brings together administrators, faculty, and

students to draw on their expertise relative to various aspects of university life and operations" (p.7).

Principles of shared governance are no longer isolated to academia, and hospitals are foregoing traditional hierarchical structures to increase employee participation through shared decision-making (Capitulo & Olender, 2019). Elements of this governance model have been making their way into healthcare systems for decades. In 1987, Ortiz et al. discussed shared governance at the University of Rochester Medical Center amongst nursing staff, and they stated they have practiced "participative management" since 1977. Although shared governance has been a topic of conversation surrounding medical centers, the literature focuses on nursing staff and not the organization as a whole.

Academic Medical Center Governance

Academic medical center governance has tremendous influence over the organizations' abilities to adapt and change. As discussed, there are many options for academic medical center governance structure. Some AMCs are stand-alone systems with their own board, others partner with universities, and some have oversight boards with limited authority but still report to a university or state board of regents. From there, the nuances within systems are innumerable. The importance of nimbleness and efficiency is vital for the sustainability of AMCs and is repeatedly discussed in the literature (Chari, 2018; Enders & Conroy, 2014; Pellegrini, 2019). The massive size and complexity of most AMCs create an environment that suppresses rather than promotes nimbleness, creating organizations that are often reluctant and slow to change (Johnston, 2019). Based

on the sheer complexity, massive size, and resource consumption required, Becker, Formisano, and Getto (2010) compared modern academic medical centers to dinosaurs. If AMCs wish to avoid extinction, they must remain responsive to climate shifts (Becker et al., 2010).

No two AMCs are the same, and each has unique needs and circumstances. The variety within AMCs discourages the analysis of their governance structures (Pellegrini et al., 2019). However, some common elements for successful governance structure exist, and an understanding of these fundamentals is crucial for academic medical centers to optimize performance (Pellegrini et al., 2019). Pellegrini and colleagues (2019) proposed three critical elements of AHC governance: "Academic oversight of the faculty practice plan, a single focal point of integrated decision making, and genuine physician leadership" (p.13). Pellegrini et al. (2019) felt that academic oversight vs. hospital oversight creates an environment that best fosters the triple mission of AHCs. Under a hospital oversight model, Pellegrini et al. (2019) suggested that AHCs' mission of education and research could suffer; however, this is the authors' experiences, not empirical evidence.

Pellegrini and colleagues (2019) recommended a single focal point in decision-making to improve nimbleness and efficiency, suggesting that physician leadership is essential. While they promoted physician leadership at AHCs, they recognized that a medical degree does not guarantee the leadership and business skills required to manage a system as complex as an academic health center (Pellegrini et al., 2019). Empirical evidence supports the need for physician leadership. A systematic review performed by

Clay-Williams et al. (2017) concluded that evidence does support the importance of physician involvement in governing boards.

A Szekendi et al. (2015a) study assessing board structure revealed commonality among high-performing academic medical centers. They formed six domains related to how effective boards function and their board members. These domains had been established in the literature to elicit effective governance, and they used these as their benchmarks (Szekendi et al., 2015a).

Using a comparative analysis of the six domains, they surveyed 58 hospital CEOs. The hospitals were sorted into three groups: higher performers, middle performers, and low performers utilizing data from the University of Health System Consortium Quality and Accountability. The high-performing cohort exhibited statistically significant results in three of the six benchmarks. The three benchmarks for effective boards were "appropriate education and development of board members, the rigorous use of hospital performance measures…, and systematic board self-assessment process" (Szekendi et al., 2015a, p. 525). Although there are many differences surrounding academic medical centers governing boards, the research by Szekendi et al. (2015a) highlighted the commonalities among highly effective boards.

As previously mentioned, the Association of American Medical Colleges (AAMC) suggested growth and expansion or "be prepared to shrink in isolation" (Enders & Conroy, 2014, p.5). Expansion is vital, and leaders at the University of California took AAMC recommendations seriously. In 2015, they made great strides in analyzing their multi-AMC system's governance structure to ensure growth and sustainability (Chari et

al., 2018). Chari and colleagues (2018) developed criteria to evaluate governance options for the University of California (UC) academic medical centers. Based on a literature review on board governance and 23 one-hour interviews, they developed criteria for assessing governance structure (Chari et al., 2018). Their findings revealed two broad goals important in academic medical center governance, which they described as "nimbleness" and "systemness," and based on these goals, they developed seven criteria to assess The University of California's multi-AMCs (Chari et al., 2018).

They performed another round of interviews with leaders from five other AMCs and developed four options for The University of California (Chari et al., 2018). This work allowed UC leadership to analyze the current governance structure alongside alternative options, resulting in leadership adopting an alternative structure (Chari et al., 2018).

Conclusion

Academic medical centers provide an invaluable service to society. Their triple mission is to educate the next generation of healthcare providers, produce cutting-edge medical research, and provide valuable medical services to the public. The nation's AMCs are the pinnacle of healthcare and garner global respect. Moreover, the COVID-19 pandemic has highlighted the importance of AMCs' role in society and placed unprecedented strains on the system. This literature review illustrates the financial difficulties faced by AMCs. It emphasizes the need for efficient government structures to ensure the continued growth and sustainability of America's most valuable healthcare organizations. Additionally, this study aims to assess the efficacy of the current

governance structure at the University of Mississippi Medical Center by exploring the perceptions of Institutions of Higher Learning board members and the University of Mississippi Medical Center senior leadership.

Overview of Plan of Manuscript 2

Given the problem of practice highlighted in this manuscript, Manuscript 2 will outline an evaluation plan for the overall effectiveness and efficiency of the governance of UMMC by exploring the perceptions of Institutions of Higher Learning board members and UMMC senior leadership regarding the efficacy of the current governance structure. Interviews will be conducted with participants/stakeholders, and Chari et al.'s (2018) seven guidelines mentioned earlier will provide a framework for developing interview questions and analyzing the qualitative data.

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MANUSCRIPT II: AN EVALUATION PLAN FOR ASSESSING GOVERNANCE AT AN ACADEMIC MEDICAL CENTER

An Evaluation Plan for Assessing Governance at an Academic Medical Center

Academic medical centers (AMCs) are vital to modern society's health through their research, clinical care, and education missions. This tri-part mission is highly complex and creates a problematic budgeting scenario for academic medical center leadership. Academic medical centers require state-of-the-art equipment and highly specialized clinicians to teach the next generation of healthcare providers. These medical institutions often provide innovative services not offered at other institutions, and providing specialized medical care is extremely costly.

Further exacerbating the financial constraints facing AMCs, is the continual reimbursement cuts from insurance carriers. UMMC recently settled an almost year-long dispute with Blue Cross Blue Shield. This dispute centered around reimbursement and resulted in 750,000 BCBS recipients being out of network with UMMC (Vance, 2022). The financial burden on BCBS recipients who sought healthcare at UMMC, during that time, was significantly increased. The cost can be substantial when healthcare services are not covered through insurance. Given the plethora of financial challenges facing academic medical centers, the governance structure must support the institution's mission and functions as effectively and efficiently as possible.

Overview of Manuscript 2

This DiP seeks to explore the perceptions of Institutions of Higher Learning board members and the University of Mississippi Medical Center senior leadership regarding the efficacy of the current governance structure. Qualitative data will be collected from semi-structured, individual interviews. Given the depth of expertise and various participants' backgrounds, board members and UMMC senior leadership will likely offer diverse opinions on the current state of the governance structure.

Guiding Questions

By exploring the perceptions of leadership, this study seeks to answer three research questions:

1. Is the current governance structure of UMMC effectively meeting the needs of the institution?
2. Is the governance structure supportive of and responsive to the UMMC mission?
3. What are the perceptions of UMMC leadership and the IHL Board of Trustees concerning the current governance?

Defining the Need

Enders and Conroy (2014) predicted that academic medical centers would undergo significant transformations in the coming decade, including but not limited to research funding, resident training, and clinical care. One recent change to clinical care is the expansion of telehealth services. A decade ago, telehealth was hardly a thought; now,

it is used regularly for routine appointments. Whether changes have been as dramatic as Enders and Conroy predicted is debatable; nevertheless, AMCs exist in a changing landscape.

AMCs continually face financial challenges that threaten their viability as intuitions. Insurance companies continue to reduce reimbursements for services rendered, and UMMC recently settled an almost year-long dispute with Blue Cross Blue Shield over disagreements concerning reimbursement contracts (Vance, 2022). However, it is not just private insurance companies. Historically, Medicare and Medicaid continue to reduce payment for healthcare services.

AMCs must be adaptable to maintain relevance and fulfill their mission. As previously mentioned, expansion and growth are vital to the sustainability of academic medical centers (Enders & Conroy, 2014) and often involve collaborating with or acquiring new healthcare facilities. These expansions require efficient and nimble decision-making. Many of UMMC's recent expansions have involved collaboration. In 2018, UMMC affiliated with Vanderbilt University Medical Center and partnered with Gulfport Memorial Hospital. In 2019, they collaborated with Merit Health Madison to provide emergency department services and utilize operating room space. Less than two years later, they completed the multimillion-dollar expansion of UMMC's Children's Hospital. Currently, the medical center is preparing a burn center.

Considering economies of scale, size offers protection against the financial challenges facing academic medicine. Although increased size and complexity can lead to slower decision-making, the literature repeatedly calls for AMCs to expand to mitigate

their financial burdens and remain sustainable in today's healthcare system. Academic medical centers' governance has tremendous influence over the organizations' abilities to adapt and change. There are many options for academic medical centers' governance structures, and it is imperative that the structure supports the institution's overall mission and promotes efficiency.

The Case of UMMC

This evaluation focuses on Mississippi's only academic medical center, the University of Mississippi Medical Center. UMMC provides valuable clinical care to one of the unhealthiest states in the nation. In fact, Mississippi ranks 50th in healthcare (U.S. News and World Report, 2019). As the state's only level-one trauma center, it serves many underserved populations, including uninsured patients. As one would suspect, this further increases the financial burdens faced by UMMC.

Scholars have consistently reported that a priority for academic medical centers is to be nimble (Chari et al., 2018; Enders & Conroy, 2014; Pellegrini et al., 2019). Throughout the institution, departments are constantly self-assessing to ensure quality and productivity. However, to my knowledge, no departments are currently analyzing the perceptions of senior leadership and IHL board members regarding their views on the efficacy of the current governance structure at the University of Mississippi Medical Center.

This DiP aims to evaluate the current governance structure at the University of Mississippi by exploring the perceptions of IHL board members and the University of Mississippi Medical Center senior leadership regarding their views toward the efficacy of

the current governance structure. In doing so, the data could identify potential areas of strength and opportunities for growth within the system upon the conclusion of this study.

Current Governance Structure

The University of Mississippi has a highly politicized governance structure. As discussed earlier, UMMC is competing with private organizations for millions of dollars in funding. With over 10,000 employees (The University of Mississippi Medical Center, 2023a), countless stakeholders have divergent interests. Recent disputes with Blue Cross Blue Shield resulted in an almost yearlong stalemate and the involvement of the Mississippi Insurance Commissioner (Vance, 2022). In May and July of 2022, IHL was in the media spotlight for issues concerning tenure (Minta, 2022a) and potential oversight changes in their relationship with UMMC (Minta, 2022b).

The medical center is paired with the University of Mississippi and therefore reports to the University of Mississippi leadership. As a member of the University of Mississippi, the governing board is IHL, and IHL is responsible for governing the state's seven other public universities.

The stakes have never been higher, and Covid-19 has only increased the financial burdens placed on healthcare systems. At the start of the pandemic, many healthcare settings saw substantial increases in operating costs, cutting into already marginal profits. Nursing homes were one of the many settings significantly affected. For example, the average 72-bed facility saw an increase in operating costs of $3,765 daily (Goldstein et al., 2020).

When discussing the continued need for federal dollars, the American Hospital Association (2020) estimated that healthcare systems would suffer losses of at least $323.1 billion. Brinster et al. (2022) found a decrease in outpatient clinic margins of over 275%, and nursing costs had to soared 178% from 2020 to 2021 at an academic vascular surgery division. In 2022, the American Hospital Association estimated that over 33% of hospitals were operating on negative margins due to the COVID-19 pandemic.

The pandemic has further demonstrated the dangers of an unhealthy population. The Centers for Disease Control and Prevention (CDC) has reported that comorbidities such as obesity, heart disease, and diabetes all increase the risk of hospitalization and death in individuals who contracted COVID-19. Per the CDC website, they continue to recommend masking in public indoor settings for individuals at high risk of severe illness (Center for Disease Control, 2023).

Methodology of Evaluation Plan

The evaluation will consist of semi-structured interviews. A similar approach was utilized by Chari and colleagues (2018) when they analyzed the governance of a multi-academic medical system at the University of California. Following a series of 17 interviews, they proposed three alternative structures for governance at the University of California's medical centers. Ultimately, leadership agreed to implement one of the alternative structures to improve the governance model (Chari et al. 2018).

Defining Participants

Participants of this evaluation will include six IHL Trustees and six members of senior leadership at UMMC (Vice Chancellor, CEO, CFO, Associate Vice Chancellor of Academic Affairs, Associate Vice Chancellor of Clinical Affairs, and Associate Vice Chancellor of Research).

Data Collection

The 12 stakeholders identified above will be interviewed during the data collection process. At the participant's discretion, interviews will be in person or via a webcam. These interviews will not be timed to increase the likelihood of gathering meaningful data. By eliminating time restrictions, participants can provide thoughtful responses at their own pace. Also, interviews will not be recorded, but I will take extensive notes throughout the conversation. After I have finalized my notes, I will perform participant validation (member checking) by giving the interviewees a hard copy of the notes and asking them to verify them for accuracy. When conducting qualitative analysis, participant validation improves accuracy and credibility. The days and times will be scheduled at the participant's preference to improve the likelihood of participation.

There can be much debate over who should lead an academic medical center. UMMC is a healthcare organization and a higher education setting, making leadership qualifications unique. Pellegrini et al. (2019) call for "genuine physician leadership" (p. 13) at academic medical centers. However, they recognize that a medical degree does not guarantee leadership skills (Pellegrini et al. 2019). While performing a systematic review in 2017, Clay-Williams et al. found evidence supporting physician leadership and noted

the importance of physician involvement in governing boards. Do stakeholders at UMMC feel the same way? Is the medical center effectively meeting the needs of Mississippians by providing clinical providers with the necessary leadership training?

Due to the nuance and depth of the information required from participants, interviews will be used as the primary source of data collection for this evaluation. Therefore, this study will consist of a significant amount of qualitative data. Qualitative data is known for being bulky and can present many challenges related to data analysis. Mezmir (2020) defined the process well, stating, "Qualitative data analysis is the classification and interpretation of linguistic material to make statements about implicit and explicit dimensions and structures of meaning-making in the material and what is represented in it" (p. 15).

A semi-structured interview approach will be used to collect data representing the participant's perceptions accurately. Semi-structured interviewing is among the most popular forms of qualitative data collection. A series of nine questions will guide the interview (see Appendix A). However, depending on the responses from interviewees, the semi-structured technique will allow for questioning to vary slightly. This technique will allow for in-depth questioning between individuals within their areas of expertise.

The versatility of the semi-structured approach allows the exploration of complicated research questions and allows the researcher to extract a deeper understanding of the data (Miles & Gilbert, 2005). However, the versatility offered by this method is not without its limitations. Pre-interview preparation is vital to deviate

appropriately from the established list of questions. The researcher must develop expertise in the field when utilizing a semi-structured approach (Kallio et al., 2016).

The interviewer must work to establish a good rapport as early as possible with participants. Good rapport between interviewee and interviewer is vital to ensure accurate data collection. After the interviews, my handwritten notes will be revised for clarity, and a hard copy will be distributed to participants for a member check.

Given the small sample size and the participants' public positions, ensuring anonymity will not be possible. Confidentiality will be of extreme importance. Direct quotes from individuals will not be included in any published material. Instead, published data will consist of themes within the interviews. All communications concerning participants' answers to interview questions will occur in person or via webcam without recordings.

Cost

Cost is always a concern with planning an evaluation, and this study involves no cost, only my time. Namey, Guest, McKenna, and Chen (2016) found that in-depth interviews cost 20-36% less than focus groups. As such, interviews are a cost-effective means of data collection.

Sampling Scheme

The stakeholders for this evaluation could include all Mississippians. Given the in-depth knowledge required from participants, this DiP will focus on 12 participants who are each an integral part of the governance structure at UMMC. Since the evaluation

seeks to explore a specific and nuanced topic, participants must understand the topic to provide valuable insight. Therefore, this evaluation will utilize a form of purposeful sampling, critical case sampling, to select participants. Critical case sampling involves sampling a small number of cases most likely to provide the information pertinent to the study and allows the researcher to draw local generalizations (Robert Wood Johnson Foundation 2008).

As mentioned, the participants will include six IHL Board of Trustees and six UMMC senior leadership members, excluding The UMMC Chancellor. His primary focus is the University of Mississippi, and therefore the medical center's day-to-day operations are primarily the responsibility of the Vice Chancellor and UMMC leadership.

Data Collection and Pilot Testing

As previously discussed, this evaluation will consist of 12 semi-structured interviews. In order to allow participants adequate time to answer questions with desired depth, there will not be a specified time constraint. Questions will be open-ended and focus on the current governance structure at the University of Mississippi Medical Center (see Appendix A).

The structure of this study does not allow for complete anonymity as the participants all hold public titles, limiting anonymity. However, steps will be taken to ensure confidentiality is maintained as much as possible. First, interviewees will not be asked to relay their responses via written format, and all interview questions will be conducted in person or via unrecorded webcam communication. Second, direct responses from participants will be maintained and seen only by myself, and direct quotes from

participants will not be published. In order to accurately interpret the data, extensive notes must be taken throughout the interview. These notes will later be revised for clarity, and a hard copy will be provided to participants for a member check.

Before finalizing interview questions, the questions will be piloted to aid in questionnaire development. One respective member from each group and two individuals from neighboring academic medical centers will be selected to participate in the pilot testing. This selection process will once again utilize the critical case sampling scheme. Based on feedback from the pilot testing, I will revise interview questions to reduce confusion and enhance the depth of responses.

Contacting Participants

Most participants are public figures whose contact information is of public record, which is easily accessible. Initial contact will be made via email or phone. During the initial contact, I must build rapport with the participants. In this first conversation, I will briefly explain the purpose of the evaluation and the study's needs and respectfully ask for their participation. I will be solely responsible for scheduling and conducting the interviews. It is essential to be flexible to accommodate the participants' schedules.

The member check will also aid in establishing trust among participants. Therefore, the final copy of handwritten transcripts will be provided to participants to help ameliorate participant's concerns about speaking on a contentious topic.

Data Analysis

Since information from the interview process will be qualitative, an in-depth reading of the notes will be required to identify common themes throughout all 12 interviews. Data will be gathered and compared to make a collective meaning of the interviewees' responses. However, making the collective meaning of narrative-derived data can be challenging. For this reason, McCormack's Lenses framework will aid in the narrative data analysis. Lesley Dibley (2011) supported using McCormack's lenses when working with verbal data and discussed how utilizing this framework allows the researcher to make sense of cumbersome narrative data and encourages the researcher to analyze the data from multiple perspectives.

Synthesizing Information and Potential Outcomes

This DiP is only a proposal; data has not yet been collected. Therefore, the potential ramifications of the data can only be speculated. Although it is uncertain what the data will reveal, one thing is certain; no system is perfect. The data will likely reveal areas of strength and growth opportunities within the current governance system. The qualitative data could later be used to improve the current governance structure and create a more efficient system. These are only potential outcomes and are beyond the scope of this study's aim of identifying the perceptions of leadership surrounding the current governance structure.

Potential Impact of the Evaluation

The improvements from this study could affect the state's citizens vastly. As discussed earlier, Mississippi's citizens are some of the unhealthiest in the nation and

deserve high-quality healthcare. As the state's only academic medical center, UMMC plays a vital role in educating citizens and policymakers. UMMC is also a significant economic contributor, employing roughly 10,000 people. Consequently, striving towards improving the governance of UMMC could result in a healthier Mississippi and improve the state's economic growth.

This evaluation is an enormous undertaking with many complexities. Therefore, it is difficult to predict the success of this project. I have participated in conversations with stakeholders to gauge interest in the topic, and there appears to be a high level of interest from the University's faculty and leadership. I suspect participation in interviews will be difficult due to the political nature of the topic and the time constraints of leadership.

Implementation of Study: Re-establishing the Need

This DiP aims to analyze the current governance structure at the University of Mississippi by exploring the perceptions of Institutions of Higher Learning board members and UMMC senior leadership regarding their views towards the efficacy of the current governance structure. Given the importance of mergers, collaborations, and expansions to the sustainability of AMCs, efficiency, and nimbleness must be prioritized. Academic medical centers face financial challenges that threaten their viability as institutions. Insurance companies continue to reduce reimbursements for rendered services.

Recently, UMMC spent nearly a year in negotiations with the largest private insurance company in the state (Blue Cross Blue Shield) due to disputes regarding reimbursement (Vance, T. 2022). However, reimbursement issues are not insular to

Mississippi. Federal-funded programs such as Medicare have a long history of reductions for healthcare services, and Medicare physician payment has declined 22% from 2001-2022 (Resneck, 2022).

The University of Mississippi serves a triple mission of education, research, and clinical care to individuals throughout the state. UMMC's governance structure must function as efficiently as possible to continue meeting its mission. To my knowledge, no department is currently analyzing the perceptions of IHL board members and UMMC leadership regarding the efficacy and efficiency of the current governance structure at UMMC. This evaluation aims to change that.

I do not suspect any financial burdens during this process, as the overall cost should be negligible. However, besides subject participation, I suspect the biggest obstacle to completing this evaluation will be time. This evaluation is a huge undertaking, and it will take countless hours to interview and interpret the results.

The twelve interviews are expected to take approximately four months to complete, allowing for flexibility in participants' schedules. I have allocated two to three months for initial planning and another two to three months for data interpretation; therefore, the project will likely take eight to ten months from inception to completion.

Project Goals

Upon completing this evaluation, UMMC senior leadership and IHL board members could better understand the perceived efficacy of the current governance. However, this is a novel evaluation. Given the lack of current data, it is not easy to project the study's outcome and how it could impact UMMC. The findings will likely

spur conversations involving the governance at UMMC and could result in the revision of previous policies and procedures. It could reveal the perceptions of leadership supporting the current structure and not seeing a need for change. Although outside this project's scope, if areas of growth are identified, ideally, these results will be used to improve efficiency within the institution. The primary objective or goal of this evaluation is to assess the perceptions of IHL board members and UMMC senior leadership regarding the efficacy of the current governance structure. Table 1 describes the evaluation plan's inputs, outputs, and outcomes (e.g., short-term, intermediate, and long-term).

Table 1.

Logic Model

←Program Development				
Inputs Staff time and energy	**Outputs** Evaluate perceptions of IHL members and UMMC leadership.	**Short term Outcomes** Gain a better understanding of the current governance structure at UMMC	**Intermediate Outcomes** Identify strengths and weaknesses within the current system and allow leadership to assess these findings.	**Long Term Outcomes** Findings from this evaluation could identify growth areas within the current governance structure and result in policy changes to favor improved efficacy in the governance structure.
Program Evaluation→				

Characterizing the Audience

The participants of the interviews will also be the audience for the results. Notes will be taken throughout the interviews, and a member check will be performed to enhance accuracy. After the interviews and member checks, an in-depth reading of the data will help identify common themes utilizing McCormack's Lenses framework to analyze the data throughout the study. The findings will then be presented back to the original interviewees. The findings could impact a much larger audience, including any Mississippian. However, for the scope of this evaluation, the findings will only be

presented to the members of the evaluation. If the study were to be published, it would be available to anyone interested in the subject matter.

The participants are well-educated and familiar with the terminology and contents of this study. Since the participants' time is respected, the final interpretation of the data finding must be condensed and succinct as possible. The audience has a vested interest in the success of the academic medical center, and their interest must be considered throughout the interviews and during interpretation. The findings from this evaluation will be delivered to participants in an executive summary (e.g., written format and visualizations such as graphs, when applicable).

Ensuring Quality

I will be responsible for interpreting the results of this evaluation and writing the report to present to the target audience. I will seek guidance from members of the academic medical center, those familiar with higher education, and members of the community whom UMMC impacts. Wisdom will also be sought from leadership at academic medical centers surrounding Mississippi. For example, the advisory team will include Louisiana State University and University of Birmingham Alabama members, previous leaders at UMMC, and prior IHL board members. These advisors will play a vital role in refining the current interview questions.

Instructional Materials and Strategies

As previously mentioned, the findings of this evaluation will be presented to the target audience in the form of a hard copy executive summary. Visualizations and graphs

will be utilized when possible to promote ease of interpretation. The contents of this document will be more informative than educational. A primary goal of this evaluation is to inform the target audience of the perceptions of their colleagues surrounding the efficacy of the current governance structure. Therefore, the educational strategy will be straightforward. After participants have had time to review the findings, I will provide a time for a face-to-face or webcam interaction for any clarifying questions the members might have.

Assembling Materials

Very few materials, such as a telephone, computer, and meeting space, will be needed to implement this project. However, one of the most valuable assets for the successful completion of this study is the knowledge required to create appropriate interview questions. The advisory team will play a significant role in providing knowledge to help guide my decision-making and final interview questions. This advisory board will consist of two prior members of the medical center's leadership, two previous IHL board members, and two out-of-state members in leadership roles at neighboring academic medical centers.

Plan for the Unforeseen

Because most of the materials needed for this evaluation are standard items, I do not expect any real emergencies or significant completion costs. However, plans can always change. The challenges I foresee pertain to timing and scheduling, and I will need to be flexible to accommodate interviewees/target audiences. Allowing plenty of time

until completion is crucial to set realistic expectations. Given the time-intensive nature of this evaluation, it will likely take close to a year to complete.

Conclusion

In closing, Manuscript 2 provides a detailed description of the proposed evaluation plan and its implementation process. As a recap, interviews will be conducted in person or via a webcam platform. All semi-structured interviews will be one-on-one, without time constraints, and consist of open-ended questioning. Due to the power dynamics (interviewing participants about their leadership) related to this project, confidentiality will be maintained as much as possible. However, complete anonymity is not possible, given the study design.

Establishing trust and good rapport between the interviewer and interviewee is vital as early as possible. An in-depth reading of the qualitative data will be performed to gain a deep understanding of participants' perceptions of the efficacy of the current governance structure at UMMC. A written report of the findings will be provided to the participants. The target audience will have the opportunity to schedule a question-and-answer session with me to clarify any findings.

Manuscript three will include a leadership statement. For this statement, I will draw on leadership theories to discuss how the results of manuscript two could be utilized to address the problem of practice.

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LIST OF APPENDICES

APPENDIX A: INTERVIEW QUESTIONS

APPENDIX A

INTERVIEW QUESTIONS

1. In relation to timeliness and efficiency what are your perceptions of the current governance structure at the University of Mississippi Medical Center?
2. How do you feel the current structure promotes strategic oversight to align the institution's triple mission of research, teaching, and clinical care?
3. Can you explain how the current governance structure reduces redundancies within is triple mission?
4. Can you identify areas of strength and/or weakness in terms of the medical center's governance structure?
5. Can you describe recent responses the medical center has had to local condition?
6. How did the current governance structure affect the timeliness of UMCs response?
7. Can you expand on the expertise of board members in relation to clinical care?
8. What are your thoughts on the importance of board members to have expertise in clinical care?
9. When thinking about feasibility and efficiency what would you consider an ideal governance structure to support the overarching mission of this academic medical center?

MANUSCRIPT III: LEADERSHIP PHILOSOPHY

Leadership Philosophy

Academic medical centers face many challenges, which can lead to financial constraints. A surplus of literature substantiates the need for AMCs to expand to mitigate their financial burdens and remain sustainable in today's healthcare system. Expansion often requires quick decision-making, so scholars repeatedly call for AMC governance to be nimble and efficient. Given the substantial impact the University of Mississippi Medical Center has on Mississippians, the institution must remain a thriving center for education, research, and healthcare for the state. This DiP explores the perceptions of Institutions of Higher Learning board members and the University of Mississippi Medical Center senior leadership regarding the efficacy of the current governance structure.

Academic medical centers are a pillar of modern society in the United States. The triple mission of these institutions promotes the advancement of medical sciences and increases access to clinical care for millions of individuals. Because of the demands and strains placed on a system this large, healthcare is ever-changing. The higher education and healthcare components of AMCs place them in a unique and challenging situation. One primary concern for AMCs is related to budgetary issues. For many AMCs, revenue from clinical care outweighs income from education and teaching, and for decades these institutions have seen continual declines in reimbursements.

To offset declining reimbursements, healthcare facilities are consolidating into healthcare systems. Based on the literature previously discussed, AMCs must prioritize

growth and expansion into a healthcare system. The Association of American Medical Colleges presents AMCs with four options, and three involve growth into a healthcare system; the fourth option is to "shrink into isolation" (Enders & Conroy, 2014**,** p.5).

AMCs play a significant role in society, and their research, education, and clinical care are invaluable. Given the significant challenges facing AMCs, they must be able to adapt to remain sustainable. As mentioned, adapting to today's tumultuous healthcare environment requires nimbleness and efficiency.

The University of Mississippi strives to ameliorate the challenges they face as an academic medical center. In accordance with literature recommendations, UMMC has made several recent expansions, including partnering with multiple community hospitals throughout the state and building a new children's hospital. The recent impact of the COVID-19 pandemic only exacerbated the University's budgetary constraints. UMMC must continue looking for ways to remain sustainable, which often means more growth. Growth requires quick and accurate decision-making. For UMMC to continue to grow and meet the demands of one of the unhealthiest states in the nation, it is imperative the governance structure is as efficient as possible.

Statement of the Problem of Practice

This study explores the perceptions of Institutions of Higher Learning board members and the University of Mississippi Medical Center senior leadership regarding the efficacy of the current governance structure. By exploring the perceptions of leadership, this study seeks to answer three research questions:

1. Is the current governance structure of UMMC effectively meeting the needs of the institution?
2. Is the governance structure supportive of and responsive to the UMMC mission?
3. What are the perceptions of UMMC leadership and the IHL Board of Trustees related to the current governance structure?

Conceptual Framework

The conceptual framework has two elements: literature surrounding the governance of academic medical centers and the criteria for assessing the "nimbleness" and "systemness" of academic medical center governance, set forth by Chari et al. (2018). For this DiP, the literature review focused on academic medical center governance. Potential for excellence begins with a proper governance structure. The literature surrounding the challenges and potential solutions for academic medical centers helps to frame interview questions for this study.

The other key aspect of this conceptual framework is the research provided by Chari et al. (2018). Based on their research, they identified salient aspects and needs of academic medical center governance and developed criteria by which to evaluate the system. The seven criteria identified by Chari et al. will play a significant role in creating interview questions for this study.

Leadership Philosophy

Leadership is crucial for the continued success of any academic medical center. Medical center leadership requires both an understanding of the complexities of healthcare and higher education. For the maximal success of the institution, these leaders must develop and maintain a personal leadership philosophy.

Leadership has been a topic of conversation amongst researchers for decades. Countless theories and opinions surround what makes a good leader and the best leadership approach. Given the breadth of literature surrounding the topic, it is essential to begin by defining what leadership is. Defining leadership is not easy and seems to change throughout the decades. However, I prefer Northouse's working definition, "Leadership is a process whereby an individual influences a group of individuals to achieve a common goal" (Northouse, 2016, p.6). Viewing leadership as a process is critical. Seeing leadership as a process helps to remove the notion that leaders are born (Northouse, 2019). By participating in the process, anyone can become a leader.

Skills and competencies can be learned and cultivated. Therefore, when considering leadership on an individual basis, I prefer the comprehensive skill-based model proposed by Mumford and colleagues (2000). This model allows for an open-access path to leadership. If an individual can develop certain competencies, then it will increase their likelihood of being an effective leader. While one could argue that the individual attributes in this model redirect the emphasis back to a trait-based approach, I believe the developed competencies differentiates the comphrehensive skill-based model. The individual attributes are nothing more than baseline qualities the individual should

possess. Therefore, they are not unnecessarily exclusive, and the comprehensive skills model does not support the born leader approach often associated with trait leadership.

For anyone aspiring to leadership, a skills assessment can be an excellent tool to identify areas of strength and weakness. By knowing their weaknesses, the individual can hone those competencies to become a more effective leader or surround themselves with individuals who excel in areas where their skills may be deficient. After taking the skills inventory assessment, I was not surprised that my conceptual skills needed improvement. Conceptualizing and solving complex problems are critical for an effective leader, and it is certainly an area I am actively striving to improve.

Moving away from the individual and turning our focus on organizational leadership strategies, research supports the need for shared leadership in higher education. I believe it is crucial for an academic medical center to implement policies and strategies that support and promote shared leadership. As Kezar and Holcombe (2017) discussed, shared leadership creates an institution that is nimbler, creates a feeling of co-ownership towards goals, and helps an institution address complexity. Academic medical centers are highly complex organizations and nimbleness within the institution is paramount (Chari et al., 2018; Enders & Conroy, 2014; Pellegrini, 2019). A leadership approach that supports this valuable quality, as seen in shared leadership strategies, should be considered by academic medical center leaders.

By allowing for increased autonomy and placing more trust in the individuals, it is clear how shared leadership promotes buy-in. Like the skills approach, shared leadership improves organizational access and opportunity. Anyone can be a leader at any time,

regardless of title or position. In one circumstance, an employee could be a leader while simultaneously being a follower on another project or goal. Under shared leadership, having individual leaders in positions of authority is still helpful. However, these leaders must learn to delegate authority to other team members, work to be inclusive, and develop co-leaders.

Given my professional background at an academic medical center, I have seen the unique strategies and approaches needed to lead effectively within these institutions. I believe leaders who emphasize the skilled-based approach and work to promote shared leadership are best positioned to effectively lead within a system as complex as an academic medical center. Skills-based leadership allows the individual to grow and places the locus of control on things they can control internally, unlike the trait-based approach, often associated with born leaders. Moreover, the trait-based approach can lead to an "either you have it, or you don't" mentality, which can be detrimental and exclusive. Shared leadership further opens access to individuals and allows the institution to gain insight from a wider breadth of their talent. If skills-based and shared leadership are absent from the conversations surrounding leadership, I believe it would be a disservice to the stakeholders within an academic medical center.

When discussing leadership at an AMC, the role of politics can not be discounted. Bolman and Deal (2021) define politics as "the realistic process of making decisions and allocating resources in a context of scarcity and divergent interests" (p. 178). Adhering to this definition, the University of Mississippi Medical Center's governance structure is very politicized. Medical centers are enormous organizations and the triple mission of

research, teaching, and clinic care ensures there is no shortage of competing interests for a finite number of resources. Reductions in healthcare reimbursement and higher education funding make financial resources scarce. As Bolman and Deal (2021) describe, one would expect coalitions to form between members of each group to strengthen their bargaining power. If participants in this study seek coalitions and respond to interview questions accordingly, this could affect the accuracy of this study's data. The propensity towards coalitions in political settings is a limitation of this study and will be duly noted during the collection and analysis of the verbal data.

Discussion

The DiP process has been an immersive learning experience. Before the DiP, I did not understand the complexities of writing a dissertation. Throughout this experience, I have gained a deeper understanding of what it means to be a scholar-practitioner. My ability to read and interpret academic literature skills have improved, and I am also better equipped to implement research findings in my practice setting. My understanding of higher education has improved, and I have been exposed to new philosophies and theories surrounding higher education that have helped shape my leadership philosophy. Moving forward, the information I have gleaned from the dissertation process will be critical in shaping the lenses through which I see challenges within higher education and will aid in my decision-making. As a scholar-practitioner, I think it is paramount to stay curious: Ask why? I plan to continue to grow and learn in the higher education field. I have begun exploring the possibility of applying for the APTA (American Physical Therapy Association) Fellowship in Higher Education Leadership.

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LIST OF APPENDICES

APPENDIX A: INTERVIEW QUESTIONS

APPENDIX A

INTERVIEW QUESTIONS

1. In relation to timeliness and efficiency what are your perceptions of the current governance structure at the University of Mississippi Medical Center?
2. How do you feel the current structure promotes strategic oversight to align the institution's triple mission of research, teaching, and clinical care?
3. Can you explain how the current governance structure reduces redundancies within is triple mission?
4. Can you identify areas of strength and/or weakness in terms of the medical center's governance structure?
5. Can you describe recent responses the medical center has had to local condition?
6. How did the current governance structure affect the timeliness of UMCs response?
7. Can you expand on the expertise of board members in relation to clinical care?
8. What are your thoughts on the importance of board members to have expertise in clinical care?
9. When thinking about feasibility and efficiency what would you consider an ideal governance structure to support the overarching mission of this academic medical center?

APPENDIX B: INSTITUTIONAL REVIEW BOARD APPROVAL

APPENDIX B

INSTITUTIONAL REVIEW BOARD APPROVAL

Prior to the onset of this study, approval will be obtained through UMMC IRB. In keeping with UMMC requirements, the Institutional Review Board (IRB) submission will include the following information: study team (myself), study summary, background statement, specific aims, study design, and methodology.

The list of finalized interview questions will also be included in the IRB submission in conjunction with a statement concerning the study's potential risk. Given the nature of this study, there is minimal risk of physical harm to participants. However, the small sample size makes complete anonymity impossible. Therefore, it is plausible that responses could be linked back to individual interviewees.

VITA

JACOB BLAKE DANIELS

Education:

Doctor of Education
The University of Mississippi
Higher Education
May 2023

Doctor of Physical Therapy
The University of Mississippi Medical Center
Physical Therapy
May 2016

Bachelor of Science
The University of Mississippi
Exercise Science
May 2013

Licensure Information:

Mississippi Physical Therapy Licensure number: 5952

Certifications (eg, ABPTS):

HawkGrips: Level One IASTM Certification
Academy of Human Movement: Kinesiology and Biomechanical Taping Certification

Employment and Positions Held:

Assistant Professor
Nontenure Track
The University of Mississippi Medical Center
Jackson, Mississippi
2022- Current

Physical Therapist
Staff Therapist
The University of Mississippi Medical Center: Pavilion

Outpatient Orthopedics
Jackson, Mississippi
2016-2022

Current Teaching Responsibilities:

Summer 2021
Human Anatomy Lab PT607
Human Kinesiology and Biomechanics II Lab PT604

Fall 2022
Systems Review and Clinical Dysfunction PT611
Principles of Physical Therapy PT630
Human Kinesiology and Biomechanics Lab PT602

Spring 2023
Clinical Tests and Measures PT621

Current/Active Research Activity:

Lead Investigator
Compassion Fatigue and Compassion Satisfaction: The Impact on Physical Therapist and
Physical Therapist Assistants Caring for Patients During the COVID-19 Pandemic
Unfunded
Lead Investigator

Virtual Reality in Concussion Assessment
Grant funded
Undetermined Authorship order

Consultative and Advisory Positions Held:
Mentoring of students with the completion of a systematic review
Sports Residency Mentor

Membership in Scientific/Professional Organizations:
Mississippi Chapter: American Physical Therapy Association Delegate

Services to the University/College/School on Committees/Councils/Commissions:
School of Health-Related Professions:
Research Affairs Committee Member
Grant Writing Task Force
SHRP Writing Group

School of Health-Related Professions: Physical Therapy

Co-Chair Admissions Committee
Promotions Committee Member
PT Graduate/Employer Follow Up Committee Member
True Learn Committee Member

Continuing Education Attended:

2022
Cervical Spine Examination and Treatment: Cases to Synthesize Learning
CITI Program Biomedical Responsible Conduct of Research course completion
Sports Physical Therapy Residency Journal Club
EDRS 703: Advanced Methods of Applied Research
EDRS 704: Foundations of Qualitative Research Method
EDRS 733 Special Topics in Educational Research
EDHE 730: Multidisciplinary Perspectives on Leadership
EDHE: Dissertation

2021
Sports Physical Therapy Residency Journal Club
Rehab Grand Rounds: VTE Prophylaxis in Orthopedic Trauma
The Movement System: Assessment and Treatment of Low Back Pain
Lumbar Spine Examination and Treatment: Cases to Synthesize Learning
Ethics for Physical Therapy Clinicians: Dealing with Child Abuse Legally, Ethically, and with compassion
EDHE 700: Models of Inquiry and Literature Review
EDHE 702: Program Planning and Assessment in Higher Education
EDHE 721: Recent Developments in Educations Practice
EDHE 713: Education and Society
EDHE 797: Dissertation
EDRS 701: Educational Statistics II

2020
Scrape, Tape, and Move: Foundation to Function
16 CCU's
Rehab Grand Rounds: Treatment Options for Severe Spasticity
Sports Physical Therapy Residency Journal Club
EDHE 701: Doctoral Studies Proseminar
EDHE 797: Dissertation

2019
Sports Physical Therapy Residency Journal Club

2018

Myofascial Release I
20 CCU's
Intersection Dilemma Opioid Epidemic and Human Trafficking
Rehab Grand Rounds ACL: From injury to Return to Play
Rehab Grand Rounds PCL: From injury to Return to Play
Sports Physical Therapy Residency Journal Club

2017
Rehab Grand Rounds: Nerve Compressions about the Elbow
Evidence Based Treatment of Lumbar Spine
4.5 CCU's
Evidence Based Treatment of the Shoulder
4.75 CCU's
Health Policy and Issues, Documentation, Healthcare Malpractice, Risk and Quality Management for
Rehab Professionals
Sports Physical Therapy Residency Journal Club

2016
Rehab Grand Rounds: Family Centered Orthopedic Care of Children with Cerebral Palsy
Rehab Grand Rounds: Neural Tension and its Relationship to Pain
Sports Physical Therapy Residency Journal Club

Community Service:
Co-Student Advisor
Rehabilitation Board Member
Jackson Free Clinic
2022-Current

Ronald McDonald House
2022

Small Group Leader and Guest Services Member
PineLake Church
2018-2019

We Will Go Ministries
2018