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STRATEGIC PLANNING AS A TOOL FOR ACHIEVING ALIGNMENT IN ACADEMIC HEALTH CENTERS

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ABSTRACT

After the passage of the Patient Protection and Affordable Care Act in March 2010, there is an urgent need for medical schools, teaching hospitals, and practice plans to work together seamlessly across a common mission. Although there is agreement that there should be greater coordination of initiatives and resources, there is little guidance in the literature to address the method to achieve the necessary transformation. Traditional approaches to strategic planning often engage a few leaders and produce a set of immeasurable initiatives. A nontraditional approach, consisting of a Whole-Scale (Dannemiller Tyson Associates, Ann Arbor, MI) engagement, appreciative inquiry, and a balanced scorecard can, more rapidly transform an academic health center. Using this nontraditional approach to strategic planning, increased organizational awareness was achieved in a single academic health center. Strategic planning can be an effective tool to achieve alignment, enhance accountability, and a first step in meeting the demands of the new landscape of healthcare.

In the last 30 years, healthcare in the United States has increasingly dominated the American conscience, primarily driven by increasing costs, perceived decrease in value compared to other industrialized countries, the existence of medical errors, and the persistent veil of health disparities. Clearly, there is a need for change; however, since the attempts of the Clinton administration, those efforts have dissolved into acrimonious debates and partisan posturing. In the midst of this vortex of rancor, academic health centers have continued to navigate the turbulence, successfully achieving goals in education, research, and service to communities. However, in the wake of the passage of the Patient Protection and Affordable Care Act in March 2010 (1), there is an externally driven mandate to urgently change not only fundamentally how care is delivered, but also how the next gen-

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eration of physicians and other healthcare professionals are educated and trained. Never before has there been a greater urgency for alignment of the key partners that comprise academic health centers, whether it is a cadre of educational institutions, partnerships between educational institutions, hospitals, and practice plans, or fully integrated academic medical centers anchored in a tripartite mission of education, research, and service, the time to fully align across a common vision and purpose has never been more poignant.

The healthcare marketplace can be described as volatile given the magnitude of the cost structure, the fragmentation of the components across the educational and delivery spectra, the slow recovery of the American economy, and the external requirements of federal legislation. Organizations must be responsible stewards of precious resources, both human and physical, despite the turbulence. Academic health centers cannot afford to fail given their sacred purpose of healing individuals and communities. Thus, the question arises, how does an academic health center survive during this period of great uncertainty?

Aligning fragmented entities across a single mission and vision has been viewed as a first step in achieving the goal of effectively meeting targeted objectives. The thesis of this article is that the process of strategic planning can be an effective first step in achieving that necessary alignment (2). The importance of strategic planning as a foundation for effective strategic management has been underscored by Steiner (3) as noted in the following quote, "[an organization] . . . may overcome inefficient internal resource use if its basic strategy is brilliant, but it is not likely to overcome the wrong strategies even with excellent . . . performance." Using a high engagement method of conducting strategic planning can increase the pace of implementation of a new strategy or work effort because of the buy-in of a critical mass of individuals involved. (4) Indeed, there has been greater attention in the literature to the need to be aligned across a single purpose and not as great attention to the actual blueprint for performing strategic planning. Nontraditional techniques such as the Whole-Scale (Dannemiller Tyson Associates, Ann Arbor, MI) engagement (5) and appreciative inquiry (6) can more rapidly transform the culture of an organization while tapping into its positive energy. Ultimately, shaping the plan into a balanced scorecard (7) will drive accountability across measureable performance metrics. Thus, the purpose of this article is four-fold: 1) To further review why alignment in academic health centers is critically important, 2) To define alignment in the context of academic health centers, 3) To review the pros and cons of traditional

versus nontraditional approaches to strategic planning, and 4) To present a case study of a nontraditional approach to strategic planning that resulted in behavioral transformation.

WHY IS ALIGNMENT SO IMPORTANT?

Although The Patient Protection and Affordable Care Act (1) is currently being challenged in the judicial system, the landscape of the healthcare industry is nonetheless progressively being transformed. With emphases on prevention, quality, and value-based purchasing, hospitals and providers must dramatically adjust their strategic and operational management to respond to new requirements to survive. Significant changes that are likely to occur that will impact academic health centers include reduction in supplemental payments such as funding for graduate medical education and disproportional share payments, greater accountability for cost of healthcare delivery and outcomes, alignment of reimbursement with a greater emphasis on preventive services and primary care (8), and a significant decrease in federal support for research (9).

As a result, academic health centers must be unified in mission, vision, and values, and agile enough to respond to these increasingly more prevalent changes in the healthcare marketplace. Fundamentally, there should be a culture of collaboration and accountability that can best be achieved by a heavy reliance on data. Although the shift to evidence-based care in practice has moved the academic culture to a more data-driven "core," a culture of collaboration has been more difficult to achieve. One may view this particular challenge as modestly achievable from an external perspective; however, when viewed from an internal perch, long-standing disagreements between providers and hospitals in particular can fuel an atmosphere of distrust and an absence of a shared purpose. When academic health centers will only be reimbursed for high quality, well-coordinated, evidence-based care in the future, it is ill affordable to ignore the core cultural elements that can derail well-intentioned strategies.

WHAT CONSTITUTES ALIGNMENT?

Before proceeding with a discussion regarding how alignment is achieved, it is important to define the outcome that is targeted and the models of academic health centers in which alignment must be attained. In a fully aligned academic health center, the medical school, practice plan, and the hospital share common goals. Fundamentally, there should be full alignment across mission, vision, and values.

The Chartis Group (8) notes five different models of academic health centers. When considering an independent model, the medical school, practice plan, and hospital are governed by separate and distinct entities. This (the first) model is likely to be the most difficult to align given the independent bodies that must ultimately agree upon a shared course of action. Another model (the second) is the academic enterprise model, in which the medical school and the practice plan are governed by a single entity and the hospital is independent. In this case, the dean may provide the oversight of both the medical school and the practice plan providing the assurance of alignment across the providers, educators, and researchers. A third model is the separated practice plan model, in which the medical school and the hospital are under a common governance body. A fourth model is one in which the practice plan and the hospital share common oversight and the medical school is separate; in this plan, there may be particular challenges in assuring that the academic mission is addressed. A fifth model, which on the surface may be the best able to foster a common vision, is the integrated model. In any of these organizational designs, the culture of the institution must be able to support the sustainability of the strategy, emphasizing the incredible importance of addressing cultural transformation from the outset.

Strategy and governance are two key dimensions of alignment. The Chartis Group (8) also notes the importance of management and economic contributors to alignment. A shared stake in improving key processes that contribute to operational efficiency of the organization is critical. Moreover, clarifying the flow of funds between the hospital and the medical school is key to the sustainability of the educational enterprise. Not only must the leadership be working together in all four dimensions, specifically strategic, accountable oversight, operational management, and fiscal, to be fully effective, but also the faculty, other providers, and staff should at least be motivated to a strive for a common purpose.

WHAT ARE THE PROS AND CONS OF TRADITIONAL VERSUS NON-TRADITIONAL APPROACHES TO STRATEGIC PLANNING?

Now that the need and urgency of bringing fragmented units together in academic health centers has been established and alignment has been defined considering the variety of organizational models that exist, it is helpful to review traditional approaches to strategic planning versus nontraditional approaches.

What are we defining as a nontraditional approach to strategic planning? For the purposes of this article, there are three components: 1) Whole-Scale engagement, 2) appreciative inquiry in approach, and 3) the balanced scorecard to drive accountability. Whole-Scale change is best described as a methodology that allows organizations to achieve rapid change with very high levels of participant engagement and commitment. It engages many more stakeholders—the whole system or a representative slice—in the process of planning and implementation (5). Appreciative inquiry is a "radically affirmative" strategy for intentional change that completely lets go of problem-based planning. It is a cooperative search for the strengths, achievements, and generative forces that are found within every system and that hold potential for inspired, positive change (6). At a high level, the balanced scorecard is a framework that helps organizations translate strategy into operational objectives that drive both behavior and performance (7). Given the limited scope of this article, only an in-depth discussion regarding Whole-Scale engagement is provided below.

WHOLE-SCALE APPROACH TO STRATEGIC PLANNING

Research findings have shown the ability of Whole-Scale change methodology to enhance the level of organizational awareness. Increasing the awareness at the institutional level supports better understanding of the organization's strategy, resulting in a common or unified view of the need for change. Using qualitative and quantitative analysis in the setting of a publisher of a large metropolitan newspaper, Arena (10) showed the benefits of using Whole-Scale methodology to increase organizational awareness as an important building block in the strategic planning process. Developed by Dannemiller et al (5) in the 1980s working with the Ford Motor Company, this technique has now been used in a variety of settings to stimulate cultural transformation, plan strategically for the future of the organization or change the design of a collective work effort. These findings support the notion of the Chartis Group (8) that building a "shared stake" in the future would support alignment versus further fragmentation of academic health centers. Bringing together large numbers of the organization serves as a catalyst of sorts, quickly engaging and moving people in a forward, vision-focused direction.

The pros and cons of traditional versus nontraditional approaches to strategic planning are summarized in Table 1. Strategy is considered a primary responsibility of the CEO—championing the planning process and setting the tone for its development and implementation.

TABLE 1
Traditional Versus Nontraditional Approaches to Strategic Planning

Questions	Traditional	Nontraditional
Who is engaged in planning?	Leadership Team	Leadership and a cross-section of stakeholders
What is the approach?	Environmental scan SWOT analysis Prioritize specific issues Develop mission/vision/goals	Environmental scan Appreciative inquiry regarding aspirations and values Develop mission/vision/goals
What are the pros?	Buy-in of the leadership Can be completed in a short time	Buy-in of a larger proportion of the stake holders/Can achieve cultural transformation more quickly
What are the cons?	Limited buy-in/Limited input Laundry list of initiatives with limited accountability Implementation takes a long time	Difficult to manage expectations

Where these two approaches differ begins after this initial assumption: Who is involved in the process? Typically, in traditional planning, a small group of executives may assemble off-site, develop a plan, and then bring it back to the "masses" for comment and implementation. Traditional, "top-down" planning has two major drawbacks: 1) it creates resistance, considering that people are usually "informed" of the answers, and 2) it requires a great deal of time to implement. In the nontraditional approach, there is a cross-section of stakeholders (defined in the Whole-Scale approach as "critical mass") engaged in the design of the plan. Thus, immediately, there is momentum deeply embedded in the organization to move the plan quickly to implementation. The preparation in developing the plan also differs. In the traditional approach there is a structured process of considering strengths, weaknesses, opportunities, and threats followed by the prioritization of specific issues and plans to address those issues. In the nontraditional approach on the other hand, participants are asked to consider the positive attributes of the organization as a lens for planning for the future. This appreciative approach taps into the positive energy of the organization and reduces the tendency for participants to merely vent about their negative experiences (6). One of the drawbacks of this nontraditional approach is the difficulty of managing expectations, particularly if participants have not had the opportunity to engage in developing strategy previously. Accountability can be addressed using the balanced scorecard (7) in the nontraditional approach rather than a laundry list of initiatives outlined in a more

traditional strategic plan. The data-driven approach (balanced scorecard) of the nontraditional model provides a useful dashboard for monitoring progress.

STRATEGIC PLANNING AT AN ACADEMIC HEALTH CENTER: AN ILLUSTRATIVE CASE STUDY

In the spring of 2010, an academic health center, consisting of a hospital, a health sciences library, and colleges of medicine, dentistry, pharmacy, and nursing and allied health sciences, brought new leadership to the helm to create an integrated and aligned structure of the currently loosely connected parts of the enterprise. The newly formed leadership team determined that a traditional approach to alignment might only support the results that were seen after the prior planning approach—a plan, created by a small leadership group with limited buy-in from the bulk of the organization. To support a radically different result that would foster engagement and alignment rather than blame and further fragmentation, the leaders identified a nontraditional approach outlined above as the framework for their planning effort. In an attempt to involve the correct "critical mass," an "extended leadership team" (leaders by role joined by other thought and high potential leaders in the organization) was created to champion and monitor the strategic planning process.

THE CASE FOR CHANGE: THE CURRENT STATE OF THE ENTERPRISE

As is true of many organizations, the components of the enterprise did not share a common mission. Each school and the hospital operated within its own scope of responsibilities, the schools focusing on educational programs and the hospital concentrating its efforts on primarily patient care and service delivery. As an example of the fragmentation, not all educational programs were conducted in the hospital or outpatient facilities, and at times contracts with third-party payers conflicted between groups practicing within the clinical enterprise. Financial obligations between the hospital and clinical subunits had not been met for years. Not surprisingly, there had not been significant growth in either patient or research revenue for decades. The accreditation of many of the programs shared between the hospital and the schools had been threatened in recent years. Finally, at the dawn of an era when hospitals and provider groups would only be paid for the highest quality care, quality scores hovering in the lowest quartile were threatening the financial sustainability of the entire enterprise. Thus, there was no time to waste

in bringing all of the stakeholders up to the same level of understanding regarding the urgency and need for change.

THE JOURNEY: HOW AN ACADEMIC HEALTH CENTER MOVED FROM FRAGMENTATION TO ORGANIZATIONAL AWARENESS

The Whole-Scale Change approach is predicated on the notion that to support real change (in the case of this health sciences enterprise, a new strategy), everyone must come together and build on a "common database" or a common level of understanding (current state and future possibilities). In this case study, the enterprise began the journey by first working with an "extended leadership team" (VP, Deans, CEO, and key "thought leaders") to build a common understanding of the case for change (referenced above), how the current fragmented system currently operates and relates, and to agree on a common taxonomy around strategy. This initial step included an external stakeholder analysis (board, community, other university leaders who were not in the health sciences part of the organization), an internal stakeholder analysis (students, other health sciences faculty and leaders), an analysis of the current operating environment (the data in the case for change was not widely understood at the time), and agreement on a robust strategy development process.

Once the "extended leadership" team came together, shared their own hopes and dreams/aspirations, and agreed on an approach and timeline, the organization began to engage others in the organization on the journey to create a shared mission, vision, values, and goals. Again, using a Whole-Scale approach, a "microcosm" (small group that represented various voices/perspectives from all different parts of the organization) team was chartered and planned a large group meeting (350 people) that would be conducted over 2 days and a subsequent series of town hall type meetings that would take place over the course of 2 months to engage the entire organization. Figure 1 shows the timeline of this case study. The large group meetings and follow-up town halls resulted in raising the level of organizational awareness and began to engage many people in a thinking and planning process in which they had never before been asked to contribute.

A written evaluation was collected from each participant at the end of the first large group meeting (see the timeline). The summary of the participant evaluations supports the work of Arena (10), in which more than half the participants listed the most significant outcome from the 2-day planning meeting was the process itself,

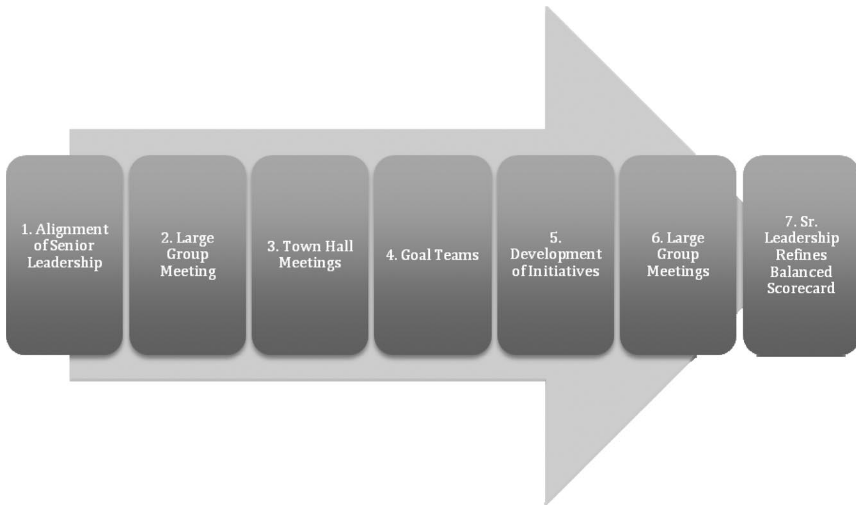

FIG. 1. Seven-month timeline: from conception to balanced scorecard.

commenting that it supported "transparency" and "involvement." One participant wrote, "The most significant outcomes for me were the engagement of faculty. I saw a faculty eager to contribute and to be part of the establishment of the healthcare enterprise. I felt faculty input was considered valuable in meeting the objectives of the health sciences enterprise." The last question of the evaluation asked participants to cite what the most important thing they believed they might do after the meeting to support the organization in moving towards its vision of success. Approximately 60% of participants noted that they would do "their part" in implementing the strategy. One participant noted, "I immediately began thinking of the things I could do differently to make this vision a reality."

The extended leadership team used all the data from the large group meeting and the subsequent town hall meeting and finalized a vision, mission, set of values and high- level goals for the enterprise. Once additional members of the organization had been involved in the thinking and creating of those parts of the plan, it was relatively easy to gain agreement and accountability across the enterprise. The leaders in the organization quickly began to see the connections across the enterprise and how they might come together and begin to move in the direction or their desired future.

Phase two of the planning processes used the Whole-Scale principle of diverging to create strategic objectives that would support each of the goals, by using members of the extended leadership team along with new microcosm teams that were selected or volunteered

from throughout the enterprise. These teams, called “Goal Teams,” worked independently over the course of 2 months to create strategic objectives and some action plans to support the objectives. Because of the urgency to choose focus for clinical activities (budget and limited resources created the urgency), one of the goal teams moved to the next level of strategic activity and selected, using a criteria-based decision-making approach, the top areas/disease states that would be the recipients of strategic investment for the future. For this particular goal area, the key leaders in the clinical and research area were used in the decision-making process so that they could support the outcome. Because the process was based on criteria (versus beliefs), decisions regarding future strategic investments were reached quite easily.

Once all of the goal teams finished their work on strategic objectives and activities, the microcosm planning team was again used to help design two half-day check-in meetings, each meeting engaging many more employees and stakeholders. The strategy was adjusted and ratified by those who attended, along with the extended leadership team. The enterprise then adopted a communication strategy that involved strategy updates to inform and educate employees throughout the enterprise who might not have attended one of the half-day meetings about the new strategy and balance scorecard. Evaluations from the final strategy meetings were almost identical to the evaluations from the first large group meeting; more than half of the participants in each of the final session said that the most significant part of the meeting was the process used for planning (i.e., their involvement supported greater understanding).

THE END PRODUCT: THE BALANCED SCORECARD

To drive accountability, it was important to create a plan that was driven by metrics and timelines. Table 2 shows an example of a balanced scorecard that became the final product of the 7-month exercise. In this case, the goal was building excellence in research and patient care. Essentially, the group decided on four important dimensions to build initiatives: 1) organizational capacity, 2) internal processes, 3) financial stewardship, and 4) customer perspective. Initiatives were distributed across these dimensions. Performance metrics were assigned to each of the initiatives chosen. This exercise was undertaken for each to the five goals. During the next year, the leadership team planned to use the scorecard to track progress.

TABLE 2
Example of a Balanced Scorecard: Mapping of a Goal to Increase Clinical and Research Revenue

Perspectives	Strategic Initiatives	Performance Metrics
Customer	Increased funding for research	Double the number of RO1 grants
Financial stewardship	Increase in the profit margin of three hospital services	10% increase in the margin of cardiovascular, mental health, and renal services
Internal processes	Improve the process for faculty appointments	Reduce time to appointment by 33%
Organizational capacity	Develop a proteomics core facility	Proteomics core facility developed by end of FY

SUMMARY

In summary, we have described an approach to strategic planning that can contribute to the transformation of a culture over a 7-month period. Unlike a more traditional approach that may engage only a small leadership group, the Whole-Scale approach provides a means of engaging a critical cross section of the organization in a very positive process. Appreciative inquiry is the second component of this approach that allows the leadership to tap into the positive energy of the enterprise. Accountability is ultimately the goal to ensure that the plan becomes integrated into the day-to-day operations of the organization. In this example, accountability was driven by a balanced scorecard approach. The balance of each of the components of this nontraditional approach to strategic planning will be determined by the needs of the organizations and the intentions of the leadership.

REFERENCES

1. Available at: www.healthcare.gov. Accessed: December 1, 2011.
2. Fawcett S, Schultz J, Watson-Thompson J, Fox M, Bremby R. Building multisectoral partnerships for population health and health equity. *Prev Chronic Dis* 2010;7:1–7; Available at: http://www.cdc.gov/pcd/issues/2010/nov/10_0079.htm.
3. Steiner GA. Strategic Planning. What Every Manager Must Know. London: Collier Macmillan Publishers; 1979.
4. Bryson J, Anderson S. Applying large-group interaction methods in the planning and implementation of major change efforts. *Public Admin Rev* 2000;60:143–63.
5. Dannemiller K, Tolchinsky P, Loup R, et al. Whole-Scale Change: Unleashing the Magic in Organizations. San Francisco: Berrett-Koehler Publisher Inc; 2000.
6. Whitney D, Trosten-Bloom A. The Power of Appreciative Inquiry: A Practical Guide to Positive Change. San Francisco: Berrett-Koehler Publisher, Inc; 2010.
7. Norton D. In: Balanced Scorecard Report: Insight Experience, and Ideas for Strategy-focused Organizations. Cambridge: Harvard Business School Publishing Corporation; 2002.

8. The Chartis Group. Achieving optimal alignment in academic health centers. Available at: www. chartisgroup.com. Accessed: March 2010.
9. US Basic Research: A need for serious attention. (2008) National Science Board. Available at: www.nsf.gov/statistics/nsb0803/start.htm. Accessed: December 1, 2011.
10. Arena MJ. Enhancing organizational awareness: an analysis of whole-scale change. *Organization Develop J* 2004; 22: 1–11.