

# Academic Medical Centers 2010: An Organizational Odyssey

1996 Forum on Emerging Issues

April 25-27, 1996

Gregg Conference Center, Bryn Mawr, PA

**ELAM**

EXECUTIVE

LEADERSHIP IN

ACADEMIC

MEDICINE

*Program for Women*

The ELAM Program is part of the  
Institute for Women's Health of  
Allegheny University of the Health Sciences

## **1996 ELAM Forum on Emerging Issues: A Summary Report**

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**ACADEMIC MEDICAL CENTERS 2010:  
AN ORGANIZATIONAL ODYSSEY**

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OF THE  
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(ELAM) *PROGRAM FOR WOMEN***

**A SUMMARY REPORT**



## Introduction

The heritage of the Executive Leadership in Academic Medicine (ELAM) *Program for Women* lies with the legacy of the Medical College of Pennsylvania (MCP)<sup>1</sup>, founded in 1850 as the country's first medical school for women. ELAM is a leadership development program targeted for women in academic medicine. ELAM's goal is to increase the number of women chairs, deans, and other senior academic administrators at medical schools.

The ELAM Program convened its inaugural class in September 1995. The 25 women selected for the 1995-96 Program were primarily associate or full professors; many of them also held administrative positions, such as vice chair or chair of a department, chief of a clinical division, or assistant or associate dean. They represented 10 disciplines and came from 22 academic health centers from across the country. These fellows participated in two 9-day sessions in September 1995 and April 1996 in Philadelphia, PA. They were involved in intensive learning in seven curricular areas: financial management; strategic planning and organizational transformation; converging paradigms of corporate and academic leadership; emerging issues in academic medicine; communications; personal dimensions of leadership; and career advancement.

The first Forum on Emerging Issues, the final two days of the ELAM Program, was held April 25-27, 1996. Participants included the ELAM fellows, their dean or senior delegate from their home institution, and some two dozen invited guests. The Forum was designed to (i) involve the fellows and their deans in an important collaborative work project; and (ii) introduce an innovative large-group organizational planning tool called a *future search conference* (see Appendix A) that participants could bring back to their own institutions. The topic for this first ELAM Forum on Emerging Issues was to define the optimal governance structures and leadership capabilities for AHCs in the future.

The *future search conference* format is designed to discover the common ground elements of the stakeholders' vision of the future (of an organization, institution or topic) and to determine the action plans to achieve their vision. This is accomplished over two days through specific tasks and timetables assigned to small stakeholder or mixed groups or to the entire group. The tasks begin with analysis of the past events and forces affecting the topic, then of the present trends, followed by preparation of ideal scenarios of the future. The final task of the Forum is to identify the common ground elements of the future vision that can be implemented by the individual participants or groups.

Stakeholders are defined as any constituency having a vested interest in or involvement with the organization, institution, or topic. At this topic-oriented Forum, one stakeholder group consisted of the 24 ELAM fellows, who represented faculty from academic health centers (AHCs) and were grouped into those from state universities and from private institutions. The ELAM fellows' deans represented another medical center leadership stakeholder group, also grouped as state or private.

An additional 16 individuals were selected to participate in the Forum because of the important function, organization, or group that each represented: government (Human Resources and Services Administration, HHS, and Office of Women's Research, NIH), associations (American Medical Association, Association of American Medical Colleges, Institute of Medicine), foundations (Pew), not-for-profit and for-profit health maintenance organizations (Health Partners, Henry Ford Health System, and US Healthcare), and non-medical school university administrators. These conference participants were placed in two stakeholder groups broadly categorized to represent academic medicine/universities and health care systems/government. (See Appendix B for list of participants.)

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<sup>1</sup> In 1993, MCP merged with Hahnemann University; the combined institution was renamed Allegheny University of the Health Sciences in 1996.

The ELAM Forum marked the first time that the *future search* process was used in a topic-oriented application for academic medicine. This unique planning approach has been used in several higher education settings since 1990 to plan the future of an individual school or department. These include George Washington University's School of Business and Public Management, which used the process to develop its undergraduate business education program for the year 2004, and the University of Minnesota-Crookston, which used the process to transform its two-year technical college into a four-year polytechnic institute with six new baccalaureate programs. Another conference is in the planning stages with Pennsylvania State University medical school's Department of Humanities. Since the ELAM Forum was held, two of the ELAM fellows were appointed by their dean to lead a modified future search conference for their medical school.

The 1996 ELAM Forum on Emerging Issues opened with a concise overview of the *future search* process, including roles, expectations, guidelines, schedule, and goals for the 63 participants. Then, the managers briefly explained the conference's topic, "Academic Medical Centers 2010: An Organizational Odyssey," and the objective of seeking to define the optimal governance structures and leadership capabilities for ensuring the future of academic health centers (AHCs).

## **UNDERSTANDING THE PAST – TIME LINES**

The first task was for each participant to record individually and then transfer to a combined time line the personal, global, and academic health center experiences recalled from the last three decades, 1965-1974, 1975-1984, and 1985-1996. Table 1A-1C summarizes the major trends.

## **ANALYZING THE PAST – THEMES AND PATTERNS**

With the individual recollections of the three decades recorded on the combined time line, the mixed groups analyzed the data. The synthesis of the personal, global and AHC time lines revealed:

**1965 to 1974** – We were young, ambitious, coming of age, open to possibilities, and greatly optimistic. Science was booming. We were taking part in the new society.

**1975 to 1984** – We reached middle age and experienced loss of innocence, loss of social trust, and recognition of our own limitations and those of the world we live in.

**1985 to 1996** – Growing into our older years, we are trying to determine what is our legacy. We want to fix what's wrong and mentor others. We are concerned about leadership. We face a diversity of leaders and values, and we seem to be looking for a new model of leadership. Because of limited resources, we must prioritize. We respond to a different style of leadership, from transactional to transformational.



Table 1A. Personal Time Line		
1965-1974	1975-1984	1985-1996
<ul style="list-style-type: none"> <li>➤ Early stages of education and/or career track, typically traditional.</li> <li>➤ Instability, confusion and protest. Vietnam a major influence.</li> <li>➤ Traditional values of marriage, children and household, but also divorce and change.</li> <li>➤ Early achievements – personal and scientific.</li> <li>➤ Era of free-love, loss of inhibitions, drugs and the counter-culture: rock, Woodstock.</li> </ul>	<ul style="list-style-type: none"> <li>➤ A return to the more traditional.</li> <li>➤ Women entered work force. Careers were building. Climbing the academic ladder and moving into prominent positions.</li> <li>➤ Continuing family dynamics, with both stability and change – children were born. Life became busy.</li> <li>➤ Formal training completed; beginning of realizing some rewards from hard work; recognition for achievements; move toward CEO level for some; loss of jobs for others.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Increasing complexity. Despite more available technology, less personal and family time.</li> <li>➤ Thoughts about retirement.</li> <li>➤ Family – children grew up and became independent. Parents grew older and became dependent.</li> <li>➤ Loss of important people – spouses, family, friends.</li> <li>➤ Increasing challenges to keep it all together.</li> </ul>
Table 1B. Academic Health Centers Time Line		
“Decade of Denial”	“Decade of Dollars”	“Decade of Forced Change”
<ul style="list-style-type: none"> <li>➤ Era of free growth, explosion in federal funding for research, but much activity without strategy. Success measured by size of program one managed.</li> <li>➤ Trend toward high specialization in medicine. USA became world leader in delivering care, but specialization was “fragmented” and “entrepreneurial.”</li> <li>➤ Resources were infinite, and our outlook on medicine was positive as we approached the next decade. We thought we should re-create ourselves. Our expectation was that society would realize the benefits of technology and live longer and more happily.</li> </ul>	<ul style="list-style-type: none"> <li>➤ We began to experience retrenchment, as reimbursement for delivery of care dried up or was significantly reduced.</li> <li>➤ An emergence of community-based centers that started performing more procedures, taking business away from AHCs as the centers and removing their isolation from the community.</li> <li>➤ Managed care entered the scene, with a new philosophy of care focused on prevention and away from treatment of disease.</li> <li>➤ HMOs began to develop, bringing a new method of payment for primary care physicians – capitation.</li> <li>➤ DRGs were imposed by the Federal government, causing significant impact on medical reimbursement.</li> <li>➤ HIV/AIDS emerged as a major force.</li> <li>➤ Technology expansion drove much of our work, e.g. transplantation.</li> </ul>	<ul style="list-style-type: none"> <li>➤ The degree of change has escalated and became dramatic and scary.</li> <li>➤ Resources became severely constrained on all levels, and management of resources became a high priority.</li> <li>➤ Managed care became a major force in shaping the delivery and payment of care. Risk and capitation are evident on all levels.</li> <li>➤ We began to reconsider that recreating ourselves might not be such a good idea. Other possibilities emerged – dual degrees, other career paths.</li> <li>➤ Societal issues and health reform created confusion about the right of receiving health care.</li> <li>➤ Downsizing began to take hold in AHCs’ world.</li> <li>➤ Research focus has changed – outcomes based, women’s health, and AIDS research emerged.</li> <li>➤ AHCs have evolved from a highly fragmented structure to a more consolidated one.</li> </ul>
Table 1C. Global Issues Time Line		
<ul style="list-style-type: none"> <li>➤ <b>Political</b> – Unrest in the US and world – Kennedy and King assassinations, Nixon and Watergate. Killings at Kent State reflected nation’s divisiveness.</li> <li>➤ <b>Economic</b> – The end of industrial boom from WWII. Medicaid and Medicare began.</li> <li>➤ <b>Cultural</b> – Hippie/Woodstock movement.</li> <li>➤ <b>Public health</b> – Awareness from government. Earth Day, environmental concerns, first warnings on smoking.</li> <li>➤ <b>Social</b> – Beginning of the women’s movement.</li> </ul>	<ul style="list-style-type: none"> <li>➤ <b>Political</b> – Vietnam ending, growth of terrorism, hostage crisis and Jimmy Carter, national consciousness of vulnerability. Transition of Carter to Reagan and the beginning of the “feel good” days.</li> <li>➤ <b>Economic</b> – Time of seeming prosperity; recovering economy, but with paradoxical dependence on others for what we need (e.g. oil); cyclical abundance and scarcity.</li> <li>➤ <b>Cultural</b> – Materialistic concerns/symbols dominate. Emergence of Yuppies.</li> </ul>	<ul style="list-style-type: none"> <li>➤ <b>Political</b> – End of Cold War, fall of communism, Gulf War, Bosnia, and rise of the third world countries. End of apartheid. No common enemies.</li> <li>➤ <b>Economic</b> – Rise of national debt, balanced-budget issues in government. Business mergers and acquisitions.</li> <li>➤ <b>Cultural</b> – Computers moving into everyday life; women’s lib, affirmative action and diversity.</li> <li>➤ <b>Social</b> – Telecommunications, rise of TV and video; drugs, crime, violence, urban decay and homelessness; family values becomes big issue; HIV/AIDS changed the mores of world.</li> </ul>

Groups then answered the question: *“What is missing from our observations of who we are personally, in our global experience, and in our AHC experience?”*

- **Personal and world changes** – Underlying personal changes seem unrelated on the time lines to what is happening in the broader world.
- **Technology** – Growth has affected all of us, yet life is not easier. The steady growth in technology has impacted all of us, but we don't see statements of its impact. The effect of TV and the impact of the globalization of communications were not captured. The reduced time of communications on a world-wide basis and the demand for instantaneous response have created pressure and a sense of isolation.
- **Diversity** – There has been growth in the idea, but little actual achievement of diversity.
- **Economy** – The time lines did not reflect the enormous growth in dollars being spent on health care, increased regulations, the impact on transition from fee-for-service to managed care, or the growth of spending containment and the impact this has had on exploration and discovery. Moreover, while there has been growth in our economic stature, there has been a widening gap between the haves and have nots. Also, there was no mention of recession and downsizing, with attendant loss of security and an increased sense of urgency.
- **Politics** – The time lines did not capture the unrest, turmoil, profusion of nuclear arms, or the general lack of trust in our organizations, government, and leaders.
- **Community involvement** – This was not really raised as a significant issue in improving the prevention of disease and the quality of care.
- **Women's movement** – This theme was only briefly noted; there was no discussion on how it impacted this group of women leaders. Also, the progress or lack of progress for women in the AHC environment was not captured, nor was the issue of minority, i.e., race, leadership raised.
- **Cultural** – There was little recognition of spirituality, wellness, yoga, balance, or care of the soul.

The overall assessment of the time lines was: “The time lines reflected a detached, unemotional analysis of the participants and their world without much feeling. Forum participants were very task oriented and goal directed. They adhered to the task boundaries and did not stray from the theme. This group saw a real disassociation between self and the environment.”

## **PRESENT TRENDS AFFECTING OUR FUTURE – CREATING THE MIND MAP**

Once the Forum participants had developed a shared picture of the past trends, the entire group began the process of “mind mapping” to capture all of the **external** current events, trends and developments presently shaping the future of academic health centers. This process enabled the entire group to build a shared context of current concerns and priorities.

In the center of the wall was the Forum's topic – “Academic Health Center Community, its Governance Structures and Leadership Capabilities.” One at a time, participants stated an external event, trend or development impacting this core topic and indicated where, as if on a clock face, each should be placed. The conference managers drew lines out from the center to represent each of the themes. Sub-themes branched out from the main themes, and related themes were connected by still other lines. Soon, the entire expanse of the wall was colorfully, wildly decorated with a Medusa-like Mind Map of the external events, trends and developments affecting AHCs.



To prioritize the trends in this complex picture, participants placed seven colored dots along the events, trends, or developments on the Mind Map that they perceived as the most important, which could represent either a threat or an opportunity, depending on how one responds to it. This activity closed the first day of the Forum.

## STAKEHOLDER PERSPECTIVES ON EXTERNAL TRENDS – ANALYSIS OF THE MIND MAP

### Initial themes

The group was presented with the tally of the priorities on the present trends, registered on the Mind Map by the colored dots. The themes with approximately 20 dots or more were identified as the predominant “Forces Shaping Our Future.” Participants, working in their stakeholder groups, selected three key trends or forces and discussed their current and future responses to each of these, as shown in Table 2.

Almost all the tables of stakeholders focused on three trends – survival/adaptation of AHCs, changing modes of leadership, and work force issues. It is interesting to note that *only the faculty* stakeholder groups focused on the survival of scholarship/research mission, and *only the health care/government* stakeholder group focused on payment/reimbursement for health care. These results point to the deep divisions among the competing missions of AHCs that must be acknowledged in developing future strategies. The common threads and overall message:

- **change is essential for the survival of Academic Health Centers, and**
- **there must be a fundamental shift in the way AHCs perform their role.**

Moreover, the entire group agreed that there was no lack of ideas, but there seemed to be a lack of understanding that action plans must follow those ideas if we are to transform AHCs. The group reached no consensus, and there was considerable disagreement with the notion that each AHC must define its individual mission. Rather, the participants agreed that AHCs must learn, as an industry, to look separately at research, education, and clinical practice.

#### *One person commented:*

“If AHCs concentrate on the ‘bottom line,’ to suit the economic market forces to become more business-like, will they risk abandoning their original mission to care for patients and educate practitioners? How can AHCs respond to the fiscal realities and still meet their community/social responsibility? As T. S. Eliot said, ‘The last temptation is to do the right thing but for the wrong reasons.’”

#### *Another said:*

“How do these proposed responses to change – collaboration versus competition – impact AHCs? What is the meaning of the move toward mergers, and how does this dynamic relate to the initial reaction of AHCs and their faculty and administrators to ‘hunker down’ and resist change? There are predictions that 40% of all the resources AHCs have today will disappear. If so, how do we protect the best, the values that we care about?”

Table 2. Analysis of Predominant Present Trends/Forces by Stakeholder Groups		
Theme	Group	Key Issues
<b>Survival/ adaptation of AHCs</b>  (36 dots; 7 of 8 stakeholder groups)  * See note at bottom of table	Deans (3)  (3 of 3 groups of deans)	<ul style="list-style-type: none"> <li>▶ Redefine and focus mission</li> <li>▶ Do much of what we're now doing, but do it better and more efficiently</li> <li>▶ Consider more collaboration and strategic alliances</li> <li>▶ Get better handle on impact and use of technology</li> <li>▶ Increase capacity for change - innate resistance to change impacts ability to move</li> </ul>
	Academic Health Ctrs (1)  (1 of 1 group)	<ul style="list-style-type: none"> <li>▶ Define more clearly mission and strategies</li> <li>▶ Align appropriate governance</li> <li>▶ Form integrated delivery systems</li> <li>▶ Identify new funding sources</li> <li>▶ Become more flexible, entrepreneurial, better consolidated</li> </ul>
	Health care/ Govt (1) (1 of 1 group)	<ul style="list-style-type: none"> <li>▶ Consider becoming part of larger health system</li> <li>▶ Redefine core competencies and right-size to meet them</li> </ul>
	Faculty (2)  (2 of 3 groups of faculty fellows)	<ul style="list-style-type: none"> <li>▶ Re-examine and focus mission</li> <li>▶ Overcome disconnect between AHC and community</li> <li>▶ Require more partnerships; use technology and telecommunications</li> <li>▶ Focus on teaching skills and practical knowledge</li> <li>▶ Seek new funding sources</li> </ul>
<b>Changing modes of leadership</b>  (34 dots; 6 of 8 groups)	Deans (3)	<ul style="list-style-type: none"> <li>▶ Shift from narrow, single-leader, loose model to broad-based, group processing model</li> <li>▶ Adopt enlarging, unifying perspective</li> <li>▶ Synthesize, communicate, and yet retain traditional embodiment of medical credibility</li> </ul>
	Academic Health Ctrs (1)	<ul style="list-style-type: none"> <li>▶ Acquire new skill sets, e.g. business, better succession planning, more continuity, greater accountability, matrix-like structures, followership, team involvement, more diversity</li> </ul>
	Health care/ Govt (1)	<ul style="list-style-type: none"> <li>▶ Become more proactive, motivated by restructured reward system</li> <li>▶ Learn partnership skills and be able to link what AHC is good at with market needs and adjust accordingly; develop new structures</li> </ul>
	Faculty (1)	<ul style="list-style-type: none"> <li>▶ View leadership as horizontal or web-like, embracing sharing as key principle</li> <li>▶ Meet skill needs <i>and</i> market needs</li> <li>▶ Select leaders with greater diversity</li> </ul>
<b>Work force issues</b>  (39 dots; 6 of 8 groups)	Deans (3)	<ul style="list-style-type: none"> <li>▶ Refocus on primary care and away from specialties</li> <li>▶ Reduce residencies and International Medical Graduates (IMGs)</li> <li>▶ Balance academic and clinical service functions</li> <li>▶ Address geographic maldistribution</li> </ul>
	Academic Health Ctrs (1)	<ul style="list-style-type: none"> <li>▶ Provide health care professionals who can meet societal needs</li> <li>▶ Place more emphasis on interdisciplinary training and primary care</li> <li>▶ Rely less on IMGs</li> <li>▶ Redefine roles and relationships</li> <li>▶ Emphasize teaching in core competencies</li> <li>▶ Uncouple training and service/labor</li> <li>▶ Offer community-based education relative to where practice takes place</li> </ul>
	Faculty (2)	<ul style="list-style-type: none"> <li>▶ Train more generalists</li> <li>▶ Increase integration in health care teams who care for populations and are responsive to the community, not just to individuals</li> <li>▶ Teach what needs to be known, not what we already know</li> <li>▶ Redistribute providers according to geographic needs</li> </ul>
<b>Survival of scholarship/ research mission</b>  (19 dots; 3 of 8 groups)	Faculty (3)	<ul style="list-style-type: none"> <li>▶ Embrace outcomes-based scholarship and broader definition of scholarship, including scholarship of clinical practice</li> <li>▶ Value system must be based on actual faculty roles</li> <li>▶ Overcome current divisiveness of research and fragility of protected time</li> <li>▶ Address the questioning of traditional tenure</li> </ul>

Payment/ reimbursement for health care (27 dots; 1 of 8 groups)	Health care/ Govt (1)	<ul style="list-style-type: none"> <li>▶ Move toward fixed payment for demonstrated value</li> <li>▶ Role of Medicare and Medicaid will increase in managed care, employee groups</li> <li>▶ Increase in uninsured portion of population from 15% to 35%</li> <li>▶ Faculty practice plans will be reorganized and refocused, yet still aimed at filling beds</li> </ul>
Social responsibility (26 dots; 1 of 8 groups)	Faculty (1)	<ul style="list-style-type: none"> <li>▶ Yield individualism to collaboration</li> <li>▶ Consider AHC's role as community based, integrated and responsible to community</li> <li>▶ Redefine tenure, with incentives matching goals</li> </ul>

\* Note: The number of dots represents the total number that all participants placed on that present trend on the Mind Map. The number of groups (in parentheses) refers to the number of stakeholder groups that selected that trend as one of the three considered most important from their stakeholder group perspective.

## COMPLETING THE ANALYSIS OF THE PRESENT – CURRENT AND FUTURE RESPONSES

Again in stakeholder groups, participants discussed the aspects of the current responses of AHCs to external trends of which they were *proud* and those about which they were *sorry*. Curiously, there were almost no “prouds” declared; the “sorries” dominated the discussion:

- ▶ not recognizing our own plight
- ▶ not collaborating
- ▶ not integrating teams
- ▶ not changing the hierarchical values
- ▶ not gaining a broader perspective
- ▶ not examining systems thinking
- ▶ not extending the boundaries of our thinking or the notion of excellence to be relevant to the communities we serve
- ▶ not having a more humble and realistic view of what the public thinks of us
- ▶ not thinking about the continuum of health care
- ▶ not even mentioning the “patient,” who is supposedly the focus of it all.

Finally, to close the analysis of the present trends, the conference managers asked the entire group to envision the future for AHCs predicted by this depiction of their present circumstances, issues, trends, and forces. The consensus was that the future was bleak, chaotic, dysfunctional, super-fragmented: if AHCs continue down their present path, they face extinction, joblessness, greater external control; and society faces declining health.

## FOCUS ON THE FUTURE – IDEAL FUTURE SCENARIOS

Participants reconvened in mixed groups and took up the next task: to imagine, in “future scenarios,” the ideal governance structures and leadership capabilities of Academic Health Centers, as they would exist 14 years hence, on April 26, 2010. The scenarios had to be feasible, desirable and sufficiently motivating for people to want to commit time and energy to them. Each group dramatized its projection of what life would be like living and/or working in these future institutions, with concrete, desirable features and significant accomplishments, as well as the barriers that had to be overcome to achieve these ideal scenarios. (The future scenarios are summarized in Appendix G.)



## CONFIRMING AND CONSOLIDATING DESIRED THEMES – DISCOVERING COMMON GROUND

In group discussion, the eight future scenario presentations were examined to identify common desired themes, unresolved differences, and the methods for accomplishing the desired outcomes. Many of these future themes were the same as those identified earlier in the Mind Map of current external trends and forces impacting Academic Health Centers. The difference here was the focus on creating *common ground* representing future desired themes and outcomes. Again, group consensus on common desired themes or outcomes was difficult to reach. The final results indicated that *new leadership competencies, team and interdisciplinary work, community focus* and *information technology* issues were critical – and that the core mission of *education* could not be ignored.

Table 3. Common Ground Desired Themes for the Future of AHCs	
<b>Mission/Core Competencies</b>	<ul style="list-style-type: none"> <li>▶ Must be aligned, responsive to, and informed by current and future health needs of the public</li> <li>▶ <b>Education</b> is the primary, core mission: <ul style="list-style-type: none"> <li>▶ for all members of patient care team - physician and non-physician</li> <li>▶ for maintaining competencies</li> <li>▶ including public/patient education</li> </ul> </li> </ul>
<b>Leadership Competencies</b>	<ul style="list-style-type: none"> <li>▶ Accountable, flexible, adaptable</li> <li>▶ Must be adaptable to be specific to the mission, what needs to be accomplished</li> </ul>
<b>Team Delivery</b>	<ul style="list-style-type: none"> <li>▶ Many participants believe this is a “how to do”; others suggest it is a reorganizing theme</li> </ul>
<b>Community Focus</b>	<ul style="list-style-type: none"> <li>▶ Feasibility of decentralizing institution in community</li> <li>▶ Core focus on prevention and wellness</li> <li>▶ Patient needs and service delivery functions matched</li> <li>▶ Creating community-based model that is aligned with education, research and patient care missions</li> <li>▶ Connecting community and patient needs, matching needs with mission</li> <li>▶ Being accountable to stakeholders and community, including cost effectiveness</li> </ul>
<b>Information Technology</b>	<ul style="list-style-type: none"> <li>▶ Utilizing present and future technology to fulfill AHC mission</li> <li>▶ Support expanded boundaries through communication management</li> </ul>

The remaining identified themes were labeled “unreconciled differences,” important to *some* participants but not *common ground* among all members of the group. Some of these have important implications for future planning among AHCs. For example, there was no consensus among the conference participants that the role of the scholarship/research mission should remain the same as today within the AHC of the future. All three faculty groups felt strongly that it should be a core component, but not all the other groups agreed. Viewpoints differed as well on the role of the payors, students, and the public in governance structures of AHCs of the future. See Table 4.

Table 4. Unreconciled Differences Among Themes for the Future of AHCs	
<b>Mission/Survival</b>	<ul style="list-style-type: none"> <li>▶ How do we align resources to core mission? How do we adapt mission for survival?</li> <li>▶ What is appropriate and effective size for survival and achieving mission?</li> </ul>
<b>Scholarship and Research</b>	<ul style="list-style-type: none"> <li>▶ What is the right of scientists to pursue basic research; can it be taken for granted in the future? Basic research mission is threatened with being buried or subsumed by prevailing economic forces</li> <li>▶ Should we vary scholarship/research emphasis at each AHC, depending on overarching mission?</li> <li>▶ Is the question not either-or but achieving balance between core research and market-driven needs?</li> </ul>
<b>Payors, Students, and Consumers</b>	<ul style="list-style-type: none"> <li>▶ What are the role, rights and responsibilities of each?</li> <li>▶ How do we address the expectations/right of public to universal access?</li> <li>▶ Where and how do AHCs pursue new resources?</li> <li>▶ What is the nature of multidisciplinary health economics? Should we become more entrepreneurial?</li> </ul>
<b>Work Force Issues</b>	<ul style="list-style-type: none"> <li>▶ How do we break down disciplinary barriers to achieve multidisciplinary health care and flexibility?</li> <li>▶ How do we resolve uneven compensation, relative to traditional vs. new strategies?</li> </ul>



## COMPETENCIES REQUIRED FOR ACHIEVING COMMON GROUND DESIRED OUTCOMES – FUTURE PLANNING

For the final task of the future search conference, participants formed affinity groups by aligning themselves according to their areas of interest. On the next page, Table 5 shows the highlights of the brainstorming conducted by the affinity groups for achieving the group's consensus of desired outcomes. Several competencies are of note.

- *Leadership* competencies emphasized the need for new skills in versatility and flexibility to adopt various structures and power relationships, as well as adapt to major changes in the role of faculty.
- *Research* competencies need not only to maintain basic research *but also* to incorporate applied/translational and clinical outcomes research, according to one affinity group, although research was not a common theme.
- The development of *strategic alliances* was stressed as a core skill for the future.
- *Teaching/education* emphasized a number of new competencies that are just beginning to be recognized as important for AHCs, such as learner-centered teaching, interdisciplinary education, engaging stakeholders in designing the educational processes, determining cost and efficiency, and evaluating outcomes.
- Several new competencies in meeting *community* needs were emphasized, including defining the community, identifying community needs, and aligning the AHC with those needs.



**Table 5. Brainstorming about Strategies for Achieving the Desired Outcomes**

Common Ground Theme	Important Competencies
<b>Mission and Core Competencies</b>	<ul style="list-style-type: none"> <li>▶ Define, articulate and prioritize mission</li> <li>▶ Include <b>four</b> core competencies: research, education, clinical care, and <b>healthy communities</b></li> <li>▶ Expand use of technology</li> <li>▶ Create a template for accountability and use for local review/revision</li> <li>▶ Develop routine participation of community</li> <li>▶ Engage stakeholders in commitment to mission</li> </ul>
<b>Leadership</b>	<ul style="list-style-type: none"> <li>▶ Reengineer, reorganize and reconfigure faculty; provide new skills and offer new approaches</li> <li>▶ Develop mechanisms of faculty accountability</li> <li>▶ Be open both to centralized and decentralized structures</li> <li>▶ Be open to sharing and/or transfer of power; examine nodes and webs of power</li> <li>▶ Mentor the mentors</li> </ul>
<b>Research</b>	<ul style="list-style-type: none"> <li>▶ Include basic, free-thinking research, applied/translational research, and outcomes research</li> <li>▶ Develop collaborative models of research</li> <li>▶ Develop new, creative funding approaches; broaden enterprise</li> </ul>
<b>Teaching/ Education</b>	<ul style="list-style-type: none"> <li>▶ Define desired competencies and successful outcomes</li> <li>▶ Develop core curriculum between disciplines</li> <li>▶ Create and share successful examples</li> <li>▶ Engage stakeholders in process and assess their needs – students, community</li> <li>▶ Emphasize learner-centered teaching systems</li> <li>▶ Develop evaluative processes and outcomes measures, with new incentive/reward structures</li> <li>▶ Use technology</li> <li>▶ Determine cost and efficiency</li> <li>▶ Develop interdisciplinary teams, multiple clinical sites, shared resources, and strategic alliances</li> <li>▶ Enhance education accessibility to public</li> <li>▶ Develop multiple funding sources for support</li> <li>▶ Maintain and nourish educational scholarship</li> <li>▶ Consider broadening continuum of education</li> </ul>
<b>Strategic Alliances</b>	<ul style="list-style-type: none"> <li>▶ Partner with not-for-profits, for-profits, and federal/state agencies</li> <li>▶ Explore product development research to increase royalties</li> <li>▶ Increase contracts as well as grants</li> <li>▶ Develop new expertise at AHCs in alliance with business development and health maintenance organizations</li> </ul>
<b>Funding Focuses</b>	<ul style="list-style-type: none"> <li>▶ Cost effectiveness</li> <li>▶ Partnerships</li> <li>▶ Assessment of insurance</li> <li>▶ Philanthropy</li> </ul>
<b>Community Focus</b>	<ul style="list-style-type: none"> <li>▶ Define community by geography, politics, common interest</li> <li>▶ Identify community needs through surveys, focus groups</li> <li>▶ Align AHC needs with community needs; involve all “learners” to address core competency needs of each group and to understand how the mission impacts them</li> </ul>



## CLOSING

The future search conference ended with the planning groups presenting their initial ideas. Because this was a topic-oriented future search conference, no additional formal planning or implementation took place as would have in an institution-focused conference. The conference managers invited all participants to offer comments or observations of the future search conference process and experience, focusing on the questions: *What did "future search" mean to you? What was the most important thing/issue you learned? How did you feel going through the process? What will you take away from the Forum?*

### Participants' comments on the future search conference:

*As an approach to institutional planning, breaking barriers and building consensus among sometimes disparate groups: "Having sat through strategic planning in academic settings, I am convinced that this is valuable." Also, "thought-provoking," "engaging," "excellent, well organized and revealing exercise," "heterogeneous interaction, especially with bright participants from the health care industry," "getting unstuck," "superb process."*

*About the process's ability to generate new ways of thinking, one participant said: "I think this group has come up with a more expansive notion of what the issues are. We don't usually see this level of creativity." On the other hand, another participant felt that there could be more creativity: "I don't think the outcomes were very different; we weren't very creative; [we] need to take ourselves out of our everyday lives and maybe be more flexible in where and how we find new answers."*

*The most powerful part of the process was declared by one participant to be the "assumption that all opinions are equal and valid." Another said, "It helps deal with the 'come-uppance' issue. That I state something obvious to me and realize that it isn't obvious to other intelligent people."*

*The future search process encouraged solid interaction between fellows and deans [i.e. between participants at different levels within an organization]. One dean remarked that this type of interaction is more critical than some of the content. Several ELAM fellows and deans noted the difficulty some women fellows displayed in expressing their ideas openly. "Now finally [the Forum's final day], the ELAM fellows are dominating the process, and it didn't happen yesterday. How they struggle to assert themselves with others with whom they usually act differently!" [Even after the intensive leadership experience of the ELAM Program, it is noteworthy how difficult it is for young women leaders to surmount the subtle societal barriers to effective assertiveness.]*

*Some participants felt that this topic-oriented conference was too hypothetical and global and would have preferred one focused on a specific institution and resulting in clear, collaborative action plans for follow up by the fellows and their deans. Some participants, used to focusing on solving problems, were frustrated with the future search format that puts aside "unreconciled differences" and focuses on common ground. "We talked about key issues but didn't really come up with solutions."*



*More diversity of various kinds is needed in future search conferences to provide the optimal richness of ideas. "The whole system is not in the room." "We need more people in the room; we are too insulated as a group, and we need to broaden our thinking." Several participants noted that minority representation in such future search conferences in planning for AHCs would be helpful. The mix of players, others stated, needs to include more business and managed care participants. Still others suggested that students were an important, missing stakeholder group. "This would be very useful in a student environment to help them prepare for the issues of how to deliver care in a changing world." Overall, "Communication with all stakeholders is key to our future survival."*

*All group participants were willing to state new ideas but not all participants were ready to try new processes. One faculty participant commented, "I found it very heartening that people in leadership positions were willing to come try this out. It is evidence that there is a new mode evolving."*

About the topic of governance structures and leadership capabilities needed in AHCs, they said:

*"Business in medicine is a reality. I worry that business will take over and that we will lose leadership if we don't quickly become more visionary."*

*All AHCs share similar issues, problems, movement toward new paradigms, while they may have a differing balance of their mission. And we face many of the same issues as the world of business; but business may move more quickly and have less constraints than we in academic medicine do.*

*One participant noted "the difficulty of changing and giving up the old ways. How difficult it is. It is almost impossible, but there is a common theme in [AHCs needing to do] this."*

*We failed to explore fully the workforce implications, the possibilities for collaboration, or the relationship of the AHC to the University.*





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## Appendix A: Definitions

**Future search conference** – A large-group organizational development methodology that makes possible consensus planning among people with diverse interests. In the last decade, it has been used in many corporate, community, government, and academic settings to make social, technical, and economic breakthroughs that *cannot* happen in top-down management meetings and workshops. Future search is an optimal planning strategy for ambiguous “problems without boundaries” – thorny dilemmas posed by the economy, the environment, employment, technology, education, health care, and community building.

The future search conference is designed to a set of principles:

- ▶ get the “whole system” in the room
- ▶ think globally, act locally
- ▶ work common ground/desired futures
- ▶ self-manage discussions/action plans, known to produce the desired outcomes.

It uniquely enables all “stakeholders” to understand their joint situation better *and* to take responsibility for it. The conference generally involves 30-72 people for up to two-and-a-half days. Their goals are to reach consensus on a desired future and action plans to realize it. The future search conference’s focus can be on a specific organization or institution or on a selected topic.

**Mind mapping** – Mind mapping uses both sides of the brain to create a comprehensive picture of those things affecting us now and in the future. The basic premise of this technique is that the brain does not think or remember in linear or outline form. Therefore, mind mapping reaches beyond brainstorming to organize information in integrated and interlinked ways that reveal major themes and sub-themes.

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1996 Forum on Emerging Issues Stakeholder Groups		
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## **Appendix F: References and Resources for *future search* conferences**

**At Work: Stories of Tomorrow's Workplace.** San Francisco: Berrett-Koehler. A bi-monthly newsletter that reports the changes that are transforming our work, workplaces, and organizations. It shows how people and organizations are breaking free of practices based on such concepts as hierarchy, control, and short-term focus and provides inspiration and guidance on how to achieve more congruence between one's values and one's work, as well as how to create more healthy, ethical, and effective organizations and workplaces. For subscription information, call 800-929-2929.

Brigham, Steven E. "Large Scale Events: New Ways of Working Across the Organization." **Change**, November/December 1996. Mr. Brigham is director of the Continuous Quality Improvement Project at the American Association for Higher Education.

Brigham, Steven E. "Future Search – A Participative Approach to Developing Campus Visions." 1996.

Bunker, Barbara Benedict and Billie Alban. **Large Group Interventions: Engaging the Whole System in Managing Change.** San Francisco: Jossey-Bass, 1996.

**SearchNet.** A program that is one of 100+ programs of Resources for Human Development (RHD), a non-profit human services organization. SearchNet's services including: linking non-profits and public sector groups with capable consultants who will run conferences for expenses or low fees; providing training for experienced facilitators who want to grow by learning the processes *and* helping their communities; and becoming a clearinghouse and resource bank for conference sponsors and facilitators to share learning, war stories, breakthroughs, research, innovations, pitfalls, applications, and dilemmas of search methods. Contact SearchNet, Resources for Human Development, Inc., 4333 Kelly Drive, Philadelphia, PA 19129; 215 951-0300 or 800 951-6333.

Weisbord, Marvin R. and 35 Co-authors. **Discovering Common Ground.** San Francisco: Berrett-Koehler, 1992. This book is a compilation of experience with the future search conference (large group organizational development) methodology in many different settings.

Weisbord, Marvin R. And Sandra Janoff. **Future Search: an action guide to finding common ground in organizations and communities.** San Francisco: Berrett-Koehler, 1995. This is the most up-to-date book on future search conference methodology. It is a clearly written description of the theory behind the process and the how-to's of putting on a future search conference. A must if you plan to use this methodology.

Weisbord, Marvin and SearchNet Members. **Future Search Conferences: Case Studies and Essays, 1992-1994.** San Francisco: Berrett-Koehler, 1992, 1993 and 1994.

## **Appendix G: Ideal Future Scenarios, 1996 Forum on Emerging Issues**

### ***The Virtual Academic Health Center (VAHC)***

Using a Web-page notion of navigating the VAHC, this group illustrated the advantages of its high-tech concept for the various stakeholders of the institution:

- Students: resources to allow them to deliver care to their (future) patients; technical, education, faculty, basic science courses, active clinical vignettes, access to chat rooms with information about practice opportunities, wellness, post-doc fellowships, etc.
- Investigators: research students, governmental agencies, graduate schools, library, interest groups, core facilities and services, clinical data bases from the whole AHC.
- Patients: appointment information, interactive capabilities, doctor data base, personal health record, some level of diagnosis, listing of services available, help desk and financial information.
- Faculty: student/practitioner/administrator directory, library, networking to library, calendar for AHC, network CME courses, wellness network, scheduling, chat rooms.
- Providers: family practice clinic, interactive capabilities, patients records, residents, follow-up opportunities such as test results, interactive conferencing with sub-specialists, resources such as outcomes data, teaching issues and evaluation capabilities.
- Community health representatives: health assessment of populations, methodologies to develop coalition.
- Payers: access to performance results of providers; business smart; know what it takes to serve the community; can access information to see if they are serving those they say they're serving; outcomes are available.

### ***Stockholders' Meeting of the Biltmore University Medical School***

This group's future AHC functioned as a corporation. Its presentation, in the form of an annual stockholders' meeting, focused on the AHC's outstanding competitive business results. The AHC was seen as "the jewel of the University: inclusive, quality, effective, a technologically advanced medical school." The University president was a woman.

The dean of the medical school described the school's goal of delivering education that is multi-disciplinary, site based, technology based, and outcome based, and that provides faculty incentives to perform. The school's product is a highly trained physician of highest quality with skills in life-long learning. The business development officer made deals with pharmaceutical companies, contracts for education products with networks, and enabled delivery of virtual training outside the US on managed care. The financial officer guided the school's revenue/profit focus, ensuring that the institution is less tuition dependent, and oversaw new business development, distribution from the all-payer pool, provider development, clinical providers, and investments from funds that once were tied up in real estate. The technology officer coordinated the home monitor system and all links to sites. Finally, the "guest consumer," always included to represent the market, indicated that consumers were pleased with the AHC's delivery of services. The stakeholders' board meeting closed with the announcement that the next meeting would be "virtual" and would take place in the institution's home office on the World Wide Web.

### ***Press Conference by 'Education R Us' Medical School Dean***

This group enacted a press conference presentation delivered by the dean of the medical school. The dean began by saying that corporate competition had driven the school to revise its mission and to begin to contribute to the health status of the community through collaboration. The thrust of the major announcement was that the school was selling off its research and patient care functions, splitting the old triad of academic health centers, in order to focus on what it does best: Education R Us. The new institution would be the medical school, which would shop for access to what it needed to provide best education. The new governance and structure would include community representatives and assessment programs. The new school would not concern itself with costs except to prepare its students for dealing with them.



### ***A Funny Thing Happened on the Way to ELAM Forum in 2010***

Using the letters in the word “patients,” this group defined its future as follows:

**PATIENTS** – the central issue

**ACCOUNTABILITY** – to all stakeholders

**TEACHING** – our core competency, our mission

**INTEGRITY** – in all health care decisions

**EXCELLENCE** – throughout

**NETWORK** – with everyone and everything

**TECHNOLOGY** – world class in development and use

**SCIENCE** – the platform for new knowledge and health care

### ***Larry Queen Half-alive (A No-Nonsense Communication Program)***

This group’s presentation focused on a spoof of “Larry King Live,” with the show’s guest “Ross Perrier” (i.e., Ross Perot). The subject of the discussion was the ideal future medical university. “Ross Perrier” advocated the following:

- Team integration of doctors, dentists, other health professionals and health care education teams
- Universal health care with a funding mechanism
- Performance (“We come to you, even if you’re on the other side of the world.”)
- Facilitative leadership where everyone works together
- Bonding with legislators, who “love us and fund us”
- Surgeons earn less than nurses, and preventive care is the big revenue maker (“If they get to surgery, the system has failed; we want to keep them out.”)

### ***Fairy Tale Theater: We WILL Entertain You in 2010***

This group’s presentation was acted out on the Web, configured with a balance of research, teaching, and health care (which would be different for each AHC); interactive; and with varying geographic reach. Activities happened in the communities served. The CEO/CFO was in the center of the organizational web; an integrated delivery plan, health services professionals, and clinical research all surrounded the center. Among the Web’s features – diverse leadership. “Web managers,” relationships, evolving educational programs and technology, staff diversity, information technology, few buildings in which health care is delivered but much community-based activity, and financial support derived from government and community. Among the obstacles: Webs are not traditional; the Web edifice is complex; current reward systems do not fit; lack of skill sets for Web structures; and proprietary agendas.

### ***Jackie O’s Children’s Memorial Auction***

This group’s scenario depicted the auctioning of the Value-Added Medical Community. This Community of students, faculty, and patients were described as working together to achieve an outcome of better health care through integration, inspiration, and innovation. The Community’s core competencies were in gender, aging, community, and ethics. The organization was idealized as flexible, dynamic, and self-renewing. It ascribed to the values of scholarship, the needs of patients, the needs of communities, diversity, and technology; it operated on the principle of healthy living and disease prevention. The Community had partnerships with managed care organizations, business, and government.