

Strategic Planning and Recruitment of Academic Department Chairs

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Over the past two decades, the role of Department Chair in academic health centers (AHCs) has become much more complex and challenging. Clinical income has grown, but so have clinical costs and competition from community medical groups and centers. Research budgets have also grown, but rapid growth in the number of research teams competing for grants in a more limited federal funding environment have made grants much harder to win. Expectations for medical education have grown while federal support has shrunk. Taken together, the effect of all these trends has been to increase significantly the responsibility placed on Department Chairs, the “line managers” of academic medicine, to manage resources effectively and efficiently. As the Association of American Medical Colleges (AAMC) and others have noted, today’s Department Chairs need different skill sets and new tools to manage departmental business, interdepartmental and institutional relationships, and broader social issues.^{1,2}

Strategic planning is a proven managerial tool for increasing organizational effectiveness and efficiency. As Kenneth Andrews of Harvard Business School described it in 1971, strategic planning integrates an organization’s values & aspirations, market opportunities, core competencies and resources, and obligations to society in a forward-looking plan that allocates resources to achieve institutional goals.³ Despite its ubiquity in large organizations around the world, relatively few medical school Department Chairs have made the commitment required to undertake true strategic planning in their departments. While planning certainly takes place, it is often internally focused and rarely as comprehensive as classic strategic planning.

STRATEGIC PLANNING AND CHAIR RECRUITMENT

Nowhere is the need for a department strategic plan greater than when a medical school is recruiting a new Chair. Many medical schools and their teaching hospitals offer multi-million dollar “packages” to new Chairs, and, while appointment letters invariably define accountabilities in some fashion, even the most detailed appointment letters fall short of true strategic plans.⁴

¹ Association of American Medical Colleges (AAMC), *The Successful Medical School Department Chair: A Guide to Good Institutional Practice*. Washington: AAMC, 2003.

² I.W. Hecht, M.I. Higgerson, W.H Gmelch & A. Tucker. *The Department Chair as Academic Leader*. Phoenix: Oryx Press, 1999

³ Kenneth R. Andrews, *The Concept of Corporate Strategy*, Homewood, IL: Dow Jones-Irwin, 1971.

⁴ For the “state of the art” in appointment letters, see AAMC, *The Successful Medical School Department Chair, op cit.* pp 30-31 and Appendix 13 and P.F. Griner & D. Blumenthal, “New bottles for vintage wines: The changing management of the medical school faculty, *Academic Medicine*, 73(6), 1998, pp. 720-724.

BDC Advisors has helped several new Chairs develop departmental strategic plans. Rather than a list of responsibilities and commitments, these plans detail the new Chair's vision for developing his or her department, link this vision to specific goals, detail specific resources (staffing, financial, etc.) required to achieve these goals, and define the commitments that both sides (the institution and the Chair) make to each other.

BDC Advisors' approach to strategic planning for academic departments incorporates all three departmental missions – patient care, education, and research. Departmental faculty can be directly involved in the planning process or brought in later, depending on the desires of the Chair and the purpose of the plan. We seek input from the medical school and hospital(s) to make sure that the departmental plan is synergistic with the plans of the sponsoring organizations. The result of this process is a departmental strategic plan that includes the following components:

- Overall departmental strategic vision
- Clinical development
- Education program
- Research program
- Recruitment phasing
- Financial resource requirements
- Implementation plan
- Monitoring plan

The strategic planning process defines resources, accountabilities, and commitments that maximize the “return on investment” to the sponsoring organization(s), with the full support of the Chair.

WHEN TO PLAN?

A departmental strategic plan can be used at different stages of the recruiting process:

- Prior to beginning the search, to clarify institutional goals and priorities for the department, resources available, and success requirements for the position
- Once the search has narrowed to one or two candidates, to help them:
 - Articulate their vision and goals for the department
 - Reconcile goals with institutional priorities and resources
 - Define a reasonable recruitment “package” that contains appropriate commitments and accountabilities
- After the search is complete, to help the new Chair get to know their faculty, prioritize investments, and mobilize faculty around his or her departmental goals

We have attached two case studies that illustrate how strategic planning was used in two of these situations:

- Case Study #1 was commissioned by the Chief Academic Officer of a large and fast-growing graduate medical education program in order to develop resource requirements for new Chairs and to establish accountability around specific commitments to institutional goals
- Case Study #2 was commissioned by a new Chair who wanted help in maximizing the “return on investment” of his financial package and mobilizing his faculty around his vision and goals

While we believe some new Chairs will, on their own, understand the value of strategic planning in helping them invest their packages, we suspect that the model described in Case Study #1 will be more common. Initiating structured strategic dialogues between the medical school and teaching hospital and future department Chairs has significant benefits to both the Chairs and the institution. Strategic planning forces new Chairs to be clear about their vision, the specifics of how they will carry it out, and the outcomes that should be expected from their effort. At the same time, strategic planning helps the institution clarify responsibilities and expectations of the new Chair and serves, in conjunction with the letter of appointment, to ensure departmental accountability to institutional goals.

FOLLOW-UP “10,000-MILE CHECKUP”

Of course, the best strategic plans are just plans. What matters is how they are implemented and the results they produce. In one case, the consultants were asked to come back a year later for a “10,000-mile checkup” to evaluate progress. We found:

- A number of the initiatives in the plan had been implemented successfully
- Several initiatives had died from lack of leadership (In some cases, faculty left the institution; in other cases, they were distracted by other activities.)
- In many cases, the plans had to be modified during implementation. In fact, “re-engineering” should be viewed as a natural part of the implementation process.

The principal value of the “check-up” was providing the Chair and the institution with an objective assessment of progress relative to agreed-upon goals. Transparency and accountability around performance is not always easy to achieve in the academic environment.

CASE STUDY # 1 – BUILDING OUT A NEW MEDICAL EDUCATION PROGRAM

BDC Advisors was contacted by the chief academic officer (CAO) of a new hospital-based medical education program that was hiring Chairs for several key departments,

including surgery and medicine. The CAO and the hospital's chief operating officer had several concerns relative to these new Chairs:

- They wanted to make sure the new Chairs had worked through their program development plans in a thoughtful, realistic way
- They needed to know how much these plans were likely to cost the hospital
- They wanted specific commitments from the new Chairs on outcomes they would achieve with the resources they were given

To address these concerns, the hospital retained BDC Advisors to work with several Chairs to develop departmental strategic plans for their first five years. BDC Advisors consultants worked directly with the Chair or Chair-designates to articulate their clinical, research, and educational programs, develop plans for faculty recruitment and other investments needed to build these programs, and define outcomes they were willing to commit to in each area. These plans were used in different ways for different departments:

- In one case, the candidate had already accepted an offer, contingent on coming up with an acceptable "package," and the plan was used to make the package explicit
- In one case, the candidate had not yet accepted an offer and used the plan to ensure the resources would be there
- In one case, it became clear in the planning process that the Chair's requirements and willingness to make commitments were out of line, and the candidate was dropped.

While the hospital commissioned these plans, the Chairs viewed the consultants as resources they could use to develop their own plans. This would have been difficult to achieve with hospital staff, since planning would then have become confused with negotiating resources.

Each of the departmental strategic plans developed in this process incorporated clinical, research, and educational program elements and integrated these elements into an overall financial plan that summarized the "package" the Chairs would be getting over five years, what their recruitment and other plans were, and the commitments to achieving outcomes they made to the hospital. Many of the financial and operating assumptions were common to all the plans, which created significant economies of scale. On the other hand, each department had its own unique set of goals and approaches that the Chairs felt strongly about, and these often required customized planning in these areas.

Several valuable outcomes were achieved through this departmental strategic planning effort:

- One Chair’s development path followed the plan closely, producing a strong recruitment effort and rapid improvements in clinical and research productivity
- One Chair’s path lagged behind the plan, which provided opportunities for dialogue between the Chair and the hospital and redirection of some programs. This plan is now back on track
- As noted above, the planning effort for one Chair revealed a mismatch between expectations of the Chair and the hospital and helped prevent a potentially costly mistake.

CASE STUDY #2 – SETTING AN AGENDA AS A NEW CHAIR

A new Chair of Surgery at a major Eastern medical school contacted BDC Advisors to develop a strategic plan for his department that would help him invest his “package” in the most productive way possible to achieve his academic goals. The hospital and the Chair agreed to share funding for this planning effort, with the expectation that it would benefit both the hospital and the department.

The planning effort was divided into three phases:

- I. Assessment and Vision Development
- II. Strategy Development
- III. Integrated Strategic Plan

In the Assessment phase, a “rapid diagnostic” was conducted to create a detailed snapshot of departmental strengths and weaknesses, threats and opportunities. Over 80 interviews were conducted, including all department faculty, faculty in other departments (e.g., Anesthesiology), hospital staff, the faculty practice organization, and referring physicians. In addition, departmental financials were reviewed in detail, including assessments of clinical and research productivity, compensation, managed care contracting, and billing & collections performance. The impact of the department on hospital financials was also evaluated.

The assessment revealed some weaknesses in clinical performance, lagging research productivity, and one or two issues of concern in the department’s educational mission. This assessment was shared in detail in a full-day faculty retreat, where the new Chair also articulated his vision, principles, and tenets for the department and identified gaps between this vision and current performance. During the retreat, the department commissioned work groups of faculty members to pursue opportunities in clinical program development, operations, marketing, research, etc. and charged them with developing strategies to fill these gaps.

During Phase II, these work groups developed a number of innovative strategies, including several multidisciplinary “centers” or “institutes” that produced significant

volume growth. The most dramatic impact was in solid organ transplants. A new Transplant Division Head teamed up with a regional dialysis center to develop a joint outreach program for referring nephrologists and primary care physicians. This effort nearly doubled the number of kidney transplants in a little more than a year. Other multidisciplinary centers developed included a digestive disease center and a weight loss center. New strategies were also developed in many other areas, including marketing (joint hospital / department marketing), operations (a new way of implementing the medical center's EMR), and payer contracting (developing rational and consistent policies regarding participating or not participating in contracts).

The integrated strategic plan developed in Phase III sequenced implementation of the high priority initiatives that the work groups had developed. Several organizational changes were sequenced early, including appointing several new Vice Chairs, developing a "balanced scorecard" performance reporting system, and consolidating practice management across divisions. Revising the department's compensation system and contracting guidelines were also high on the list.

Overall, the Chair used this strategic planning process to knit together a disjointed department and pursue his vision of creating a "top 10" academic department of surgery.

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To learn more about departmental strategic planning, please contact BDC Advisors consultants David Anderson (danderson@bdcadvisors.com or 925-352-9462) or Orry Jacobs (ojacobs@bdcadvisors.com or 216-470-3352).

The BDC Advisors Rapid Insight Series

You have probably decided that if another piece describing our “turbulent times” crosses your desk, you will have a seat belt installed on your Chair. Hearing and reading about how tough our current environment is, and how it is only going to get tougher does nothing to help you with your strategy, operations, or mission.

We can speak ad nauseum (and are often asked to do so for board retreats and physician audiences) about our challenging environment, and how health care may very well be the “third bubble.” That said, there is a time to get informed about 30,000 foot issues – and there is a time to get busy determining what is happening in your market, how you are positioned, and what to do next.

For 2009 BDC Advisors is unpacking some of the most effective tools that we have used with systems in our larger strategic engagements.

