Creating and Implementing Strategic Plans Workshop

AAMC
Tomorrow's Doctors, Tomorrow's Cures®

Tools For Success:

Evaluation, Ongoing Assessment and Accountability

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Critical Success Factors

Key Factors to Consider Before Embarking on a Strategic Plan:

- Organizational Readiness
- Prioritization for Implementation
- Ownership and Accountability
- Ongoing Monitoring and Evaluation

Organizational Readiness

Organizational Readiness

Is the organization ready to actually use the plan that will be developed?

In specific what areas is the organization not well-positioned to act?

What is your plan to address these areas before, during or after the planning process?

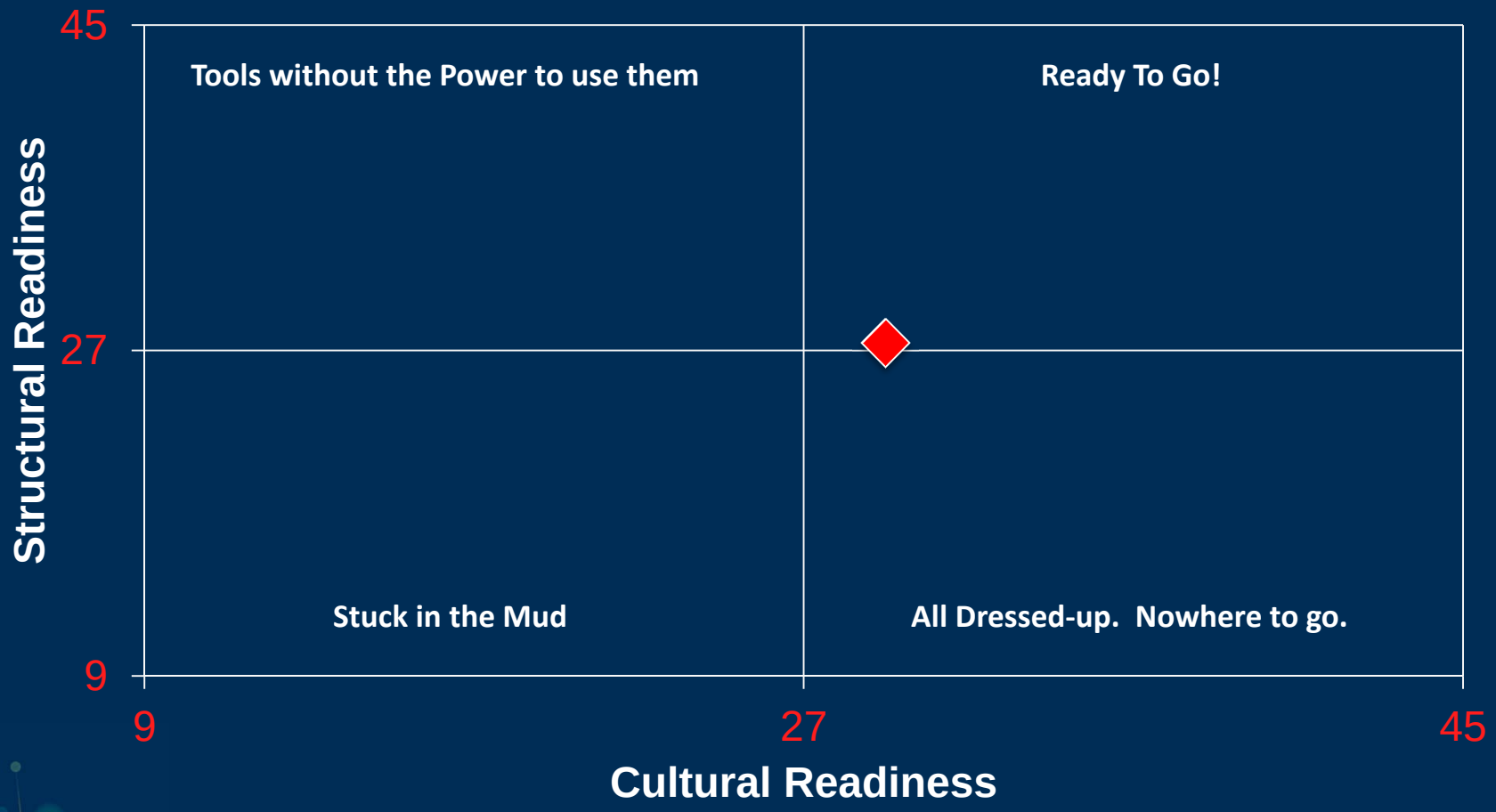
Organizational Readiness Assessment

Cultural Readiness	NEVER		SOMETIMES		ALWAYS	SCORE
Leaders use strategic plan to frame important decisions	1	2	3	4	5	
We are able to forego consensus in order to reach timely strategic decisions	1	2	3	4	5	
We value the role of the “devil’s advocate” and the contrarian voice	1	2	3	4	5	
Our COO/CFO embraces strategic plan and supports implementation with analyses	1	2	3	4	5	
Staff at all levels see the connection between strategic plan and their work	1	2	3	4	5	
We have demonstrated ability to adapt quickly and act on opportunities	1	2	3	4	5	
We are willing to innovate without success models elsewhere	1	2	3	4	5	
We are willing to “pull the plug” when a strategy doesn’t pan out	1	2	3	4	5	
Our leaders embrace change and consider experts’ predictions	1	2	3	4	5	
					TOTAL	

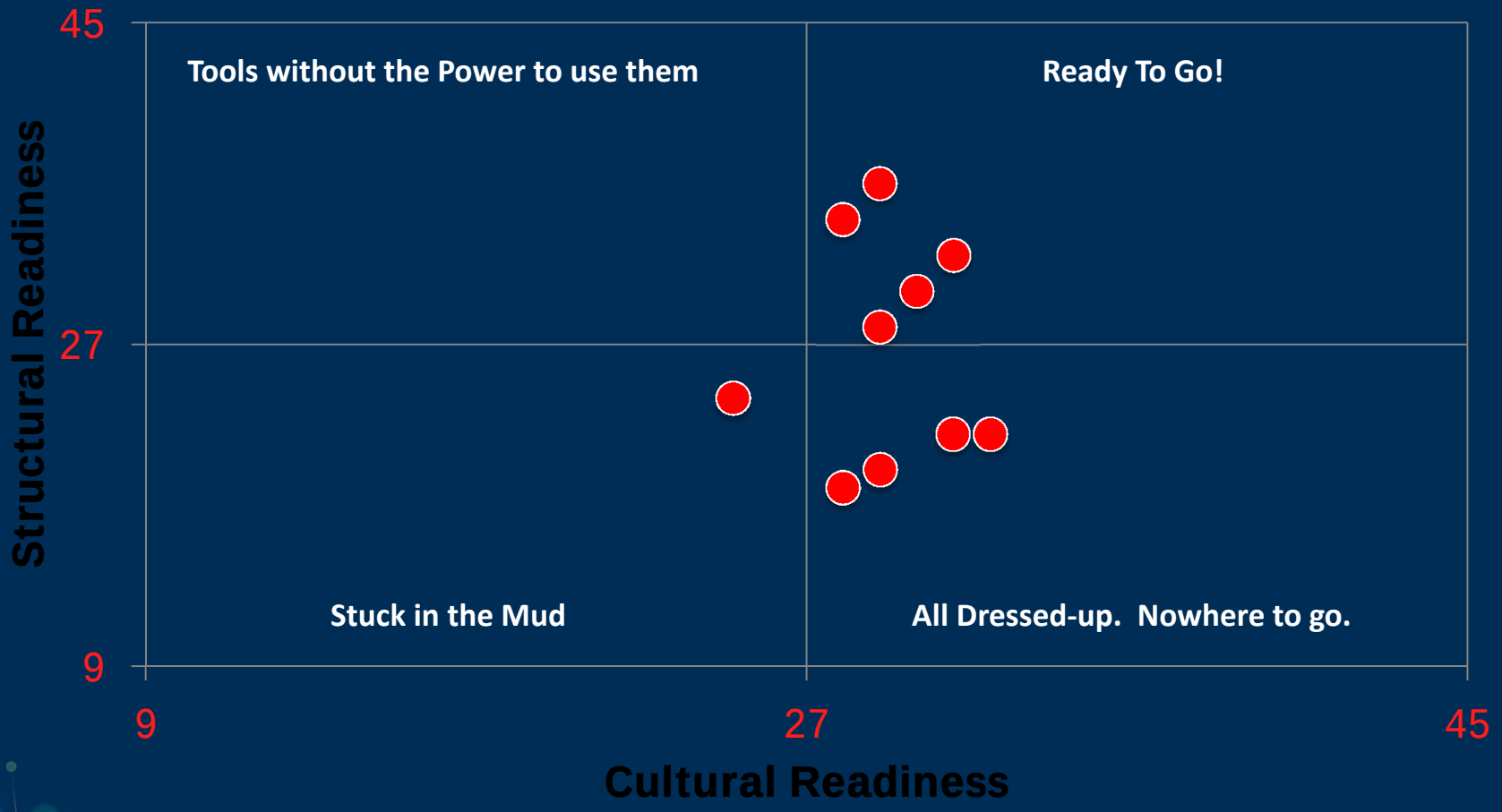
Organizational Readiness Assessment

Structural Readiness	NEVER		SOMETIMES		ALWAYS	SCORE
"Decision Rights" for implementation are clear and understood	1	2	3	4	5	
We monitor plan implementation regularly	1	2	3	4	5	
Our plan incorporate outcomes measures and measures of success	1	2	3	4	5	
We have experience using scenario planning and other tools to address uncertainty	1	2	3	4	5	
Strategic Planning and Financial Planning are integrated into one process	1	2	3	4	5	
We communicate our strategic position assessments broadly	1	2	3	4	5	
We are comfortable setting and using "triggers" to monitor changes and provide early warnings	1	2	3	4	5	
CEO, COO and CSO participate in key decisions	1	2	3	4	5	
We monitor actual vs predicted result for key strategic investment decisions	1	2	3	4	5	
					TOTAL	

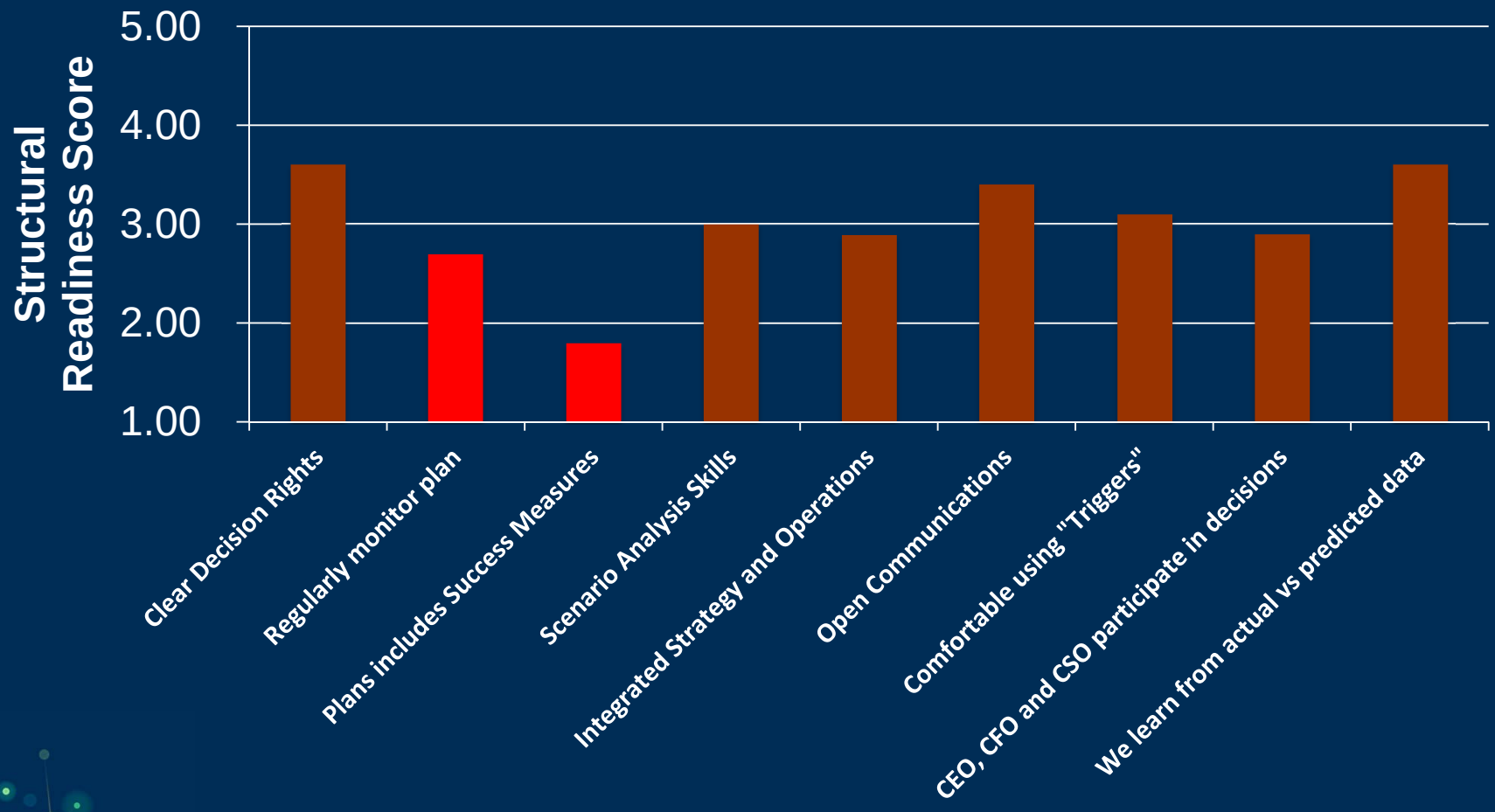
Organizational Readiness Assessment



Organizational Readiness Assessment



Organizational Readiness



Prioritization for Implementation

Prioritization for Implementation

Prioritize, "What"?

Mission

Vision

Goals

Strategies

Tactics

<u>Strategies:</u>
The specific initiatives or projects that must be undertaken to achieve your strategic goals.

What we invest in.

These must be scheduled, budgeted for and managed.

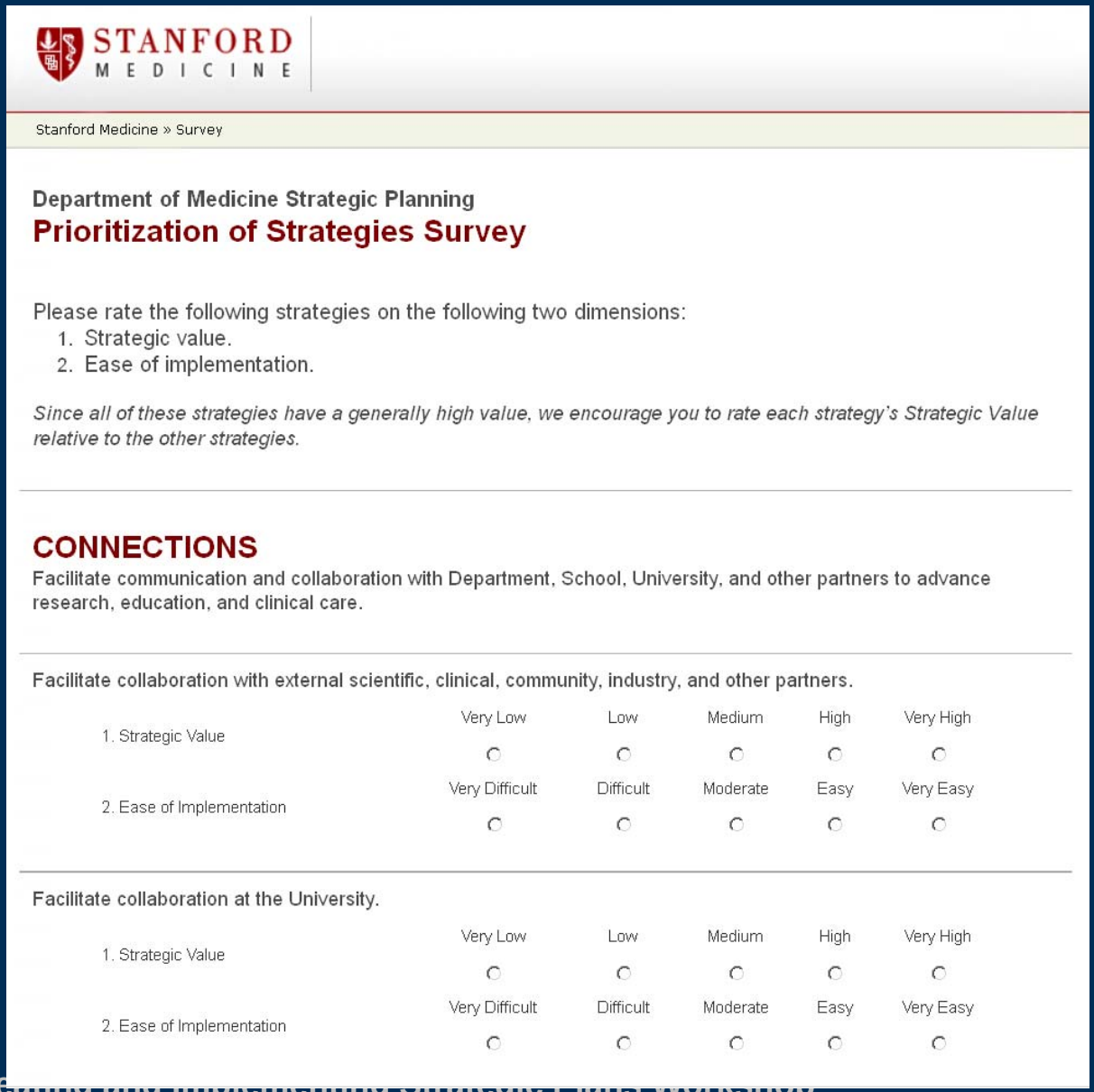
Prioritization for Implementation

Three Prioritization Dimensions:

- Strategic Impact
- Ease/Difficulty of Implementation

- Critical Path Dependencies

Strategic Priorities Survey



STANFORD MEDICINE

Stanford Medicine » Survey

Department of Medicine Strategic Planning

Prioritization of Strategies Survey

Please rate the following strategies on the following two dimensions:

1. Strategic value.
2. Ease of implementation.

Since all of these strategies have a generally high value, we encourage you to rate each strategy's Strategic Value relative to the other strategies.

CONNECTIONS

Facilitate communication and collaboration with Department, School, University, and other partners to advance research, education, and clinical care.

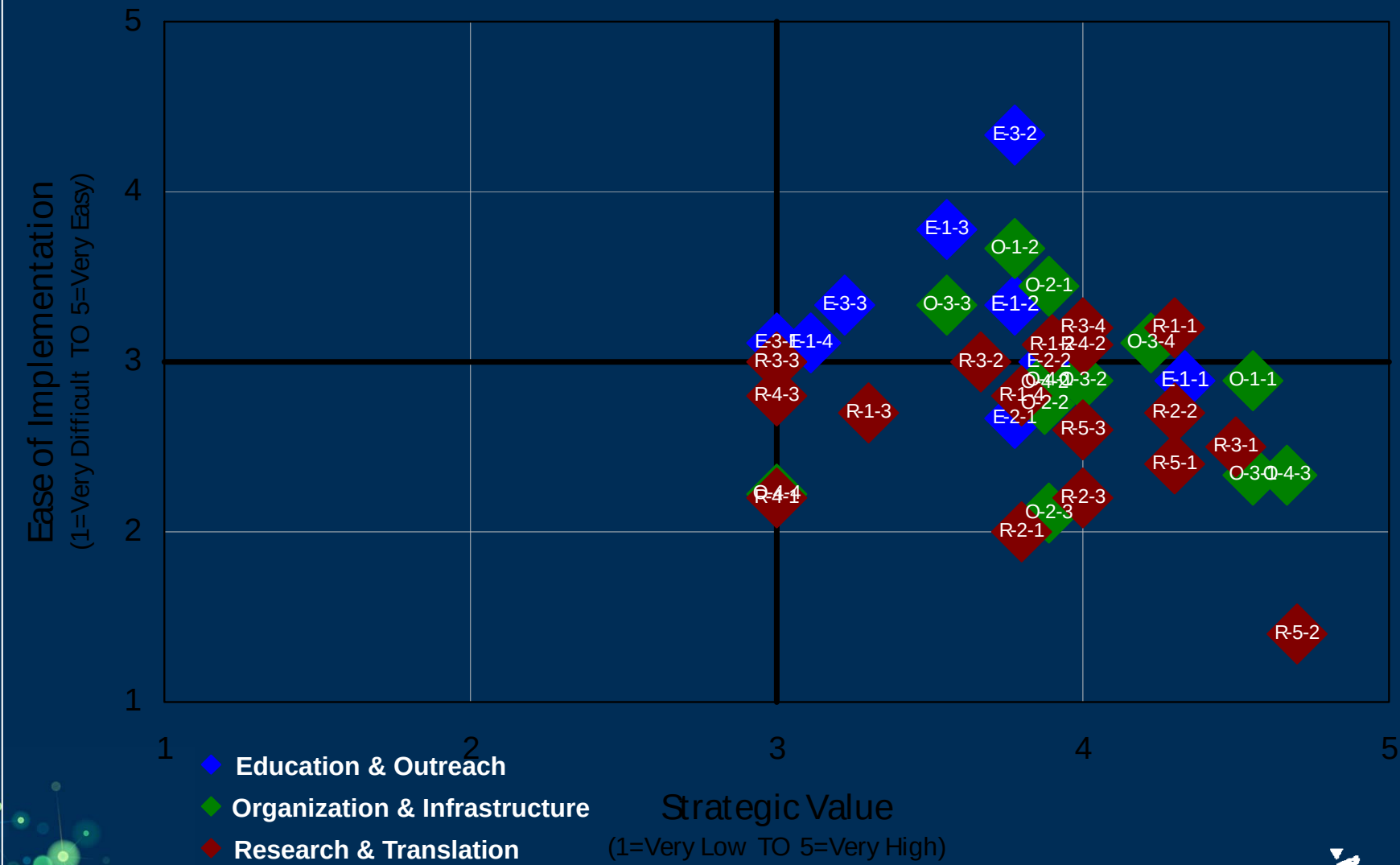
Facilitate collaboration with external scientific, clinical, community, industry, and other partners.

1. Strategic Value	Very Low	Low	Medium	High	Very High
2. Ease of Implementation	Very Difficult	Difficult	Moderate	Easy	Very Easy

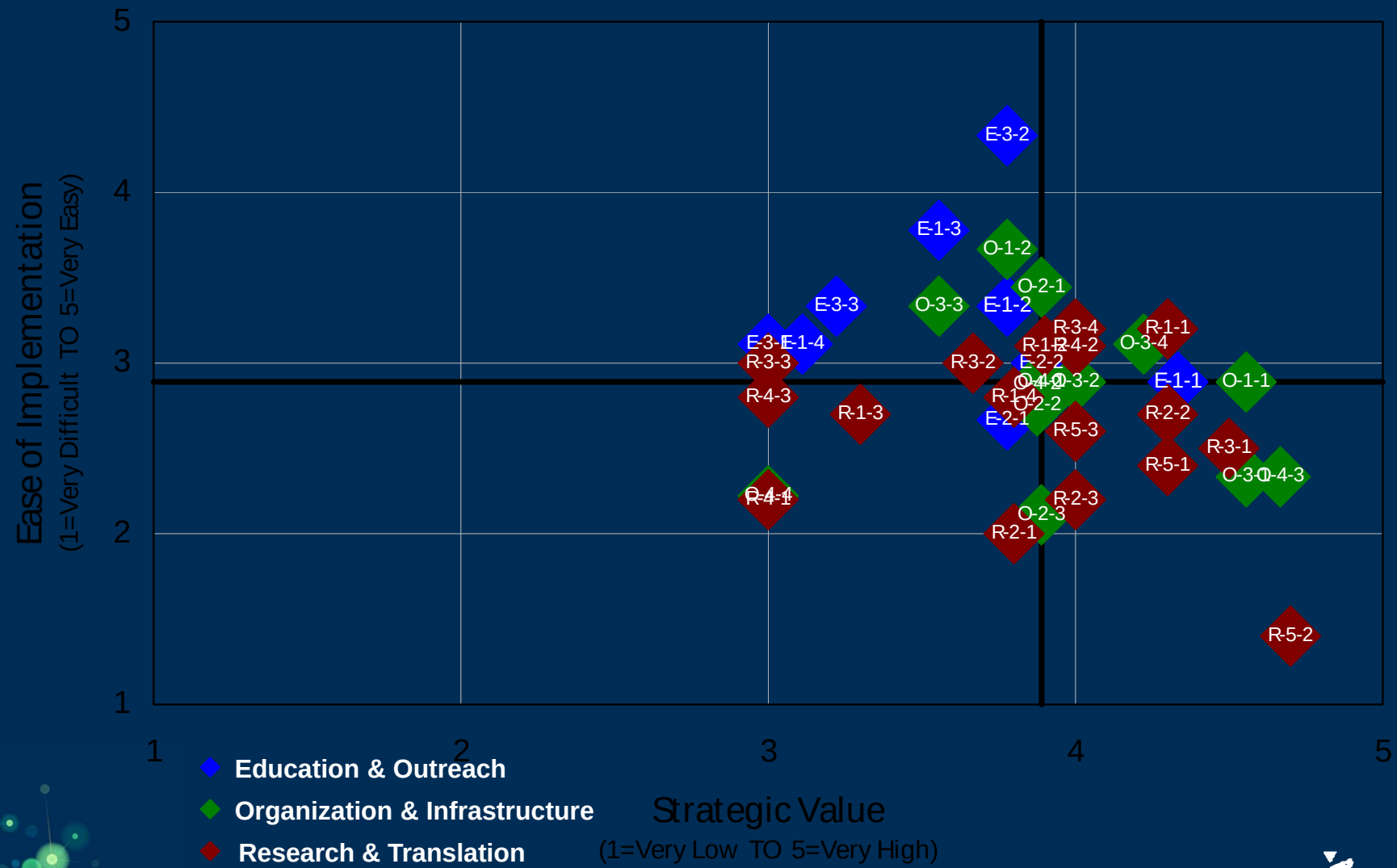
Facilitate collaboration at the University.

1. Strategic Value	Very Low	Low	Medium	High	Very High
2. Ease of Implementation	Very Difficult	Difficult	Moderate	Easy	Very Easy

Strategic Priorities Survey Results

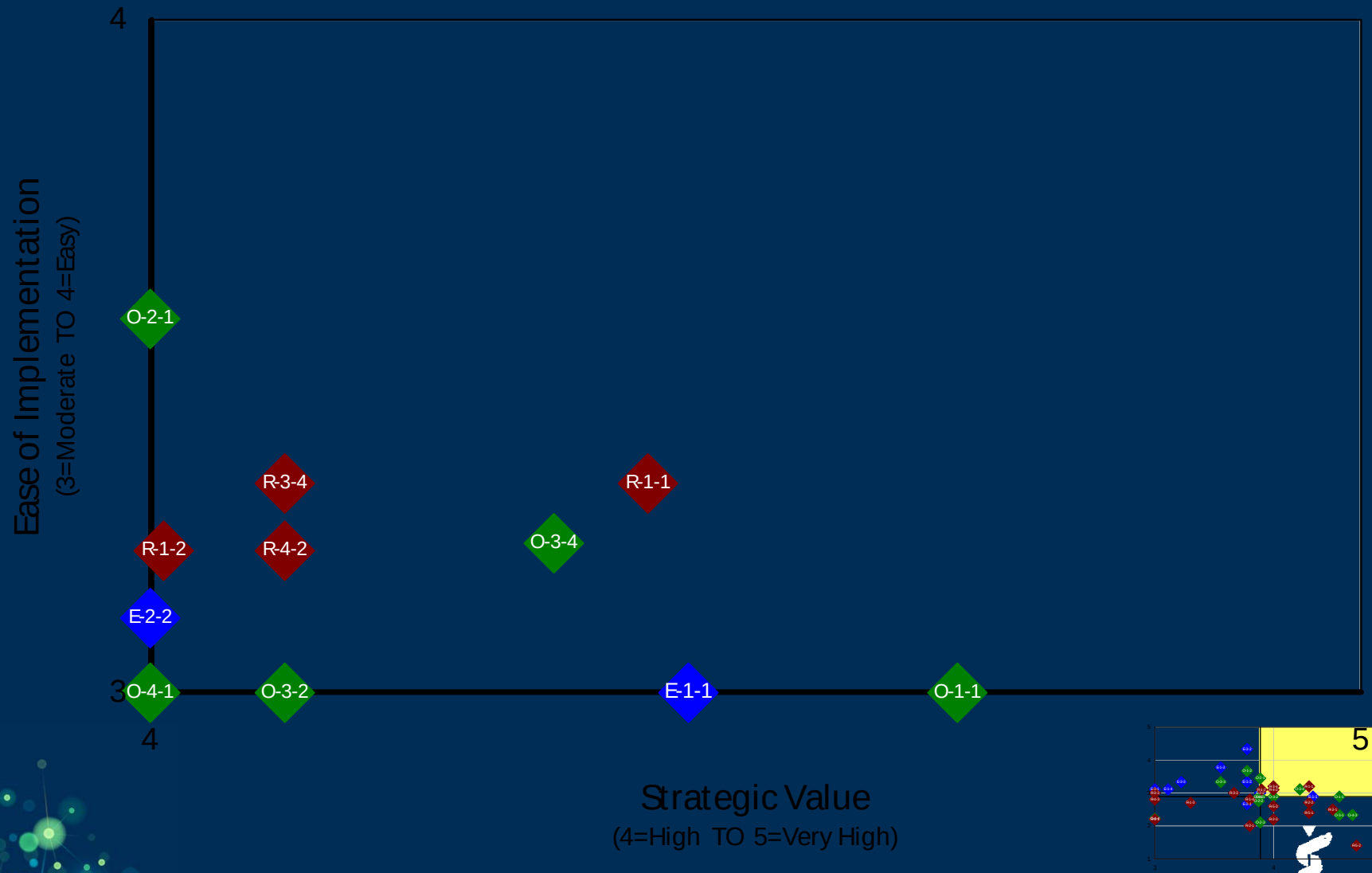


Survey Results: Adjusted Medians



High Strategic Value, Moderate Implementation

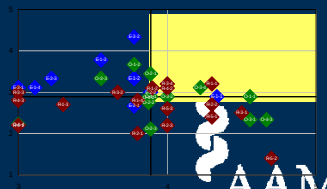
Quick Wins
Low-Hanging Fruit



High Strategic Value, Moderate Implementation

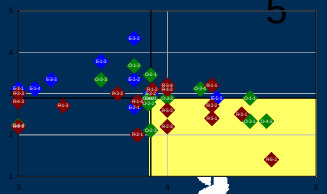
Quick Wins
Low-Hanging Fruit

Area	Goal	Strategy	Label
Education & Outreach	Students & Trainees	Recruit top undergraduate, graduate, and post-doctoral students to keep pace with the anticipated growth of the Canary Center.	E-1-1
	Scientists & Physicians	Educate the broader scientific community on early cancer detection research findings and applications.	E-2-2
Organization & Infrastructure	Reputation	Develop and promote the Stanford Canary Center identity as a place where outstanding scientific research is occurring in early cancer detection.	O-1-1
	Collaboration	Promote collaboration within the Center including inter-lab and inter-core partnerships.	O-2-1
	Faculty/Staff	Incorporate faculty outside of the Canary Center to expand collaboration and research opportunities.	O-3-2
		Create a positive and collaborative work culture that reflects the promise and excitement of the Center's vision and mission.	O-3-4
	Management	Establish and maintain an organizational framework that provides ongoing Center leadership and guidance and effectively manages the growth of the Center.	O-4-1
Research & Translation	Identify	Create an ongoing dialogue with clinicians to identify opportunities for basic and translational research.	R-1-1
		Create an interactive network of scientific colleagues that meets regularly to explore research avenues.	R-1-2
	Discover	Broadly and effectively disseminate research results.	R-3-4
	Translation Infrastructure	Identify industry and clinical collaborators to broadly evaluate new technologies, diagnostic tests, and ideas.	R-4-2



High Strategic Value, Difficult Implementation

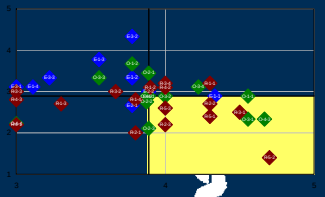
Strategic Investments



High Strategic Value, Difficult Implementation

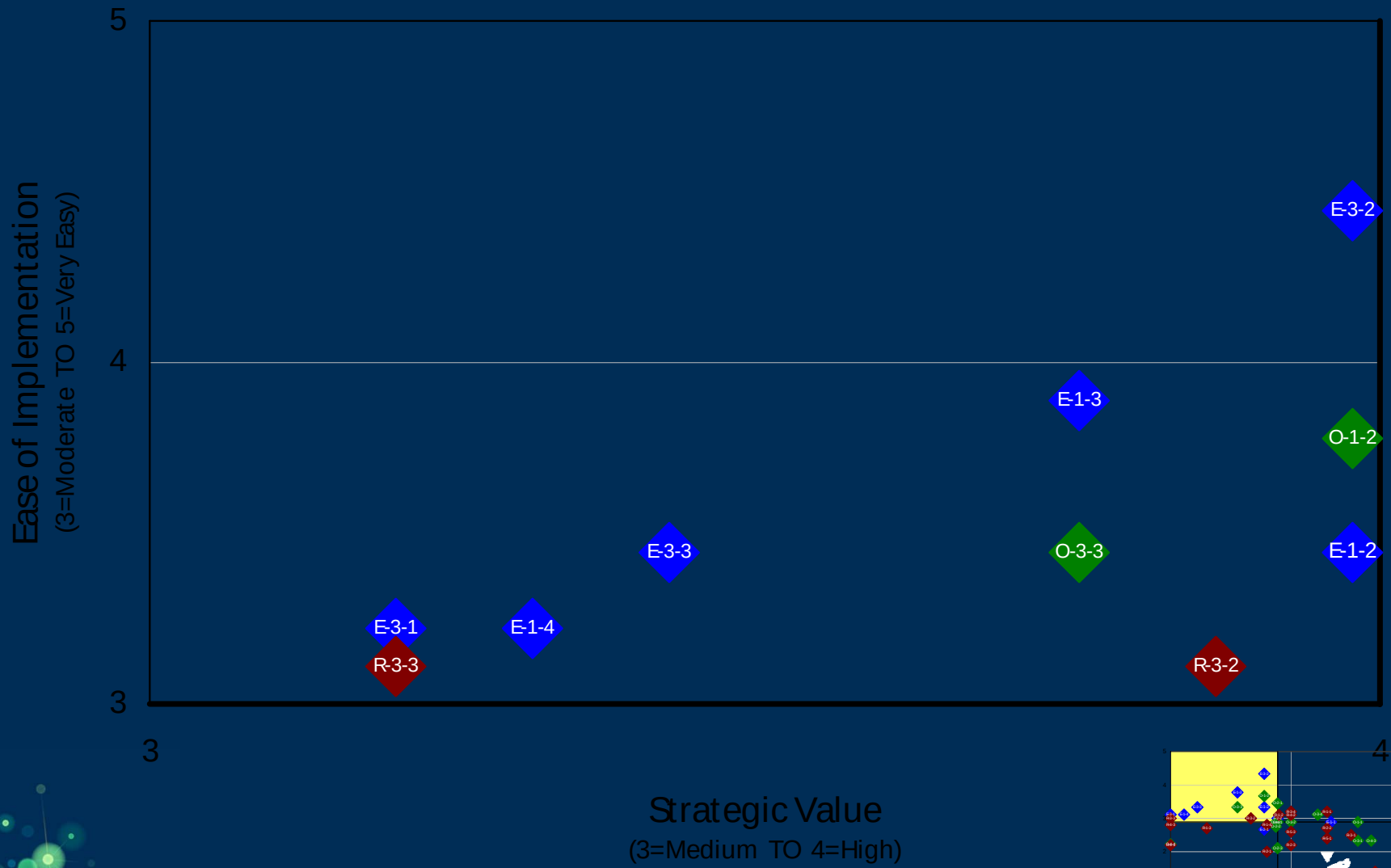
Strategic Investments

Area	Goal	Strategy	Label
Organization & Infrastructure	Collaboration	Increase collaboration across the scientific, industry, and non-profit community that further the research, education, and organizational missions of the Canary Center.	O-2-3
	Faculty/Staff	Selectively recruit faculty and staff that support excellence and key areas of focus for the Center.	O-3-1
	Management	Ensure the Center's financial viability and ability to thrive.	0-4-3
Research & Translation	Discovery Infrastructure	Create and sustain a dynamic, robust, and well equipped infrastructure that supports Canary research.	R-2-2
		Obtain, store and make available a robust inventory of bio-specimens and patient information.	R-2-3
	Discover	Help faculty identify, pursue, and attain funding for discovery.	R-3-1
	Translate	Conduct and participate in clinical trials to verify and validate discoveries.	R-5-1
		Translate discoveries into tools that can be routinely used by patients and clinicians.	R-5-2
		Identify and work with industry and clinical collaborators to broadly disseminate new technology, tests, and ideas.	R-5-3



Medium Strategic Value, Moderate Implementation

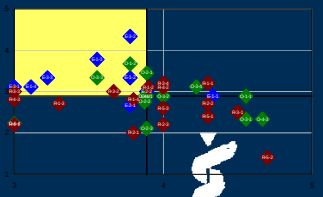
Strategic Opportunities
Load Levelers



Medium Strategic Value, Moderate Implementation

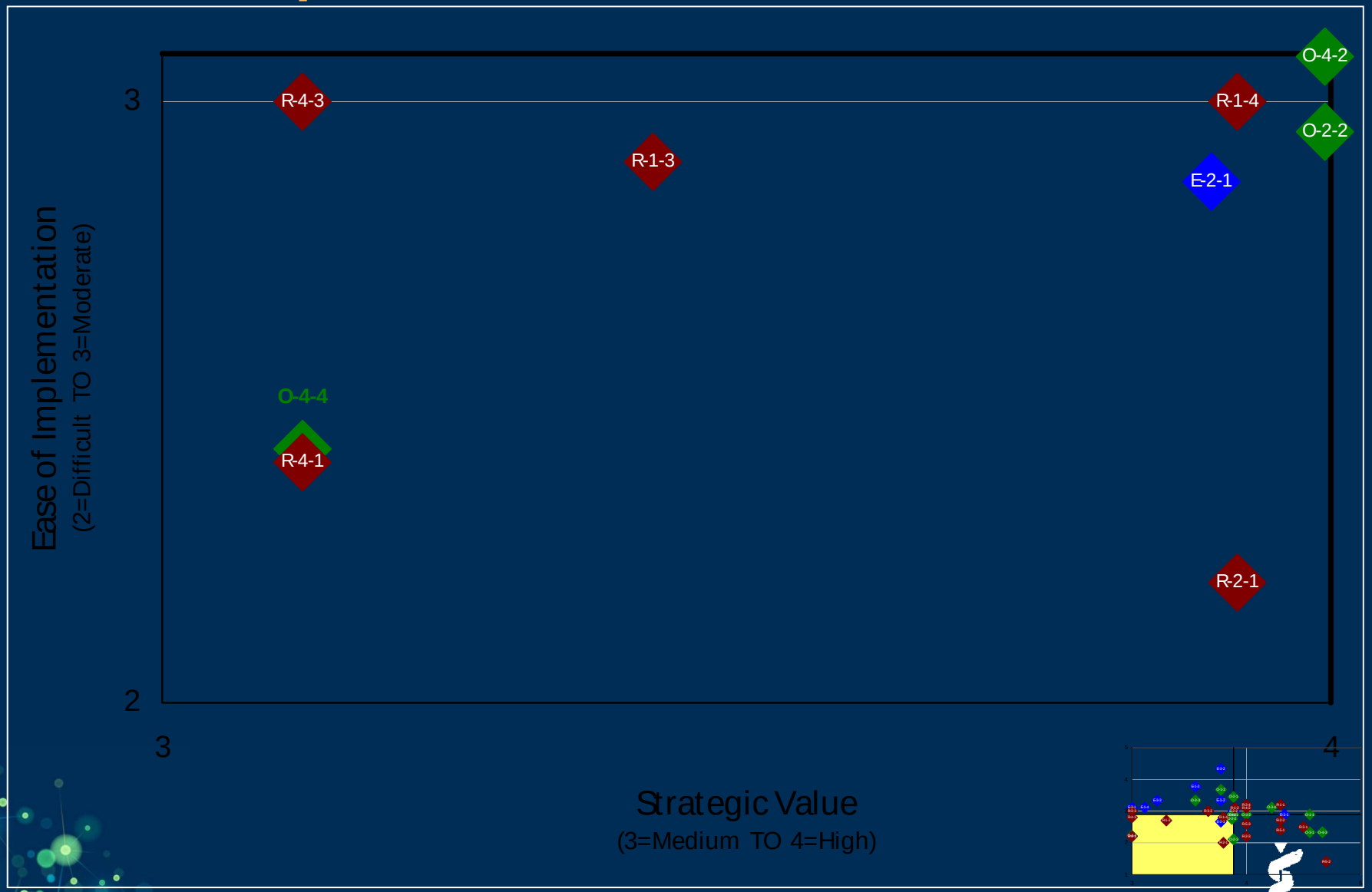
Strategic Opportunities
Load Levelers

Area	Goal	Strategy	Label
Education & Outreach	Students & Trainees	For students and trainees based at the Center, create innovative and interactive learning opportunities.	E-1-2
		Create mechanisms for recognizing and rewarding excellence in research.	E-1-3
		For students and trainees in other programs, create opportunities to expose and inspire them to focus on early cancer detection.	E-1-4
	Community	Reach-out to the public to increase knowledge around early cancer detection.	E-3-1
		Partner with the Canary Foundation on outreach activities.	E-3-2
		Partner with Cancer-focused groups to provide education and outreach.	E-3-3
Organization & Infrastructure	Reputation	Disseminate and promote Canary Center achievements.	O-1-2
	Faculty/Staff	Provide professional development to Center faculty and staff.	O-3-3
Research & Translation	Discover	Promote and reward high-risk, high reward, big ideas.	R-3-2
		Create review/mentoring boards to support the direction and implementation of research.	R-3-3



Medium Strategic Value, Difficult Implementation

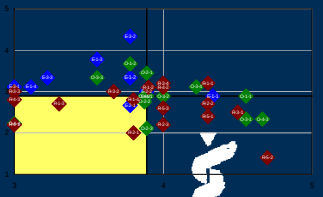
Timed Investments



Medium Strategic Value, Difficult Implementation

Timed Investments

Area	Goal	Strategy	Label
Education & Outreach	Scientists & Physicians	Increase scientist and physician knowledge around the importance of early detection, research methods, and clinical tools at Stanford.	E-2-1
Organization & Infrastructure	Collaboration	Enable inter-disciplinary collaboration between the Center and Stanford colleagues.	O-2-2
	Management	Effectively manage the achievement of Canary Center strategic goals.	O-4-2
		Leverage the Center's off-site location as an asset.	O-4-4
Research & Translation	Identify	Establish ties to industry to explore research needs and translational opportunities.	R-1-3
		Establish a process to evaluate and prioritize promising areas of research.	R-1-4
	Discovery Infrastructure	Develop data systems to integrate multiple sources of information.	R-2-1
	Translation Infrastructure	Create an infrastructure to support clinical trials.	R-4-1
		Develop mechanisms to efficiently and effectively manage the regulatory process.	R-4-3



Strategic Priorities: Critical Path

OUTREACH AND ENGAGEMENT STRATEGIES			
O&I.3.2: Incorporate faculty outside the Center to expand collaboration and research opportunities			
→	R.1.1: Create and ongoing dialogue with clinicians to identify opportunities fro basic and translational research		
→	R.1.2: Create an interactive network of scientific colleagues that meets regularly to explore research avenues		
	→	R.4.2: Identify industry and clinical collaborators to broadly evaluate new technologies, diagnostic tests and ideas.	
		→	R.5.3: Identify and work with industry and clinical collaborators to broadly disseminate new technology, tests and ideas.
		→	R.1.3: Establish ties to industry to explore research needs and translational opportunities

Ownership and Accountability

Ownership and Accountability

The Hierarchy of Ownership:

- Plan Sponsor: The leader who will ultimately be asked to “approve” the plan and support its implementation.
- Plan Owner: The leader who is responsible for the overall success of the plan.
- Goal Owners: The individuals who advocate for implementation resources, monitor implementation and measure progress.
- Strategy Owners: The individuals assigned responsibility (and allocated resources) to implement a specific strategy or set of strategies.

Strategy Ownership

"Owns" all aspects of a strategy, including:

- Specific Context – Why is the strategy included in the plan?
- The Environment – What is the current state of the environment that defines the strategy?
- The Goal – What is it that will be achieved via the strategy?
- Options and Alternative – What other approaches were considered, and why is this strategy preferred?
- Recommendations – What exactly is the strategy?
- Implementation Plan – What are the steps that must be taken (and managed) to execute on the strategy?
- Resources – What are the one-time and on-going resources investments that will be needed to execute on the strategy?
- Deliverables – How will we know if we've succeeded?

Strategy Ownership: A3s

STANFORD SCHOOL OF MEDICINE

STRATEGY *III. Program Delivery: "Creating Healthy People and Communities"*
Goal 3.1: Develop a plan to grow the Center's service mission.
Strategy 3.1.1: Develop a detailed implementation plan to grow the Center's service mission.

LEAD
Randy Stafford
Wes Alles

IMPLEMENTATION TEAM
Core SPRC Team:
Randy Stafford, Wes Alles, Chris Scholberg and Sonoo Thadaney

DATE
July 18,2013

BACKGROUND

The Stanford Prevention Research Center faculty have a long history of, and are highly respected for, innovative research on behavioral and environmental determinants of health. Through earlier community-based projects, the current HIP/Be Well programs and a reputation for clinical study quality, the SPRC also enjoys a reputation for efficacious health education, health promotion and disease prevention programs. Trends and recent innovations in health systems design and healthcare economics suggest a potentially significant role for health promotion and disease prevention programs as "clinical services". The Stanford and SPRC reputations for quality, and the Be Well program delivery experience provide the SPRC with an opportunity to develop and deliver a unique and successful clinical service in health promotion and disease prevention.

CURRENT CONDITIONS

Currently, some larger self-insured employers are investing in employee health promotion and disease prevention programs in the belief that they will reduce healthcare utilization and costs. The SPRC provides one such set of programs to Stanford University via Be Well and is discussing others through the SHC Corporate Partners Program.
Currently, the economics of our procedure –based reimbursement system incentivize providers to promote utilization and insurers to prevent access to services. Incentives for health promotion programs are minimal to non-existent. However, when fully implemented, the structural changes included in the Affordable Care Act will align the incentives of patients, employers, insurers and providers to value and programs that promote health, reduce illness and reduce utilization of traditional health system resources.

GOAL

The SPRC seeks to create a Stanford Medicine "service mission". The SPRC Health Promotion service will leverage the strengths and reputation of its basic researchers and its experience with Be Well. By designing and implementing a "Learning Health Promotion System", SPRC faculty will continuously translate basic and clinical research findings into proven health promotion programs. SPRC Health Promotion Programs will be known for their quality, efficacy and alignment with healthcare system economics. SPRC Health Promotion Programs will contribute to the financial health of the center and institution.

ANALYSIS: HEALTH PROMOTION PROGRAMS VALUE PROPOSITIONS

STAKEHOLDERS:	CURRENT ENVIRONMENT	ACA/ACO ENVIRONMENT
Individuals	Perceived Personal Health Benefits	Measured Personal Health Benefits Employer/Insurer Financial Incentives
Employers	Perceived Productivity Benefits	Measured Productivity Benefits Insurance Costs Savings
Insurers	Perceived Utilization Reimbursement Savings Perceived Utilization Costs Savings (Self-Insured Employers)	Unclear
Health Systems and Providers	Disincentive: Unreimbursed Services Disincentive: Reduced Utilization = Reduced Rev.	ACO Incentives: Red. Utilization = Incr. Income ACO Incentives: Impr. Health Measures = Incr Inc
Health Promotion Providers	Market = Individuals and Self-Insured Employers Value is not well defined or measured	Market = Individuals, Employers and Providers Value **MUST BE** well defined and measured.

RECOMMENDATIONS

(1) SPRC should develop a "clinical" health promotion service delivered through the Stanford Medicine healthcare and provider systems.
The SPRC service should be an academic program that included teaching and research elements.
The SPRC service should be integral to the Stanford Medicine community-based care strategies.

(2) SPRC should develop a Stanford Medicine branded health promotion program design that can be commercialized and implemented by non-Stanford partners.
A key value-add of the SPRC program should be the continuous improvement of program modules based on the basic and translational research findings of SPRC faculty.

IMPLEMENTATION PLAN

Activity	Lead	FY14				FY 15				FY16			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Develop Clinical Service Business Plan		X	X										
Design Stanford Medicine Delivery System				X	X								
Design "Learning Health Promotion System" Data and Metrics Systems					X	X							
Implement Stanford Medicine Pilot						X	X	X	X				
Evaluate Pilot and "Go Live"								X	X	X			
Develop Branded Program Business Plan						X	X						
Design Program Elements								X	X				
Design and Implement Pilot Program									X	X	X	X	X
Evaluate Pilot and "Go Live"												X	X

RESOURCE REQUIREMENTS

Resource	Total	FY14	FY15	FY16
Service Bus. Plan Consultant	$100,000	$100,000		
Service Impl. Costs			$ tbd	$ tbd
Prog. Bus. Plan Consultant	$50,000		$50,000	
Program Impl. Costs				$ tbd
Grand Total				

DELIVERABLES & SUCCESS MEASURES - How will you monitor progress and measure effectiveness?

* Financial Performance against business plan
* Measured health status improvements
* Measured health care utilization reductions
* Increased health promotion "clinical trials" support

Monitoring and Evaluation (Goal Ownership)

Ongoing Monitoring and Evaluation

"I have always thought that one man of tolerable abilities may work great changes, and accomplish great affairs among mankind, if he first forms a good plan

- Benjamin Franklin

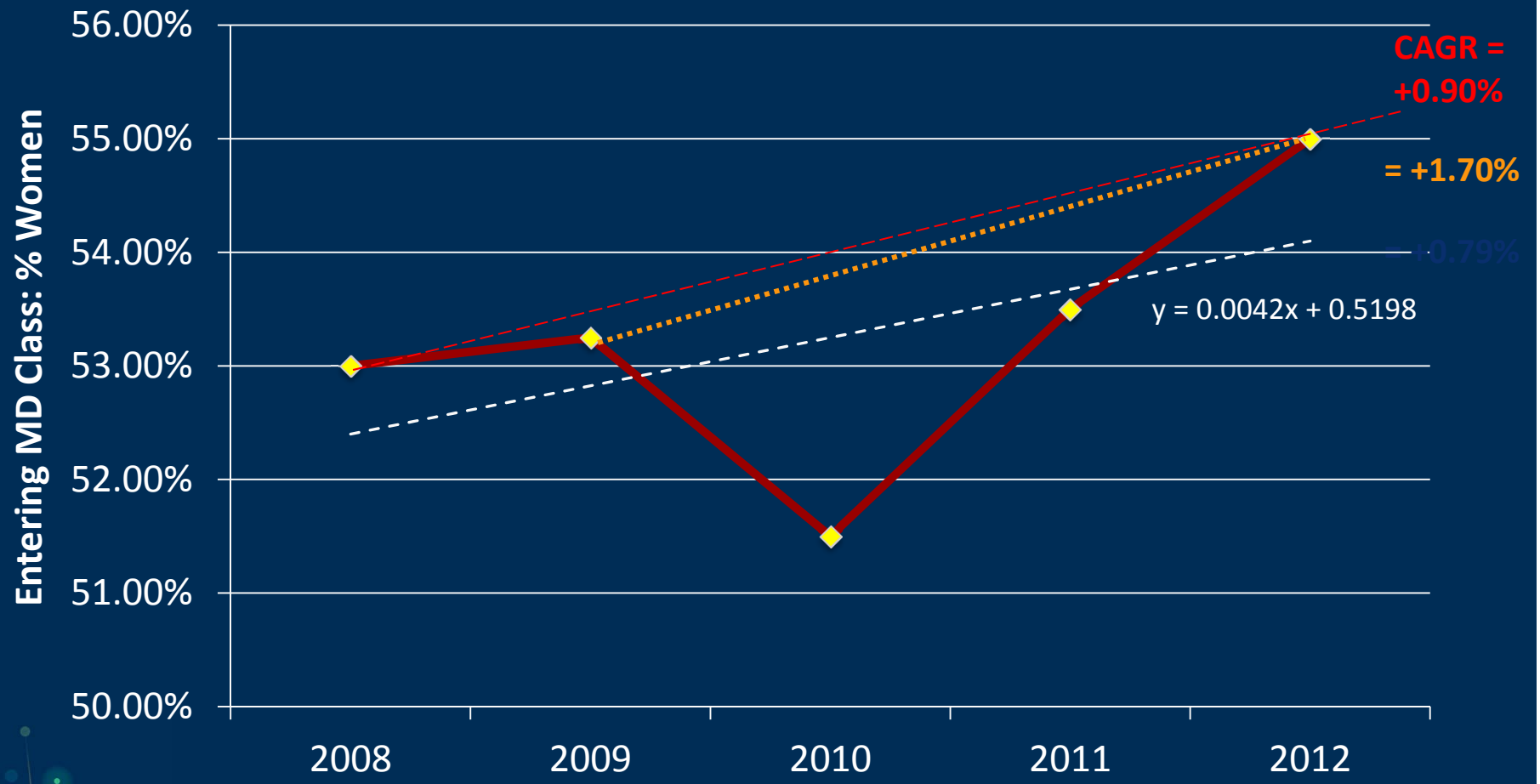
Ongoing Monitoring and Evaluation

Measuring “Success”

- Measures vs Metrics (Key Performance Indicators)
- Reports vs Dashboards
- Information Value vs Reporting/Tracking Effort
- Business Intelligence and Data Visualization

Measuring "Success": Trends

Be Clear on What You Are Measuring



Measuring "Success": Dashboard

Research	5-Year Time Frame (2008-12)			3-Year Trend*
	Min	**Current**	Max	
NIH rank (all medical schools, excluding ARRA)	12	**12**	12	**0%**
Market share	2.3%	**2.6%**	2.6%	**1.7%**
PI-Eligible faculty	870	**937**	937	**1.9%**
Percent funded	64.4%	**69.2%**	69.2%	**3.2%**

Research	5-Year Time Frame (2008-12)			CAGR*
	2008	Trend	2012	
NIH rank (all medical schools, excluding ARRA)	12		12	**0%**
Market share	2.3%		2.6%	**2.7%**
PI-Eligible faculty	870		937	**1.9%**
Percent funded	64.5%		69.2%	**1.8%**

Measuring "Success": Dashboard

STANFORD MEDICINE

Key Institutional Facts 2012

Education	5-Year Time Frame (2008-12) 2008	Trend	2012	CAGR*
Medical Education (MD)				
Enrollment (entering class)	86		92	**1.7%**
Percent women	53%		55%	**0.9%**
Percent under-represented minorities (URM)	17%		15%	**-3.4%**
GPA [average]	3.75		3.79	**0.3%**
MCAT Score [average]	11.32		11.76	**1.0%**
Applicants (entering class)	6,567		6,810	**0.9%**
Acceptance rate	2.6%		2.8%	**1.5%**
Percent accepted who matriculated (i.e., yield)	50.0%		48.7%	**-0.7%**
MD student graduating debt [$K] [average]	$ 86		$ 101	**4.2%**
Graduate Education (Master's & PhD)				
Enrollment (entering class)	94		111	**4.2%**
Percent women	55%		50%	**-3.7%**
Percent under-represented minorities (URM)	20%		10%	**-16.3%**
GPA [average]	3.70		3.74	**0.3%**
Applicants (entering class)	1,289		1,909	**10.3%**
Acceptance rate	13.0%		11.3%	**-3.4%**
Percent accepted who matriculated (i.e., yield)	56.3%		51.6%	**-2.1%**
Graduate Medical Education				
Residents & Clinical Fellows	788		937	**4.4%**
Percent in ACGME positions	95%		94%	**-0.3%**
Residents who matched with their first choice	71.1%		70.7%	**-0.2%**
Residents who matched with 1 of their top 3 choices	87.8%		84.0%	**-1.1%**
Postdoctoral Training				
Postdoctoral Research Scholars	880		1,165	**7.3%**
Percent in basic science departments	33.4%		28.8%	**-3.7%**
Percent in clinical science departments	61.1%		62.7%	**0.7%**
Percent of all postdocs at Stanford	68.9%		64.4%	**-1.7%**
Years at Stanford [average]	2.5		2.6	**1.1%**

Research	5-Year Time Frame (2008-12) 2008	Trend	2012	CAGR*
Expenditures [direct costs, $M]	$ 279		$ 355	**6.2%**
Percent from federal sponsors	77%		74%	**-0.9%**
Proposals [count]	1,639		1,891	**3.6%**
Proposals [$M]	$ 1,333		$ 1,882	**9.0%**
Awards [count]	702		850	**4.9%**
Awards [$M]	$ 379		$ 479	**6.0%**
Percent from NIH	64%		73%	**3.4%**
NIH rank (all medical schools, excluding ARRA)	12		12	**0%**
Market share	2.3%		2.6%	**2.7%**
PI-Eligible faculty	870		937	**1.9%**
Percent funded	64.5%		69.2%	**1.8%**
Average expenditures per funded PI [$K]	$ 624		$ 686	**2.4%**
Percent of all sponsored research at Stanford [a]	55%		60%	**2.1%**
Intellectual property (IP) royalties received [$M]	$ 13		$ 18	**7.7%**
Dockets (inventions) filed	240		260	**2.0%**
US News rank (best medical schools: research) [b]	6		2	**24.0%**

Patient Care	5-Year Time Frame (2008-12) 2008	Trend	2012	CAGR*
School of Medicine Departments				
Faculty clinical FTEs (full-time equivalent units) [c]	602		686	**4.4%**
Work RVUs (relative value units) [#K]	2,605		3,602	**8.4%**
Profit & loss balance [$M] [d]	$ 36		$ 76	**20.7%**
Stanford Hospital & Clinics (SHC)				
Inpatient: Discharges [#K]	23.1		25.2	**2.1%**
Patient days [#K]	135.4		141.1	**1.0%**
Surgeries [#K]	22.6		27.4	**4.9%**
Outpatient: Visits [#K] [e]	278.3		489.1	**15.1%**
Operating revenue [$M]	$ 1,720		$ 2,298	**7.5%**
Operating margin [$M]	$ 106		$ 237	**22.3%**
Operating margin percent	7.4%		9.7%	**7.0%**
EBIDA [$M]	$ 198		$ 379	**17.6%**
Lucile Packard Children's Hospital at Stanford (LPCH)				
Inpatient: Discharges [#K]	17.1		16.5	**-0.9%**
Inpatient: OR cases [#K]	4.7		5.5	**3.9%**
Outpatient: Cases [#K]	35.7		57.6	**12.7%**
Outpatient: Clinic visits [#K]	134.3		151.2	**3.0%**
Operating revenue [$M]	$ 681		$ 979	**9.5%**
Operating margin [$M]	$ 42		$ 81	**17.9%**
Operating margin percent	6.1%		8.2%	**7.7%**
EBIDA [$M]	$ 76		$ 125	**13.3%**

Benchmarks (2011)	Stanford	Benchmark Medical Schools Average	Median	Percentile
Education [headcount]				
Medical Students (MD)	456	616	634	11
Residents & Clinical Fellows	923	1,156	1,071	36
Graduate Students (MS, PhD)	546	685	642	31
Research [$K]				
Federal research grants & contracts per faculty	$ 507	$ 232	$ 205	100
Patient Care [$K]				
Hospital support per clinical department faculty	$ 198	$ 150	$ 144	73

* Compound Annual Growth Rate (CAGR) represents the smoothed annualized change over the time horizon. Values in green font indicate a > 5% **beneficial** change, whether increase or decrease. Values in red font indicate a > 5% **detrimental** change.
Benchmarks source: Association of American Medical Colleges (AAMC), 2011. The 20 medical schools with the highest amounts (cost) of research grants and contracts in 2011. Quality metrics denoted with tan shading.
[a] Time frame is 2007-11. [b] U.S. News & World Report: Graduate Schools, time frame is 2010-14. [c] Time frame is 2009-12. [d] In FY11, the funds flow methodology between LPCH, SoM, and the clinical departments changed, resulting in one-time payments for the tail of patient accounts receivable ($12M) and the posting of two academic grants in one year ($4M in FY10, $7M in FY11). [e] Billing frequency increased with implementation of new clinical information system (Epic) in FY2010.

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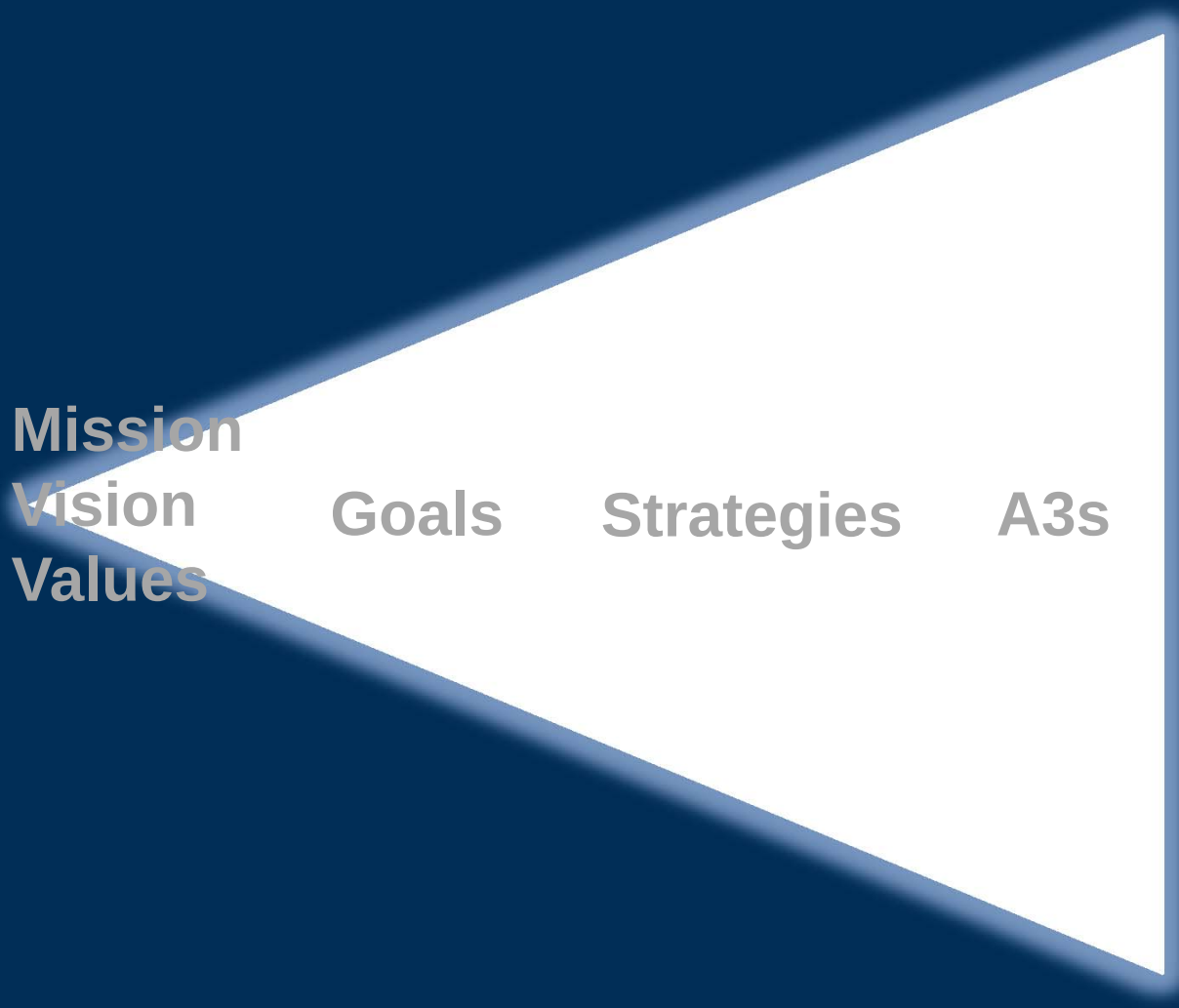
Measure “Success”: Value vs Effort



= 800 elements

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Summary

Organizational Readiness

- Honestly evaluate how well your organization is prepared to act on the recommendations of a well-constructed plan.
- Specifically include, in the plan, strategies to mitigate any key risks.

Prioritization for Implementation

- Be strategic!
- Pace yourself and respect your “bandwidth” and resource limitations

Summary

Ownership and Accountability

- Successful implementation is very hard.
- Create an organization within the organization.
- Clearly delegate responsibility to individuals.

Ongoing Monitoring and Evaluation

- Measure success (not activity).
- Be creative, but work within your (IT) means.
- Don’t underestimate the data management burden

Questions?

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