# Strategy for Academic Medical Centers

## FRAGMENTATION KILLS!

## WHY BEING **DELIBERATE** AND **INCREMENTAL** IS THE BEST WAY FORWARD

Southeastern Institute for Health Care Strategy and Innovation Charleston, South Carolina

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WHY BEING DELIBERATE
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**Southeastern Institute for**
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# TABLE OF CONTENTS

## Introduction

Fragmentation is the most significant threat to the vitality of America's academic medical centers (AMCs). Fragmentation undercuts the delivery of affordable quality care. But it also disrupts the ability of organizations to design and pursue a compelling future.

This monograph is intended to capture the thinking, processes and results pursued by the Medical University of South Carolina (MUSC) as it sought to avoid the perils of fragmentation through the development and implementation of a strategic plan for its Clinical Enterprise – a strategic plan that would help the organization achieve its aspirations by being deliberate and incremental in the face of change and uncertainty. This effort was undertaken with significant forethought and much dialogue. It is the authors' hope that this summary of their experience may prove helpful to the efforts of other AMCs as they face the challenges presented by fragmentation in an increasingly volatile environment.

As we undertook our work, we looked for insights in many places but were particularly influenced by the experience of Johns Hopkins Hospital. AMCs throughout America, after all, are direct beneficiaries of Hopkins' innovative organizational architects including Billings, Osler, Welch, Halsted, Kelly and, of course, the philanthropist, Johns Hopkins.

Mr. Hopkins' generosity to the enterprise that would bear his name represented the largest financial contribution in the nation's history to that point. But it was more than a philanthropic gift. Hopkins bequeathed an idea that many have regarded as revolutionary – the marriage of patient care with teaching and research. Like other precious gifts, this one carried a heavy obligation of careful stewardship. The AMC is, at its heart, an idea – an idea worth purposeful preservation and commitment lest it wither from neglect.

Mr. Hopkins' contribution came with strings attached. He required that teaching, research and patient care be unified in one enterprise. This tripartite commitment established the guardrails for the remarkable leadership of Hopkins' founders as they brought teaching and research to the bedside and the operating table. It attracted a breed of physicians and scientists with a sustaining passion for combining discovery with patient care. And it gave American AMCs coherence and constructive dynamism.

Because of its tripartite mission, a dynamic tension was hardwired into the American AMC. Tension animates change. As Steven Muller, a former president of Johns Hopkins University, would one day put it, *"Change is here, like it or not. More change is in view. Change breeds doubt. Doubt kindles choice. Choice is opportunity, opportunity to do better or worse."* In a complex enterprise like an AMC, "choice" that translates into "better" requires unified commitment and discipline.

While Hopkins' gift was a force for unification, each of the three mission domains brought its own traditions and cultural imperatives. With insufficient attention, those differences could diverge into fragmentation and conflict.

Central to our understanding of the Hopkins' experience was the masterful work of John Kastor, M.D., whose epic accounts of challenges faced by America's AMCs provides particularly rich perspectives not only on the costs of fragmentation but also on its remedies. One of Kastor's books, Governance of Teaching Hospitals: Turmoil at Penn and Hopkins, focuses specifically on conflicts at Hopkins and the University of Pennsylvania. We have also relied heavily on the work of Arthur Feldman, M.D., PhD., and his book, Pursuing Excellence in Healthcare: Preserving America's Academic Medical Centers, which represents an excellent and comprehensive treatment of the strategic challenges facing AMCs today. It is worth noting that, despite their importance, the role of strategy related to AMCs has received very little attention in the literature of health care management. Hopefully, this monograph will make a contribution in that regard.

This monograph is dedicated to the notion that while fragmentation can never be fully vanquished – it is too much a piece of the human fabric – its ill effects can be mitigated by leaders and organizations that are deliberate in their intentions and incremental in their actions. Such deliberate incrementalism must not be accidental. It should be planned collaboratively with discipline so as to define a future worth becoming and a path worth taking. Such a plan should articulate high-level aspirations as well as the important initiatives to be accomplished in pursuit of those aspirations even when faced with uncertainty and change. It should focus itself to those commitments essential to enterprise vitality and sustainability. In other words, the plan should be "strategic." It should be a "strategic plan" that reaches beyond analysis and prediction to capture imagination and commitment worthy of the AMC idea. This monograph profiles one organization's efforts to knock down walls of fragmentation and sustain that powerful idea.

## Chapter 1: Academic Medical Centers and Strategic Fragmentation

In 1995, two leaders at the most revered health care organization in America went to war against one another. Those who knew them suggested they had once been friends – "thicker than thieves."

In June of that year, according to John Kastor, the Baltimore Sun revealed that, *"Two Hopkins titans, hospital president, Dr. James A. Block, and the dean of the school of medicine, Dr. Michael E. Johns, are engaged in a fierce struggle."*

Although Kastor acknowledged that there had always been tensions at Hopkins, he also emphasized that, *"For a century, the Johns Hopkins University School of Medicine and the Johns Hopkins Hospital, despite being governed separately, has coexisted and flourished with faculty and staff dedicated to the same missions."* The Block-Johns conflict represented a potentially destructive break in that tradition. Kastor characterized the conflict in the words of Hopkins' faculty at the time:

- *"Johns versus Block, always pulling in opposite directions."*
- *"They were constantly fighting and not talking to each other."*
- *"The staffs were slandering each other."*
- *"The smoke between them became a raging fire."*

According to Alfred Sommer, then Dean of Hopkins' Bloomberg School of Public Health, because of the conflict the hospital became a *"nonfunctioning medical center."* The director of one of the clinical departments at the time commented, *"In twenty-three years, I've never seen anything like it"* (Kastor, 2004, 159). Kastor observed that, *"Whereas former hospital president Robert Heyssel and medical school dean Richard Ross had maintained a controlled tension between them that worked for the benefit of the Hopkins medical enterprise, their successors could not do this. Two alpha dogs in a kennel that's too small and charismatic Jim versus scrappy Mike were the pictures two senior faculty members drew of the conflict"* (Kastor, 2004, 213).

What divided Block and Johns, and what bubbled into paralyzing conflict, was a difference in high-level strategic direction for Hopkins overall. Theirs were strategic disagreements that resulted in fragmentation that cascaded into seismic disruption that forced changes in leadership that might have been avoided with the benefit of constructive dialogue.

Johns, a surgeon, had grown up professionally within Hopkins. His strategic mindset was conservative. It was consistent with Hopkins' history and its culture. He was comfortable letting Hopkins be carried forward by the momentum and trajectory of its past. On the other hand, Block, a pediatrician, had been shaped in the competitive fray of Cleveland where, as a leader of University Hospitals of Cleveland, he had experienced that institution's marginalization at the hands of its aggressive neighbor, the Cleveland Clinic. He pursued strategies that were later embraced not only by many in the industry but ultimately by Hopkins as well, including development of a network of community-based hospitals and physicians, satellite campuses in prosperous suburbs, joint ventures with other AMCs and proactive managed care negotiations. Block was to be frustrated and stymied not because his ideas were wrong but because of the way he sought to pursue them (Kastor, 2004).

Fragmentation can be thought of as arrayed along a continuum of time. At one end of the continuum there is "fragmentation of the present." This includes breakdowns in communication and action across initiatives with short time horizons. Failure to make a well coordinated handoff or convey information vital to appropriate and timely care is an example of fragmentation of the present. At the other end of the continuum there is "strategic fragmentation" which negatively impacts the ability to sustain important intentions into the future. Fragmentation over time erodes resolve. It undercuts overall organizational purpose and vision. It is strategically corrosive.

Difficult and perhaps impossible to fully quantify, the costs of strategic fragmentation are significant and include an inhibited ability to develop and leverage strategic advantages into overall institutional sustainability. Strategic fragmentation distracts an organization from its opportunities as a whole, blinds it to threats, and dilutes its impact at all levels.

Strategic fragmentation is dangerous because it so often generates conflict that is pervasive across entire organizations. Kastor chronicled fragmentation not only at Hopkins but also at the University of Pennsylvania and University Hospitals of Cleveland. In Specialty Care in the Era of Managed Care, he concludes that, *"Penn, Hopkins, and the medical institutions at University Circle suffered primarily because of the conflicts between their leaders"* (Kastor, 2005, 226). And here again, the conflicts were a function of disagreements which were fundamentally strategic. Fragmentation that leads to conflict can spiral into more fragmentation until the organization is crippled by dysfunction.

Although problems at institutions like Hopkins, Penn and University Hospitals of Cleveland represent high profile examples, the impacts of strategic fragmentation are varied and widespread. As Arthur Feldman, M.D., PhD., comments in his book, Pursing Excellence in Healthcare: Preserving America's Academic Medical Centers, *"At the West Virginia University Health Science Center, an outside report noted that the AMC was plagued by 'serious leadership and productivity issues' in the Anesthesia Department; an 'alarming deficiency of cardio-thoracic surgeons;' an 'alarming lack of surgeons in key areas,' including trauma, urology, and transplantation; an erosion of operating margins; an atmosphere of 'uncertainty and leadership confusion;' and a 'lack of cohesive and unified leadership structure'"* (Feldman, 2010, xxv). At the University of Virginia Health System, governance and leadership conflicts have eroded the organization's ability to relate to its referral sources and undercut its institutional standing compared to competing AMCs.

Today, most AMCs continue to outperform community hospitals, and the nonprofit hospital sector in general, based on their bond ratings and margin levels. They also continue to enjoy the highest levels of consumer preference in most markets. But for AMCs, the future may prove to be a particularly bad time to be fragmented and to let potential advantages lie fallow.

Already at AMCs throughout America, costs are significantly higher on a case-mix-adjusted basis compared to community hospitals as are their operating expenses. From 2010 to 2012, AMC operating expenses grew 7%. The NIH budget for research grants fell by 22% from 2003 to 2013 while private research funding declined by 15% from 2007 to 2012. AMCs are more reliant than community hospitals on federal funding. Median Medicaid levels are 18.5% for AMCs and 13.1% for nonprofit hospitals in general. McKinsey Health has projected that AMC operating margins will fall 4 to 5% by 2019. The ongoing impacts of health care reform are likely to translate into continuing downward pressure on clinical revenues as well as declining research funding from government and corporate sources. Furthermore, some studies suggest AMCs show no discernable advantage over community hospitals related to quality. Fragmentation lies at the root of these financial challenges and will only acerbate them over the coming years if left to fester.

## Chapter 2: The Strategic Nature of AMCs – Core Differentiators

The tripartite mission of an AMC is its most distinguishing feature. The three missions of an AMC are like magnets arrayed on a table. While they harbor the capacity for attraction, they also hold the potential to repel one another. Too heavy a commitment to one mission can marginalize the others. Thus, too strong a focus on research might compromise efforts to be patient focused or deliver quality training and these shortcomings might then diminish the organization's reputation overall. Conversely, too much emphasis on patient satisfaction or teaching might undercut research and by so doing also erode institutional reputation.

In 2004, the authors of Academic Health Centers: Leading Change in the 21st Century observed that, *"Organizationally, an AHC* is essentially a conglomeration of organizations. Most AHCs function like a holding company, a central entity that loosely supports and coordinates the component organizations. The component organizations grew under separate governance and have generally pursued their own individual objectives, with a minimum of central management and oversight. The AHC roles are performed at different places in the institution and have to satisfy different customers. Clinical care is the primary focus of the hospital and faculty practice plans. They must meet the needs of patients who want the best care possible. Education and research are the primary foci of the professional schools and, where they exist, research centers. Educational activities must be responsive to the needs of students, who have the right to expect the best education they can get; research activities must be responsive to the needs of funders, who expect sound inquiry and utility from the research they support. Each organization also has its own culture. The faculty at professional schools identify most closely with their own discipline rather than any organization, whereas the hospital tends to place greater value on cooperative institutional efforts"* (Kohn, 2004, 127).

Yet, it is out of such differences of emphasis across the three missions that AMCs have more fully distinguished themselves. For example, Hopkins, from its earliest days, can be seen to have given more emphasis to research and teaching than to the patient experience. The Hopkins' example was spread by the missionary spirit of its faculty, and its example would shape most of America's AMCs. After a young Will Mayo visited Hopkins, he took its tripartite mission back with him to Minnesota. Today, it is reflected in the three shields that comprise the Mayo logo. But Mayo gave more emphasis to patient experience than it did to teaching and research. These differences in mission emphasis created a constructive imbalance and gave rise to two very different academic enterprises while helping propel each to worldwide acclaim.

*AHC stands for Academic Health Center. Throughout this monograph we use AMC and AHC interchangeably.

The distinguishing pattern of emphasis given to one mission over another ought not be accidental. It should be intentional and leveraged to strategic advantage as an AMC seeks to compete effectively with other AMCs as well as with tertiary level community hospitals.

The tension between the three missions of the AMC has supplied energy that has generated some of society's most valuable institutions. It has also provided fertile ground for disagreement and acrimony. While it is their tripartite missions that most clearly unifies and distinguishes AMCs, this combination also constantly threatens to push them apart. The essence of effective leadership in the AMC has been the ability to productively manage the tension between patient care, teaching and research. Tension is, after all, a kind of constrained energy. When judiciously harnessed, it can serve as an agent for constructive change. But energy unfettered and unguided can also burn the house down. When tension reaches its combustible threshold, it can, as the Hopkins' example demonstrates, explode into destructive conflict.

On the other hand, the melding of teaching, research and patient care has produced enterprises that are truly differentiated and imbued with competitive potential that community hospitals cannot replicate. There are four characteristics unique to AMCs that arise directly from their tripartite missions. (Diagram A, see page 100.) Those characteristics represent "Core Differentiators." Differentiation is the essence of competitive strategy. It is only through meaningful differences that organizations create value and competitive advantage. Academic medical centers enjoy considerable benefits derived from the following Core Differentiators:

**Depth and Breadth of Capability**

Because of the depth and breadth of their specialty capabilities as well as their commitments to research, academic medical centers are well positioned as the preferred resources for complex care. And this favorable positioning arises, of course, from specialization.

The benefits of specialization have been undeniable. It allows for tenacious focus and efficiency derived from divisions of labor and inquiry. In AMCs, specialization makes available in one relatively concentrated location capabilities often not available in the community setting and, in some instances, possibly available no where else. Individually, or as members of departments and divisions, academic specialists, because they are intent on their area of practice or research, are likely to be highly sensitive to the latest advances in methods and technology. This equips them to be responsive across their relatively narrow domains.

Harvard's strategy expert, Michael Porter, popularized the notion of *"generic strategies"* which suggests there are essentially three ways at a macro level to be successful in a competitive market: (1) *"focus"* involves choosing to serve a subset of the universe of available customers or customer needs; (2) *"cost leadership"* involves offering a lower price relative to competitors; and (3) *"differentiation"* involves being different in ways that can command a higher price (Magretta, 2011).

Michael Treacy and Fred Wiersema expanded on the concept of generic strategies in The Discipline of Market Leaders by adding *"value disciplines"* to three generic strategies. They labeled these generic strategies *"best total solution"* (supported by an operating discipline of *"customer intimacy")*, *"best total cost"* (supported by *"operational excellence"*) and finally, *"best product"* (supported by *"product leadership"*). (Diagram B, see page 101.) It is *"differentiation"* in Porter's model and *"product leadership"* in Treacy and Wiersema's that represents the enviable market advantage enjoyed by most AMCs. AMCs match up well against Treacy and Wiersema's description of an organization that *"continually pushes its products into the realm of the unknown, the untried, or the highly desirable . . ."* and *"strives to provide its market with leading edge products or useful new applications of existing products or services."* According to Treacy and Wiersema, this requires a value discipline with operating characteristics that are already reflected to some degree in many AMCs including:

- *"A focus on the core processes of invention, product development and market exploitation.*

- *A business structure that is loosely knit, ad hoc, and ever-changing to adjust to the entrepreneurial initiatives and redirections that characterize working in unexplored territory.*

- *Management systems that are results-driven, that measure and reward new product success, and that don't punish the experimentation needed to get there.*

- *A culture that encourages individual imagination, accomplishment, out-of-the-box thinking, and a mind-set driven by the desire to create the future"* (Treacy, 1995, 39).

Most community hospitals, on the other hand, face the danger of what Porter has described as *"getting stuck in the middle."* This occurs when an organization tries to be all things to all people and is, as a result, outflanked by "cost leaders" on one side and "differentiators" on the other. Indeed, many community hospitals are sustained by only one key point of differentiation – location in and identification with a particular community or geography (which is a kind of "focus"). This advantage of a *"franchise of location"* continues to be protected by a variety of barriers to entry including Certificate of Need laws which limit competition.

Ed Miller, M.D., who succeeded Block and Johns as CEO and Dean of Hopkins Medicine, reflected on the importance of preserving the leading edge reputation embodied in depth and breadth, *"We understood that we could probably compete effectively with community hospitals, but we realized that we would not be different from them if we focused only on clinical care; what made us different is innovation. We have to innovate if we are to stay in the lead . . ."* (Aaron, 2001, 69).

The strength seen in the differentiation of an AMC can perhaps best be explained by what marketing experts describe as "positioning." Al Ries and Jack Trout, proponents of the concept, suggested that consumers are overloaded with information regarding competing products and services. The way they deal with this overload is by sorting and prioritizing the information. Ries and Trout used the rungs of a ladder to illustrate their point. For any definable market, a product or service that isn't sorted onto one of the top three mental rungs of the ladder is in jeopardy of being out of the game. But once clearly positioned on one of those rungs, particularly the top one, the product or service is very difficult to dislodge. This seems to be true for hospitals as well. And it is AMCs that, because of the depth and breadth of their capabilities, have invariably owned the top rungs, particularly when it comes to complex care (Ries and Trout, 1981).

Arthur Feldman reinforces the importance of leveraging the unique value proposition of the AMC, *"The future of academic medical centers will be dependent on their ability to provide the highest level of patient care across the entire spectrum of an individual's disease* [and] *. . . the most effective means of increasing AMC revenues is to ensure the delivery of outstanding patient care"* (Feldman, 2010, 224).

In commenting on Hopkins, Kastor, too, drives home the advantage depth and breadth of capability delivers, *"It is Hopkins' reputation in clinical medicine . . . that creates much of the esteem in which the public holds the institution"* (Kastor, 2004, 276) . . . *"To the public, it's the name of the hospital, redolent with history and medical accomplishment that wins it a top standing in national surveys. The doctors and scientists, whom the public sees as contributing to medical knowledge through research and advanced clinical care, and the reputation of its medical school help establish the standing of a teaching hospital"* (Kastor, 2004, 436).

The power and impact of the intrinsic differentiation of AMCs is reflected in their bond ratings and relative market positions. In 2001, Nancy Kane reported on her analysis of the financial performance of AMCs. She mentioned the 2000 report from bond rating agency Standard & Poor's that noted that AMCs *". . . have fundamental strengths, including broad regional market penetration, strong regional and sometimes national reputations, and great financial flexibility. Advantages accruing to many AMCs include special state and federal subsidies, strong fund-raising capabilities, and dominance in the market for specialized services, which permits them to charge premium prices."* Despite persistent concerns about the future of AMCs, Kane references the S&P report's conclusion that regardless of increasing financial pressures, many AMCs *"have managed not only to survive but also prosper"* (Aaron, 2001, 13). In 2014, Moody's commented that AMCs generally have stronger overall credit quality than do community hospitals. Moody's rates 85 AMCs (defined as a hospital that receives more than $50 million per year from the National Institute of Health). Overall, the median rating for an AMC is "A1," which is two rating notches higher than the median "A3" rating for all nonprofit hospitals. In addition, AMCs continue to dominate U.S. News & World Report's list of top hospitals whether at a national, regional or local level.

**Commitment and Collegiality**

An AMC is not a big community hospital. AMCs and community hospitals have evolved along different paths and represent fundamentally different kinds of organizations in terms of their purpose, history, structure and culture. The tripartite mission of the AMC explains much of this difference. Most community hospitals have focused on one mission – patient care. While in some ways this has made them less fragmented as well as less complex to orchestrate, there has typically been a much sharper and more impervious boundary line drawn between community hospitals and the physicians who comprise their medical staffs.

Physicians go through a self-selection process during and after their training that ultimately shapes their professional path. Historically, most new physicians have opted to move into private practice. This occurred for a variety of reasons including a stronger preference among many physicians for independence. Economic influences have also played a role. Generally, physicians in private practice have earned more than their colleagues in academic medicine. Thus, academic physicians as a group have traded off independence and income for something else. For some faculty, perhaps there has simply been a greater sense of security associated with being part of a larger organization. However, for many others there clearly has been a deeply shared interest captured well here by oncologist, Joseph Simone, M.D.: *". . . we in academic medicine are blessed in many ways compared with those in most jobs. We have the privilege of working in a profession that helps the sick and dying while we are engaged in intellectual inquiry."*

"Intellectual inquiry," by definition, involves a hunger for discovery and this translates into a mindset of hopeful optimism among many academic physicians. H.G. Wells conveyed the essence of that optimistic academic mindset in The Discovery of the Future, *"It is possible to believe that all the past is but the beginning of a beginning and that all that is and has been is but the twilight of the dawn."* Such an attitude generates a culture characterized by the potential for sustained commitment to the institutional purpose and vision that set an AMC apart as well as to strategies designed to transform those aspirations into reality.

In his book, Thinking Fast and Slow, Daniel Kahneman, Nobel Laureate in Economics, emphasized the importance of the kind of optimism that characterizes AMCs, *"Optimistic individuals play a disproportionate role in shaping our lives. Their decisions make a difference; they are the inventors, the entrepreneurs, the political and military leaders – not average people . . . Their confidence in their future success sustains a positive mood that helps them obtain resources from others, raise the morale of their employees, and enhance their prospects of prevailing. When action is needed, optimism, even of the mildly delusional variety, may be a good thing . . . the contribution of optimism to good implementation is certainly positive. The main benefit of optimism is resilience in the face of setbacks . . . I have always believed that scientific research is another domain where a form of optimism is essential to success. I have yet to meet a successful scientist who lacks the ability to exaggerate the importance of what he or she is doing, and I believe that someone who lacks a delusional sense of significance will wilt in the face of repeated experiences of multiple small failures and rare successes, the fate of most researchers"* (Kahneman, 2011, 256-264).

Optimists consistently display hopeful expectations. Years ago, when one of this monograph's authors had the occasion to interview Hopkin's Ed Miller, there was a small scrap of paper taped to his computer monitor. On it was typed a single word, "Hope."

While shared interest in "intellectual inquiry" creates the basis for cohesion at an overall institutional level, it can be a particular source of unification within the departments and divisions of AMCs where interests tend to be highly specialized and focused. Military experts have long recognized the power of "unit cohesion" whereby smaller groups within a broader organizational structure demonstrate a stronger sense of shared identity and willingness to fight for one another.

Faculty physicians in AMCs tend to demonstrate greater cohesion than will be found across the medical staff of a typical community hospital where specialists are much more prone to compete than collaborate. This difference persists despite growing numbers of physicians accepting employment with community hospitals. Even as hospital employees, many community physicians continue to retain a stronger orientation towards independence than academic physicians who have surrendered a degree of autonomy in exchange for other benefits.

Also unifying faculty physicians is a stronger desire for collegiality. In many ways, an orientation towards collegiality is the opposite of an orientation towards independence. Collegiality describes a desire for association among professionals with shared interests. Collegiality does not suggest an absence of rivalry. Instead, it describes a desire to play the game with respected peers on a common field.

According to Kastor, many at Hopkins believed that *". . . collegiality and collaboration account for much of its success in research and in the development of its faculty, in spite of the competition for promotion, grants, and scientific recognition inherent in such a place.* And Murray Sachs, a director of the department of biomedical engineering had suggested, *'People here are intensely competitive in themselves, not against others.'* While former Hopkins University president, William Richardson, suggested that, *'The collaborative spirit is in the blood, in the culture and deeply ingrained'"* (Kastor, 2004, 274).

Academic physicians are also distinguished by their interest in association with a strong institutional reputation. They are much more likely to think of themselves as "Hopkins Doctors" or "Duke Doctors" than community physicians are to associate their professional identity with that of a community hospital. Faculty physicians are prone to share a common ambition and competitiveness that can serve as a unifying force. Although community hospitals may threaten the referral base of AMCs, that's not what gets the competitive juices flowing within most AMCs. What stirs the blood of faculty is their position relative to other AMCs. Historically, the scorecards that have come to mean the most in this regard are U.S. News & World Report's list of top hospitals and the National Institutes of Health listing of research grants. Historically, these rankings, more than other points of comparison, have come to define the playing field.

**Proximity**

Proximity has been at the heart of many of civilization's forward thrusts. People in proximity to one another in a tribe have certainly proved more productive and secure than one or two people alone. The printing press, the telegraph, the telephone, the railroads, the highways, the automobile, the television, the internet – all of these were transformative because they were distance busters and proximity builders.

Proximity really is magic. At the most fundamental level, it is a trigger in nature. Cells become something very different in proximity to other cells than they were when they were independent and alone. When they get close, they set off changes in one another, sometimes remaking and reorganizing themselves into a higher order of things – a more complex "republic of cells." The old adage that 1 + 1 = 3 wasn't wrong. Indeed, people in proximity, like cells in proximity, don't just become a multiple of what they were before. They change into something fundamentally different. From such differences they generate rich, new options.

A unique pillar of strength inherent to AMCs results from locating high powered clinicians, researchers and educators in close proximity to one another. It is physical closeness in time and space that overcomes many of the obstacles presented by fragmentation.

And it is simple stuff, like the ability to walk down the hall to consult with a colleague, to trade ideas over coffee, to bump into somebody who has part of the answer to the question you're battling. Proximity gives legs to ideas that might otherwise languish. It provides a setting in which an idea can spring from a single mind, then capture the imagination and the commitment of many.

All things exist in relationship to other things. They draw their identities and purpose out of such relatedness. Absent proximity, there can't be a full sense of relatedness. And absent relatedness, there can be no shared sense of purpose.

As Feldman commented, *"The principle that value is driven by provider experience, scale, and learning in medical conditions should be easy to achieve in an AMC: Academic specialists and subspecialists concentrate their efforts, innovate rapidly, develop dedicated teams rather than relying on part-time practitioners, have dedicated facilities, and have multiple colleagues in the same practice with whom to discuss difficult cases . . ."* (Feldman, 2010, 225).

It may have been proximity that supercharged Hopkins' rise. Kastor reflects on the early days of the institution and the influence of William Osler, *"When the hospital opened and for decades afterward, resident physicians and surgeons lived on the upper floors. In one of these resident's rooms, which he appropriated for his literary use, Dr. William Osler, the first professor of medicine and a renowned figure in medicine and in Hopkins lore, wrote his textbook on medicine, which became the leading authority in its field at the time*" (Kastor, 2004, 162). In the formative period during which Hopkins' reputation grew towards greatness, its founding leaders were in continuous contact with one another including Osler, Shaw, Welch and Halsted.

AMCs are, as a rule, large and they concentrate lots of highly specialized talent, technology and infrastructure across a relatively tight geography. Such proximity can yield tremendous advantages derived from the ability to interact and collaborate more quickly, continuously and efficiently. In this they resemble cities and share many of the characteristics that have made cities both durable and productive. Like cities, AMCs appear scaled to last. In the September 2011 issue of *Scientific American*, Geoffrey B. West and Luis M.A. Bettencourt, both theoretical physicists at the Santa Fe Institute and Los Alamos National Laboratory, observed that, rather than *"unnatural human conglomerations blighted by pathologies … cities do more with less … because they concentrate, accelerate and diversify social and economic activity."*

Bettencourt and West's research indicates that while a city may double in size, its infrastructure – roads, sewer lines, retail – does not. In fact, the bigger the city, the more efficiently it uses resources.

But more than physical infrastructure, the key to *"virtuous cycles of innovation and the creation of wealth"* are *"a spirit of local entrepreneurship, a reputation for cutting-edge novelty and a culture of excellence and competitiveness . . . Concentrated population promotes more intense and frequent social interactions, occurrences that correlate with higher rates of productivity and innovation as well as pressures that weed out inefficiencies"* (West and Bettencourt, 2011). The same argument can be applied to AMCs that geographically concentrate talent and capacity rather than physically distributing it.

In health care, there are many reasons to invest in electronic links, but the most compelling is to simulate and stimulate proximity – to put patients, physicians and others in more immediate contact. To deliver value, such links must be as simple to use as a telephone or sending an e-mail message.

Technology can augment personal face-to-face interaction, but it can't replace it. Ultimately, the benefits of proximity must be secured eyeball to eyeball and shoulder to shoulder. Electronic links need to be translated into relationships, relationships into commitments, commitments into action. And that requires people being in the same space. Not all the time or even most of the time, but some of the time (Isaacson, 2014).

Familiarity may occasionally breed contempt, but it also breeds trust. There are different kinds of trust, of course. There is the kind that people come to expect by living in civilized society. For example, we trust that we'll not be run over when we're in a pedestrian crossing. But a deeper kind of trust is built on a foundation of familiarity. People need to know each other to truly trust. They only get to really know each other when they are in proximity to one another where they learn from direct experience who they can trust. Proximity is the fertilizer of trust.

Proximity is an elixir often readily available but also often ignored, perhaps because its benefits are simply too obvious. If fragmentation is the enemy of quality, cost effectiveness and accessibility, then proximity is a priceless ally.

## Loose Coupling

AMCs are what the University of Michigan organizational theorist, Karl Weick, has labeled "loosely coupled." This can be attributed largely to the high degree of autonomy and, in many instances, resource control vested in their departmental structures rather than in a centralized hierarchy. According to Thomas Gilmore in his paper entitled, "Challenges of Leading and Planning in Academic Medical Centers," a loosely coupled system is evident when *"individual elements have high autonomy relative to the larger system in which they are imbedded, often creating a federated character of the institution. In loosely coupled systems, actions in one part of the system can have little or no effect on another or can unpredictably trigger responses out of proportion to the stimulus. The linkages among elements are often ill understood and/or uneven. In loosely coupled systems, the forces for integration – for worrying about the whole, its identity, its integrity and its future – are often weak compared to the forces for specialization. Central authority is, in important respects, derived from the members rather than the member elements receiving delegated authority from above"* (Gilmore, 1999, 1).

One attribute of loosely coupled organizations is their inherent stability and sustainability. Because so much of their power and leadership has been contained within departments and because the leadership is emergent rather than delegated, AMCs, by their nature, tend to be decentralized. Weakness or failure in one department or division doesn't necessarily threaten the others. They resemble a network more than a hierarchy.

Historically, AMCs have proven remarkably durable and resilient. According to Weick, loose coupling allows organizations like AMCs to *"temporarily persist in the face of rapid environmental fluctuations, improves the organization's sensitivity to the environment, allows local adaptation and creative solutions to develop, permits subsystems and subunits to underperform and break down without pulling down the entire organization, and allows more individual self-determination"* (Weick, 1976). Loose coupling may yield greater sustainability over time because it permits greater flexibility than the more rigid command-and-control models employed by most corporations as well as most hospitals. Rigid things are more prone to fracture in volatile environments, while flexible things can absorb a blow. They can "take a licking and keep on ticking."

Before the tenure of Block and Johns, Robert Heyssel, then president of Johns Hopkins Hospital, had reinforced Hopkins' loose coupling by introducing a more decentralized organization. Kastor reflected on the positive impact of decentralization at Hopkins: many faculty felt that *". . . the decentralized nature of the Hopkins governance, which is characteristic of the medical school as well as the hospital, contributes to the spirit of innovation and independence. 'This is a place where people who are bright and excited about what they are doing have a chance to do it . . . The decentralization has allowed us to be creative and develop services that would otherwise not have developed,'"* said Marty Abeloff (Director, Department of Radiology). According to Kastor, *"Delegation of much of the authority to the department directors has encouraged the strongest and most able to build outstanding units . . . The directors think that the absence of departmental boundaries among these groups provide one reason why their colleagues are so productive." "There's little sense of turf."* observed Jeremy Berg (Director, Department of Biophysics and Biophysical Chemistry), and, William Agnew (Director, Department of Physiology*)* warned, *"if we become less collegial and more turfy, we'll be in even bigger trouble."*

Loose coupling also creates room for entrepreneurial discovery, a characteristic many have suggested energized Hopkins from its founding. As Kastor observed, *"Hopkins lives on the entrepreneurial enthusiasm of its faculty since the medical school has few funds to support departments and investigators and depends so much on 'soft money,' the grants won by the faculty. This is vitally important since few members of the faculty develop enough money to support their colleagues in addition to themselves. 'Hopkins gives you a hunting license,' is the way several faculty members describe the value of the Hopkins connection."* And neurologist, Guy McKhann, said, *"They don't give you much but they don't get in your way."* (Kastor, 2004, 275-276).

In a study by M. Keroack and colleagues published in the Journal of Academic Medicine, factors that distinguished the most successful AMCs from those that were only moderately successful included multidisciplinary approaches and teams. The top performers also embodied a *"blend of central control and decentralized responsibility"* (Keroack, et al., 2007).

To outsiders unaccustomed to them, AMCs may look confused, inefficient and ponderous. Dr. Michael Bishop, a Nobel Prize-winning scientist leading the University of California-San Francisco, agreed. He viewed *"academic health centers as inherently inefficient even when aggressively managed"* (Kastor, 2001, 438).

But inefficient does not necessarily mean ineffective. Viewed from the distance of their century of existence, AMCs display an impressive level of coherence and resilience. Semiautonomous faculty consume themselves with diverse initiatives, but also display a propensity to stay in formation over time. The aligning force is commitment to a shared purpose derived from teaching, research and patient care.

It may once have been appropriate to think about navigating an organization into the future as being analogous to guiding a ship across an uncertain sea. There were reefs, storms and currents to avoid, all while keeping your destination in mind – a vision of arrival on a safe and desirable shore. But an oceangoing ship is a metaphor that may have outlived its usefulness. When confronted with accelerating change and growing uncertainty, it might be better to think about moving a fighter squadron across skies made hostile by opposing fighters.

The squadron seeks to maintain formation in pursuit of its mission (purpose) but when confronted can break into the individual combatants. This yields flexibility. The squadron embodies "loose coupling;" it is simultaneously tight and loose; tight about its commitment to its mission but embodying the potential to be loose about how it gets there. That looseness is on full display when fighters break away from formation to engage in dogfights then reassemble into formation.

Shared commitment to delivering complex care, collegiality and proximity give academic medical centers coherence sufficient to overcome the fragmentation that might otherwise accompany loose coupling. Organizations can benefit from being loosely coupled but they can’t afford to be so loose they lack purpose and direction. On the other hand, they can be paralyzed by being too tightly coupled. Academic medical centers that become too integrated and centralized risk squandering the advantages embodied in loose coupling.

The good news is that the four Core Differentiators described above, Depth and Breadth of Capability, Collegial Commitment, Proximity and Loose Coupling, continue to support significant advantages for academic medical centers and will be very difficult for competitors to emulate. The bad news is that they are largely a fortuitous inheritance. Because each differentiator arises naturally from the tripartite mission that distinguishes academic medical centers rather than from intentional strategy making, they are subject to neglect. Success for academic medical centers will require more than good fortune. It will require embracing the characteristics that make academic medical centers unique and the advantages those characteristics can yield. Focused investment of attention, time and resources will be necessary to fully leverage Core Differentiators into sustainable advantage. Absent plans that cultivate and build on these Core Differentiators, AMCs are bound to become less resilient and less competitive. They may edge towards commodities unable to justify continued market preference and premium pricing.

## Chapter 3: The Perils of Strategic Fragmentation

Fragmentation is the enemy that most threatens the ability of AMCs to translate their Core Differentiators into strategic advantage. The forces of fragmentation take many forms. And like the unique characteristics that distinguish AMCs, they often spring from the tripartite mission and represent the flipside of what otherwise represent strengths.

Unfortunately, the strength and durability of their intrinsic differentiation can blind AMCs to competitive threats. Absent sufficient sensitivity to external threats, the unified effort needed to leverage this differentiation can fall victim to the fragmentation that results from inattention, distraction and loss of focus as well as arrogance and parochialism.

For example, AMCs will find themselves threatened if the growing proliferation of outcomes data indicates that there is an insignificant difference in the quality of the outcomes they produce compared with that produced by tertiary level community hospitals. Some large community hospitals, even though they make no investment in research or teaching, have achieved a high degree of specialized clinical capability. The long-held presumption that teaching and research contribute to quality of care will be tested and, if not validated, may strip away from AMCs the pretense of being different in a way that matters. It is possible that, as a result, rankings such as those provided by U.S. News & World Report could get shuffled and AMCs find themselves knocked out of their dominant positions.

Tertiary-level community hospitals can be expected to continue to develop advanced capabilities that once could be found only in AMCs. Such a trend will be reinforced by the rapid diffusion of knowledge and technology as information grows ever more democratized and proprietary barriers erode. Already in many markets, the ability of AMCs to claim leadership in specialized care and technology has been challenged by community hospitals that have built advanced capabilities in key service lines, particularly heart and cancer. In Wisconsin, for example, the market leader for advanced capabilities in heart care has for more than a decade been a large, tertiary-level community hospital. And in the suburbs of Chicago, a highly profitable community hospital with only limited tertiary capability installed a proton accelerator in 2010. Such investments, if successfully implemented, threaten the differentiation of AMCs based on depth and breadth of clinical capability.

Strong reputations derived from depth and breadth of capabilities can be taken for granted and breed organizational hubris. Thus, AMCs can be lulled into inattention and inaction by their high status in rankings like that of U.S. News & World Report. Leaders can begin to believe that they, rather than the intrinsic distinctiveness of their organization, are the drivers of success. It is an affliction that often affects leaders in other industries. Kahneman comments on the perils of overconfident CEOs and cites a study supporting his assertion, *"The damage caused by overconfident CEOs is compounded when the business press anoints them as celebrities; the evidence indicates that prestigious press awards to the CEO are costly to stockholders."* The study's authors write, *"We find that firms with award-winning CEOs subsequently underperform, in terms both of stock and operating performance. At the same time, CEO compensation increases. CEOs spend more time on activities outside the company such as writing books and sitting on outside boards, and they are more likely to engage in earnings management."* Kahneman observes that, *"Leaders of large businesses sometimes make huge bets in expensive mergers and acquisitions, acting on the mistaken belief that they can manage the assets of another company better than its current owners do. The stock market commonly responds by downgrading the value of the acquiring firm, because experience has shown that efforts to integrate large firms fail more often than they succeed. The misguided acquisitions have been explained by a 'hubris hypothesis:' the executives of the acquiring firm are simply less competent than they think they are."* Kahneman's observation can be extended to characterize overconfident organizations where entire leadership teams are subject to the malaise of organizational hubris.

Among AMCs, the problem of organizational hubris may be compounded by a tendency towards overconfidence among physicians generally. According to Kahneman, overconfidence *". . . appears to be endemic in medicine. A study of patients who died in the ICU compared autopsy results with the diagnosis that physicians had provided while the patients were still alive. Physicians also reported their confidence. The result 'clinicians who were 'completely certain' of the diagnosis antemortem were wrong 40% of the time.' Here again, expert overconfidence is encouraged by their clients: 'Generally, it is considered a weakness and a sign of vulnerability for clinicians to appear unsure. Confidence is valued over uncertainty and there is a prevailing censure against disclosing uncertainty to patients'"* (Kahneman, 2011, 258-263).

The narrow focus inherent in the specialization that legitimizes and fortifies the reputation of AMCs can also result in a kind of myopia that impairs the ability to see and respond holistically beyond the boundaries of specialty silos. Specialists are often quite disinterested in developments in other specialties and insensitive to broader issues confronting the AMC overall.

*"The modern American medical school,"* according to Feldman, *"consists of numerous clinical departments that often operate in their own individual silos. This nonintegrated structure presents a number of different challenges to achieving the core mission of providing outstanding patient care. For example, at some AMCs, the same procedure may be provided in multiple departments without development of common protocols and without an assessment of which group of physicians does it best"* (Feldman, 2010, 21).

Relentless specialization has caused the number and the variety of clinical departments and divisions to balloon. Research, like clinical care, has become ever more specialized and, in many instances, increasingly distanced from teaching and patient care. And specialization in education has quite naturally mirrored specialization in patient care and research. Administrative and management functions, like clinical and research capabilities, have also become more specialized. Every new node of specialization intensifies the potential for fragmentation.

Osler was deeply concerned about the impact of overspecialization. He felt it was critical that physicians be exposed to *". . . the lessons of the laboratory and wide contact with men in other departments may serve to correct the inevitable tendency to a narrow and perverted vision, in which the life of the ant-hill is mistaken for the world at large"* (Feldman, 2010, 22-23).

Will Mayo reinforced Osler's concern with a story, *"A prominent specialist in gastrointestinal diseases once asked, 'How is it possible that you, a general surgeon, see so many of these cases while I, who am devoting all my time to this work, see so few?' I could only answer, 'The thickness of the abdominal wall prevents you from seeing them'"* (Clapesattle, 1969).

Shared commitments and collegiality within specialties can reinforce a tendency toward distinguishing between "us" and "them." Absent clarity regarding overall organizational purpose and persistent coordination by leadership, specialties as well as departments and divisions can adopt an adversarial stance in their relationship with those outside their group. In the words of Harvard biologist, E.O. Wilson, this may reflect a tribal instinct in which members of one group quickly begin to judge members of other groups *"to be less likable, less fair, less trustworthy, less competent"* (Wilson, 2013). And as Matt Ridley observed in The Rational Optimist, *"Human beings have a deep capacity for isolationism, for fragmenting into groups that diverge from each other."* This is a persistent threat in large complex organizations like AMCs, particularly when specialization is a distinguishing characteristic (Ridley, 2010).

Specialized experiences give rise to specialized perspectives related not only to medicine but also to leadership and management. Absent general agreement about purpose and vision, these differences in perspective can foster strategic fragmentation. During the Block-Johns conflict at Hopkins, according to Kastor, opposing camps solidified around each man. An administrator remembered a retreat that Johns, Block, and their staffs held, *"It was supposed to be collaborative, but the two teams just spent their time sparring with each other. Palpable discomfort accompanied most meetings that both Block and Johns attended . . . Gradually, the membership and attitudes of the opposing teams congealed – the dean and many of the faculty leaders on one side, Block, his staff, and supporters among the faculty and on the hospital board of trustees on the other. The conflict between Block and Johns became so intense that the observer has difficulty separating fact from opinion, so strongly did supporters of one criticize the other"* (Kastor, 2004, 215).

Effectively maneuvering the modern AMC has increasingly demanded an ability to navigate in an environment roiled by complex forces not the least of which are economic. This has meant that those trained and engaged in patient care, teaching and research need to be complemented with individuals who bring management competencies and experience. Not surprisingly, such individuals are prone to also bring a different set of professional norms and perspectives. The differences in such perspectives have been described as giving rise to 'church-state' dynamics. According to Gilmore, *"Church-state divisions in academic and other professional organizations are far more profound than the characteristic line-staff tensions of the corporate world . . . The church role is viewed as a mission driven calling and is filled with 'the promise of discovery, adventure and independence.' While the state role is managerial and carries with it the 'world of constraints, trade-offs and the relentless necessity of collaboration . . .'"* (Gilmore, 1999). The church role also tends to generate high levels of emotional commitment that can be sustained over time. Generally, community hospitals don't demonstrate the same church-state dynamics found in AMCs. In other words, they are secular and agnostic. The state prevails in community hospitals and most conflicts with physicians tend to be economically based.

Like the differences between specialists, church-state differences can disintegrate into fragmentation and conflict. For many AMCs this arises from misunderstanding and distrust between faculty (church) and hospital leadership (state). Not surprisingly, this situation has ripened into power struggles that continue to distract and disrupt many AMCs. Within AMCs, the hospital has become the primary vehicle for generating margins and hospital executives have gained significant power as lords of the checkbook. As a result, many deans have found themselves compelled to go to hospital leaders with hat in hand to fund initiatives in the academic realm. Yet, deans continue to shape the supply of the critical element for the states' means of production when it comes to delivering the patient care that fuels the economic engine of an AMC – faculty physicians, residents and medical students. The result of such church-state differences can be paralyzing standoffs and fragmenting dysfunction. According to Kastor, Mark Rogers, former Director of Anesthesiology at Hopkins, had viewed the Block-Johns conflict from a historical perspective, *"It was Henry VIII versus the Pope. The dean was the Pope, the keeper of the flame and the reliquary, but the hospital director had the money, and the dean needed the money"* (Kastor, 2004, 213).

Overemphasis on "state values," such as organizational hierarchy, productivity and profitability, can raise concerns regarding the motivations underpinning the care delivered and this, in turn, can erode trust among physicians as well as patients and the community. Commitments to "church values" embodied in research, education and patient care cultivate the cultural behavior fundamental to building and sustaining trust for an intimate human service like health care. Absent a balanced orientation towards the role of church and state, values like intellectual inquiry and collegiality can be overwhelmed and submerged by the values of the state. On the other hand, inattention to state values can derail prospects for the financial performance necessary to support organizational aspirations including those anchored in church values.

Absent a unifying shared purpose as well as mechanisms that encourage and facilitate interaction, proximity can lose its power. Proximity means little if it involves specialists who are oblivious to one another or in conflict. There are a wide variety of silos – specialty, departmental, institutional – into which faculty and staff can hunker down in pursuit of very narrow and potentially conflicting goals. Proximity that is not in service of overall organizational purpose can actually drive individuals into deeper isolation as collegial interaction transitions into distraction, interference and annoyance.

The benefits of concentrating talent and resources on a single campus can be wasted without attention given to facilitating productive interaction not only for specialists but for their patients as Feldman suggests here: *"Another example of how a lack of integration across different departments adversely influences patient care is the geographic separation of closely related specialists. As a result, patients must travel from one outpatient location to another and go through a registration process at each location; their care is often interrupted as the patient has to wait for the different physicians to communicate with each other regarding his or her care"* (Feldman, 2010, 21-22).

AMCs must be simultaneously loose and tight. When they are tight about a few strongly held commitments, they can often then be loose about the rest. Still, the shortcomings of too loose a structure for an AMC are obvious enough. Department chairs whose only interest relates to the relatively narrow sphere of their specialty focus are prone to suboptimize the broader institutional goals, including those related to communication, collaboration, coordination and synergies across specialties. Preservation of a loosely coupled enterprise requires answering the question, "What is the basis for coupling?" The best answer for this question is mission and vision.

Leveraging advantages and mitigating the potential for fragmentation requires consistent effort by leaders to build and reinforce organizational purpose. The potential for intra-group friction is reduced when groups have a sense of shared purpose and can execute against a clear vision and strategies. When clarity is lacking, intentions are often invented. Precious energy and emotion are wasted on speculation. Creating opportunities for groups to regularly interrelate and synchronize with one another can enhance coordination, build trust and reduce friction.

An organization that is too loosely coupled can dissolve into an aimless mob. According to Feldman, *"Perhaps the most important impediment to managing a loosely coupled AMC is what has variously been termed 'jurisdictional proliferation,' 'semi-autonomous units,' or 'turf.' In loosely coupled systems, there are not only departments, divisions, and schools but also centers, institutes, and programs. Each of these entities lives in a microenvironment with its own leader and administrator. Each unit has worked to develop its internal structure and relationships, which may or may not mesh well with the structure of the overall federation. Microalliances between these various centers and departments may provide some opportunities for collaboration; however, in many cases, these individual structures polarize rather than unite the whole"* (Feldman, 2010, 50).

*". . . many medical schools have over 20 different clinical departments. By the 1960s and 1970s, some departments, including medicine and surgery, became larger than entire medical schools had been a decade earlier; however, the administrative structure of medical schools did not change to accommodate these marked differences. As a result, departments often became independent fiefdoms that further entrenched the silo model – often battling each other for the limited resources that exist in today's AMCs"* (Feldman, 2010, 23).

Too much looseness can also result in a strategic vacuum that fosters scattered initiatives not well aligned with the overall interests of the organization, too piecemeal to have the benefit of synergistic coherence and too poorly resourced to have impact. Such a strategic vacuum can, in turn, create circumstances that allow forceful individuals to launch initiatives that may not have sufficient concurrence and support from across the institution. According to Kastor, Alfred Sommer, dean of the school of public health, described how Block withheld his plans from colleagues. At a meeting to discuss health policy, when someone asked Block what he suggested should be done about health care in Maryland, *'"He told us very little, as if he hadn't worked it out,' remembered Sommer. 'Then, a few days later, he laid out a whole program to the legislature. None of us knew anything about what he was going to say."'* Block was described by some as "smooth as silk" but he drove people crazy because he proceeded without telling others what he wanted to do (Kastor, 2004, 217). In similar fashion, Block withheld his plans for the development of the Hopkins' $12 million, 75,000 square foot outpatient facility at Green Spring Station, a suburban location with attractive demographics. Ultimately, the move proved successful, but Block's lack of transparency further alienated other leaders at Hopkins (Kastor, 2004, 200).

Unilateralism that fragments AMCs then transcends into conflict is a central theme in Kastor's books. He recounts not only the leadership conflict at Hopkins but also the example of William N. Kelley, M.D. who became dean of the University of Pennsylvania School of Medicine and chief executive of the University of Pennsylvania Health System. By all accounts, Kelley was a forceful personality. Over his decade long tenure he launched a variety of high-level initiatives, some of which lacked organizational support and ended up as costly misfires. These appear to have emerged as unilateral dictates rather than as the result of well considered strategic dialogue. According to Kastor, in the final three years of Kelley's tenure the University of Pennsylvania Health System lost $300 million and Kelley lost his job.

Kastor shared this view of Kelley's leadership style from Clyde Barker, then Chair of the Department of Surgery, *"'Things were decided before they got to a forum where there might be objections.' When Penn bought Presbyterian and Pennsylvania hospitals, the clinical leadership was informed but not involved in making the decision, an example of the centralization of power under Kelley. He would just announce, 'This group of doctors is coming here,' or 'I just bought this hospital,' commented Leonard Jarrett",* Chair of the Department of Pathology and Laboratory Medicine from 1980-1998. Kastor quotes Priscilla Schaffer, then Chair of the Department of Microbiology, who recalled that several of her colleagues tried to convince Kelley not to buy more hospitals, *"He blocked it out. What they said didn't register"* (Kastor, 2004, 87).

In Specialty Care in the Era of Managed Care, Kastor described the competitive struggle between University Hospitals of Cleveland and the Cleveland Clinic during the period of roughly 1990 through 2005. In Kastor's telling, it was a struggle that University Hospitals positioned itself to lose because it succumbed to internal struggles that limited its ability to respond effectively to its more entrepreneurial and strategically adept competitor down the street. James Block had served as president of University Hospitals of Cleveland before moving into the hospital presidency at Hopkins. Block reflected on the experience of competing with the Cleveland Clinic, *"Even by 1990, we still couldn't spell 'market.' Cleveland Clinic was spelling it in the 1970s and 1980s"* (Kastor, 2005, 151).

University Hospitals' internal conflict and inattention to external forces were of long standing and resulted in substantial financial losses as well as demoralization. According to Kastor, conflict between the chief executives of University Hospitals of Cleveland and Case Western Reserve University *". . . affected the academic and clinical missions of the medical school and hospital. The difficulty was not limited to the 1990s. Harry Bolwell, chairman of the hospital board from 1978 to 1987 and the dominant leader for much of that time, didn't believe that a medical school was necessary for a hospital to be great and was so anti-Case that he wouldn't read mail on university stationery."* While the Cleveland Clinic had the benefit of a coherent and cohesive strategic plan, at the time University Hospitals of Cleveland did not. For this it paid a high price. According to Kastor, *"As the leaders of the institutions at University Circle struggled with each other, their neighbor one mile west on Euclid Avenue grew and flourished."*

Unilateralism that engendered fragmentation and conflict was on full display as the Cleveland Clinic got the better of its cross town competitor. Highlighted in this tale of fragmented leadership are the effects of University Hospital's CEO, Farah Walters' tenure. According to Kastor, *"Meeting with her could be productive and cooperative or, as one of the chairmen put it, 'a one-way dialogue, a unilogue.' Another senior faculty member who knew Walters' operating style well, commented that while meeting to discuss such issues as 'finances and patient access, she totally monopolized the meetings and didn't allow time for general discussion. She wasn't receptive to contrary opinions, and most chairs remained silent when they disagreed with her'"* (Kastor, 2005, 135). Ultimately, a new CEO, Thomas Zenty, with unified authority over University Hospitals' various conflicted entities was hired. Zenty launched a financial turnaround, stabilized the institution and then turned his attention to development of an ambitious strategic plan that included a compelling vision for growth. As a result, University Hospitals has become a competitor which at last commands the attention of Cleveland Clinic.

Internal power struggles can be debilitating and potentially disastrous when they fragment leadership to the point of diverting attention and resources from opportunities and threats. They can also inhibit the ability to remain deliberate and coordinated. As Herb Kelleher, CEO of Southwest Airlines wrote to the company's employees in the early 1990s, *"The number one threat is us. We must not let success breed complacency; cockiness; greediness; laziness; indifference; preoccupation with nonessentials; bureaucracy; hierarchy; quarrelsomeness; or obliviousness to threats posed by the outside world"* (Loop, 2009, 117).

Although Hopkins carried enough momentum from its past accomplishments to stumble through its crisis of fragmentation, there were surely significant opportunity costs. It is impossible in retrospect to assess what those opportunities and their costs might have been. It is possible, however, to ask whether accomplishments subsequent to resolution of the Block-Johns conflict could have been realized in the throes of such significant fragmentation. These accomplishments included Hopkins' replacement and renewal of key facilities, the development of integrated outpatient capacity, the merger of Howard County Hospital, and the filling of its inpatient hospital beds thus giving Hopkins the ability to reject poorly paying contracts from HMOs (Kastor, 2004).

And despite the Block-Johns conflict, Hopkins was able to preserve its top ranking on U.S. News & World Report's list of best hospitals. Its faculty continued to generate an enviable flow of NIH research funds and sustained strong representation on the National Academy of Sciences and the Institute of Medicine. In the first five years of his tenure, Hopkins' CEO/Dean Ed Miller appointed 16 new department directors. But things could have turned out much differently. For example, those recruitment efforts might have been much less successful if they had taken place when Hopkins was still in the midst of conflict. Promising candidates invariably consider the stability and prospects of professional opportunities, particularly those that might define their careers.

Hopkins' durability certainly reflects the organization's considerable momentum from the past. It could also be attributed to the new structure which created a CEO position for the entire Hopkins health enterprise that was combined with the traditional role of the Dean to create a CEO/Dean. And it may reflect the unified leadership under an individual much different than either Block or Johns in the form of Ed Miller. Miller brought coherent strategies to his role while carefully soliciting input from leaders across Hopkins. Ron Peterson, President of Hopkins Hospital, reflected on what Miller did to begin to bridge the strategic fragmentation that resulted from the Block-Johns conflict, *"From the start, Dr. Miller articulated succinctly the fact that we were going to work together and that Johns Hopkins Medicine was going to begin thinking collectively. That would be reflected in how we would budget and plan"* (Peterson, 2012, 1).

In an interview with the Baltimore Sun in June of 2012, Miller reflected on his early efforts as Dean/CEO, *"First thing we did was take everybody away and spent a weekend talking about what are we all about. What's our core mission? What do we really stand for? . . . So we had a set of core values that I think everybody resonated with and kind of got them on the right page. Then after that the question was, 'How do you address the issues that had languished for awhile because there was inability to move forward'"* (Walker, 2012).

What Miller brought to his leadership role was integration of strategic thinking and commitment. While Hopkins had built its international reputation without a unified strategic plan, that would change with Miller who recognized early on that the future was bound to punish organizations suffering from strategic fragmentation.

Some would suggest that the fragmentation at Hopkins, as well as at other AMCs, has largely been the result of differences in the character and personality of leaders. This implies that strategic fragmentation can best be avoided by focusing on getting the right people in place. Indeed, this seems to be Kastor's view, at least as it relates to Hopkins and Penn. He concludes his book, Governance of Teaching Hospitals, with this: *". . . whether an academic medical center successfully meets its inherent responsibilities to teach, advance medical knowledge and provide exemplary care depends more on the character and ability of its faculty and its leaders than on the structure under which they are governed"* (Kastor, 2004, 293).

As Miller's leadership was to demonstrate, "character" and "ability" certainly matter. Still, the importance of structure shouldn't be discounted. Organizational structure can intensify as well as dampen fragmentation and conflict. The tripartite mission of teaching, research and patient care has long been reflected in AMC organization charts. Those vested with leadership for education, research and patient care come to their responsibilities shaped and often constrained by their role in that tripartite structure. A dean is bound to arrive having been shaped by academic concerns while top executives for the hospital and faculty practice plan will bring a strong business and operations orientation. Their priorities are defined by the components of the structure they have responsibility for and where their experience has been concentrated. Such structurally-based mindsets must be bridged by high-level interaction and dialogue focused to furthering the enterprise as a whole.

Although it can outlive its usefulness and become a barrier, most structure is, at its creation, intended to be an enabler. It is designed to enhance progress, not inhibit it. Few people and few organizations aspire to simply maintain their current condition. They strive for something better. Thus, by definition, there is invariably a gap between the status quo and the better place. That gap may be a gully or it may be a canyon. In any case, the passage across the gap often benefits from a structure of some sort – a bridge, for example. Absent such a structure, the path may prove too daunting for even the most motivated travelers.

## Chapter 4: Integration as the Antidote to Fragmentation

To fully leverage the advantages associated with the four Core Differentiators that make AMCs unique, leaders must deal with the forces of fragmentation. The antidote to fragmentation is clear. It is "integration." What is much less clear is what is meant by "integration" and how it can best be achieved. For many, integration involves weaving organizations together more tightly through a variety of means including ownership (e.g., merger and acquisition), employment, reorganization, structural hierarchies, information systems and incentives. While the meaning and means of integration may vary, the outcomes sought are relatively consistent including enhanced communication, coordination, consistency and commitment resulting in improved performance on key ingredients of value including quality, cost and access.

Feldman emphasizes the importance of integration in improving AMC performance:

- *"Contemporary AMCs require higher levels of integration among and between the component entities to succeed as a distinctive Clinical Enterprise in a competitive market.*
- *Departmental silos are anachronistic at a time when patient care must be multidisciplinary and collaborative.*
- *AMCs with the highest levels of performance and the best reputations were founded as or are evolving toward highly integrated systems.*
- *Integrated systems are more able to meet the current challenges facing AMCs and better achieve the goal of providing outstanding patient care.*
- *A separation of the hospital and the medical school makes it more difficult to take advantage of market opportunities, align vision and strategy across all parts of the AMC, invest in the academic missions of the AMC, and rationally invest in capital improvements.*
- *Restructuring is not simple and requires a shared vision across the entire AMC regarding the core goals and missions"* (Feldman, 2010, xxx).

Too often the default response when faced with the challenge of integration has been merger; as if a change in ownership could overcome fragmentation and conflict*: "A merger is not a panacea for anything,"* warned William Gurtner, a former executive in the University of California president's office. *"If you can't solve it alone,"* he warned leaders of AMCs, *"you can't solve it together. Why should something larger necessarily help you do it?"* (Kastor, 2001, 438).

Feldman looks to the performance of academic medical centers like Mayo Clinic and Cleveland Clinic for insights on how integration might best be accomplished. *"A report from the Dartmouth Institute for Health Policy and Clinical Practice looked at a group of the top-ranked academic medical centers to see whether higher spending and greater use of supply-sensitive care are associated with better care in a group of patients with chronic illness in their last 2 years of life. Supply-sensitive care was defined as services where the supply of a specific resource had a major influence on utilization rates . . .*

*Surprisingly, higher spending and greater use of supply-sensitive care were not associated with improved outcomes from the perspectives of either patients or physicians. . . . Medicare spent more than $93,000 per patient at UCLA, but little more than half of that at the Mayo Clinic. To manage similar patients, the Mayo Clinic used fewer beds and half the number of physicians as did UCLA" (*Feldman, 2010, 273).

As key to productive integration, Feldman points to the multispecialty group practice model at Mayo and the Cleveland Clinic that extends across not only the provision of the clinic's ambulatory care but also their hospital care as well.

In considering the integration achieved by Cleveland Clinic and Mayo Clinic, much attention has been given to their employment model which places all their physicians on salary. While this certainly has been a key element in their success with integrating care, it is important to remember that most AMCs have also placed their physicians into an employment model, the faculty practice plan, and these physicians, in most instances, comprise the exclusive medical staff of the AMC. Furthermore, for a decade or more, both Cleveland Clinic and Mayo Clinic have relied on a mixed employment model with some affiliated physicians remaining independent or in a separate employment arrangement distinct from the one used in their main clinic operations.

By focusing on the employment model at Cleveland Clinic and Mayo, there's been a tendency to ignore the role that a shared mission and vision have played at both organizations. Absent these, their employment model as well as their unified leadership structure would not have proven such potent tools for integration. The integrated multispecialty group practice structure, so central to both, was a means of delivering on well defined mission and vision. Greater emphasis given to the patient care mission by clinic founders relative to research and teaching has been apparent at both organizations for a century and is well captured in Will Mayo's admonishment that *"The best interest of the patient is the only interest to be considered . . ."* He had also emphasized that *". . . in order that the sick may have the benefit of advancing knowledge, union of forces is necessary."* Charlie Mayo reinforced his brother's perspective when he suggested that *"The keynote of progress . . . is system and organization – in other words, 'teamwork'"* (Berry, 2008).

In focusing on "system," "organization" and "teamwork," leaders at both clinics also emphasized that these attributes, rather than being constraints on individual potential, serve as means for its fulfillment. They liberate and harness that potential by bringing management systems to bear that relieve physicians of onerous business concerns while facilitating the teamwork essential to care that is well coordinated and responsive to patient needs (Clapesattle, 1969), (Clough, 2011).

One of the authors of this monograph had an opportunity to interview the late doctor Bob Heyssel and asked him what, in retrospect, he would have liked to have done differently during his tenure as hospital president at Hopkins. He responded by saying he would have made Hopkins "more like Mayo." A strong advocate for decentralized organization, Heyssel certainly wasn't advocating a command and control hierarchy. Rather, he was suggesting greater tightness of mission and vision across Hopkins as well as physician-driven teamwork.

Ralph Muller, M.D., CEO of the University of Pennsylvania Health System and former CEO of the University of Chicago Hospitals and Health System, echoed the perspectives of Heyssel, *"A model for AMCs to consider is the traditional group practice, which places a premium on integration of aims across key fronts. A fully integrated system may be an idealized standard that can never be entirely met. But aiming for maximum feasible assimilation of goals and objectives, as group practices do, should be a touchstone"* (Safyer, et al., 2010).

It is incumbent on AMC leaders seeking to build integration across their clinical enterprises to consider and apply lessons from organizations that have decades of experience successfully addressing this challenge. Central to this should be, as Feldman encourages, an open-minded consideration of the integrated group practice model pioneered by Mayo and those organizations that sprung from the Mayo example including not only the Cleveland Clinic but also Geisinger, Lahey, Ochsner, Lovelace and Scripps. Also instructive is the example of the Kirkland Clinic at the University of Alabama-Birmingham, which arose from the leadership of James Kirkland, M.D., after he left the Mayo Clinic. Although the mechanisms, methods and structures employed by these organizations have played a significant role in creating and enhancing integration, guiding all of these have been a compelling mission and vision deliberately and incrementally pursued in some instances for more than a century.

In an article in Academic Medicine, Douglas Barrett, M.D., Senior Vice President of Health Affairs at University of Florida, Gainesville, spoke to the importance of shared vision and what he describes as "functional integration." Detrimental to the organization over the long run is the failure of the components of an AMC, to agree on *". . . a common strategic vision about how to move forward. This lack of synchrony can manifest itself in a variety of ways – from the profound to the petty – leaving a trail of missed opportunities, anemic performance, and personal animus that can prevent the combined organizations from achieving their full potential as an AHC."* Barrett goes on to quote Ed Miller, from an interview for the Association of Academic Health Centers 2006 annual report: *"You cannot have wars between the school of medicine and the hospital. It just doesn't work. You spend too much energy protecting your own turf rather than thinking about the entire enterprise."*

Barrett distinguishes between "functional integration" and "formal organizational integration." It is what Barrett describes as "functional integration" that represents the right medicine for the disease of strategic fragmentation and its attendant ailments, including debilitating conflict, *"Functional integration operates at both the strategic and operational levels and is more a choice than a structural condition or constraint. At the strategic level, it involves reaching and then upholding agreements – about who we are, what we will do, and how we will support each other. At the operational level, functional integration is about the hard work of building interdisciplinary teams around agreed-on objectives that define our combined success and then holding the organizations and their leaders accountable for their results. Functional integration can be thought of as the degree of shared vision, collaborative strategic planning, and transparency in business functions that exists between the clinical and academic elements of a college of medicine and an affiliated teaching hospital, even though the formal organizations may remain distinct business and legal entities."* Barrett concludes by suggesting that, *". . . at a minimum, AHCs must achieve improved functional integration at the strategic and tactical operational levels to advance in the new environment. In other words, as a practical matter, if AHCs in this country are to effectively manage the daunting challenges they face, we'd better have our act together, and we'd better 'act together'"* (Barrett, 2008, 804-808).

In a panel synopsis developed in 2010 by the Association of American Medical Colleges (AAMC) on the topic of "Integrative Leadership," panelists suggested, *"Much can be accomplished with good people and good will. Each person-to-person interaction builds upon the next and the past leads to the future. Stability and civility amongst colleagues is very important; animus between leaders and co-workers is not productive and it must be bridged. Integration involves talking about things honestly and having shared accountability based on very clear goals and measures of progress towards those goals"* (Safyer, et al., 2010).

Mission and vision brought to fruition through enterprise wide strategic commitment represent the highest use of organizational structure. A central conclusion of this monograph is that meaningful and sustainable integration that dampens fragmentation cannot be accomplished absent shared mission and vision supported by enterprise wide strategies. These provide the fundamental foundation for productive integration.

## Chapter 5: Volatility as a Driver of Strategic Fragmentation

Even when leadership is clear and resolved about mission and vision, an organization can be threatened by strategic fragmentation. Change and uncertainty constantly generate the potential for fragmentation that can knock organizations off the tracks.

Taken together, change and uncertainty combine to generate varying degrees of volatility. Volatility describes the frequency, significance and predictability of swings in a situation. Big, frequent and unpredictable swings can make things break and fall apart. Highly volatile situations are ripe with the potential for unintended consequences as well as unexpected cascades of reaction disproportionate to any stimulus (Axelrod and Cohen, 2000).

Volatility increases fragmentation and makes it unpredictable. It can disrupt the path forward a small piece at a time or in big chunks. It can erode efforts slowly and then suddenly in a rush. Volatility can rip plans apart, undercut investment and douse bold hubris with sobering reality. Volatility can whiplash organizations into confusion and wear them out.

Michael Porter has suggested considering "five forces" in assessing the attractiveness of an industry (Porter, 1979). The authors would argue that the extent to which the strength of one or more of these forces is high contributes to an increased rate of change and level of uncertainty for the industry in question, including health care. The five forces are interrelated and can have a significant influence not only on industry volatility but for individual markets as well. Porter's "five forces" can provide the basis for assessing the volatility of the health care industry in general as well as the discrete geographic markets that comprise it.

- **Competitive rivalry** – **The level of rivalry amongst existing competitors.** Competitors include other AMCs as well as tertiary level community hospitals. In some states, there may be only one AMC while in others like Massachusetts they proliferate. And in some markets a community hospital may have a stronger reputation and preference than a competing AMC.

- **Bargaining power of buyers** – **The degree to which customers have leverage.** Government payers and commercial health plans have considerable power. Together, they can comprise most of an AMC's payer base. Employers are more active in pursuing value in some markets than others. Buyers have greater power in markets where they are highly consolidated.

- **Threat of new entrants** – **The extent to which a new competitor can effectively enter the market.** New entrants often enter at the low cost end of the market with relatively undifferentiated products. Walgreen's, CVS and Walmart have entered the health care market at the "low end" with retail clinics. Strong CON laws in some states have provided hospitals with a degree of protection from new entrants.

- **Threat of substitute products** – **The ease with which customers can switch to alternate products or services.** Health plans and others are arming consumers with the information and incentives they need to switch from higher priced hospital-based services to lower cost alternatives such as ambulatory surgery centers and freestanding imaging centers.

- **Bargaining power of suppliers** – **The extent to which providers of critical resources can withhold or restrict them.** For AMCs and most other health care providers the ultimate supplier is the physician. Although the typical AMC employs hundreds of physicians in faculty practice plans, these physicians are predominantly specialists who are dependent on community physicians for referrals. Community physicians whether they are still independent or are in the employ of community hospitals have considerable bargaining power related to the referrals they make to AMC physicians.

The following describes attributes that can be expected to have a direct impact on Porter's five forces, and thus on volatility, for a specific health care market. Like the five forces, these characteristics are interrelated. This list is not intended to represent an exhaustive set of possibilities and is likely to change as the health care industry continues to evolve:

- Number of AMCs in the market.
- Number of tertiary community hospitals positioned to compete with an AMC.
- Financial and market strength of competitors.
- Degree of consolidation, employment and integration among community physicians.
- Growth in number of urgent care centers, surgicenters and imaging centers.
- Prevalence of nontraditional channels for delivery of care (e.g., telehealth, retail clinics, chronic care).
- The number, financial strength, market position and degree of consolidation of insurers and other payers.
- Degree of regulatory and reimbursement pressure.

A discrete health care market can be characterized with a diagram we call a "volatility circle." It incorporates Porter's "five forces" as well as related characteristics that contribute to volatility. Each of the five vectors can be qualitatively assessed and scored on a 10-point scale for intensity. The higher the score, the higher the volatility. Some forces and their related characteristics are likely to be more important than others so weighting of scores may be appropriate. (Diagram C, see page 102.)

Market characteristics are external to the AMC. As has been previously chronicled, internal conflicts, particularly differences in leadership perspectives on strategic direction, can also fragment an organization. Volatility increases the potential for strategic fragmentation. And strategic fragmentation will intensify the effects of volatility.

Adding "complexity" to the mix of market characteristics described above generates greater potential for volatility. Complexity emerges in situations characterized by a growing number of interactions between a growing number of things. What drives complexity are the number of things, the number of connections between them and the amount of information flowing across the network of connections. The things and their interactions are emergent, interrelated and in continuous flux. Emergent things in complex environments can't be managed or directed in ways that are mechanistic or deterministic. They change unpredictably, sometimes in small inconsequential ways and sometimes in big consequential fashion. Growing levels of complexity are like gasoline thrown on the fire of volatility. It further disrupts predictability, accentuates swings in a situation and accelerates the rate of change. Today's environment is becoming significantly more complex (Axelrod and Cohen, 2000).

It is important that AMC leaders consider the relative volatility of their strategic situation. Such an assessment will help drive the pace of strategic decision making and implementation.

## Chapter 6: Deliberate and Incremental as the Best Path Forward

Decisions consequential to the sustainability of an organization's mission and vision are strategic decisions. Strategic decisions are an organization's most important decisions. Strategic fragmentation compromises these important decisions and their implementation. In volatile environments, shared purpose, understanding and commitment can easily fall victim to strategic fragmentation.

To leverage their inherent strengths while avoiding and overcoming destructive fragmentation, AMCs must be both deliberate and incremental. Deliberateness, incrementally pursued, is the stuff out of which a solid bridge to the future is made and maintained. "Deliberate" suggests that when an organization is confronted with a fork in the road, its leaders don't flip a coin; they are intentional in choosing one path over the other because there is clarity related to their desired destination.

Lack of deliberateness in strategic decision making holds the potential for a reduction in the quality of the resulting decision because any decision degrades when there is insufficient clarity regarding its intentions. Being deliberate puts high stakes strategic decisions to the test by always asking the question: "Towards what end?" An absence of deliberateness increases the likelihood that an organization will sacrifice its mission through erosion of its resolve. Volatile environments are filled with distractions where the important can easily be driven out by the urgent.

Deliberateness is translated into results through action. Volatility requires that such actions be incremental in order to adjust to inevitable surprises and stay in synch with the pace of change. The more intense the volatility, the greater the necessity to remain deliberate and proceed incrementally. Volatile environments can be dangerous environments particularly for those who presume to boldly shove a straight path through them. In volatile situations, fragmentation is not amenable to a single, big fix. Volatile environments demand flexibility – a willingness to go right, then left; to stop, retreat and start over again but all in the direction of organizational aspirations. In volatile environments, what worked yesterday may not work today, but might work again tomorrow.

Boldness is the oft cited antidote to the increased change and uncertainty generated by volatility. Boldness has come to suggest a significant, potentially revolutionary leap from a current state to a place of discontinuity – presumably to a fundamentally different and better place. That, of course, implies that the better place is knowable and attainable. Knowability and attainability require predictability. Doyne Farmer is a professor at Oxford University and the Santa Fe Institute. He is a pioneer of chaos theory and complexity science. In a rapidly changing and uncertain environment filled with complexity, Farmer has suggested that while you may be able to predict short, you can't predict far. Bold leaps are, by definition, long leaps. Predicting long in the face of change and uncertainty has a name. It's called "gambling" (Kelly, 1994), (Taleb, 2012). Pursuing deliberate intentions incrementally reduces reliance on long predictions and thus improves the odds of making progress.

The fallacy of prediction, including prediction by experts, is well illustrated by this example shared by Kahneman: *"For a number of years, professors at Duke University conducted a survey in which the chief financial officers of large corporations estimated the returns of the Standard & Poor's index over the following year. The Duke scholars collected 11,600 such forecasts and examined their accuracy. The conclusion was straightforward: financial officers of large corporations had no clue about the short-term future of the stock market; the correlation between their estimates and the true value was slightly less than zero! When they said the market would go down, it was slightly more likely than not that it would go up. These findings are not surprising. The truly bad news is that the CFOs did not appear to know that their forecasts were worthless . . . Most of us view the world as more benign than it really is, our own attributes as more favorable than they truly are, and the goals we adopt as more achievable than they are likely to be. We also tend to exaggerate our ability to forecast the future, which fosters optimistic overconfidence. In terms of its consequences for decisions, the optimistic bias may well be the most significant of the cognitive biases. Because optimistic bias can be both a blessing and a risk, you should be both happy and wary if you are temperamentally optimistic"* (Kahneman, 2011, 255-261).

Instead of making a bold "big bet" commitment that invariably involves a high degree of uncertainty, an incremental approach involves launching many smaller, time constrained bets. These moves are analogous to experiments. If the results are not favorable, then other small moves (experiments) can be attempted (Rumelt, 2011). This translates into a more flexible and responsive path forward.

When thinking about deliberate incremental moves versus big bold moves, consider the challenge of balancing a broomstick on your fingertip. The broomstick can only be kept balanced by making many small incremental moves of your fingertip. On the other hand, bold swings in the position of your finger will quickly make the broomstick uncontrollable and send it toppling. Organizations can find themselves out of control in similar fashion.

Because the direction and magnitude of consequences are always uncertain in situations with high levels of volatility, a big bold move into the future is more likely to push an organization irretrievably out of synch with its environment. It can put the organization too far out on a limb to crawl safely back. Smaller, incremental moves reduce the risk of being significantly out of synch and can help preserve organizational relevance as conditions shift. (Diagram D, see page 103.)

The path through a volatile environment is best made from the zigs and zags of branching experimentation. Such deliberate, experimental incrementalism has its advocates including strategy expert, Gary Hamel: *"Passion and foresight will only get you so far. When it comes to executing a strategy, the end target may be clearly visible – 'I want to climb that mountain over there' – but much of the route may be invisible from the starting point. The only way you're going to see the path ahead is to start moving. Thus strategy is as much about experimentation as it is about foresight and passion.*

*The more experimentation, the faster a company can understand precisely which strategies are likely to work. The goal is not to develop 'perfect' strategies, but to develop strategies that take us in the right direction, and then progressively refine them through rapid experimentation and adjustment . . ."* (Hamel, 1997).

Experimental incrementalism is, in the end, a much more scientific way of addressing an uncertain world than boldness. According to Jeanne Liedtka, professor at the Darden School of the University of Virginia, effective strategy formulation is about *". . . using the scientific method, a way of thinking that relies on hypothesis generation and testing. In hypothesizing, you ask the creative 'what if' questions. To test your hypothesis, you ask the analytic 'if … then …' questions. You adopt a mindset that treats your method of accomplishing your purpose as an experiment. If that experiment fails, you try something else.*

*Seen this way, strategic thinking is both creative and analytic. It is an iterative process you cycle through continuously, learning something new with each pass that allows you to develop a better hypothesis for the next pass. It is intelligently opportunistic in search of its goals, in a way that enhances the intended strategy, while leaving room for new and unintended strategies to emerge"* (Liedtka, 1997).

The consequences of the single thrust, bold move was well captured by one of the 20th Century's most respected military strategists, Liddell Hart, who in 1954 observed, *"A plan, like a tree, must have branches if it is to bear fruit; a plan with a single aim is apt to prove a barren pole."* Hart's choice of a tree as a metaphor reinforces the extent to which nature, because of its demonstrated durability and adaptability, continues to provide some of the most useful insights for formulating organizational strategy. Life is the water in which the faculty and researchers of every AMC swim. Every day, the most robust recipes for carving out sustainable advantage pulse through the operating rooms, exam rooms, and laboratories of AMCs.

Life is deliberate. Living things are resolved to carry their DNA into the future. But life is also flexible about how it persists. Incrementalism is the pattern of evolution. Life proceeds in iterative fashion through interaction with shifting situations. Mutations are life's experiments. Useful mutations are retained while the less useful wither away. As the computer pioneer, John Kay, once observed, *"A happy creature is one whose characteristics match the environment within which it operates, and that is what the gradual process of biological evolution helps to achieve."* Kay goes on to describe a tortoise that had been advised to stick to the environment to which his capabilities were well tuned: *"The tortoise thought this advice was shrewd, and trundled back into the marshes. It proved to be a wise decision. A few weeks later, a pride of lions found its way onto the plains and ate all the hares. The tortoise lived on in the marshes, slowly but happily, almost ever after"* (Kay, 1997).

Branching experimentation provides an organization with options. Tightly designed blueprints disintegrate when subjected to extreme surprises. Nassim Taleb has called such surprises "black swans." Black swans are "large scale, unpredictable and irregular events of massive consequence" that are only "explainable in retrospect." There are negative black swans and positive ones. Taleb suggests that the antidote for black swans is "optionality."

Optionality is a mindset. It requires an openness to adjusting as circumstances change, even to the point of abandoning significant tactical commitments. Abandonment is nature's way of moving forward. Life has its own hierarchy. Some things are more important than others. So the lizard leaves its tail in the cat's mouth. When a person falls through the ice, blood is triaged from the extremities to preserve the heart and brain. And evolution leaves behind the unfit.

Optionality has a shape. It looks like a branching stream where some tributaries end their journey to the sea while others continue to split, deepen and widen. Branching is the shape of nature. It describes the path of evolution. It is also the shape of experimentation and of trial and error. Taleb describes how optionality works in nature and industry:

*"It is worth insisting that the most wonderful attribute of nature is the rationality with which it selects its options and picks the best for itself – thanks to the testing process involved in evolution. Unlike the researcher afraid of doing something different, it sees an option – the asymmetry – when there is one. … In trials and errors, the rationality consists in not rejecting something that is markedly better than what you had before . . .*

*Like Britain in the Industrial Revolution, America's asset is, simply, risk taking and the use of optionality, this remarkable ability to engage in rational forms of trial and error, with no comparative shame in failing, starting again, and repeating failure."*

A branching movement into the future is, by its nature, incremental rather than bold. Boldness correlates with risk. If you could clearly map such branching, the length of any single limb would convey the degree of risk it embodies. The longer the limb extends without branching, the greater the risk it carries. A long uninterrupted limb evidences a lack of trial and error along the way. There are no purely straight lines in nature for a reason. All robust and sustainable progress is of the crooked and incremental variety. That's why an incremental path is always the wisest path. It doesn't put the organization too far out on a limb.

Optionality provides freedom for maneuvering. If one path under delivers or becomes endangered, another path is open. Failure to consider options cuts off their availability. Such failure usually results from two sources, both potentially dangerous: shortsightedness or arrogance. Or, even more deadly, a myopic combination of both (Taleb, 2012).

Deliberate incrementalism is the proven path forward in many fields and is in evidence in a variety of well established methods and tools. As Liedtka suggests, the scientific method is a fundamentally incremental approach that involves the articulation and testing of a hypothesis. The Plan, Do, Check, Act (PDCA) method popularized by W. Edwards Deming and applied to quality improvement is also incremental as is the OODA Loop developed by the fighter pilot and grand strategist, John Boyd, which involves Observing, Orienting, Deciding, Acting (Richards, 2004). The prototyping advocated as a fundamental element of "design thinking" is also incremental as is the use of wind tunnels to develop aerodynamic surfaces. Rather than rely solely on mathematical modeling, wind tunnels involve putting various iterations into the flow of air and then observing what works best.

Deliberate incrementalism can be summed up in the Latin maxim: *Frangi non flecti,* "bend but never break." Rigid things are more likely to fracture when whiplashed by intense volatility. But things that are completely flexible can ravel up and go nowhere. Think about uncooked spaghetti. Push it forward against resistance and it's going to break. Boil it and it becomes too flexible to push. Pushing it forward requires that the spaghetti have a degree of "semi firmness." Deliberate incrementalism, likewise, requires flexible persistence.

Many organizations spend considerable effort trying to anticipate and adjust to the vague outlines of an uncertain future. They spend too little time assessing their existing capabilities fortified by past experience and how best to leverage those capabilities to continuing advantage. They turn to futurists rather than to thoughtful historians who might identify the stepping stones upon which past success was built. Too often, organizations plunge headlong into a rapidly changing and uncertain situation leaving hard-won competencies behind (Dudik, 2000). Leveraging competencies requires recognizing them, then deliberately preserving and building on them. In its strategic plan, Kings College, cofounded by the Duke of Wellington in 1829, captured the essence of looking back as well as forward when it asserted, *"Kings will build on its numerous accomplishments and formidable current advantages to become an outstanding university institution comparable in all respects with the best in the world."* AMCs are unique in that many of them are deeply aware of their history and they have tended to preserve it. This is seldom the case among community hospitals.

History can be seen everywhere. Once a river branches, it cannot retrace its path. Once life evolves along some branch, it never backtracks. It keeps branching or it dies out. Every branch represents an irreversible commitment as well as an irreversible sacrifice of other possibilities.

Consider DNA. It is both past and future. It is at once a complex blueprint of what the organism has been – its history writ out in nucleotides and proteins – and a bundle of limited possibilities. What it can become is constrained by a pathway that has a trajectory that originates in the past and is the best predictor of its future. In 1905, the Belgian biologist, Louis Dollo, declared, *"An organism never returns to its former state."* Researchers have since validated Dollo's Law.

As James Collins and Jerry Porras wrote in their book, Built to Last: *"Corporations resemble nations in that they reflect the accumulation of past events and the shaping force of underlying genetics that have their roots in prior generations"* (Collins and Porras, 1994).

Having a strong sense of history provides compelling benefits including:

- **Belonging**. There is intrinsic in most people a desire to be part of something. They draw their own identity from belonging. That's why most people have an interest in their genealogy. They become anchored and relevant within their histories. The same is true for people who join an organization that has a strong sense of history.

- **Confidence**. A history that includes truthful tales of accomplishment and failure provides an organization with more confidence as it moves into the future. It knows where it's been, what worked and what didn't. And although it can be dangerous to become a slave to the past, it is equally dangerous to face the future with a blank stare.

- **Leverage**. Past successes can only be capitalized on if they are known and understood. Past failures are best avoided in the same way. There is no way to create leverage without having a place to set your fulcrum. And the most solid place to set your fulcrum is in the past. A past is also a necessary ingredient for momentum. There can be no momentum without a past. Something from the past must be carried forward.

- **Values**. There is no better way to bring values alive than to illustrate them through stories gleaned from the past. History can show how values have been lived out and provide role models for the future. History can also display the consequences of living without values.

- **Vision**. Paradoxically, the only way to create a vision is to project the past into the future. We can imagine only on the basis of what we have experienced. All experience is framed in the past tense. A sense of history allows the organization to take what it found inspiring in the past and weave it into its vision of the future.

Today, health care organizations, including AMCs, are constantly encouraged to boldly transform themselves. They are less often advised to identify and reinforce those characteristics that served them well in the past and may be well suited to their future (Taleb, 2012). The future of every organization is woven into its past. It's not possible to pull out a blank sheet and just start over (Diamond, 1997). No path can be retaken once it’s traversed. Deliberate incrementalism recognizes this "path dependence" by not venturing wildly beyond the organization’s realm of demonstrated competence and value. It keeps a strong tether to the defining characteristics that have underpinned past successes. Boldness that encourages a break with the organization's prevailing path threatens its ability to maintain the momentum of past successes and leverage current strengths into the future.

There is another argument for being deliberate and incremental and it has to do with the dynamics of change in complex organizations. As one AMC dean observed, *"The problem . . . is that your survival frequently is dependent upon the faculty at large, their judgment; and that can make it difficult to take the bold steps you may need to take at a time when there's a lot of change going on around you. [There is] always the fear that you're going to upset too many people, and the more people you upset, the less you could manage"* (Feldman, 2010, 48).

**Accelerated Incrementalism**

Deliberate incrementalism is expansive. Although movement into the future may occur in incremental steps, it still involves growth. When it is accelerated, deliberate incrementalism can generate rapid growth. If it could be plotted, growth that is deliberate and incremental would reveal patterns of expansion not unlike the rings of a tree with each ring building at different rates upon the ones that preceded it but always pushing out a ring at a time. The width of each ring reveals the tree's growth rate and would have been influenced by the tree's situation over time including rain, heat, light and nutrients – all unpredictable external variables.

In markets with less volatility, time can be an ally by broadening the opportunities to be more deliberate, make more incremental moves and learn more. Such markets may offer AMCs more room to maneuver and greater flexibility related to options that, by their nature, require time to undertake, such as alignment with other hospitals and physician groups. Additional time opens up opportunities to build credibility, mutual respect and trust. A well paced incremental approach allows expectations and incentives to be brought into closer alignment.

In some instances haste <u>does</u> make waste and this is particularly true when decisions are both consequential and complex, which describes the domain of strategic decision making. Absent sufficient time given to understanding their context and implications, such decisions can devolve into crapshoots. Indeed, the very arguments often made for going fast are the ones that should encourage moves that are deliberate and incremental. It is when competition has increased, risks of loss have grown and opportunities have become more transient, that the situation has grown more volatile. In the face of volatility, the question becomes not whether to be incremental but what is the proper pace at which to make incremental moves.

An organization can damage itself by moving faster than its situation requires. By essentially "outrunning its headlights," it robs itself of the options and learning incrementalism yields. Assessing the situation is essential. Just how volatile is it? And importantly, what is the degree and rate of change that is truly necessary to remain relevant? An organization that outruns its situation is in as much danger of becoming irrelevant as an organization that is lagging.

Arguments for bold moves become more seductive when organizations have fallen significantly out of synch with their environment. But in such situations, a bold move can generate unintended consequences that throw the organization even further off track. Of course, being perfectly synchronized is impossible. The key is not to get too far ahead or too far behind. The pace of incremental moves initiated by an AMC should reflect the volatility of its specific market rather than the dynamics of the national health care market more generally (Karpf, et al., 2009).

In volatile situations, organizational sustainability depends on being able to adjust at the rate of change. When speed is a necessity, the best response is usually accelerated incrementalism. A useful metaphor is a firefighter facing the prospect of being trapped inside a burning building. In such a volatile situation, it is most advantageous to put one foot in front of the other and to quickly move out of the building along whatever path is least obstructed by flames. The firefighter's mission is clear and he is deliberate in its pursuit. He is seeking safety. Boldness isn't an option. Life evolves in similar fashion.

Although the evolution of life has generally occurred across large spans of time, dramatic evolutionary change can occur over relatively short periods through a selection process consistent with accelerated incrementalism (Weiner, 1994). When confronted with threatening situations, life accelerates its rate of mutation. And while it evolves faster, it still evolves incrementally.

Going faster requires "doing" faster. Speed enriches rather than endangers an organization when lots of small moves are accompanied by feedback loops that capture the learning associated with those moves and converts that learning into improvement (Stalk, 1988, 1990). A deliberate and incremental approach can provide the feedback necessary to validate and embrace those initiatives that clearly contribute to enhancing purpose and performance as well as to jettison those that don't (Kaplan and Norton, 2000). Such learning doesn't need to be an overwhelming or tedious commitment. The U.S. military has long made use of an efficient learning tool it calls the After-Action Review (AAR). An AAR is a retrospective discussion of an event conducted by *"openly and honestly discussing what actually transpired in sufficient detail and clarity that everyone will understand what did and did not occur and why . . ."* (A Leader's Guide to After-Action Reviews, 1993). An AAR enables soldiers and their leaders to leverage strengths, shore up weaknesses and avoid future mistakes. When applied consistently, the AAR methodology generates continuous learning. And in rapidly changing environments it can generate accelerated learning. The faster the rate of its incremental moves, the faster an organization can learn as knowledge accumulates more quickly creating a smarter more adaptive organization. But unless speed is in service of deliberate intentions, it can disintegrate into much ado about nothing.

## Leading in Volatile Conditions

Leveraging the inherent advantages embodied in the Core Differentiators of an AMC and avoiding the fragmentation that can undercut those advantages requires unique leadership. A command and control philosophy is unlikely to yield results in a complex loosely coupled organization comprised of specialists unaccustomed to responding to centralized authority. Overemphasis on one of the three missions to the exclusion of the others can generate alienation and conflict as can subordination of "church interests to those of the state."

The leadership necessary to sustain balance and harness the energy of constructive tension across the tripartite mission requires continuous and credible involvement on the front lines where value is generated. It requires leaders who are visible on the floors and in the clinics and labs.

It is important for leaders of AMCs to maintain a connection to the work of the organizations they seek to lead. Absent this, they may find they lack credibility and authenticity. When Ed Miller became CEO and Dean of Johns Hopkins Medicine, he moved quickly to reinforce its faculty's connection with the work. According to Kastor: *"Miller deliberately changed the character of the jobs of the vice-deans from full-time to part-time to assure that the vice-deans would never forget that they are fundamentally members of the active faculty and to prevent their becoming academic administrators isolated from the day-to-day work of their colleagues."* During his tenure, Miller was described as reinforcing the message through his own behavior*, ". . . he returns to his faculty role, dons scrubs, helps administer anesthesia, talks with his colleagues, and instructs trainees as he has done throughout his career . . . If the dean has time to visit like this, he must consider the clinical work important." "Frankly,"* Miller observed, *"I do it because I love it."* He was seldom away from Hopkins and its work. *"You mustn't travel much in this job,"* he warned. *"You work for your faculty and your board"* (Kastor, 2004, 239).

Deliberate incrementalism also relies on leaders who position themselves as "first among equals" rather than powerbrokers sitting atop hierarchies. It requires leaders who involve key stakeholders in important decisions rather than unilateralists who dictate direction and expect the organization to follow in lockstep. Miller captured the essence of this kind of leadership, *"In the old days, 20 or 30 years ago, I guess the chief could say, 'I'm king, I tell you what to do.' The faculty does not work that way anymore. The faculty wants to be involved in their practices. They want to be involved in decision making. And, the chief has to be able to listen to them, and listen to them politely, and be able to bring them together and move the organization forward"* (Safyer, et al., 2010).

As Peter Drucker and others have suggested, complex organizations like AMCs require leadership akin to that demonstrated by the conductor of an orchestra. The members of the orchestra are, of course, all highly trained specialists. The conductor, on the other hand, may not be able to play any of the instruments. His expertise and talent resides in an ability to guide and meld each instrument into a harmonious symphony. Through differences in emphasis and pacing, the orchestra will produce music at once true to the composer's intent but also distinct and differentiated. Thus, Beethoven by The Cleveland Orchestra will be different than Beethoven played by the London Symphony Orchestra.

Feldman suggests that, *". . . in loosely coupled systems the end game becomes the ability of management to convince the individual stakeholders that each will profit by collaborating . . . This involves establishing a system of fairness in the decision-making process so that all elements feel equally protected, and making the decision-making process transparent . . . The second element of leadership is referred to as 'creating space to build leadership.' By assembling a group of individuals who have a long-term history with the AMC and mixing in a group of new recruits, AMC leaders can identify surrogates who can help lead the institution"* (Feldman, 2010, 50-51).

Feldman also suggests that leaders, while maintaining a businesslike approach *". . . must ensure that all of their business decisions are consistent with the core mission of providing outstanding patient care. Thus, the core mission provides a compass for all decision making. As pointed out by Porter and Teisberg, AMCs that do not focus on providing excellence in patient care will not be able to compete in the increasingly competitive healthcare marketplace. More importantly, AMCs that lose their focus on providing excellence in patient care and make decisions based on what is best for their 'business' risk compromising patient care and losing the trust of the society that they serve . . .*

*. . . Although good business practices are important for supporting the core mission of providing excellence in patient care, making business decisions without the constant internal compass of the core mission can lead to making the wrong decision. A century ago, Osler raised the same concerns when he noted that 'the practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head'"* (Feldman, 2010, 211-223).

It is the strong sentiment of this monograph's authors that leaders in an AMC have one additional and overriding obligation, and that's to minimize the potential for conflict and dysfunction that arises when there is fragmentation related to overall strategic direction. There was tension at Hopkins prior to the Block-Johns conflict but balanced tension can be constructive. According to Kastor, *". . .* hospital president, Heyssel, was described by one observer *as 'the bulldog'* while medical school dean, Ross, was described as, *'the terrier.'"* While they *"argued mightily in their time, the intensity of their conflict never approached the passion or led to the consequences of the discord between Block and Johns. Although they battled continuously on behalf of their charges, Heyssel and Ross made their decisions based on what was good for Hopkins' academics. This would be expected from the dean, but was also the case for the hospital president . . . their arguments centered more on money than fundamental principles, upon which they basically agreed"* (Kastor, 2004, 173). Reaching agreement among leaders on an organization's fundamental principles and its most important decisions requires dialogue – strategic dialogue – including occasionally heated strategic arguments.

In 2004, the IOM's Committee on the Role of Academic Medical Centers in the 21st Century made the following observations regarding the need for leaders to manage tension and to integrate to enhance operating performance and accountability: *"Even under routine operating conditions, AHCs face an inherent and continuing tension in managing their enterprise. They must simultaneously run each individual entity and carry out each role with excellence, but must also integrate their various distinct organizations and cultures into a cohesive and smoothly running enterprise that collectively is accountable to meeting social needs . . . AHCs are not facing routine operating conditions, so their challenges become even more acute. Whereas coordination and cooperation may not be mandatory during times of growth, they become imperative when retrenchment is required"* (Kohn, 2004, 128).

The committee went on to suggest that none of its recommendations for transforming the AHC roles can be implemented *". . . unless the AHCs' organizational components work together more closely than has historically been required. The demands of transforming the roles surpass the capabilities of any individual organizational component. Although each component will have responsibilities for a portion of the changes required, none can accomplish those changes on their own."*

In addition, the committee commented on the fundamental importance of focus and the need to make tough choices, *"The targets of opportunity are so plentiful that it would be impossible to undertake them all. Even the most generous level of resources is likely to be insufficient given the enormous range of potential activities. Whereas the past decades have been an era of growth for AHCs, during which they were able to expand all of their activities, the coming decades will be an era of choices"* (Kohn, 2004, 128).

Miller and his leadership team brought unified strategic decision making to Hopkins after the Block-Johns conflict. He later succinctly summarized the choices he and other leaders made: *"Four years ago, Johns Hopkins Medicine focused on the Clinical Enterprise. We decided that service was our top priority and that the best way to attract patients was to deliver the best possible medical care, which we defined as taking care of the needs of both patients and their families. Without buying practices, we developed relationships with physicians that made it easier for them to refer patients to us and helped them to get timely responses to their referrals. We decided not to take contracts on which we would lose money, even if that meant that we had to shrink. What we found, however, was that our patients became our advocates and that the managed care companies needed to have us in their panel for them to remain competitive"* (Aaron, 2001, 69).

## Chapter 7: Strategic Planning as a Tool for Deliberate Incrementalism

A central question related to the sustainability of AMCs becomes, "How do we best become deliberate and incremental and by so doing avoid the debilitating effects of strategic fragmentation?" A copy of the minutes from a University of Wisconsin Hospitals and Clinics Authority Board (UWHC) meeting in November of 2009 pointed towards that organization's answer. Contained in those minutes was an update on the Strategic Plan for University of Wisconsin Health (UW Health). The update described the finalization of new mission, vision and values as well as goals for seven areas of strategic focus. Appended to the minutes was a board policy document related to *"managing conflicts."* It was included in response to past and potential leadership conflicts related to the organization's strategic direction. Described were mechanisms designed for managing such conflicts including the participation of the President of the UW Medical Staff and President of the UW Medical Foundation (faculty practice plan) in strategic planning retreats as well as the participation of medical staff members on strategic planning committees. It also emphasized the importance of collaborative participation of leaders from across the academic enterprise including the hospital, school of medicine and faculty practice plan in the revision of the strategic plan.

UW Health's policy document suggests a view that the process of developing a strategic plan is a critical tool for avoiding the conflicts and fragmentation that invariably occur when key stakeholders don't participate in designing the future of organizations seeking their commitment. In this, UW Health echoed the advice of the IOM's Committee on the Role of Academic Medical Centers in the 21st Century, *"Regardless of the approach taken, the aim is to provide the means and structures for the right players to be at the table, with the right information, from throughout the AHC"* (Kohn, 2004, 137).

In 2001, the Wisconsin state legislature had described the financial performance of the University of Wisconsin Hospital and Clinics as "mixed." But by February of 2013, Moody's had upgraded the organization from A1 to Aa3, its highest rating. Reasons for UWHC's strong performance and resultant high rating was, according to Moody's, consistent with the intrinsic differentiation that accrued to AMCs in general and included UWHC's *"prominent reputation and market position in tertiary and quaternary services."* That reputation *"draws patients from not only the Madison (WI) metropolitan area but a much wider geography throughout the state and beyond."* Also significant was UWHC's "*unique role as the state's only academic-based medical center . . ."* In 2014, it was ranked as the state's top hospital by U.S. News & World Report, a position it has maintained since 2012. As of September, 2015, it had also earned an A+ rating from Standard & Poor's. In the preceding decade it had invested in major strategic initiatives that required committed support and collaboration across the entire academic enterprise. It is worth considering whether these initiatives would have been undertaken or succeeded if UWHC had not been deliberate in using participation in enterprise-wide strategic planning to avoid conflict and fragmentation.

Planning focused to the future remains imperative given that the only alternative is to be continuously and helplessly roiled by external and internal forces. Without a plan, the organization loses its ability to be an instrument of its intentions. It becomes flotsam tossed about on an uncertain sea. Arguably, planning is the most notable manifestation of the unique human capacity for purposefulness and foresight. The late University of Pennsylvania professor, George Keller, emphasized the primacy of planning in his book, Academic Strategy, *"The Greeks planned cities; Plato's Republic is a plan. The Romans planned, and so did the Chinese in the Han dynasty and the Incas of Peru. Sir Thomas More, John Knox, Diderot, Rousseau, and Jeremy Bentham drew up plans. The Federalist Papers are to a considerable extent a planning document. Alexander Hamilton's 1791 Report on the Subject of Manufacturers to the U.S. Congress was a plan to make the new republic less dependent on foreign countries for manufactured goods; it has recently been called 'the most memorable plan for national economic planning that our early history affords.' Thomas Jefferson had a strategic plan for the United States when he negotiated the Louisiana Purchase in 1803, and he devised an educational plan for Virginia and later one for the University of Virginia"* (Keller, 1983).

Plans have played an important role in laying the foundation for success of many AMCs. Although it didn't have a unifying strategic plan during the Block-Johns conflict, at its founding Hopkins did have a plan focused to its future. According to Kastor, *"The man who proposed this plan was, as much as anyone other than Johns Hopkins, the creator of the hospital, Dr. John Shaw Billings, a physician with the Office of the Surgeon General of the Army whom the trustees retained to design the hospital, had become a leading authority on the construction and function of hospitals. He provided the trustees not only with a plan that would make the new hospital uniquely effective for medical teaching and research as well as the care of patients but also provided much of the educational scheme that the medical school would later adopt"* (Kastor, 2004, 162).

Some AMCs have turned to a plan as the basis for restoring success. In November of 2014, the Special Committee on Research at the University of Virginia reflected on the decline in the University's academic standing in its minutes, *"A review of NIH funding over a 30 year period shows that the SOM has historically ranked 32nd among 125 schools and has consistently garnered about 0.6% of the funding. During the last five years, however, the ranking dropped from 32nd to 41st. In the rankings by U.S. News and World Report, the school is listed at 26th; five years ago it was in the top 20. Rankings are influenced by a school's research portfolio, which at the University has decreased by more than $20 million since FY 2008 . . . To improve its standing, SOM recently completed a strategic plan. It intends to focus on being really good in a few areas."*

A strategic plan is unique in terms of its focus on defining and addressing an organization's most important questions including, "What do we aspire to become?" and "How will we accomplish our aspirations?" Strategic planning has been the object of consistent skepticism over the years. But it has been the process by which strategic plans are developed that has most often been criticized, particularly those processes that are over reliant on data and analysis. Critics object to strategic planning carried out in bureaucratic fashion by staff who have little operating experience or exposure to market realities and who will not be expected to implement the plan that the process produces. Still, the need for a plan for the future continues to be recognized. Today, despite its skeptics, strategic planning remains an essential tool of leadership. Properly developed and implemented, a strategic plan reduces fragmentation through a disciplined approach that generates a clear vision for the future and a deliberate and incremental path toward that future.

While definitions, approaches and frameworks vary, there is general agreement that a comprehensive strategic plan should include a statement of mission (or purpose) and values as well as articulation of vision and strategies.

Douglas Moodie, M.D., came to the Cleveland Clinic from the Mayo Clinic in 1978. He was chairman of the department of pediatrics from 1987 to 2002 and reflected on the organization's mission and values, *"Our mission has always been very clear. Number 1, number 2, and number 3 was to take care of patients. Everything was organized to make this happen."* Hard work by the staff of the Cleveland Clinic impressed him, *"'They were here at all hours.' Moodie emphasizes the importance of pressure from peers and an entrepreneurial spirit as the motivators for the excellence of clinical care"* (Kastor, 2005, 16-17). "Take care of patients" is a clear statement of overall organizational purpose or "mission." "Patient first" and "hard work" are values. So are "entrepreneurial spirit" and "excellence." Taken together and made real in practice, values constitute organizational culture.

According to Kastor, founders at Hopkins are often credited with setting its mission as well as its prevailing values: *"Hopkins devotees believe that the first professors, Halsted in surgery, Kelly in gynecology, Osler in medicine, Welch in pathology, and their colleagues in the basic sciences set a tone for the institution that has endured. On the walls of many offices of both doctors and executives hang pictures of early buildings and renowned professors. The executives of the hospital as well as the doctors in the medical school are also inculcated with the culture. A copy of a letter from Johns Hopkins to his trustees setting out what he wanted built in East Baltimore hangs on the walls of many of their offices."* At Hopkins as well as at Mayo and Cleveland Clinic, mission and values are preserved and promoted by highlighting the history of the organizations. Hopkins cardiologist, Stephen Achuff, a history buff, helped establish a museum in the room where Osler wrote his famous text on medicine. Achuff commented that, *"Many of us feel we are the inheritors of a great tradition in American medicine."* Several books focused to the histories of all three organizations have been published. Mayo histories are sold in its gift shop.

Steven Muller, a former president of the university, made this observation about values at the Hopkins medical institution, *"There's an uncompromising and deeply inbred commitment to quality. If you can't hack it, you don't stay."* John Lombardi, a former provost of the university, described the Hopkins culture as consisting of *"the ruthless pursuit of excellence with a focus on performance and weeding out the nonperformers"* (Kastor, 2004, 272-273). "Quality," "excellence" and "performance" are values that define a culture.

Another key outcome produced by effective strategic planning is a vision that is understood and supported across an organization's leadership team. The IOM Committee on the Role of Academic Medical centers in the 21st Century concluded, *"If AHC leaders are unable to create a vision for the future and take their organizations forward, AHCs will not succeed, regardless of the support they receive . . . During times of major change, an enduring vision enables leadership and staff to stay focused on a clear and consistently stated mission and allows leaders to make strategic decisions that are understood by staff and external supporters."* The committee went on to reference Berkeley professor, Stephen Shortell, *"Shortell notes that undertaking strategic change absent a vision is likely to fail because of a lack of understanding of the need for change or the direction of that change. Notes Shortell, if there is no vision, the result is confusion"* (Kohn, 2004, 137-140).

Deliberate incrementalism requires a vision of a future worthy of organizational commitment supported by disciplined action to achieve that future. And this requires allocation of scarce resources toward the best opportunities for progress along a path forward. To meet those requirements, leaders must be deliberate in articulating a picture of a compelling future. They must create shared awareness and support for that future among individuals able to adapt incrementally in ways consistently aligned with the organization's vision. They must build shared accountability for the future.

In the late 80s, the Cleveland Clinic underwent a crisis of leadership and direction that underscored the importance of a unified strategic plan. It had launched development of two significant satellite campuses in Florida. This initiative failed to achieve expectations and produced financial losses that constrained the Clinic's ability to invest in core capabilities on its main campus in Cleveland. This resulted in considerable frustration and disagreement. Strategic fragmentation ensued. Largely in response to the situation in Florida, a new team of physician leaders took control. A new CEO, the late Floyd (Fred) Loop, M.D., developed a strategic plan then ensured it was understood and supported by the Clinic's physician leaders and its board. This reflected Loop's view that, *"To take charge of planning influences your peers, emphasizes the importance of planning and is one of the best examples of proactive leadership."* While the Clinic never completely abandoned its Florida operations, its strategic plan led it to pare them back and refocus attention and resources to expanding its Cleveland-based capabilities.

"Loosely coupled" begs the question: "Coupled by what?" It is a principle of effectiveness in loosely coupled, federated organizations like AMCs that, while much can be left loose, to be sustainable such organizations must be exceedingly tight about a few things. To be advantageous, looseness needs to be balanced against tightness. When conflict and fragmentation occur, it is often the result of insufficient tightness. For a loosely coupled AMC, a strategic plan can answer the question, "What are we going to be tight about?" For an AMC, Depth and Breadth of Capability, Collegial Commitment, Proximity and Loose Coupling (the Core Differentiators) provide foundational building blocks out of which a powerful vision and its supporting strategies can be built.

Tightness must be achieved related to those unique attributes that are embodied in the organization's vision and driving strategies. From these, a clearly defined set of "minimum specifications" can be derived. These specify what the organization will be resolutely tight about. While such minimum specifications should be nonnegotiable, they benefit from understanding, acceptance, and commitment across the AMC leadership. Participation in a strategic planning process is an effective way of building such support. What the participants provide is input related to the formulation of vision and driving strategies. In this, they offer their guidance regarding what the AMC should aspire to be (vision) and what it must do (driving strategies) in order to become that aspiration. Leadership must then consider and incorporate this input, where appropriate, while providing feedback on their rationale for the final result. In doing so, they recognize that people tend to own what they help create.

Ultimately, the purpose of a strategic planning process is to make and implement an organization's most important decisions; an outcome reflected upon by Louis Gerstner, former CEO of IBM, *"All too often, the end product of present-day strategic planning activities is a strategic plan period. Nothing really new happens as a result of the plan, except that everyone gets a warm glow of security and satisfaction now that the uncertainty of the future has been contained. Unfortunately, warm feelings do not produce earnings or capture market share. Neither do graphs of five-year earnings projections, gap charts, or complex strategy statements. What do produce earnings are strategic decisions, and strategic decisions should be the ultimate output of a strategic planning program . . ."* (Gerstner, 1973).

In 2007, the study by M. Keroack and colleagues published in the Journal of Academic Medicine provided evidence that key elements of a strategic plan when effectively deployed have a significant positive impact on the performance of AMCs. The authors emphasized that while *"pockets of clinical excellence"* may be found in most AMCs, leaders of these organizations continue to face the challenge of *". . . high performing areas existing side by side with underperforming ones."* The study compared top performers to lower performers. Among the characteristics identified as key to the success of top performers was a shared sense of purpose reflected in *"explicit values articulated in mission and vision statements,"* as well as a focus on *"gaps between the current state and a future ideal state."* (A "future ideal state" is one way to characterize a "vision.") At comparison institutions (lower performers) there were unresolved conflicts among the tripartite missions of patient care, teaching and research. Clinical department chairs were inconsistent in their emphasis on the *"patient care mission"* and *"leaders were either unable or unwilling to address this inconsistency."*

Ultimately, a strategic plan ought to guide an organization towards a future of advantage. Top performers in the study saw *". . . excellence in service, quality and safety as a source of strategic advantage within a highly competitive marketplace"* and a requirement for *". . . the strategic survival of the institution"* while lower performers saw these commitments as simply *"the right thing to do."* In addition, leaders of top performers were skilled at storytelling that articulated the vision and highlighted the strategic gaps to be closed. The top three performers were led as *". . . an alliance among the department chairs and executive leadership with joint participation in strategy, program development and performance improvement."* Alignment with commitments to quality, safety and service was achieved not with financial incentives but through a *". . . strong but subtle pressure executed on clinicians to conform to the values of the institution. . ."* Further, top performers blended *"central control"* with *"decentralized responsibility"* while strategic priorities and success measures were developed by a central committee with *"tactics"* typically *"entrusted to unit leadership."*

Rather than focus on factors aligned with strategic priorities, according to the study, lower performing institutions tended to gravitate to *". . . complex statistical methods such as Six Sigma or Lean Toyota . . ."* and this orientation *". . . seemed to dampen the initiative of less expert frontline staff."* Importantly, top performers tended to be optimistic about the potential for improvements that would lead to advantage. *"There was an abiding sense that improvement was both necessary and possible . . ."* while at lower performers the focus was on *"gradual gains"* as well as a tendency to allow *"wide dissention in approaches to common clinical problems"* as well as a sense that *"technology might substitute for attention to work or redesign . . ."* And finally, at top performers, a multidisciplinary approach was the rule with deference paid to *"expertise and situational knowledge rather than rank or position."* Contributions to improvement at all levels of the organization were recognized and celebrated (Keroack, et al., 2007).

The kinds of things Keroack identified as key to a high performance AMC are the attributes an effective strategic plan can help define and develop. There is a hierarchy to a strategic plan. Or at least there ought to be. Every organization has a purpose – its mission. A mission has a very long time horizon and is inflexible. If the organization can no longer fulfill its purpose, it's time to turn out the lights. Vision has a shorter time horizon, three to five years, and embodies what the organization aspires to become as it fulfills its mission.

A strategy is a plan for getting from the present to a better future in the face of uncertainty and resistance. Absent uncertainty and resistance, there is no need for a strategy. A "to do" list will suffice. Some strategies are more important than others. "Driving strategies" represent the organization's most important strategies. They represent the handful of things that must be done to secure continuing sustainable advantage. A goal is not a strategy. A goal is an endpoint. A strategy describes how you intend to get across the goal line. It is a means to the end. Mission and vision provide the boundaries within which driving strategies are focused – the outer boundaries of what the organization will and won't do. Organizations need more than one driving strategy. "What's your strategy?" is the wrong question. Complex organizations operating in complex conditions need a handful of driving strategies that are complementary and synergistic. They build and leverage unique capabilities that add up to a difference that matters.

Good strategies aren't teleological in origin. They reflect a mix of qualitative and quantitative information combined with judgment. Driving strategies may change during the three- to five-year time horizon, but only if there is a significant shift in the organization's situation or it becomes apparent a strategy isn't working. An effective strategic plan for an AMC will leverage the four Core Differentiators that make AMCs unique – Depth and Breadth of Capability, Collegial Commitment, Proximity, and Loose Coupling – into impactful driving strategies. Core Differentiators are not strategies. They make driving strategies more robust and effective. Core Differentiators offer potential. But potential must be exploited. It has to be translated into advantages like a powerful brand derived from depth and breadth, collaboration derived from collegial commitment, higher productivity and innovation derived from loose coupling. When exploited, Core Differentiators can supercharge an academic medical center's driving strategies. They are fuel for the fire of competitive advantage.

Tactics are the more specific to-do lists that underpin driving strategies. It is at the tactical level that rubber hits the road and the incremental work of implementation proceeds. There may be a handful of tactics supporting each strategy; they have a shorter time horizon – typically one to three years. Changes in the strategic plan ought to occur most frequently at the tactical level. That's where flexibility is derived. Indeed, tactics should reflect a constant flux. Some are accomplished and replaced while others are dropped because they appear unworkable or are squeezed out by higher priority commitments as circumstances shift.

Each level of the strategic planning hierarchy ought to sharpen the focus of tactical commitments. Think of each level as a screen. The weave of the mission screen is widest. The vision weave is tighter. And the driving strategy weave is even tighter. A lot of possibilities will work their way through the mission screen, fewer through the vision screen and even fewer through the strategy screen.

Effective implementation requires more than reaction to whatever the circumstances seem to demand. Implementation requires constrained action. Some opportunities and threats are more important than others. Options within a situation ought to be bounded by strategy. In other words, the organization should focus on doing things that are consistent with its driving strategies. It shouldn't waste resources pursuing things that are clearly inconsistent with those strategies.

Resolve is a virtue in the upper reaches of the strategic planning hierarchy. Flexibility is an asset in the lower reaches. It takes both resolve and flexibility to reach the future. Organizations that fulfill their ambitions combine resolve with flexibility. An organization that is made only of resolve will find its prospects of reaching the future limited if the environment it faces is uncertain and turbulent. Rigid things often break when confronted with volatility and surprises.

On the other hand, an organization that is simply flexible is likely to be headed nowhere in particular or merely circling the drain hole. For the long run, just staying afloat is an insufficient aspiration. Organizations merely committed to survival invariably lose sight of a purpose bigger than themselves and devolve into a self-centeredness that eventually extinguishes their ability to generate value for the external constituencies for whom they exist. When this happens, the organization is no longer generating unique value and begins to spiral down the drain.

Blueprints work great for machining and assembling inanimate parts that can be trusted to fall obediently into place and do their job. But a blueprint is a sorry tool when it comes to channeling the human commitment necessary to design and implement a strategic plan. A recipe is a much better metaphor. A recipe recognizes that things interact, that there is sequentiality involved and that a little pinch of something can have an outsized impact on the outcome.

Far too many efforts to implement a strategic plan suffer from debilitating over-specification. Detailed action plans are blueprinted as if the future can be clearly seen and complex undertakings can be pursued with precision. They can't. The future is uncertain and the present pushes back. Small things can cascade into big things. And people generally resist being over-specified. They want to be respected and trusted enough to design their own path. It is a fundamental reality of management that people tend to own what they help to create. Leaders err when they over-specify rather than defer to those closest to the frothy interface where "action" generates value.

## Building Shared Purpose, Understanding and Commitment

If there is consistent agreement related to meeting the most important challenges certain to be embedded in the future of health care, it is that those challenges will require dramatically increased multidisciplinary and multispecialty collaboration. This will be true not only for day-to-day delivery of quality care, it will also be true for the development and implementation of strategic direction at a leadership level. A strategic plan is a tool uniquely suited to fostering multidisciplinary dialogue and decision making focused to the organization's most important decisions.

But strategic dialogue takes time. According to McKinsey consultants, Chris Bradley, Lowell Bryan and Sven Smit, *"Companies need to spend as much time on building and executing strategies as on operating issues. Those that do will build institutional skills and generate strategic ideas that evolve over time. Rather than fear uncertainty and unfamiliarity, these strategic leaders can embrace them, and make the passage of time an ally against competitors that hold back when the future seems murky."* McKinsey's experience with a variety of clients suggests that*, " . . . the only way to set strategy effectively during uncertain times was to bring together, much more frequently, the members of the top team, who were uniquely positioned to surface critical issues early, debate their implications, and make timely decisions"* (Bradley, et al., 2012).

A properly structured strategic planning process must accommodate the loose coupling that characterizes AMCs. According to Gilmore, *"The loosely coupled character of educational institutions requires a different approach to leading and planning . . . Medical centers are pervasively loosely coupled. Not only are they a federation of basic science and clinical departments and divisions, but below the level of deans and vice presidents and department heads they are a world of sub-units, centers, institutes, programs, functions and special activities. Each of these sub-units has its own micro-church and state elements such as a chief and an administrator"* (Gilmore, 1999). Top leadership must play the role of conductor in orchestrating all these micro church and state elements towards a shared future. Participation in a strategic planning process for every "chief and administrator" in a way that invites and genuinely considers their input can help orchestrate such a result.

A strategic plan can serve as a powerful tool for reconciling and melding fragmented perspectives into shared commitment for a compelling purpose and desirable future. Achieving this result requires discipline as suggested here by Loop, *"As the plan is drafted, broad input and healthy debate, even dissent, is essential. The process has to stimulate extensive discussion. Ingenuity comes from encouraging bottom-up thought and driving top-down initiatives. This plan, if followed, will be the course of action for the next several years. The plan must be well-financed, all resources accounted for, estimated risks clearly understood by knowledgeable and influential participants, and internal consultation widely sought to finalize the drafts. Luck is where preparation meets opportunity* (Loop, 2009, 116).

To reduce the potential for fragmentation while leveraging Core Differentiators that fuel intrinsic advantages, AMCs need to be intentional in charting a unified path into the future. Progress along that path requires that the AMC's many specialists cultivate a common view of a future worthy of their commitment. Progress also requires that the three missions of the AMC be continuously balanced and the virtues of constructive tension preserved. The development and implementation of a strategic plan can provide the intentionality and unity necessary to overcome fragmentation. In its design and implementation, the strategic plan can become the embodiment of deliberate incrementalism – the recipe for building a bridge to the future.

A solid strategic plan can overcome the fragmentation that occurs when individual perspectives are out of synch. Such synchronization is vital to organizational performance. Harvard management professor, Joan Magretta, suggests that, *"On the one hand, performance depends on the contributions of individuals, each of whom is just that, stubbornly individual, each of whom needs to feel valued. On the other hand, while individuals – and especially the right ones – are fundamental, the organization and its purpose come first. Performance depends on collaboration, on teamwork, on individuals committing their talent and their best effort to something larger than themselves . . . resolving this tension between the individual and the organization is at the heart of management's work"* (Magretta, 2002, 197). An effective strategic planning process clarifies purpose, builds understanding and solidifies commitment across what otherwise might have been a disunified mass of individuals.

As Loop counsels, "healthy debate" and "dissent" can and should be designed into the strategic planning process. Kahneman shares a method for this, referred to as a "premortem," and advocated by Gary Klein, a research psychologist and pioneer in the study of decision making, *"The procedure is simple; when the organization has almost come to an important decision but has not formally committed itself, Klein proposes gathering for a brief session a group of individuals who are knowledgeable about the decision. The premise of the session is a short speech: 'Imagine that we are a year into the future. We implemented the plan as it now exists. The outcome was a disaster. Please take 5 to 10 minutes to write a brief history of that disaster.' . . . The premortem has two main advantages: it overcomes the groupthink that affects many teams once a decision appears to have been made, and it unleashes the imagination of knowledgeable individuals in a much-needed direction"* (Kahneman, 2011, 264).

While primary responsibility for strategy and strategic planning resides in the executive suite, smart leaders reach out and enlist others in defining a future worth achieving and determining the best way to get there. Not only do people tend to own what they help create, they tend to implement what they own. Setting off conversations about the future throughout the organization's leadership ranks builds ownership and commitment for a path into that future. Strategic planning launches such conversations. A disciplined strategic planning process forces the organization to think and talk about the future.

In a complex and turbulent environment, ambiguity is the natural state of things. But there's a big difference between ambiguity and ambivalence. Ambivalence is a kind of indifference. It is disorienting, demoralizing and destabilizing. Take a human being, any human being. Put him on a ship headed into an open sea with no clear destination in sight and the first question out of his mouth will be, "Where are we going?" The metaphor applies to people in organizations.

It is true that it's hard to think about draining the swamp when you're up to your eyeballs in alligators. But it's also true that if you don't spend some time thinking about draining the swamp, you'd better develop a tolerance for both water and alligators because that's what the future is sure to hold. Ultimately, the alligators will write your strategic agenda; the resources of the organization all go to day-to-day problems while the opportunities starve. Activity gets confused for action.

A transparent strategic planning process can be a phenomenal trust builder. Done well, it involves a lot of information sharing and respectful dialogue. There are few better ways to cultivate trust than by sharing important information and through the sincere solicitation of someone else's perspectives on an important question. Mistrust melts when information is shared openly and leaders are asked for their advice on the future of the institution.

A solid strategic planning process identifies an organization's best options and thus generates focus. This focus is liberating because it breaks up logjams of indecision and concentrates the energy of the organization. Even if every option selected isn't optimal, getting moving is usually better than standing still and scratching your head. You can't steer a ship unless it's moving.

Decisions have quality. Some decisions are better than others. There's no solid evidence that groups make better decisions than individuals. However, it's likely that better tested decisions often emerge from groups. Not because the group came up with better ideas than an individual alone might, but because the ideas were debated and forced to withstand constructive scrutiny. Smart organizations subject their most important decisions to Darwinian dialogue in which the strongest ideas survive and evolve to higher levels of fitness.

One powerful consequence of a solid strategic planning process is the potential it holds for replacing pessimism with hope. This is particularly important in organizations that have endured tough times. Nothing so lifts the spirit of an injured enterprise than the picture of a future worth achieving.

Leaders make meaning. They lead followers toward a place worth going. Like destiny and opportunism, leadership begs the question, "Leading toward what?" A sound strategic planning process provides the disciplined method of delivering an answer to that timeless question.

## Chapter 8: Developing a Strategic Plan for MUSC's Clinical Enterprise – A Case Study

It was with an appreciation for the dangers of fragmentation in the face of growing volatility as well as a clear sense of compelling opportunities to leverage its advantages that MUSC dedicated itself to using strategic planning as a leadership tool to define and achieve the future of its Clinical Enterprise.

MUSC was founded in 1824. It has the oldest medical school in the south. It has survived a civil war, an earthquake, a city wide fire and several hurricanes. Today, it consists of six colleges and multiple hospital facilities and clinics. It is the largest non-federal employer in the Charleston, South Carolina, metro region and in 2011 employed nearly 12,000, including over 1,200 faculty and 600 residents. More than 700 physicians are salaried by the faculty practice plan, MUSC Physicians. In 2011, it had an operating budget of approximately $2 billion. Its facilities included more than 700 licensed beds divided between an adult hospital and a children's hospital which together served 35,500 inpatients and 950,000 outpatients, including 75,000 emergency room visits.

The Charleston metropolitan service area has a population of approximately 700,000. There is no dominant health system serving the metropolitan area. The market is relatively consolidated with three health systems accounting for about 90% of market share. Approximately 60% of physicians are employed by two of three health systems. There are significant numbers of independent urgent care centers and surgicenters. In addition, there is only one dominant insurer. MUSC is the only comprehensive AMC in South Carolina. It draws referrals from across the state. In Charleston and throughout the state, MUSC's prime competitors are large tertiary community hospitals.

In 2010, MUSC recruited a new dean for the College of Medicine. She quickly and clearly communicated her aspirations and expectations for MUSC including movement up in the NIH research rankings. She also began to convene top leaders from across the Clinical Enterprise on a weekly basis in what was called the Clinical Leadership Council (CLC). This was the first time these leaders had met on a regular basis.

It was expected that an enhanced position in research would, in turn, enhance the reputation of the Clinical Enterprise, catalyzing a virtuous cycle across the tripartite missions. This view was consistent with Loop's observations about the importance of research in an academic enterprise, *"We believe that research begets research as discoveries yield more material for investigation, more grants, more citations, and more discoveries . . . As these activities are integrated, we build the intellectual endowment. In a progressive academic medical center, the bonds between research and clinical medicine are powerful and indissoluble. An integrated academic and patient care environment attracts the best talent"* (Loop, 2009, 45).

While it was clear the dean's aspirations resonated across the enterprise, it was also clear they would require investment. It became apparent that the money for that investment would need to come, in large part, out of margins generated by MUSC's Clinical Enterprise. It was also clear that MUSC needed a disciplined process for growing margins. A strategic plan for the Clinical Enterprise could provide that disciplined process.

MUSC had developed strategic plans previously including for some of its clinical departments. In addition, there was a strategic plan for the university overall. There was, however, no single fully integrated strategic plan for its Clinical Enterprise. The Clinical Enterprise was defined as all those aspects of the broader AMC that related to the direct provision of patient care including the hospital, the ambulatory care sites and the faculty practice plan.

Energizing the development of the new strategic plan for MUSC's Clinical Enterprise was the recognized necessity of establishing a compelling and aspirational goal, a unifying vision. Shared purpose, engaged leadership, accountability and focused results as well as productive collaboration were recognized as essential to deliberate incrementalism in the face of growing volatility (Keroack, 2007).

Applying the "volatility circle" (as illustrated in Diagram C, page 102) to MUSC's situation in the spring of 2011 when the strategic planning process commenced would have yielded a rating of "moderate volatility." Despite this, MUSC anticipated significant change and uncertainty ahead. It was clear to leaders at MUSC that reform mandated at the federal level had increased volatility throughout the health care industry. This was acerbated by other dynamics including economic recession as well as continuing shifts in technology. The prospect of increasing volatility reinforced the need to make good use of the window of opportunity MUSC's situation offered.

In considering the experience of other AMCs, leaders at MUSC reflected on what Hamilton Moses, a former Vice President of Medical Affairs at Hopkins, had concluded relative to the conflict at Hopkins, *"Organizations go through seizures of this sort. The outcomes can be positive or negative. Those unpleasant years forced the hospital and university to make changes . . . I see those periods of conflict as therapeutic. The changes were unfortunate and difficult for many people involved, but necessary and in the long run positive for the institution. The result has been clarification of first principles and values"* (Kastor, 2004, 268). While Moses' conclusion was acknowledged, there seemed to be little advantage to be gained by suffering the consequences of a "seizure" if such a condition was avoidable. MUSC leadership became convinced that by cultivating deliberate incrementalism across the Clinical Enterprise there would be no need for such a "therapeutic" experience.

In designing its strategic planning process, leaders at MUSC asked: "What should a good strategic plan embody and how should it be developed?" From the onset, it was apparent to MUSC's leadership that clear and transparent processes linking high-level goal setting, decision making and resource allocation would be critical success factors (Karpf, et al., 2007). MUSC looked to the advice offered by the IOM's Committee on the Roles of Academic Medical Centers in the 21st Century, including this: *"The committee offers two broad principles for AHCs to adopt as they endeavor to strengthen the level of integration across their diverse organizations. First, each AHC should develop a shared vision based on the interdependence of their roles and organizations. Although each entity of an AHC will still pursue its own unique objectives, each should also work toward achieving common goals across the AHC . . . Each AHC should support openness and transparency of information across the enterprise. All parties should have access to performance information about the entire AHC enterprise for sound decision making and resource allocation."*

According to the IOM committee: *"A lack of transparency in setting and communicating strategic priorities creates misunderstandings about the need for change and hampers its progress. Capturing the intellectual energy across the AHC and breaking down barriers within the institutions requires an openness and transparency of information that makes it possible to understand the cross-subsidies and interdependencies across the AHC roles, organizations, and populations served"* (Kohn, 2004, 128-129).

Ralph Muller has reinforced the need for clarity and transparency, *"To ensure both fairness and widespread comprehension of the institution's goals, the process of reaching agreement on objectives and standards of measurement should be an open one that includes complete sharing of information. This means explaining previous results (both institution-wide and on an individual or departmental basis), what they're tied to, whether they're satisfactory, and, if not, where and how to improve them"* (Safyer, et al., 2010).

MUSC leaders identified the following key criteria as fundamental to the design of the strategic planning process for the Clinical Enterprise. The process would:

- Engage leadership throughout the Clinical Enterprise in providing meaningful input.
- Demonstrate to those participating in crafting the strategic plan that their input is valued and considered.
- Proceed in an iterative manner so the plan would emerge in coherent and understandable fashion.
- Support enterprise wide transparency.

- Incorporate the means and methods required for effective implementation, accountability, adjustment and adaptation.

- Provide an ongoing recipe for strategic decision making that supports deliberate incrementalism.

**A Strategic Planning Framework**

MUSC adopted a strategic planning framework that incorporated concepts and methods consistent with those advocated by leading experts and which would support deliberate incrementalism. (Diagram E, see page 104.) The components of the integrated strategic plan framework MUSC embraced were designed to answer ten questions:

- What are the most significant challenges likely to face the Clinical Enterprise over the next three years? (Strategic Issues)

- Why does the Clinical Enterprise exist? What is its purpose? (Mission)

- What does the Clinical Enterprise stand for? What are its cultural commitments? (Values)

- What should the Clinical Enterprise look like in the future? What does it aspire to become? (Vision)

- What will the Clinical Enterprise be really good at that will make it different in a way that is meaningful and valuable to those it serves? (Value Proposition)

- What will be the Clinical Enterprise's measurable stretch goal – its rallying cry? (Strategic Intent)

- What are the five to seven high-level things the Clinical Enterprise must do to realize its Vision, Strategic Intent and Value Proposition? (Driving Strategies)

- How will each Driving Strategy be incrementally accomplished? (Tactics)

- How will the Clinical Enterprise organize and deploy its time, talent, energy and resources to effectively implement the Driving Strategies? (Implementation)

- How will the organization know it's succeeding? (Strategic Performance)

The framework is focused. It defines not only what the Clinical Enterprise will **be** and **do** but sets the boundaries for what it will **not be** and **not do**. The dynamic relationship between the various components of the strategic plan is reflected in the framework as is the need for alignment, focus and differentiation. Ambition and stretch are also inherent to the framework because Vision and Strategic Intent compel the organization to seek high performance breakthroughs.

Within MUSC, the strategic plan framework was often described as a "circle of light" diagram. It suggested that the organization's Mission projects a broad circle of light. This circle defines the boundary for what the organization will and won't do. (For example, this circle of light will be different for a religiously-sponsored system than a for-profit hospital; and it will be different for an AMC compared to a community hospital.) Values then cast a brighter, but narrower, cluster of light within that cast by Mission. Likewise, the Vision circle that shines within that cast by Values is brighter and narrower still. The pattern continues down through the level of Tactics. The effect of ever brighter, ever narrower circles of light, in the end, is a cluster of light that is focused, aligned and unique.

The framework is simultaneously firm and flexible. This supports the desire to be deliberate and incremental. From top to bottom, the framework represents a continuum. A number of things happen moving from the top of the framework to the bottom.

| **Top of Framework** | **Bottom** |
|---|---|
| Long-term | Short-term |
| Resolved | Flexible |
| Inside/outside | Inside |
| Conceptual | Detailed |
| What to be | What to do |

Using Mission as an example (at the top of the framework), it describes why the organization exists and is very long term (the "never changing purpose of the organization"). It is usually just a sentence or two and is conceptual. It is communicated both inside and outside the organization. On the other hand, Tactics (at the bottom of the framework) are pursued across a much shorter timeframe. Tactics change as soon as they are substantially completed or if the environment changes. They are detailed and generally only communicated within the organization. Rather than dealing with what "to be," they deal very much with the specifics of what "to do." They are undertaken in incremental fashion to fulfill the deliberate intentions set forth in Vision, Value Proposition and Strategic Intent.

The top of the framework puts a boundary around where to be deliberate while the bottom supports navigation through the distractions and surprises volatility always produces. The Tactics at the bottom provide the flexibility needed to deal with the "urgent." Within the constraints of what is most important, the top of the framework provides the focus needed to identify the urgent things that matter. This allows the urgent things that aren't consequential to be set aside.

As the writer, philosopher and creator of the iconic Whole Earth Catalog, Stewart Brand, once commented, *"The urgent finds you; you have to find the important. Important is not fast. It is slow. It is not superficial. It is deep. And as a result, it's extremely powerful. When important matters go wrong, they undermine everything. When they go right, they sustain everything."* When "they go right," they support the organization's Mission and accomplish its Vision.

The top of the framework is slow; the bottom is fast. Again, according to Brand, *"The fast parts learn, propose and absorb shocks; the slow parts remember, integrate and constrain. The fast parts get all the attention. The slow parts have all the power . . . The combination of fast and slow components make the system resilient . . . All durable systems have this sort of structure. It is what makes them adaptable and robust"* (Brand, 2000).

The framework also correlates with Kahneman's suggestion that there are two principle modes of decision making; what he calls "System 1" and "System 2," which he described in his best selling book, Thinking Fast and Slow. System 1 is *"fast, instinctive and emotional while System 2 is slower, more deliberate and more logical."* The top of the framework represents System 2 decision making; the bottom represents System 1 (Kahneman, 2011).

Taken together, the hierarchy of the strategic plan framework adopted by MUSC for its Clinical Enterprise promised to combine slow, long-term resolve with fast, short-term flexibility. (Diagram F, see page 105.)

Leaders at MUSC concluded that deliberate incrementalism required ongoing dialogue and decision making rather than reliance on annual or quarterly strategic planning retreats. There was a recognition that MUSC had an opportunity to use the breathing room afforded by its moderate level of market volatility to generate higher quality strategic dialogue, deliberation and decision making. Critical to this approach was the creation of the Clinical Leadership Council (CLC) which consolidated strategic decision making by bringing the Clinical Enterprise's key leaders together on a regular basis. The CLC met weekly and the strategic plan became an ongoing conversation rather than a completed task.

One of the CLC's roles was to keep the strategic plan on track organization-wide by maintaining deliberateness and supporting continuous incremental moves and adjustments at the tactical level. The CLC allowed MUSC to continuously reinforce the Vision that was to become the overarching goal for the next three to five years. It also provided a forum in which to emulate After-Action Reviews that kept Tactics synchronized and aligned with Driving Strategies. This facilitated adjustments when the unexpected occurred and helped the CLC learn from successes, failures and mistakes.

The CLC included nine members. The Dean of the College of Medicine (Vice President for Medical Affairs) and the CEO for the Medical Center (Vice President for Clinical Operations) served as co-leaders. The CLC is not a strictly hierarchical model, nor is it structurally integrated – rather it is a functional matrix that provides virtual integration. In such a model desired attributes were leader interdependence, mutual trust, transparency, continuous communication, and a focus on achievement while sublimating control concerns. By creating a virtually integrated matrix organization, MUSC avoided cumbersome legal and financial issues while using its strategic plan to create the common purpose, focus and continuous dialogue needed to achieve and sustain alignment across the entire Clinical Enterprise. The CLC provided the flexible structure that yielded the resolve and flexibility a loosely coupled AMC required.

The CLC served as the central architect for the strategic plan with overall responsibility for developing, refining and endorsing the plan. A Project Team was formed to provide ongoing guidance and support relevant to the planning process. Members of the Project Team served as points of continuity and shepherds for the plan. The Project Team also conducted preliminary reviews for key recommendations as they emerged. All members of the Project Team were also members of the CLC.

The Project Team identified participants for eight Stakeholder Groups each comprised of approximately twelve individuals representative of a particular constituency of the Clinical Enterprise. For example, there were Stakeholder Groups established to represent executive leadership of the hospitals, the board of the faculty practice plan, department chairs and service line administrators. These eight Stakeholder Groups widened and diversified the input provided resulting not only in more robust thinking but also generating stronger understanding and commitment for the strategic plan. Input from the Stakeholder Groups flowed to the CLC through the Project Team and was incorporated iteratively as the plan was developed. More than 100 individuals participated on the eight Stakeholder Groups.

A strategy consulting firm was engaged to support the strategic planning effort. These consultants worked with the Project Team to design and facilitate the planning process. They also provided advice regarding strategic direction based on their experience with a variety of health care organizations in other markets.

Each group, including the CLC, the Project Team and the Stakeholder Groups, went through essentially the same agenda in the planning sessions to develop the strategic plan. Although the focus of each of these meetings was the same, the conversations, including reaction and input, varied significantly. A key challenge in gathering this feedback and employing it to shape strategic direction was to identify where perspectives converged and could be melded into shared commitment while reconciling differences. Also important was avoiding dilution of focus and impact through unnecessary compromises.

The approach employed involved having the Project Team and the CLC address in sequence the questions comprising the strategic plan framework (see page 69). Key components of the strategic plan were then defined in draft form and shared with each of the eight Stakeholder Groups for reaction and input. The CLC then, based on stakeholder input, validated and revised the key components. This iterative process can be likened to the work of a potter who starts with an unformed lump of clay, then begins the process of shaping it towards her Vision. Leaders from across the Clinical Enterprise put their hands on the clay and influenced its ultimate shape.

At the onset of the process, the consultants interviewed all members of the CLC as well as other key leaders from across the Clinical Enterprise. Then they facilitated development of a Situation Assessment that served as a common foundation of strategic information regarding the Clinical Enterprise and its environment. This comprehensive document combined qualitative input gained through the personal interviews with quantitative data related to such characteristics as volume trends, market share, productivity, quality and reputation. It was descriptive rather than prescriptive. The Situation Assessment provided a shared context for identification of Strategic Issues – the most critical challenges likely to confront the Clinical Enterprise over the coming three to five years.

In the first round of planning sessions, the key Strategic Issues were identified and prioritized by the CLC as well as the eight stakeholder groups then consolidated into a single list of a dozen issues. This required anticipating the future. In the foreseeable future where the landscape was discernable, leaders at MUSC could "predict short" with reasonable confidence. For example, it was clear that lower costs would be required regardless of the ultimate impacts of reform. There would be declining demand for new inpatient capacity and growing interest in more affordable outpatient settings. In contrast to prevailing industry biases, participants in the strategic planning process determined that low cost, high value "network affiliations" would hold the potential to generate better returns than resource intensive mergers and acquisitions. And participants also determined that moving high-cost subspecialty and super-specialty capabilities into rural settings that couldn’t generate the volume necessary to amortize their high costs wasn’t going to be a sustainable strategy.

Also in the first round of planning sessions, the existing Mission and Values for the Clinical Enterprise were validated recognizing that these long-term commitments would provide the boundaries for the other components of the strategic plan. Key words and ideas that captured the aspirations of leaders for the Clinical Enterprise were also generated in the first round sessions. These served as the essential ingredients for development of a new preliminary Vision statement, Value Proposition and Strategic Intent. This input represented the "paint" with which a picture of a desired future would be crafted. MUSC's position on the U.S. News & World Report and NIH rankings became compelling goalposts – symbolic proxies for achievement of MUSC's aspirations. These rankings were understood and relevant throughout the enterprise.

In a second round of planning sessions, the CLC and stakeholders reviewed and suggested revisions to a first draft of the Vision statement, Value Proposition and Strategic Intent prepared by the consultants based on input in the first round. They then shifted their focus from "What to Be" to "What to Do" by providing the input needed to begin to define a set of interrelated high-level Driving Strategies.

Throughout development of the strategic plan for the Clinical Enterprise, leaders of MUSC remained mindful of the need to define it within the context of the four Core Differentiators that were at the center of AMC uniqueness, including that of MUSC. Dialogue focused on how to leverage the Clinical Enterprise's Depth and Breadth of Clinical Capability, how to deepen Collegial Commitment, how to continue to enjoy the advantages of Proximity and how to maintain the balance of centralization and decentralization that productive use of Loose Coupling required.

Efforts were made, particularly at the level of Vision, to calibrate the strategic plan for the Clinical Enterprise with direction for the university overall. Because the leaders who created the university plan also participated in the development of the strategic plan for the Clinical Enterprise, such calibration tended to occur naturally.

The strategic planning process was intentional in incorporating initiatives that already had standing and relevance within the organization. These were assimilated into the Driving Strategies and Tactics unless they were at odds with the overall direction of the emergent strategic plan, in which case lack of alignment was signaled and such initiatives moved off the list of strategic priorities. The identification of seven Driving Strategies completed the development of the key components of the strategic plan. It was incumbent on the CLC to finalize the plan to the level of Driving Strategies transforming it from preliminary to a final version that could be shared for approval by governance. (MUSC has multiple governing boards.)

With board approvals in hand, the Project Team then moved to the next phase of the process – Implementation, which included defining Tactics. The strategic planning process's collaborative approach combined with top leadership's commitment made movement from planning to Implementation relatively seamless and rapid.

**Implementing MUSC's Strategic Plan for the Clinical Enterprise**

The approved strategic plan was used by the CLC to define a unifying set of targeted performance goals. University Health Consortium (UHC) benchmarks were used to set key performance targets. While MUSC's performance on patient satisfaction was exceptional, it lagged on other indicators including those related to productivity. This gap became a focus in setting metrics. Financial goals were relatively straightforward and included margins, reserve funds, debt service coverage ratios, cost/case mix index for discharges, and others. Goal setting driven by the strategic plan created alignment in the Clinical Enterprise that had not existed previously. Like Tactics, these goals could be adjusted incrementally in response to changes in MUSC's situation. Performance goals were not just reserved for the institutional leadership but were cascaded throughout the Clinical Enterprise. A more uniform and transparent system-wide compensation plan for clinical faculty linked to the strategic plan was developed to further facilitate performance and accountability.

The CLC functioned as a high-level standing committee and continued to meet on a regular basis after the plan was approved. The eight Stakeholder Groups were dissolved once their work of providing input was finished. As the Project Team shifted its focus to Implementation, it adopted an approach that was understood by many throughout the Clinical Enterprise – an approach that resembled a clinical trial. The process for conducting a clinical trial provided a familiar framework that could be used for broad Implementation of the strategic plan. A clinical trial is widely based, multidisciplinary and when well conducted, rigorous in its methods and integrity. The Project Team functioned in a manner similar to a "coordinating panel" in a clinical trial. It was renamed the Coordinating Group and became one of three groups designated to support ongoing Implementation of the strategic plan.

Strategic plan Implementation that is deliberate and incremental requires the active ongoing involvement of individuals who are close to the value creating capacity of the organization – in other words, they are close to patients, colleagues and technology as well as competitor activity and political realities. Faculty physicians and senior administrative executives were appointed by the Coordinating Group (formerly the Project Team) as Strategy Leaders organized as dyads. Each of these seven Strategy Leader dyads was charged with responsibility for overseeing the effective Implementation of one of the seven Driving Strategies including defining its supporting Tactics, timing and resources as well as individual accountabilities. These Strategy Leaders then, in turn, formed seven Strategy Teams whose participants supported Implementation of their assigned Driving Strategy. (Diagram G, see page 106.)

Strategy Teams defined the Tactics to support the Driving Strategies. A set of five to seven Tactics was identified to support each of the seven Driving Strategies. These Tactics represented the most specific and the most malleable component of the strategic plan. It is at the tactical level that the plan would have the greatest flexibility. While some Driving Strategies might have a time horizon of 1 to 3 years, a Tactic would usually extend over a year or less. The Strategy Team identified the timing and resources associated with each Tactic. Strategy Teams had the discretion to assign a leader for a Tactic. Depending on the nature of the Tactic, a Tactic Leader might then appoint a Tactic Task Force if he decided he could not effectively implement the Tactic alone.

Strategy Teams and Tactic Task Forces were drawn from throughout the Clinical Enterprise. These leaders were vested with responsibility not only for defining Tactics but also for cascading Implementation to colleagues and subordinates across the Clinical Enterprise. At MUSC, the Implementation phase of the strategic plan involved institution-wide engagement of nearly 100 physicians and non-physician leaders, most of whom had also participated during the development of the strategic plan.

Strategy Leaders convened their Strategy Teams on a regular basis to assess progress at a Tactical level, determine where obstacles might exist and how they could be overcome. Over time, Strategy Teams would find that conditions internally or externally dictated that their Tactics needed to be revised, eliminated or augmented. This continuous updating at a Tactical level provided deliberate incrementalism in the face of growing volatility.

As previously mentioned, once the strategic plan was approved, the Project Team transitioned to become the Coordinating Group and focused on coordinating Implementation through time, reporting directly to the CLC and supporting it in maintaining deliberate pursuit of Driving Strategies. Strategy Leaders met periodically with the Coordinating Group to convey progress at a Tactical level, communicate recommended changes and ensure the coordination that deliberate incrementalism across the seven Driving Strategies required. Members of the Coordinating Group then conveyed progress as well as necessary modifications and adjustments to the strategic plan to the CLC. (Members of the Coordinating Group are also members of the CLC.) The strategic plan thus became a regular agenda item for leaders from across the enterprise.

The Coordinating Group monitored the pace and success of Implementation; identified faculty and staff to lead specific Implementation initiatives; helped assure availability of needed resources; and coordinated collaboration among Strategy Teams. The Coordinating Group was also responsible for other tasks such as development of supportive infrastructure, assuring continuous engagement and leadership training, as well as considering and providing timely feedback as Driving Strategies were continuously implemented and, where appropriate, revised.

Given the need to sustain deliberate incremental progress through multiple years of Implementation, two additional standing implementation groups were created. A problem-solving Operations Group focused on identifying, planning and resolving operational issues in real time. This group facilitated greater collaboration and integration of activities among the clinical entities comprising the Clinical Enterprise. This was essential to supporting the incremental moves demanded by MUSC's constantly shifting internal and external environment. Included among its activities was systematic dissemination of best practices across the Strategy Teams and tactical groups as well as Implementation of consistent practices across the Clinical Enterprise. The Operations Group also facilitated reengineering of work processes to improve efficiency and standardization of clinical procedures related to areas of strategic emphasis as well as Implementation of various initiatives with strategic implications such as deployment of an enterprise-wide EMR.

A third implementation group, the Communications Group, helped leaders of the Clinical Enterprise communicate MUSC's Mission, Vision and Driving Strategies throughout the organization. This team provided a consistent and continuous message regarding strategic direction and priorities to all faculty and employees. These communication efforts included special educational sessions for clinical leaders and staff from the clinical entities, multiple formal and informal presentations, town hall meetings, and an array of information made readily available on an intranet web site established expressly to support the strategic plan. The Communications Group also conveyed important updates regarding changes in MUSC's market as well as resulting adjustments in its Tactics. Consistency in communication of the strategic plan was an essential aspect of Implementation. An important ingredient for consistency was the disciplined use in every communications venue of a common strategic plan framework supported by clear definitions and nomenclature.

Like most organizations, MUSC had a variety of existing avenues for communication, but these tended to be focused within operating entities including the hospitals, the College of Medicine and the faculty practice plan. The strategic plan provided clear cross-cutting messages to be delivered with consistency by leaders across the Clinical Enterprise. This helped avoid fragmentation in understanding and commitment. The strategic plan thus became a vehicle for moving everyone onto the same page.

An important ongoing role for the Coordinating Group was to keep the strategic plan up to date. By periodically revisiting Strategic Issues as the environment shifts as well as revising and replacing Driving Strategies and Tactics as they are accomplished or deemed no longer on target, the plan was continuously updated. Every three years or so, the Vision, Value Proposition and Strategic Intent will be adjusted. Driving Strategies and Tactics were continuously recalibrated as needed. In this way, the strategic plan became a living tool rather than an exercise redone every few years from scratch. In conducting such continuous updating, the importance of maintaining the integrity of strategic dialogue was critical. This required avoidance of the "group think" for which Klein's "premortem" provides a useful tool: *"The main virtue of the premortem is that it legitimizes doubts. Furthermore, it encourages even supporters of the decision to search for possible threats that they had not considered earlier. The premortem is not a panacea and does not provide complete protection against nasty surprises, but it goes some way toward reducing the damage of plans that are subject to the biases of WYSIATI ("what you see is all there is") and uncritical optimism"* (Kahneman, 2011, 265).

In the design of its framework and its approach to development and Implementation, the strategic plan adopted by MUSC for its Clinical Enterprise met the criteria outlined by its leadership (see page 68). It engaged leaders from across the Clinical Enterprise in a process that valued and integrated their input, proceeded iteratively to support coherence and understandability, facilitated transparency and ensured effective Implementation. And importantly, it allowed MUSC to move forward in a way that was deliberate and incremental.

**Deliberate Incrementalism in Action**

Deliberate incrementalism required that MUSC be resolved in pursuit of its strategic direction. Absent fundamental changes in its situation, it would adhere with dogged tenacity to its strategic commitments, including its Driving Strategies. On the other hand, it would adjust its Tactics incrementally to meet unanticipated changes as they occurred. Early into Implementation of its Driving Strategies, MUSC encountered a disruptive shift it hadn't expected.

Competitors had doubled down on traditional inpatient care by opening two new hospitals in growing segments of the Charleston market. Both of these hospitals languished in terms of their inpatient utilization levels. Meanwhile, MUSC had very deliberately sustained its commitment to move its subspecialty capabilities out into Charleston's suburbs by building comprehensive outpatient facilities. Utilization of those facilities grew quickly and plans were put in place to expand them into additional markets. What leadership had not anticipated was continued demand for MUSC's inpatient capacity. So while inpatient volume fell for other hospitals in the Charleston market and nationally, it grew for MUSC. It was utilization that MUSC wanted to accommodate, but building new hospitals was not part of its strategic plan. Instead, in a tactical move representative of accelerated incrementalism, it cleared out office space in one of its patient towers and converted it to inpatient capacity. Building a new hospital would have taken years even if such a move had been part of MUSC's Vision.

Another development constituted a surprise reflective of an increasingly volatile environment. One of MUSC's seven Driving Strategies focused on securing its referral base. This required solidifying the relationships its faculty had with community physicians throughout South Carolina. In the past, these relationships were almost exclusively physician-to-physician. Participants in MUSC's strategic planning process had assumed the rate of physician employment by hospitals in its service area would continue to lag that of other markets nationally. That assumption proved wrong. In Charleston, and throughout the state, the number of once independent physicians employed by community hospitals grew at a rapid rate. Many of these newly employed physicians constituted major sources of referrals to MUSC. Administrative leaders at community hospitals, who previously had not been in a position to influence referrals, suddenly had growing numbers of physicians under their employment. It became obvious that MUSC not only needed to fortify relationships with referring physicians but would also need to secure partnerships with the community hospitals that increasingly employed those physicians.

While maintaining the deliberate commitments embodied in its Driving Strategies, MUSC redefined supporting Tactics to include incremental responses to the growth in physician employment by community hospitals. For example, within a span of 18 months, it conducted joint strategic planning efforts with three of the community hospitals whose medical staffs constituted some of the most significant sources of referrals. In addition, it designed and began to implement a clinically integrated physician network (CIN) that would allow community physicians, employed and independent, to enjoy "dual citizenship." They were invited to become valued members of the MUSC Physician Network while remaining productive members of their community hospital medical staffs. It also intensified investment in telemedicine linkages in alliance with community physicians and hospitals throughout the state. All of these initiatives emerged as new Tactics when MUSC's strategic situation shifted and its strategic plan shifted with it.

## Chapter 9: Principles Distinguishing the MUSC Approach to Strategic Planning

Foremost in the design of MUSC's approach to strategic planning was a commitment to reduce fragmentation by pursuing a process that was both deliberate and incremental. There were notable principles related to the approach that MUSC undertook in developing the strategic plan for its Clinical Enterprise:

**Delicate Balance.** A continued focus on its patient care Mission had helped generate exceptional performance for MUSC related to patient satisfaction. The arrival of a new Dean and her focus on research necessitated a rebalancing. Indeed, it was a recognition that aspirations related to research could only be realized through funds generated by MUSC's Clinical Enterprise that had given the strategic planning process much of its initial impetus. Implicit in this was a belief that an enhanced position in research would contribute significantly to MUSC's reputation overall and by so doing further strengthen its patient care and teaching Missions. However, too overwhelming a focus on research could dilute the commitment to patient care and thus diminish MUSC's existing differentiation.

Balance across the three Missions was not seen as static. "Balancing the broom" demanded continuous adjustment. At the heart of MUSC's Value Proposition was the depth and breadth of its specialized clinical capabilities. This is what most forcefully differentiated it across the region. That Value Proposition required deliberate emphasis. Investment across the service lines required balancing depth against breadth. Some service lines make a greater contribution to MUSC's reputation for advanced capabilities than do others. Some attract more research funding. In some instances, the strength of one service line was dependent on the availability of other service lines. Service line offerings were viewed as a portfolio that had to balance investment against returns to MUSC's financial and reputational position.

Responses to external and internal realities also had to be balanced. Too strong an internal focus could blind the organization to competitive threats and other external realities. Likewise, too great an emphasis on external considerations could distract leadership potentially causing the capabilities at the core of its Value Proposition to wither from inattention. For example, the strategic planning process took place as the industry tried to sort out the realities of health care reform. MUSC disregarded quite intentionally the calls to form an ACO, opting instead to concentrate investment in the continued expansion of its specialty and subspecialty capabilities along with improvements in access to those capabilities.

**Ambitious Stretch.** The strategic planning process captured the ambition and energy of those who participated in it. Much of this resulted from identifying a desirable position relative to other respected AMCs in the south – institutions that inhabited the upper tiers of the U.S. News & World Report rankings. MUSC articulated a Vision of an elevated trajectory that would move it towards the reputational standing of AMCs like Duke, Emory and the University of North Carolina. In doing so, it took the advice of the renowned urban planner, Daniel Burnham, who caught the very essence of such deliberate stretch when he exhorted, *"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."* In setting an ambitious Vision, there was a recognition that its accomplishment would require deliberate resolve along an incremental path. "Big plans" aren't necessarily "bold plans." High hopes are often best achieved through aggressive incrementalism; what Burnham called *"ever growing insistency."*

**Pragmatic Optimism.** It is common for strategy advisors to encourage organizations to identify a "burning platform" as a means to gain the attention of stakeholders and engage their commitment to change. But fear is one kind of catalyst. Optimism is another. Many AMCs post their strategic plans online including their Missions and Visions. Many of these statements reveal some remarkable similarities, including a consistent sense of optimism. Words that show up with frequency include "lead" and "transform." There's an unshakable view that constructive change is possible and that AMCs should be drivers of that change. Deliberate incrementalism requires the push and pull of optimism. It takes optimism to span the gaps between the present and a desired future. It takes optimism when setbacks break forward progress. While leaders at MUSC were well grounded in the challenges facing their institution, they evidenced from the onset of the strategic planning process an open enthusiasm for the future. In doing so, they reflected the sentiments of the English historian, Thomas Babington Macauley, who in 1830 asked, *"On what principle is that when we see nothing but improvement behind us, we expect nothing but deterioration before us?"*

**Top Down.** All participants in the MUSC strategic planning process were drawn from leadership ranks across the Clinical Enterprise. Today, there is a popular tendency to cast the strategic planning net widely and to invite large numbers of individuals at all levels of the organization to provide the input out of which a consensus view of the future is cobbled. Unfortunately, although such exercises may feel good, they ignore the necessary and appropriate role of leaders to lead. Margaret Thatcher once captured the dulling influence of "consensus" when she said: *"For me, pragmatism is not enough. Nor is that fashionable word, 'consensus.' To me, consensus seems to be the process of abandoning all beliefs, principles, values and policies in search of something in which no one believes, but to which no one objects – the process of avoiding the very issues that have to be solved, merely because you cannot get agreement on the way ahead. What great cause would have been fought and won under the banner, 'I stand for consensus?'"* While group participation and input is important in building and solidifying understanding and commitment, there is no solid evidence that it delivers superior strategies.

Organization wide visioning initiatives seem to assume that those below the level of leadership will somehow resent and resist efforts by top leadership to set overall direction. MUSC's experience suggests just the opposite. Generally, MUSC employees expected their leaders to provide strategic direction and welcomed it. The process of strategy formulation and Implementation can be likened to making champagne. If the recipe for fermentation is well defined and communicated from the top, the effervescence necessary for Implementation will bubble up as aligned action.

Implicit in the word "leadership" is a question, "Leading where?" Answering that question requires strategic thinking. High level strategy is the work of top leadership. It is not something that bubbles up out of participatory democracy from the bottom of the organization. It is the job of top leadership to define a place worth going, a path to that place, and then to enlist the organization in getting there. Followers are more likely to follow when they sense depth of commitment and insight at the top of the organization. Former IBM CEO, Lou Gerstner, captured the essence of top leadership's responsibility to provide strategic direction, *"Since the purpose of strategic planning is to make basic decisions on the future course of the company, it is ultimately a responsibility of the CEO and his or her key lieutenants. In other words, top management cannot confine itself to perusing written plans and giving perfunctory once-a-year approval. That would be abdication, not responsible delegation. To ensure that the right set of critical issues and decisions is in fact identified, top management must actively involve itself in the planning process. It is top management's responsibility to weigh strategic issues, apply judgment, and make the decisions. Strategic planning may be a staff function, but strategic decision making is the responsibility of the CEO and the top management team"* (Gerstner, 1973).

Leaders must work to overcome the potential for fragmentation of perspective and commitment by fulfilling their responsibility to help their organizations see things whole. A unified message regarding direction, consistently and persistently communicated, along with mechanisms for establishing accomplishment and accountability help overcome tendencies toward fragmentation.

Once overall strategic direction was set by top leadership, the strategic plan was cascaded widely across MUSC. At that point, participation expanded through the enlistment of stakeholders at all levels in defining the Tactics and action plans necessary to ensure effective Implementation.

**Fit.** The temptation in many contemporary organizations is to declare everything equally important so as not to alienate 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. Honest and open dialogue that results in focus beats the anxiety and aimlessness that results from ambiguity and ambivalence. Absent focus, people invariably begin to work at cross purposes and fragmentation becomes inevitable.

For MUSC's Clinical Enterprise, the components of the strategic plan framework – Mission, Values, Vision, Value Proposition, Strategic Intent, Driving Strategies and Tactics – formed a hierarchy and served as mechanisms for filtering and focusing options. A lot gets through the wide weave of the "Mission screen" while very little should get through the much tighter weave of the "Tactic screen" to become the work of the organization.

Occasionally, as a strategic plan solidifies, it becomes apparent that some existing or contemplated initiatives are at odds with overall strategic direction. This represents a situation in which a strategic plan is called upon to do one of its most important jobs – to define "what not to do." Harvard's Michael Porter has emphasized that tradeoffs are essential to the development of sound strategy by suggesting that, *"The essence of strategy is choosing what not to do."*

Porter further observed that, *"Great leaders are able to enforce the trade-offs: 'Yes, it would be great if we could offer meals on Southwest Airlines, but if we did that it wouldn't fit our low-cost strategy. Plus, it would make us look like United, and United is just as good as we are at serving meals.' At the same time, great leaders understand that there's nothing rigid or passive about strategy – it's something that a company is continually getting better at – so they can create a sense of urgency and progress while adhering to a clear and very sustained direction"* (Mintzberg, 1994).

Activities and investments should be consistently tested against the question, "How does this align with and support our strategic plan?" Initiatives not clearly aligned with the strategic plan should be stopped or delayed. This is essential if the strategic plan is to effectively allocate scarce resources to the organization's best opportunities. It is also key to helping those who must implement the plan see it as a productive tool for prioritization rather than just more work piled on already full plates.

As the strategic plan for MUSC's Clinical Enterprise became a tool for determining "fit," recruitment of faculty and other key hires became "strategic" by focusing attention on the recruit's potential contribution to accomplishing the strategic plan. The strategic plan drew a line between where MUSC would invest itself and where it would not. It recommitted to its existing campus on the Charleston peninsula as the locus for concentrating its inpatient capabilities. This meant it would not build or buy new inpatient capacity off the main campus. The strategic plan also meant MUSC would not launch broad-based employment of community physicians or develop an Accountable Care Organization. The focus derived from deliberate commitments pursued incrementally over time overcame the siren song of distractions inconsistent with overall direction. And this helped avoid the fragmentation and dilution that results when the urgent crowds out the important.

**Simplicity.** The strategic plan developed for the Clinical Enterprise could be fit onto a single sheet of paper. It was simple in format and language. But getting to that level of simplicity took many hours of engaged iterative dialogue. In this, the result was reflective of Oliver Wendell Homes' perspective on the kind of simplicity that's desirable, *"I would not give a fig for the simplicity this side of complexity, but I would give my life for the simplicity on the other side of complexity."* Simple doesn't mean superficial or cryptic. For example, there is a view that Vision statements should be as short as possible – reduced to an easily memorable slogan. But Visions reduced to slogans can be vacuous, bereft of the specificity essential to delivering on the purpose of a Vision which is to provide overall direction. And memorable is not the same as meaningful. W. Edwards Deming often warned against the emptiness and ineffectiveness of slogans. The first obligation of a strategic plan is clarity. Clarity requires meaningful simplicity. Meaningful simplicity has a kind of elegance. It feels right. Jeanne Liedtka makes the point when she reflects on how much is enough, *"Antoine Saint-Exupery has noted (about planes, not little princes), elegant design is achieved not when nothing else can be added, but when nothing else can be taken away"* (Mintzberg, 1994).

**Quality.** Strategies have quality. Some strategies are better than others. There is experience and art involved in strategy formulation. An ability to think strategically is key to formulating high impact strategies. A Driving Strategy with quality is simple, succinct, directional and differentiating. It clearly contributes to accomplishment of the organization's Vision. It is consistent and synergistic with other Driving Strategies. It is stripped of what UCLA strategy expert, Richard Rumelt, calls "fluff," which takes the form of buzzwords, lack of substance and unnecessary complexity. Experience and insight are necessary prerequisites for strategic leadership as the Cleveland Clinic's Floyd Loop once observed: *"Vision isn't about knowing where the company is going. It's about knowing where the industry is going. If you don't understand the profession, the market, and the mission, you are not fit for leadership"* (Loop, 2009. 117).

Loop referenced Rumelt, when he observed, *". . . most corporate strategic plans have little to do with strategy. They are simply three-year or five-year rolling resource budgets and a rough projection of market share. Calling this 'in-the-box' instrument a strategic plan creates false expectations that the exercise will somehow produce a coherent strategy. Likewise, best practice benchmarking may be important for improving operating efficiency, but organizations seeking to distinguish themselves should draw the line at mimicking a competitor's strategy"* (Loop, 2009, 116). This view is consistent with that of Porter who has emphasized that organizations should compete to *"be different"* rather than to *"be the best."* Competing to be the best invariably leads to convergence and loss of differentiation as organizations all migrate towards the consensus view of the best competitive position.

MUSC was intentional in ensuring that its Driving Strategies were well tested in planning sessions against principles of strategy advocated by leading thinkers like Porter and Rumelt. For example, participants were encouraged to recognize that a strategy is not a goal but a pathway; a bridge that links means to ends; a plan for getting from one place to a better place in the face of uncertainty and resistance. MUSC's Driving Strategies represented much more than a prioritized "to do list." They represented the essence of the leadership team's strategic thinking related to what to do in a complex world of limited resources, tough competitors, relentless uncertainty and change. They defined a deliberate and incremental pathway from the present to a compelling future in the face of volatility that might otherwise have fragmented the organization.

The strategic planning process caused stakeholders across the Clinical Enterprise to reframe their view of the organization's situation and clarify its strategic options. For example, the importance of linkages with a committed primary care referral base was underscored. Focused tactical plans emerged including those describing what MUSC would do to solidify high value linkages with community physicians and community hospitals in target markets throughout South Carolina. These options emerged gradually out of iterative dialogue and a variety of perspectives, some of which arose as the strategic plan was implemented. In this, MUSC's experience validated the perspectives of McGill University's management and strategy professor, Henry Mintzberg, as he reflected on where good strategies come from, *"We have found that strategy formation must draw on all kinds of informational inputs, many of them nonquantifiable and accessible only to strategists who are connected rather than detached. We know that the dynamics of the context have consistently blocked any efforts to force the process into a predetermined schedule, or onto a predetermined track. Strategies inevitably exhibit some emergent qualities, and even when largely deliberate, they often appear less formally planned than informally visionary. And learning, in the forms of fits and starts, discoveries based on serendipitous events, and the recognition of unexpected patterns, inevitably plays a key role, if not the key role, in the development of strategies that are novel. Accordingly, we know that the process requires insight, creativity, and synthesis; all the things that formalization discourages"* (Mintzberg, 1994).

**Legacy.** No solid strategic plan proceeds from a blank sheet. An effective strategic plan leverages the legacy of past accomplishments and captures the momentum of existing commitments. Absent recognition of past successes, a strategic plan will lose linkage with previous investments of scarce resources and squander any advantages they yielded. At the onset of development of a strategic plan, there are always multiple high-level initiatives already underway or being contemplated. For example, the new emphasis on research at MUSC was already in motion when the strategic planning process for the Clinical Enterprise was launched. During planning sessions, the rumble of bulldozers could be heard as two new research buildings were being constructed in close proximity to patient care facilities to support translation of research from bench to bedside. MUSC had also already begun to launch regional specialty centers – strategically located outpatient sites designed 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. One important goal for a strategic planning process ought to be to assess such high-level initiatives for fit then herd the aligned ones into a single unified strategic plan that connects rather than ignores past and current strategic commitments. This helps avoid fragmentation of effort over time.

In some instances, initiatives that are already underway can become catalysts that magnify a strategic plan's impact. At MUSC, this dynamic occurred related to the enterprise-wide implementation of an EMR. Although the EMR initiative did not originate out of the strategic planning process, it reinforced MUSC's commitment to the crosscutting consistency and cohesion necessary to make unified incremental moves by putting vital information into the hands of decision makers and caregivers. The EMR initiative also clearly reinforced leadership's commitment to significant change. This, in turn, helped catalyze other major initiatives including a push for clinical standardization.

MUSC had also launched a major rebranding and advertising initiative that was already well underway as the new strategic planning process was launched. The campaign's theme, "Changing what's Possible," had begun to resonate within the organization as well as with consumers across MUSC's regional marketplace. "Changing what's Possible" emphasized the depth and breadth of MUSC's clinical capabilities and became a linchpin for the strategic plan's new Vision as well as an important aspect of its Driving Strategies.

**Quality Strategic Dialogue.** Strategic rationale, the "why" behind a driving strategy, develops best when it emerges out of reasoned dialogue. Although "expert" perspectives can help inform the rationale, such expertise is rarely sufficient by itself to enlist sustainable commitment. Smart people insist on intellectual engagement, particularly when their support is being solicited. Such engagement requires space for conversation and debate. While some strategic planning processes may involve many individuals, departments and functions, they often do little to encourage meaningful and continuous dialogue as the plan is developed.

Organizations inside and outside health care dedicate a very small percentage of their available time and resources to strategic dialogue. In their book, Competing for the Future, Gary Hamel and C.K. Prahalad underscored how little time leadership teams really dedicate to considering the future: *"In our experience about 40% of senior executive time is spent looking outward, and of this time about 30% is spent peering three or more years into the future. And of the time spent looking forward, no more than 20% is spent attempting to build a collective view of the future (the other 80% is spent looking at the future of the manager's particular business). Thus, on average, senior management is devoting less than 3% (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%. Our experience suggests that to develop a prescient and distinctive point of view about the future, a senior management team must be willing to spend 20% to 50% of its time over a period of months. It must then be willing to continually revisit that point of view, elaborating and adjusting it as the future unfolds"* (Hamel and Prahalad, 1994).

It is strategic dialogue that builds the shared understanding and commitment necessary to sustain deliberate incrementalism. At MUSC, more than 100 leaders in eight stakeholder groups participated across 28 planning sessions to develop its strategic plan. Each of these sessions was interactive with the focus on critical strategic questions. Rather than emphasize the number of individuals providing input, MUSC emphasized quality of leadership dialogue recognizing that productive conversation requires sufficient time and that productive group dynamics break down when the size of the group extends much beyond a dozen individuals.

At MUSC, strategic dialogue extended beyond the planning sessions formally scheduled as part of the strategic planning process. There were numerous ad hoc Project Team conference calls and one-on-one discussions involved in managing the planning process, vetting ideas and honing strategies as well as numerous hallway conversations. To facilitate transparency, trust and understanding, all participants in the planning process were encouraged to share ideas and developments related to the strategic plan with colleagues and solicit feedback as the plan developed. The intent was to spark ongoing strategic conversations across leadership enterprise-wide. These conversations continued during the Implementation phase which involved an even wider cross section of MUSC's management team.

**Iterative Development.** In some instances, executives dive down the rabbit hole and emerge with a strategic plan as a *fait accompli* hoping to then gain organizational understanding and commitment for a finished product. In contrast, MUSC developed its strategic plan in iterative fashion. Stakeholders identified more than fifty Strategic Issues then prioritized them into a single list of a dozen. They were also asked to suggest words and ideas that they felt should be represented in the Vision statement. This input was synthesized and eventually crafted by top leadership into a preliminary Vision statement for stakeholder reaction. In their planning sessions, stakeholders were then asked, "What do you like about the statement?" "What don't you like?" "What's missing?" A similar approach was taken to develop the other key aspects of the strategic plan including Value Proposition, Strategic Intent and Driving Strategies. That feedback was provided to the CLC, explored and incremental revisions to the emerging strategic plan were made accordingly.

By taking an iterative approach, the strategic plan was molded and shaped gradually over six months with continuous input so that when the final version emerged, it wasn't a surprise but something that was understood and supported because it had been shaped and endorsed by participants in the process.

The CLC's weekly meetings provided the intellectual space needed to flesh out the implications of MUSC's Vision and make the continuous adjustments to Strategies and Tactics deliberate incrementalism requires. This iterative approach created continuity of thinking as it gradually assembles the key pieces of the plan together into a coherent and harmonious whole. The experience can be likened to that described by Mozart as he composed, *"First bits and crumbs of the piece come and gradually join together in my mind; then the soul getting warmed to the work, the thing grows more and more, and I spread it out broader and clearer, and at last it gets almost finished in my head, even when it is a long piece, so that I can see the whole of it at a single glance in my mind, as if it were a beautiful painting or a handsome human being; in which way I do not hear it in my imagination at all as a succession – the way it must come later – but all at once as it were. It is a rare feast. All the inventing and making goes on in me as in a beautiful strong dream. But the best of all is the hearing of it all at once"* (Mintzberg, 2005, 138).

Iterative development applied not only to creation of the strategic plan but also to its Implementation. Doyne Farmer's prediction coin has its flip side. While you can't predict far, you can predict short; but doing so requires being continuously engaged with the patterns of an emerging future. The CLC provided a mechanism for such engagement. At MUSC, ongoing dialogue in the CLC allowed leaders from across the Clinical Enterprise, in a timely and continuous fashion, to share observations, make sense of those observations, reach important decisions, ensure that those decisions were effectively implemented and make adjustments.

**Ownership and Commitment.** It is certainly possible for a single individual to articulate sound strategies and to do so without the benefit of input from others. But inviting others to participate in a strategic planning process yields increased understanding and commitment particularly related to the rationale for strategic focus and investment. And there is little that is more important to an organization than leaders who own together a shared Mission and Vision then demonstrate a mutual commitment to transform their aspirations into results. The communication, collaboration and coordination necessary to support a strategy that cuts across the organization is much more likely to be forthcoming when that strategy has been informed and shaped by those whose support is necessary to implement it. It is a truism that individuals tend to own more fully those things they help create.

Ownership and commitment among leaders throughout an AMC must be supported by a multidisciplinary approach. This is necessary to execute against crosscutting Driving Strategies. An example of such a crosscutting strategy relates to the potential to improve margins by targeting "distant referrals of complex cases." Numerous studies suggest that referrals from tertiary and quaternary markets can be more profitable than those drawn from primary markets. But a strategy focused to attracting complex high margin cases from distant markets requires unity of commitment across multiple departments, specialties, functions and disciplines. For example, referring community physicians must be able to consistently reach specialists at the AMC with relative ease, have the benefit of an effective transfer process and receive ongoing communication regarding the status of their referred patients. In addition, lower complexity cases may need to be relocated to open up capacity for higher complexity cases referred from distant markets. And scarce resources may need to be reallocated towards high complexity cases and away from lower complexity ones. All of this requires multidisciplinary collaboration across the Clinical Enterprise.

**Process Efficiency.** Development of the strategic plan for MUSC's Clinical Enterprise took six months. Throughout the process, there was an emphasis placed on generating quality dialogue, sustaining forward progress and making productive use of people's limited time. But too fast a pace could compromise the quality of dialogue. And too slow a process could frustrate participants and cause the process to stall out. Most planning sessions lasted two hours. Some went for three. In the interest of process efficiency and effectiveness, some popular strategic planning tools were intentionally rejected. These included "SWOT analysis" (too prone to bog down around distinctions between strengths and opportunities, weaknesses and threats) and "Scenarios" (too likely to devolve into infinite variations). Also avoided was the "group hug" approach that attempts to involve individuals at all levels organization wide in developing the strategic plan. Responsibility for strategy development remained with leadership where it belonged. To enhance process efficiency, a consistent strategic planning framework and nomenclature were employed. Rather than dedicating an inordinate amount of time to definitions and avoid confusion, leadership early on "agreed to agree" on the framework and definitions that would be used consistently throughout the organization related to the strategic plan.

**Cultivating Future Leadership.** There must be a recognition among participants that strategic planning is not an empty exercise. It can be highly consequential because it allocates dollars, time and power. And it provides benefits not only for the organization but for individuals as well. Strategic planning can yield visibility, credibility and influence for those who actively engage in it. The deployment of Strategy Leaders and Tactic Leaders along with their supporting teams provided a dynamic laboratory for the identification and development of leaders. At MUSC, as at all organizations, there is variance in individual aptitude and interest related to leadership and strategy. Effectiveness in a functional or clinical role does not always translate into effectiveness in a strategic role. But sorting out and developing strategic leaders becomes necessary for strategy development as well as for Implementation pursued deliberately and incrementally over time. By identifying and working with participants in the strategic planning process, top leadership can become more adept at assessing the strategic aptitude of those participants and be better positioned to develop the talent needed to sustain accomplishment of the strategic plan.

**Trust.** An environment of trust is an essential catalyst in the development and Implementation of an effective strategic plan. This cannot be overstated. It would be disingenuous to suggest that there was a complete absence of rivalry, disagreement and tension across MUSC's Clinical Enterprise. As has been suggested earlier, tension is intrinsic to every AMC and is arguably essential to energizing the organization. But it is important to emphasize that at MUSC tension rarely escalated into destructive conflict and dysfunction. Indeed, there was, at the onset of the strategic planning process, a relatively high degree of trust exhibited across the leadership of the Clinical Enterprise. As a result, planning sessions were characterized by thoughtful openness. This contributed to productive dialogue.

Because AMCs 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 . . ."* Those who cannot be trusted need to be shoved out, *"ruthlessly if need be."*

The only substitutes for trust are "systems of control," often experienced as onerous impositions, particularly by professionals. Systems of control also are prone to breakdown and collapse when they are confronted with too much complexity and uncertainty. The "system is the problem" school of improvement in health care provides too easy a dodge. Sometimes there is individual fault involved. Sometimes even the most robust systems cannot overcome the influence of a few rotting apples in the barrel. Some people just can't be trusted to care enough about what matters most. 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"* (Handy, 1992).

Leadership style plays a key role in cultivating trust. The leadership style that has delivered success in America's best AMCs is very different from that which has been promulgated at most community hospitals. It relies on a "first among equals" distributed approach to leadership rather than the single "CEO on high" model. A future in which hundreds of faculty commit themselves to a shared Vision requires leaders able to unify and motivate a highly trained and deeply independent class of experts. And this requires the active cultivation and preservation of trust by those leaders.

**Transparency.** The strategic planning process for MUSC's Clinical Enterprise was open and transparent. The benefits of transparency, including trust and understanding, outweighed those associated with keeping MUSC strategies hidden from competitors. Updates were shared on MUSC's intranet. Participants in the strategic planning process were encouraged to engage their colleagues throughout the organization in discussion regarding strategic direction as it developed and to solicit reactions. It was obvious that transparency and understanding would require conveying the "whole picture."

The need to allocate scarce resources in strategic planning reinforced the importance of transparency. For example, funds flow remains a mystery in many AMCs. Yet, defining the organization's top strategic priorities invariably transitions into the question of how to adequately resource those priorities and addressing that question leads to another – "How are things funded now?" According to Thomas Gilmore, *"By building a base of information that highlights key indicators such as the flow of funds, unit productivity, overhead utilization and personnel allocation, the executive creates a context over time for thinking about the relationship between the parts and the whole. By highlighting which units get what proportion of the funds, how cost and productivity are related and who consumes what proportion of the overhead, the executive highlights the implicit and often poorly understood financial linkages between the units"* (Gilmore,1999). At the University of Wisconsin Medical School, a tool described as the Mission Aligned Management and Allocation (MAMA) model was implemented to help focus attention and transparency on the alignment of funds flow at the department and individual faculty levels with the School of Medicine's Mission and Strategies.

Recognizing the importance of transparency in funds allocation related to resourcing strategic initiatives, MUSC launched a separate parallel effort designed to bring more clarity to its funds flow. This effort was conducted simultaneously with the development of the strategic plan and reached completion just as the critical questions related to resource allocation were being addressed in the planning process. Funds flow was not the only dynamic the strategic planning process gave transparency to. Gaps in the performance of the various departments became more apparent. As a result, leadership attention soon shifted to closing those gaps. In some cases this required the recruitment of new department leadership.

**Strategic Teamwork.** The development of the strategic plan and its Implementation relied on the productive use of a variety of teams. There are prerequisites for the formation of a team. One is shared purpose. Teams exist to accomplish something. Organizations cannot exist for themselves. When they do, they quickly collapse. They exist for a purpose. That purpose is not emergent. It does not bubble up from the organization. The organization bubbles up from its purpose. Absent a coherent shared purpose, teams often ricochet off in unintended directions and work at cross-purposes.

What productive teams produce is combined and coordinated effort that generates value beyond what individuals alone can produce. Humans have a natural, perhaps instinctual, tendency toward teamwork. In his book, The Social Conquest of Earth, E.O. Wilson suggests that *"from infancy we are predisposed to read the intention of others, and quick to cooperate if there is even a trace of shared interest. … Humans, it appears, are successful not because of an elevated general intelligence that addresses all challenges, but because they are born to be specialists in social skills"* (Wilson, 2013, 227).

According to Nassim Nicholas Taleb, in his book Antifragile, *"Collaboration has an explosive upside, what is mathematically called a super additive function, i.e., one plus one equals more than two, and one plus one plus one equals much, much more than three…"* (Taleb, 2012, 233).

Physicians, nurses and administrators cooperate, but this is different from teamwork. Cooperation often lacks the intentionality of teamwork. People who have little or no familiarity with one another can, on an ad hoc basis, cooperate at the scene of an accident, for example. Where teams do exist within health care, they are overwhelmingly focused on relatively narrow tasks with limited time horizons. These are "task-based teams."

Effectively implementing high-level Driving Strategies across health care organizations requires far greater connection and coordination among physicians and other caregivers than has been the case in the past. Implementing such strategies is not the work of a task-based team focused to a discrete time-limited problem or objective. It is the teamwork necessary to support understanding and commitment for high-level initiatives sustained across an entire organization over time. It is "strategic teamwork." Strategic teamwork requires collaboration that is not only purposeful but has coherence and exhibits coordinated effort despite surprises and distractions.

At MUSC, as in most organizations, there are a wide variety of teams already at work. In strategic teamwork, communication, coordination and collaboration must crosscut the organization so as to integrate many existing teams into a "team of teams." A team of teams has a central compass – its broad purpose, its Mission. It has standards of expected behavior – its Values. It has shared aspirations – its Vision. It works to realize these by accomplishing Strategies and Tactics.

When there is an absence of purpose in the space between teams, that space doesn't remain empty. It can get filled with uncertainty, mistrust, rumors and anxiety. When there is a lack of clarity, intentions are often invented. People end up standing in the hallways wasting precious energy and emotion on speculation. Such ambiguity undercuts broad organizational cohesion. For MUSC's Clinical Enterprise, its strategic plan filled in the space between teams with purpose and direction. It provided the clarity needed to overcome debilitating ambiguity.

**Disciplined Implementation.** A common criticism of strategic plans is that they lack "legs." Once written, they too often gather dust on a shelf. The strategic plan at MUSC was designed from the onset with Implementation in mind. Understanding and ownership were intentionally cultivated not only at the level of strategy formulation but related to implementing the plan. Strategy Teams and Tactic Task Forces were formed to support the Implementation of each Driving Strategy and implementation groups were established to facilitate and guide the work of these teams. Participation expanded significantly when Implementation was launched. Crosscutting communication, coordination and collaboration continued as the strategic plan moved to action. The teams assigned to Implementation were given plenty of latitude in defining how best to accomplish Driving Strategies and Tactics. This further enhanced ownership. An Implementation Guide was developed to provide those involved in Implementation with a "user's guide" – a toolbox of ideas and methods that could be used by Teams and Task Forces to facilitate effective Implementation.

**Consistent Communication.** There are a wide variety of audiences in an AMC. They are distinguished by differences in their roles, their training, their experience and their priorities. Many of them simultaneously wear multiple hats. They range from physician scientists to housekeepers. The same approach to communicating the strategic plan cannot be used with every audience. At MUSC, the Communications Group was responsible for helping craft messages well targeted to each audience. But although the approach to communication may have differed, the message did not. In each case, strategic direction and supporting rationale was repeated with consistency. Decisions and initiatives that might otherwise have been viewed as unconnected were explicitly linked to the overall Vision and strategic direction set forth in the plan so stakeholders could see things whole and orient themselves accordingly.

As Porter has observed, *"Strategy used to be thought of as some mystical vision that only the people at the top understood. But that violated the most fundamental purpose of a strategy, which is to inform each of the many thousands of things that get done in an organization every day, and to make sure that those things are all aligned in the same basic direction.*

*If people in the organization don't understand how a company is supposed to be different – how it creates value compared to its rivals – then how can they possibly make all of the myriad choices they have to make?*

*The best CEOs I know are teachers, and at the core of what they teach is strategy. They go out to employees, to suppliers, and to customers and they repeat, 'This is what we stand for, this is what we stand for.' So everyone understands it. This is what leaders do. In great companies, strategy becomes a cause. That's because a strategy is about being different. So if you have a really great strategy, people are fired up; 'We're not just another airline. We're bringing something new to the world"* (Mintzberg, 2005, 44).

**Accomplishment-driven Accountability.** During MUSC's strategic planning process, an important distinction was made between "accomplishment" and "performance." Many strategic planning processes focus attention on setting "goals" as ways to target performance then develop a plan ostensibly to deliver that performance. This gets things backwards as performance is always a result, not a cause. Accomplishments generate performance. Defining the future only in terms of performance goals ignores the rationale that is necessary to guide action. And it is action that must be sustained over time if an organization is to be deliberate and incremental. The strategic plan operates in the realm of accomplishment by broadly asking the questions, "What will we become?" and "What will we do?" It is the "becoming" and the "doing" that produce performance that matters. Performance goals should be set after these two questions are addressed and answer the question, "How will we know accomplishment of our strategic plan is generating the desired performance?" For example, that question might be answered by quantifying targeted increases in preference and quality or reductions in costs and wait times. Unlike many organizations, MUSC held itself accountable not only for performance but for accomplishment of the commitments set forth in its strategic plan.

## Chapter 10: Results and Conclusions

Implementation of the strategic plan for MUSC's Clinical Enterprise began in the fall of 2011 and served as a recipe for significant improvements in its strategic position in subsequent years. In 2013, market research indicated MUSC was the most preferred health system by a wide margin across its nine-county regional service area. Preference had increased by 10% since 2012, and MUSC was rated as having the best image and reputation by a margin twice that of its nearest competitor. Furthermore, it grew its overall market share by 7.5% over the same time period.

Importantly, improvements in its financial performance tracked improvements in its market performance with the hospital achieving a turnaround of 5% in operating margin largely as the result of an intensive cost reduction program. From fiscal year 2011 to 2014, hospital admissions increased 6.1%. Hospital revenues increased over $41 million, an increase of 5.9%. This growth occurred despite a baseline occupancy rate near 90%.

Ambulatory visits increased nearly 20% in FY 2014. This growth was accompanied by a 14.1% increase in ambulatory revenues. New primary care visits more than doubled and primary care revenues nearly tripled. New specialty visits increased by 16%, and specialty revenue growth increased nearly 11%.

By 2014, MUSC's primary care network had expanded to 30 sites with 89 physicians and physician extenders, an average growth rate of over 20% per year since 2011. A statewide telehealth alliance comprised of community hospitals, physicians and a variety of agencies was established and promoted with an aggressive advertising campaign. MUSC's telehealth network now encompasses more than 60 unique sites, hospitals, physician offices, and schools unified in a statewide alliance.

MUSC's focus on improving the quality of patient care resulted in improved rankings in the University Healthcare Consortium (UHC) Quality and Accountability Study conducted annually on over 100 of its AMC members. Its scores on HCAHPS put it among the highest performers nationally not only among AMCs but other hospitals generally. In 2013, on quality of patient services, MUSC was ranked 6$^{th}$ nationally among AMCs in "patient centeredness" based on HCAHPS metrics.

The strategic plan for MUSC's Clinical Enterprise cannot be solely credited with the results described above, but a direct link exists between the plan's Driving Strategies and those results. All align with focused efforts undertaken by Strategy Teams across the enterprise.

MUSC moved deliberately and incrementally across the discernable terrain of its near term future. Through a transparent, inclusive and iterative process, it articulated a Vision that was widely understood and supported. It was towards that aspiration that MUSC resolved to steer, no matter how strong or uncertain the winds. It built on its reputation for advanced capabilities. It significantly reduced its operating costs. It eschewed building new hospitals and instead invested in offering subspecialty care at anchor outpatient campuses. It passed by opportunities to acquire community hospitals and community physicians and instead focused on building a voluntary network of affiliated hospitals and physicians. And it aggressively expanded telemedicine linkages statewide so its faculty could connect with community physicians in an efficient and affordable way that improved access. When it ran into obstacles and surprises, it made incremental adjustments at the level of Tactics while maintaining a deliberate course towards its Vision.

MUSC very intentionally pursued an approach to designing its future that was deliberate and incremental. This contributed significantly to its ability to avoid the perils of fragmentation. In retrospect, implementation of MUSC's strategic plan has positioned it favorably in the face of growing volatility.

**Diagram A**

## INTRINSIC DIFFERENTIATION OF AN ACADEMIC MEDICAL CENTER

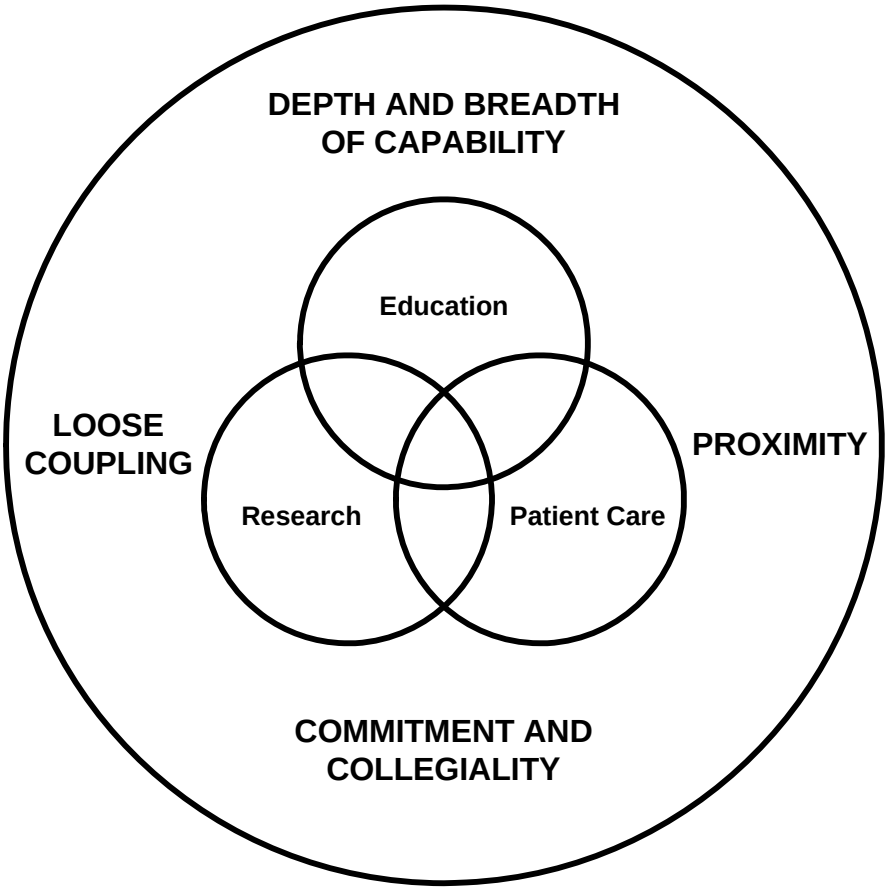


**Diagram B**

## GENERIC STRATEGIES

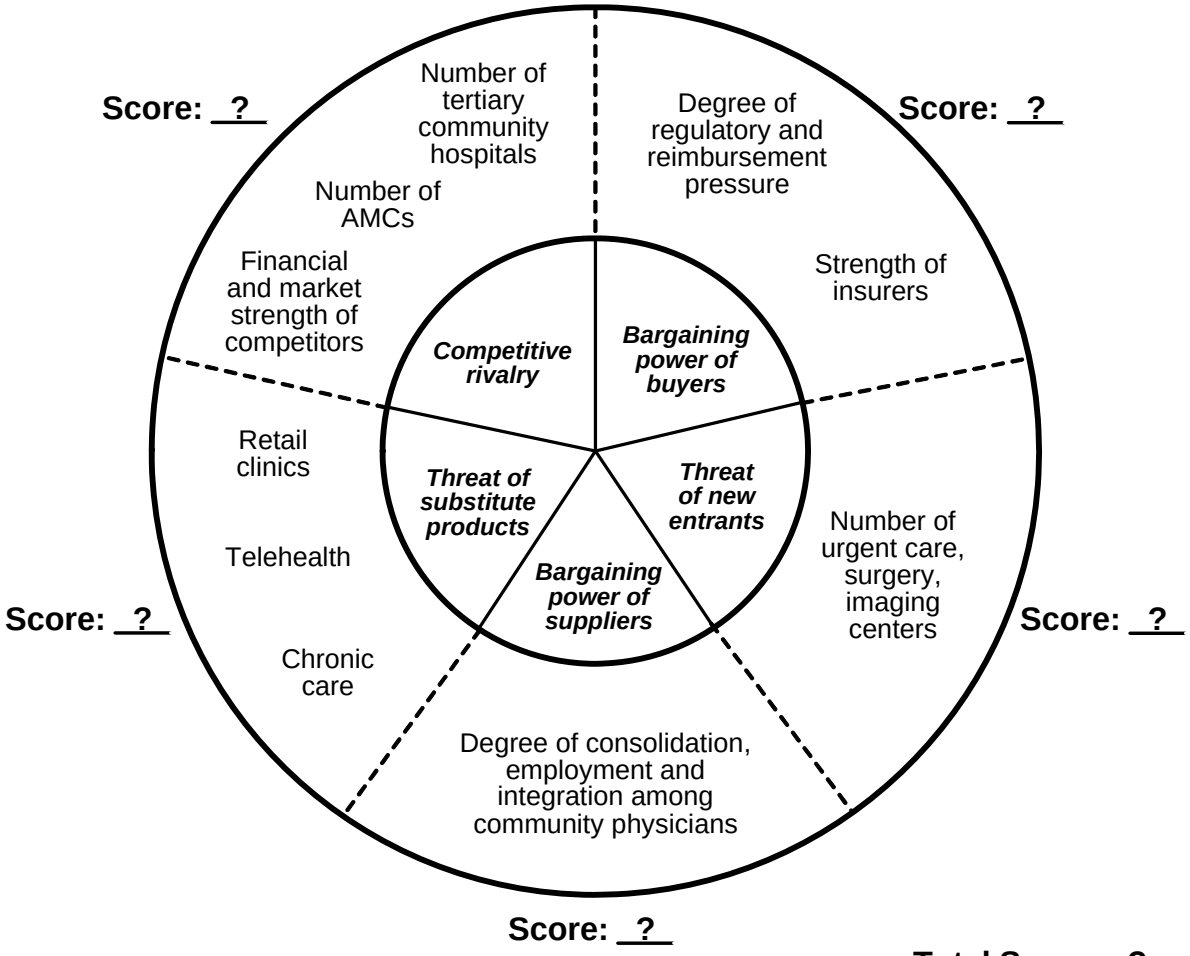
| Strategy | Value Discipline |
|---|---|
| **Best Total Solution * (Focus **)** | **Customer Intimacy * (e.g. Service Excellence)** |
| **Best Total Cost * (Cost Leadership **)** | **Operational Excellence * (e.g. Efficiency)** |
| **Best Product * (Differentiation **)** | **Product Leadership * (e.g. Innovation)** |

*** Treacy and Wiersema generic strategies and discipline**
**** Porter's generic strategies**

**Diagram C**

## VOLATILITY CIRCLE

### Porter's Five Forces Applied to Health Care Market Volatility

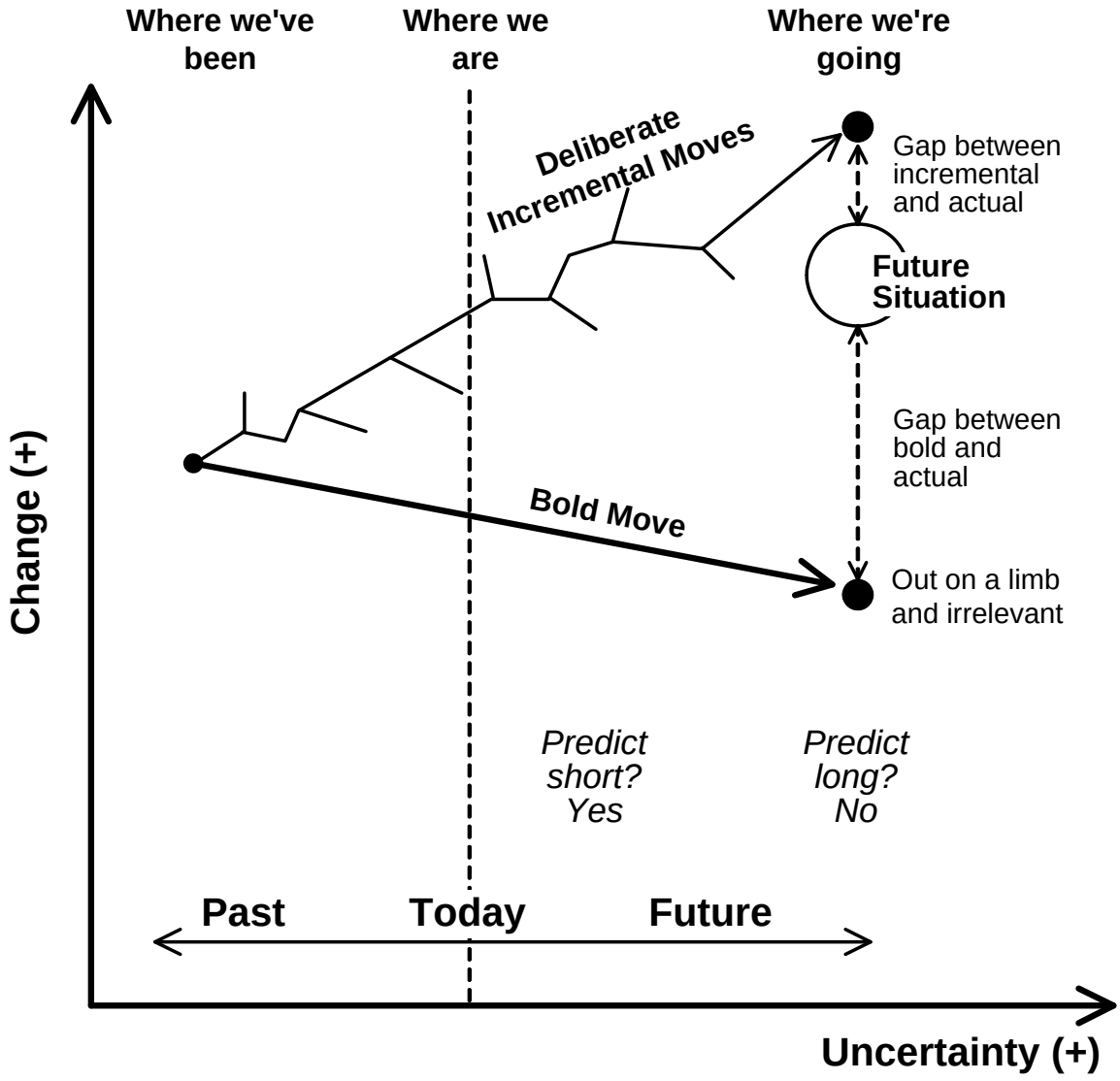



**Total Score: ?**

A qualitative score can be assigned to each of Porter's Five Forces reflective of market intensity. Some forces are likely to be more important than others so weighting of each score may be appropriate. (Porter suggests "competitive rivalry" is the major determinant of profitability.) Totaling the five scores provides a basis for comparing relative volatility of markets.

**Diagram D**

## DELIBERATE INCREMENTALISM CAN ENSURE RELEVANCE THROUGH BRANCHING ADJUSTMENTS AND EXPERIMENTATION




The distance between terminus of "Moves" and "Actual Situation" defines degree of relevance.

**Diagram E**

## STRATEGIC PLAN FRAMEWORK

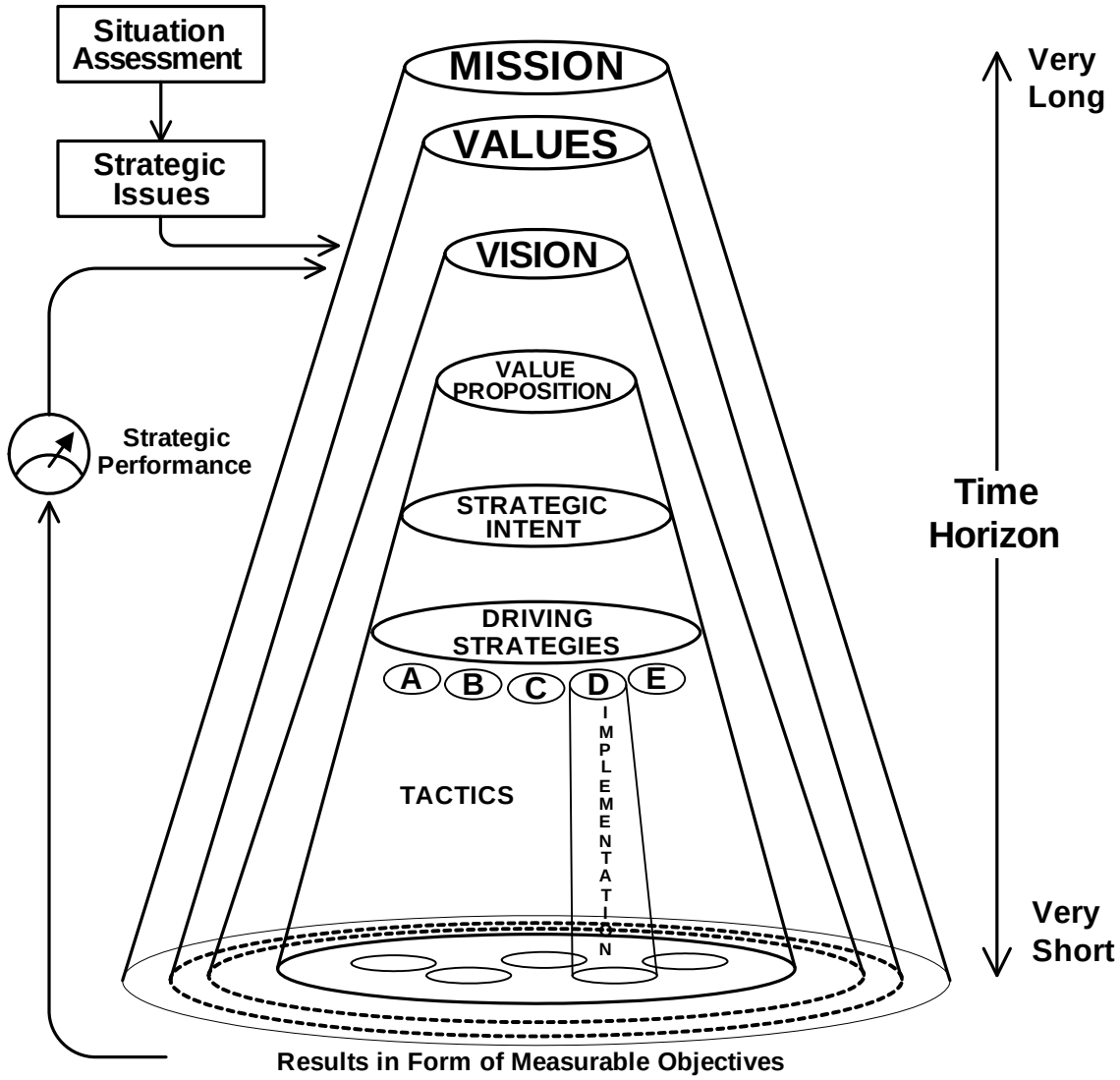


**Diagram F**

## A STRATEGIC PLAN FRAMEWORK
## THAT SUPPORTS DELIBERATE INCREMENTALISM

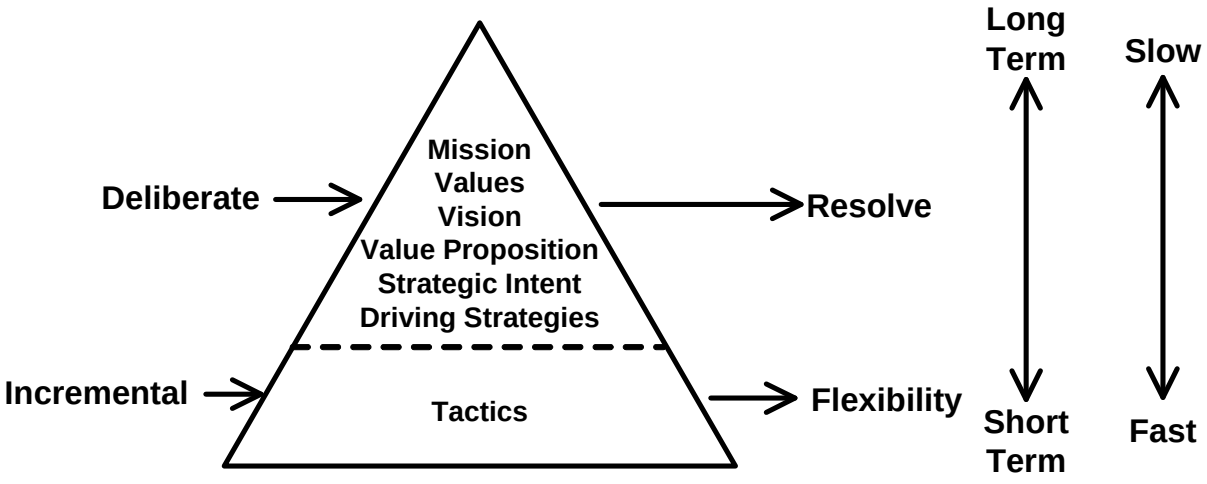
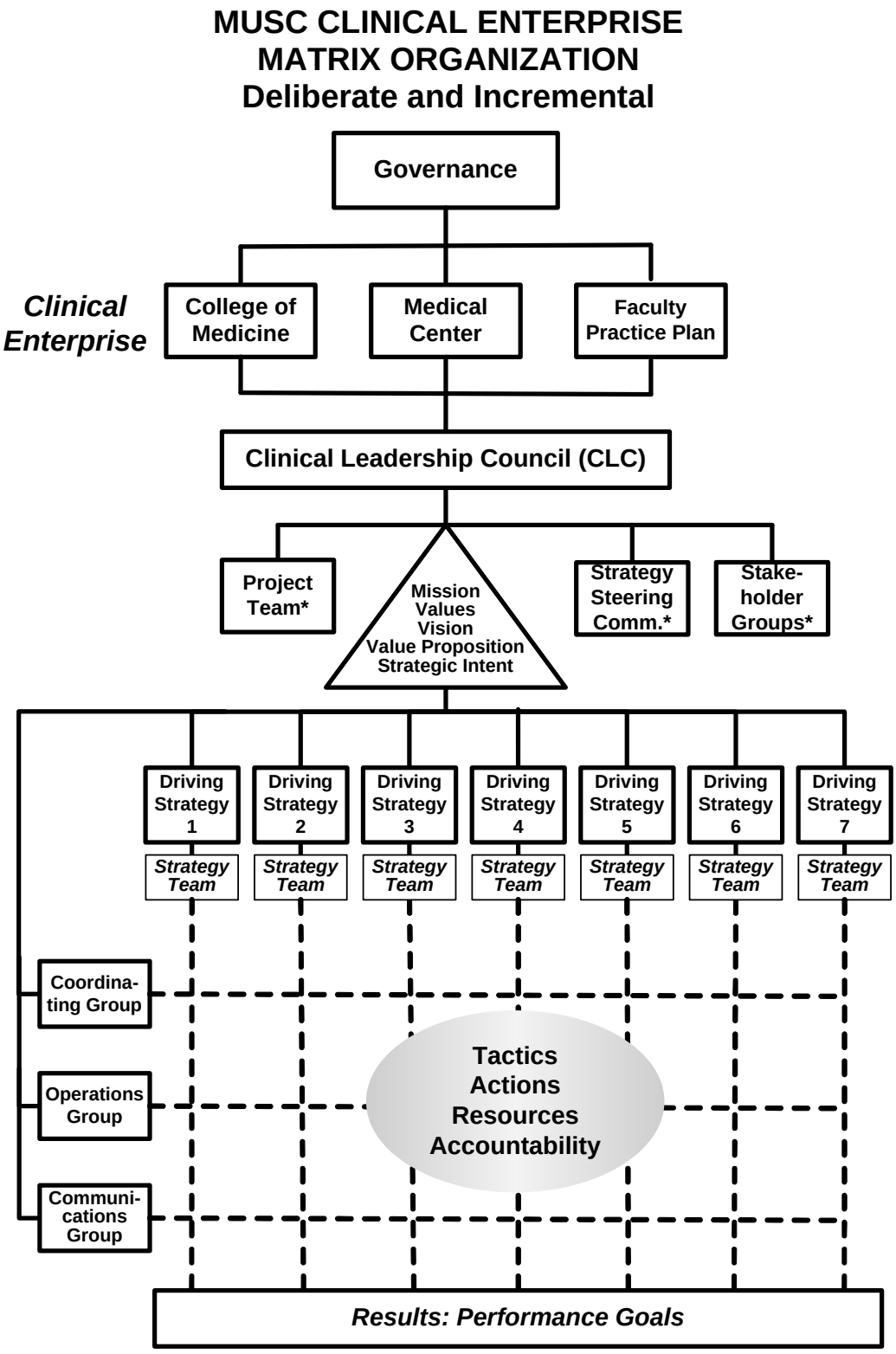


**Diagram G**




* Dissolved once the strategic plan was developed and approved by the Board.

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Jack Feussner is a Distinguished University Professor and previously the Executive Senior Associate Dean for Clinical Affairs at the Medical University of South Carolina. He served as the Professor and Chairman of the Department of Medicine from 2002-2011. Also, from 2005-2009, Jack served as the President of the College of Medicine's Faculty Practice plan and led the dramatic expansion of its clinical enterprise, especially developing outreach clinics in the Charleston metropolitan area. During his term, the Practice Plan expanded to nearly 670 physician members, with approximately 750,000 outpatient visits, and experienced its lowest tax rate, and highest net revenues in recent history.

Before coming to MUSC, Jack was the Chief Research and Development Officer for the Department of Veterans Affairs from 1996 to 2002. During that time, he served also as the Director of the VA Cooperative Studies Program. While in Washington, Jack served on the President's Committee on Science in the Office of Science and Technology Policy. He was Chairman of the Gulf War illnesses Research Working Group for the consortium of the Departments of Veterans Affairs, Defense, and Health and Human Services. He served on the Policy Council for the AHRQ and the Clinical Trials Inquiry Panel for the United Kingdom's MRC. He currently serves on multiple advisory committees for the Department of Veterans Affairs and the Department of Defense. Jack completed a four-year term as a member of the Clinical Research Roundtable for the Institute of Medicine, a major product of that work being the concept for the new NIH CTSA initiative.

Prior to his time in Washington, Jack was a Professor of Medicine and Chief of the Division of General Internal Medicine at Duke University. Jack led the Division to national prominence on the basis of its extramural research funding, and the Division was among the top 3 research funded divisions in the Department of Medicine. In Durham, Jack led one of the first nationally funded VA Centers of Excellence in Health Services Research. Jack co-founded and co-directed the Biometry training program at Duke in 1986, one of the first clinical research training programs in the nation directed specifically to physician investigators. While he was Division Chief, the Department of Medicine further diversified its training program to create a separate residency track for primary care general internal medicine, in addition to the categorical training program.

**John R. Feussner, MD, MPH** (continued)

Jack completed his undergraduate education at the University of Pennsylvania; received his MD degree from the College of Medicine at the University of Vermont and completed his Internal Medicine training, and served as Chief Medical Resident, at Duke University Medical Center. He received his MPH degree from the Department of Health Policy and Administration at the University of North Carolina in Chapel Hill. Jack continues as an Adjunct Professor in the Department of Health Policy and Administration at the School of Public Health, University of North Carolina. He has authored or co-authored nearly 250 publications including peer reviewed research papers, editorials, symposia and other articles.

Jack is a member of Alpha Omega Alpha, the National Medical Honor Society and is a Fellow in the American College of Physicians. Jack was elected to Delta Omega, the Honorary Public Health Society. He was the first recipient of the Wolcott Award for Clinical Excellence from the Department of Veterans Affairs. He received a Distinguished Investigator Award from the Sheps Center for Health Services Research at the University of North Carolina, and the Medical Alumni Association Award for Distinguished Academic Achievement from the University of Vermont. He was the second recipient of the John Eisenberg Award for Career Achievement in Research from the Society of General Internal Medicine. Other honors include designation by the Medical University of South Carolina as a Distinguished University Professor. In 2009, he was honored to receive the Earl B. Higgins Achievement in Diversity Award, also from MUSC.

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Dan Beckham has consulted with some of the most influential and successful health care organizations in America. The Beckham Company's unique strategic planning approach has helped more than 150 hospitals, health systems and physician group practices produce important results including significant financial turnarounds and dramatic market share growth.

In addition to helping clients develop comprehensive strategic plans, Dan often assists with key strategic initiatives like acquisitions and mergers as well as organization design and restructuring. Engaging physicians as productive and committed participants in hospital and health system strategy formulation is a particular strength.

Prior to joining the executive team of a hospital, Dan was an executive with two Fortune 500 health care companies. He also participated in taking a hospital management company public in the early 90s.

Dan is past-chairman of the Board of Directors of the American Marketing Association, the world's leading association for marketing professionals. In 1986, Dan's contributions to health care marketing and strategic planning earned him the Steuart Henderson Britt Award for excellence in marketing and strategy presented by the American Marketing Association (an honor he shares with the late Ray Kroc, founder of McDonald's).

In 1989, the Academy for Health Services Marketing further recognized Dan's contributions to the field, particularly his efforts related to physician strategy, by awarding him the Kotler Award named for Northwestern University's renowned marketing professor, Philip Kotler. (Former Surgeon General, C. Everett Koop, M.D., was also a recipient of the Kotler Award.)

For more than two decades, Dan has been a contributing editor on strategy to American Hospital Association publications. He has published more than 100 articles on strategy and leadership. He is a three-time winner of "best article of the year" awards from the American College of Healthcare Executives and the American Hospital Association.

Dan earned an undergraduate degree in history from Northern Illinois University and an MBA from DePaul University.