CAREER WATCH

Leveraging Chairs and Division Chiefs to Build a Culture that Gets Results

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Every spring, our medical school and hospital partner—like yours—goes through a familiar but all too painful process that has come to be known as the annual budget ritual. The drill is reasonably straightforward—every department chair is responsible for preparing and justifying the following year's budget: projected admissions, outpatient visits, revenues, expenses, margins, and so on. Curiously, dozens of department chairs, division chiefs, administrators, and finance people become consumed (or so it seems) by the process, one that logically should be simpler and more automatic than it is. Historically, though, the ordeal has had more bark than bite. When the process was over, the budget was real in theory (on paper), largely conceptual in practice, and a complete illusion in some cases.

Part of the problem was that everyone breathed a sigh of relief when the budget roll-up was complete, an audible sigh that symbolized a deeply ingrained aspect of the academic medicine culture: that execution is an afterthought. Or in academic parlance, "If the paper is written, then the task is complete." This aspect of our culture has become entrenched without much conscious intent and thus is difficult to challenge, discuss or even recognize.

Today, that conceptual budget that is built each spring must be grounded in reality. Chairs and division chiefs must behave differently—the myriad past excuses for not submitting and then delivering a balanced budget are no longer viable. "Technical" solutions of the past, such as, "The Dean will erase our red ink with that pot of money under his desk" or "The Hospital or State or [insert your favorite here] will come up with the funds" are pipedreams in light of today's economic realities. Successful budgeting is a complex learning problem that can be solved only by doing adaptive work. Adaptive work, notes Heifetz,[1] involves facing a challenge for which the organization has no easy answers. Your boss can't solve the problem for you—rather than giving you the answers, your chief may provide you with direction by clarifying core values and guiding principles.

The budget dilemma can be solved only by people learning new ways of working it out. In solving the problem, chairs and chiefs must learn, grow, and change. This is especially gut-wrenching when it involves changing values and beliefs. Cerebrally, people may realize the need for change but they don't do anything about it because they lack the passion or commitment to

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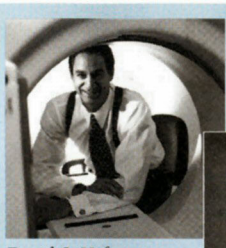
break out of the status quo. Because adaptive challenges force people to make agonizing trade-offs, it is common for them to avoid the problem by treating the symptoms rather than the problem itself. Creating and delivering a balanced budget forces chairs and chiefs to ask some pretty tough questions, such as, "Which of these programs might we have to consolidate, or downsize, or even close?" These kinds of painful trade-offs are just part of it. The real work begins when those numbers on paper have to be monitored and managed—they have to become real.

Consider this scenario. It's May or June and you (the Chair of Surgery) and your teaching hospital's CEO (with input from many others) have just finalized your budget for next fiscal year. The plan is to increase the number of surgical cases by 4% (60/40 inpatient/outpatient mix), increase clinic visits by 12%, and boost case mix severity by 2%. You've translated these volume targets into revenue and you have a strategy for reducing total expenses by 2%. The net result is a positive bottom line for your department, allowing you to pay incentives to your faculty while maintaining a solid contribution margin for the hospital.

Sound good? Absolutely—you've put together a budget that spells out the results you are supposed to achieve, to include revenues, profits, and the resources that will be allocated in order to get those results. But there's a problem. The process doesn't address how—or even if—you can deliver on those results, so it is not grounded in reality. No one has given much thought to where that new volume will come from, the actions the institution and individual faculty members must take to improve market share, and exactly how costs in an already lean department are going to be trimmed. There was no operating plan—it was strictly a numbers exercise, with little attention paid to action plans for delivering growth, productivity, or expense reductions.

In most academic medical centers (AMCs) today, the difference between one that can turn a 5% operating margin and one that produces only a 1% operating margin is its ability to execute. In contrast to strategic planning—often viewed as an intellectual exercise in which high-ranking people sit around a mahogany table drinking designer coffee, and talking about the castles they intend to build—execution involves being in the trenches with your sleeves rolled up. Historically, execution has gotten little respect or admiration, but today's AMC leaders must be deeply involved with it so it becomes baked into the organizational culture.



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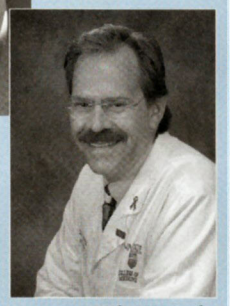

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Execution involves three core processes[2]: strategy, people, and operations. Most AMCs are solid on the strategy piece—their missions are clear and they know where they want to go. The struggle is with the other two. The operating plan entails the specific tasks and actions that will deliver the strategy—it specifies how the hydraulics of the organization will be coordinated to achieve the intended results and includes contingency plans for dealing with the ever-present unanticipated circumstances. The people process defines who is going to get the work done.

A healthy budget process begins with wide-open dialogue, in which assumptions are tested and mental models are challenged. This becomes the basis for building a budget that is grounded in reality. If the chair and/or chief don't think the cardiology business can grow, they should explain why. If the conversation is roundabout, elusive, or whitewashed, it does no one any good. Second, specific action plans need to be defined. If, for example, the strategy is to increase referrals to the neonatal intensive care unit (NICU), how will that happen? Which referring doctors and hospitals in the region will be targeted? What changes in pre-hospital transport will need to change to deliver the service and improve customer satisfaction? What will the NICU do to handle the extra load?

Finally, the organization must provide coaching and resources so that people can get the work done. In the case of physicians, their role in running an efficient, high-quality, world-class hospital cannot be underestimated. How will they be evaluated and held accountable? What tools and resources do they need in order to deliver the strategy? How do we build alignment between the practice plan and the hospital so that each entity's goals can be achieved simultaneously? Honest, clear communication is essential and information must be handled in an open, transparent manner whereby the faculty begin to trust that resource allocation is fair and that their achievements are being recognized and rewarded.

This new paradigm will be difficult for some chairs and chiefs. As David Korn, MD, Senior Vice-President for Biomedical and Health Sciences Research at the AAMC and former Dean of Stanford Medical School, said, "Perhaps nowhere in the evolving academic medical center will the impact of change be more stressful and consequential than for the traditional clinical academic chair, who I believe is an endangered species."[3] But good leaders recognize that leadership is fundamentally about change. They hold people's feet to the fire as part of the self-development process; in so doing they are gentle but firm, patiently showing others that learning, growth, and self-discovery come from dealing with uncertainty and adversity. They help others find the courage to get back up when they stumble, teaching them to trust the energy of the universe in a world that is in desperate need of leadership. It is in trusting this energy that character is shaped, a moral foundation is wrought, more conscious choices are made, and academic medicine moves in a positive direction. ❖

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