By J. Daniel Beckham

The Transformation of an Academic Medical Center

The Medical University of South Carolina used planning principles to realize its aspirations.

Some of the challenges that confronted the Deep South's first medical school, the Medical University of South Carolina, were unique. In 1861, a fire destroyed a wide swath of Charleston. Then the Civil War shut MUSC down for four years, leaving it to resurrect itself out of a wrecked and impoverished city. Two decades later, an earthquake with an intensity rivaling San Francisco's in 1906 leveled much of what was left of Charleston. These setbacks occurred in the broader context of the ruined economy that characterized the South from 1865 well into the middle of the following century.

Through much of that period, Charleston remained frozen in its past, "too proud to whitewash and too poor to paint." Eventually, the economic renaissance of the South spilled into the low country and Charleston began to stir.

An About-Face

Like most academic medical centers, MUSC began to grow as funding for research, medical education and patient care flushed into the American health care system during the 1950s and '60s. As an institution, however, it remained relatively passive, satisfied with its position as its state's only academic medical center even as it operated in the lengthening shadows of Duke, Emory and Vanderbilt. There were lessons in the rising pre-eminence of these Southern institutions; chief among those was that leadership, both administrative and clinical, mattered.

Unlike Duke, Emory and Vanderbilt, MUSC was a public institution without the benefit of a philanthropic portfolio. It served as the safety net for Charleston and much of the low country. This proved both a burden and a blessing. On one hand, community hospitals managed the profitability of their patient mix at MUSC's expense. But it also gave the academic medical center a degree of political clout that was useful at local, regional and state levels. Still, the patient care environment at MUSC languished as its facilities aged compared with those of its community-based competitors as well as those of other academic medical centers.

Then MUSC began a remarkable transformation. The hospital invested in the construction of a new bed tower, which opened in early 2008. Alarmingly, initial utilization fell well short of projections. Soon there was a realization that recruiting additional faculty was the key to generating increased utilization.

MUSC's faculty practice plan leaders stepped forward and took on the challenge. With this came a recognition that recruitment of new faculty offered an opportunity for a significant upswing in clinical reputation and entrepreneurialism. Within two years, it had recruited 114 additional faculty, its new facilities were fully in use and its brand was beginning to really shine. MUSC had begun to build market momentum.

MUSC then committed itself to becoming one of America's most highly rated academic medical centers on the basis of patient satisfaction. This was an extraordinary undertaking. Size and organizational complexity can conspire to create seemingly insurmountable barriers when it comes to significantly improving patient experience. As a rule, academic medical centers are both big and complex. In most markets, because of their smaller size and less complex structures, community hospitals consistently outperform academic medical centers on patient satisfaction. Despite this, leaders at MUSC pushed their institution to the top of the patient satisfaction pile.

Today, anyone walking through the halls of MUSC immediately will notice an energetic, welcoming and proud spirit. Not only does MUSC now outperform other academic medical centers on patient experience, it consistently outpaces most of the community hospitals in its region. By 2010, statewide market research revealed that MUSC had become the preferred health system for much of South Carolina. The research reflected the impact of its growing clinical reputation and the satisfaction of those who used its services. These successes generated more fuel for MUSC's transformation by imbuing it with a growing sense of confidence.

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United Leaders

Perhaps most remarkable in these accomplishments was the extent to which leaders across MUSC united to achieve them. Like all academic medical centers, MUSC was distinguished by its tripartite mission of education, research and patient care. However, unlike many academic medical centers, it did not develop debilitating conflicts related to these three mission commitments. There were no ongoing high-level battles between the dean and the hospital CEO, for example. Within other academic medical centers, such conflict had sometimes flared into well-publicized and distracting leadership struggles that undercut institutional potential.

At MUSC, a high degree of trust and collegiality extended across the institution. This was no lucky coincidence. Nor was it a manifestation of Southern hospitality. Trust and collegiality had been quite consciously cultivated as organizational assets worthy of preservation and accentuation. This translated into the potential to act with a relatively high degree of unity compared with other academic medical centers.

It also resulted in a willingness to move resources, including dollars, across organizational boundaries where they could generate the greatest good for the institution overall. This sometimes involved hospital funding of initiatives that directly benefited the medical school or the faculty practice plan. Similarly, MUSC's faculty practice plan took on the preponderance of the investment necessary to build out MUSC's outpatient capabilities, letting the hospital focus on inpatient capabilities.

In 2011, MUSC began a search for a new dean for the college of medicine. The search committee found Etta Pisano, M.D., a hard-driving individual whose leadership was producing impressive results at the University of North Carolina. Pisano was ambitious and direct in laying out her expectations. She wanted to push MUSC up significantly in the ranks of NIH-funded research institutions.

Unlike some of its peers, MUSC does not have the benefit of a rich endowment nor does it serve a population that can afford much philanthropy. It was clear that fueling the dean's aspirations would require expanded funding. The only realistic source of that funding was operating revenue from across the clinical enterprise, which encompassed the delivery of patient care by the hospital and the faculty.

Soon after her arrival, Pisano affirmed Jack Feussner, M.D., as executive senior associate dean for clinical affairs. Among his new responsibilities was the formulation and implementation of strategies to put MUSC's clinical enterprise on what the dean described as an "elevated trajectory" — a dramatic jump above the curve of its already impressive rise. The concept of an elevated trajectory became a linchpin in MUSC's vision for the future. The dean's vision drew the hospital CEO, Stuart Smith, and Feussner into thoughtful consideration of the challenge it represented.

In the past, Feussner and Smith had translated MUSC's tradition of collegiality and trust into improved clinical reputation and patient satisfaction. Putting MUSC on its elevated trajectory was going to demand an even greater degree of unity and focus. Department chairs and administrators were going to have to work together to clear a path to a compelling future. Feussner and Smith soon determined that the leadership tool best suited to their needs was a strategic plan for MUSC's clinical enterprise. Dean Pisano agreed. Because Pisano, Feussner and Smith enjoyed respect and authenticity throughout MUSC, their endorsement gave the strategic planning effort considerable credibility from its onset.

A Common Framework

MUSC had developed strategic plans in the past for its various operating entities and clinical departments, but this was the first strategic plan designed to extend across the entire clinical enterprise. For that reason and because there are a variety of models, methods and nomenclature used in strategic planning, MUSC took time to establish a common framework and definitions.

While the framework incorporated components recognizable in most strategic plans, including a situation assessment, mission, values and vision, it also included some less common elements such as a rigorously defined value proposition and strategic intent, as well as a set of focused driving strategies and supporting tactics. Then all of these were to be tied to very specific mechanisms for ensuring effective implementation.

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The framework was hierarchical. It addressed the most critical questions facing the clinical enterprise, including:

- Why does it exist? (mission)
- What does it stand for? (values)
- What does it aspire to become in the future? (vision)
- What is it going to be really good at that will make it different? (value proposition)
- What's its stretch goal? (strategic intent)
- What is it going to do in order to achieve its vision? (driving strategies and tactics)

Ambition and stretch were intrinsic to the framework. An assertive vision and strategic intent would force the organization to seek high-performance breakthroughs. The framework also was designed to generate focus. It would define not only what the organization would be and what it would do, but also what it would not be and what it would not do.

Early in her tenure, Pisano established a new leadership structure that greatly facilitated the development of the strategic plan. Every Monday morning, key leaders from across the clinical enterprise met to address challenges that cut across MUSC. Development of a strategic plan for the clinical enterprise clearly represented such a crosscutting challenge. To support the strategic planning process and to provide insights from institutions in other markets, MUSC retained a boutique strategy-consulting firm which reported to Feussner and Smith.

The notion of "dyad leadership" that combines administrative executives with clinical leaders was already in place at MUSC as the strategic planning effort was launched. Pat Cawley, M.D., had functioned as the chief medical officer of the hospital since 2006. Although he reported to the hospital CEO, he and Smith had established a strong relationship best characterized as coequal. Significantly, Cawley had been trained and mentored by Feussner when they were both at Duke.

With Feussner's confidence and trust in Cawley came the support of the dean. Cawley had been deeply involved in MUSC's focus on clinical quality improvement as well as its patient satisfaction accomplishments. He was well-positioned to put in place the working relationships across the hospital and the faculty to achieve the improvements in productivity and financial performance that an elevated trajectory would demand.

By early 2013, as Smith's long-planned retirement approached, the strategic plan had generated clear implications for the kind of chief executive the hospital would need to support its elevated trajectory. The hospital's board voted unanimously to name Cawley as Smith's successor.

Planning Principles

Several principles came to characterize the strategic planning effort for MUSC's clinical enterprise. Some of these were identified at the onset of the process while others emerged as the plan solidified. These included:

Ambitious stretch. When the dean articulated her vision of an elevated trajectory, it was in relation to other academic medical centers. The physicians and executives at MUSC were not highly motivated to parry with local community hospitals. They were moved to carve out a desirable position relative to other respected academic medical centers in the South — institutions that inhabited the upper tiers of the *U.S. News & World Report* and National Institutes of Health rankings — remembering the advice of Daniel Burnham: "Make no little plans. They have no magic to stir men's blood and probably themselves will not be realized. Make big plans; aim high in hope and work, remembering that a noble, logical diagram once recorded will never die, but long after we are gone will be a living thing, asserting itself with ever-growing insistency."

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Pragmatic optimism. While leaders at MUSC were well-grounded in the challenges facing academic medicine in general and their institution in particular, they cultivated from the onset of the strategic planning process an open enthusiasm for the future. It reflected the question asked by English historian Thomas Babington Macauley in 1830: "On what principle is that when we see nothing but improvement behind us, we expect nothing but deterioration before us?"

Mission balance. A delicate balance was judged fundamental to fulfillment of MUSC's tripartite missions. A focus on the patient experience had helped generate MUSC's exceptional performance on patient satisfaction. The arrival of a new dean and her focus on research necessitated a rebalancing that, while preserving MUSC's edge in patient satisfaction, would give greater emphasis to the research mission. Implicit in this was a belief that an enhanced position in research would contribute significantly to MUSC's reputation overall and, in so doing, further strengthen the clinical enterprise so it could give sustenance to MUSC's patient care and teaching missions. Leaders did not view balance across the missions as static but as dynamic — more like balancing a broom on a fingertip. Persistent potential for imbalance required equally persistent adjustment.

Leader driven. There is a popular tendency to cast the strategic planning net widely across organizations, then rely on a variety of methods to encourage large numbers of individuals at all levels to provide the input out of which a consensus view of strategic direction is cobbled. Unfortunately, although such exercises may feel good, they run in the face of what leadership exists to do — define a place worth going, along with a path to that place, then enlist the organization in getting there. Implicit in the word *leadership* is a question: "Leading where?" Defining and accomplishing strategic direction was seen as the responsibility of top leaders.

Focused commitment. The temptation in a complex enterprise like an academic medical center is to declare everything equally important to avoid alienating constituencies. But everything is not equally important, and tough choices must be made. Attention, energy and resources must be focused if they are going to have impact. As Harvard Business School strategy expert Michael Porter has suggested, "The essence of strategy is choosing what not to do." Trade-offs are essential to the development of sound strategy. For MUSC, the strategic plan drew a relatively bright line between where it would invest itself and where it would not. The strategic plan became a tool for determining "fit." Activities and investments that might have been unfocused, ad hoc and unchallenged began to be tested against the question, "How does that support the strategic plan?"

Strategies with quality. There was a recognition that some strategies are better than others. MUSC intentionally ensured that its driving strategies were well-tested against proven principles of strategic thinking, including concepts like differentiation, focus and stretch. Participants recognized, for example, that a strategy is not a goal; it is a pathway, a bridge that links means to ends. The driving strategies represented much more than a to-do list. They represented the leadership team's best thinking related to a world of limited resources, tough competitors and relentless change. They defined the pathway to a compelling future in the face of uncertainty and resistance.

Things in flight. In most organizations there are multiple high-level initiatives under way or being contemplated as a strategic planning effort is launched. An effective planning process identifies these existing strategic commitments and herds them into one corral, a single unified strategic plan. For example, the dean's commitment to research was already in motion. During planning sessions, the rumble of bulldozers could be heard as two new research buildings were being sandwiched in close proximity to patient care facilities to help bring research to the bedside. MUSC also had already launched regional specialty centers — strategically located outpatient sites to provide a wide array of subspecialty care concentrated on convenient campuses. Such strategic initiatives already "in flight" or "on the runway" were incorporated into the strategic plan and built upon.

Iterative development. MUSC developed its strategic plan in iterative fashion. For example, it asked stakeholders to suggest words and ideas they wanted to have in the vision statement. This input was synthesized and eventually crafted into a preliminary vision statement for stakeholder reaction. In their planning sessions, stakeholders then were asked, "What do you like about the statement?" "What don't you like?" "What's missing?" They used this same iterative approach in developing other key components of the strategic plan. Feedback flowed to top leaders who then used it to shape the plan.

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Space for dialogue. Overall, nearly 100 leaders participated in 28 planning sessions, all of which lasted more than two hours. But rather than emphasize the number of individuals providing input, MUSC emphasized quality of dialogue. Meetings were interactive with the focus on addressing critical strategic questions. There was a recognition that productive conversation requires sufficient time. Organizations inside and outside health care dedicate a very small percentage of their available time and resources to setting strategic direction.

In their book *Competing for the Future*, Gary Hamel and C.K. Prahalad underscored how little time leadership teams dedicate to thinking about the future: "In our experience, about 40 perent of senior executive time is spent looking outward, and of this time about 30 percent is spent peering three or more years into the future. Of the time spent looking forward, no more than 20 percent is spent attempting to build a collective view of the future (the other 80 percent is spent looking at the future of the manager's particular business). Thus, on average, senior management is devoting less than 3 percent (40% x 30% x 20% = 2.4%) of its energy building a corporate perspective on the future. In some companies, the figure is less than 1 percent."

Ownership from participation. It is certainly possible for a single individual to articulate a sound strategic plan without input from others. But quality of thinking is not the most important goal of inviting others to participate in a strategic planning process. The real benefit of such participation is strength of understanding and commitment. It is a truism that individuals tend to own more fully those things they help create. There is little that is more important to an organization than leaders who together own a plan for the future and share a mutual commitment to transform that plan into reality.

Leadership development. At MUSC, as in all organizations, there is variance in individual aptitude and interest related to strategic thinking and leadership. Effective leadership in a functional or clinical role does not always translate into effectiveness in a strategic role. This is as it should be. But sorting out and developing strategic leadership becomes a necessary ingredient for effective formulation and implementation of strategies. Today, there is recognition across MUSC that participation in strategic planning is not an empty exercise. Participation yields credibility and influence because it provides a laboratory for identification and development of leaders.

Process efficiency. Developing the key components of the strategic plan took six months. Throughout the process, there was an emphasis placed on maintaining efficiency — making good use of people's limited time — and generating dialogue of high quality. In the interest of process efficiency, some popular strategic planning tools were intentionally set aside. These included "SWOT analysis" (too prone to bog down in distinctions between strengths and opportunities, weaknesses and threats), "balanced scorecard" (too goal-centric and insufficiently strategic) and "scenarios" (too likely to devolve into infinite variations). To enhance process efficiency, MUSC employed a disciplined strategic planning framework and consistent nomenclature.

Transparency of process. The allocation of scarce resources in strategic planning reinforces the importance of transparency. For example, "funds flow" remains a mystery in many academic medical centers. Yet, defining the organization's top strategic priorities invariably transitions into the question of how to adequately resource those priorities; addressing this question leads to another: "How are things funded now?"

Recognizing the importance of transparency in resourcing strategic initiatives, MUSC launched a separate parallel initiative to bring clarity to its funds flow. It conducted this initiative at the same time as its strategic planning process and finished just as the critical questions related to resource allocation were being addressed in the process. Funds flow was not the only dynamic to which the strategic planning process gave transparency. Gaps in the performance of the various clinical departments became more apparent. As a result, MUSC soon focused on closing these gaps. In some cases, this led to the recruitment of new department leaders.

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Accomplishment driven. During MUSC's strategic planning process, an important distinction was made between "accomplishment" and "performance." Many strategic planning processes focus attention on setting goals early in the process as ways to target performance, then develop a plan ostensibly to deliver that performance. This is backward: Performance is always an outcome, not a cause. Accomplishments generate performance. The strategic plan operates in the realm of accomplishment by asking the questions "What will we become?" and "What will we do?" It is the "becoming" and the "doing" that generate performance. Performance goals should be set after those two questions are addressed. Unlike many organizations, MUSC has held itself accountable not only for performance but for accomplishment of commitments set forth in its strategic plan.

Targeted communication. There are a wide variety of audiences in an academic medical center, some of whom wear multiple hats. They are distinguished not only by differences in their functions, but also by their training and experience. They range from housekeepers to physician scientists. The same approach to communicating the strategic plan cannot be used with every audience. MUSC deployed a variety of communication venues and methods, including town hall and departmental meetings as well as online and print summaries and updates. In each instance, while MUSC crafted its communication to fit the audience, it repeated the core messages with relentless consistency.

Trust-based. An environment of trust is an essential catalyst in developing and implementing a powerful strategic plan. This cannot be overstated. The only substitutes for trust are "systems of control," which are often experienced as onerous impositions, particularly by competent professionals. Systems of control are also prone to breakdown and collapse when confronted with too much complexity and uncertainty. Because academic medical centers are by their nature complex and loosely coupled, a federated approach to organization and leadership is a necessity.

As the English management expert Charles Handy emphasized, the glue that matters most in a loosely coupled federated model is trust. By trust, Handy meant "a confidence in someone's competence and in his or her commitment to a goal." Those who cannot be trusted need to be shoved out, "ruthlessly if need be." According to Handy, "Trust requires leaders. At their best, the units in good trust-based organizations hardly have to be managed, but they do need a multiplicity of leaders."

Results

Ultimately, every strategic plan ought to be measured against the extent to which it generates important results. Despite growing challenges to MUSC's revenues and margins, it set not one thing aside that was targeted for focused implementation. MUSC has generated impressive results: The number of specialties in which MUSC is nationally ranked doubled. Growth targets for its primary care network were exceeded by 50 percent.

Perhaps just as importantly, the strategic plan fortified and leveraged MUSC's unique legacy of collegiality and trust into greater advantage. It generated awareness and pride for past accomplishments and optimism for the future. It captured, directed and intensified the energy of existing market momentum. It created productive virtual integration without cumbersome structural changes. It engaged community hospitals and physicians as partners in unified effort. And it solidified commitment to common purpose while strengthening the foundation for continuing success. MUSC's elevated trajectory holds lessons for all health care organizations facing an uncertain future.

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