A new strategic plan, an additional one hundred faculty members, a new financial model, an incentive compensation plan, a new $200 million research building, closing one professional school and repositioning assets to help another, redirecting net revenues from two parking garages, and a building renewal and replacement plan—all are outcomes of a strategic planning and budgeting process.

Strategic Planning and Budgeting to Achieve Core Missions

Heather J. Haberaecker

Northwestern University and its Feinberg School of Medicine adopted a new university and school strategic plan to help the school achieve its strategic vision. This chapter describes how the school organized, planned, and implemented change over a ten-year period, with special attention devoted to the importance of data analysis and to the linkage of the strategic plan to budgeting.

The University and School

Northwestern University is a private, extensive research university consistently ranked among the top twenty research universities in national rankings. With campuses in Evanston and Chicago and a full-time faculty of more than 2,300, the university enrolls more than 13,400 students in ten schools and colleges. Of these, 7,500 students are undergraduates, 2,700 are graduate students, and 3,200 are enrolled in professional schools. The professional schools are the Feinberg School of Medicine, the Kellogg School of Management, and the School of Law, the latter two being recognized as among the best in the country in their respective fields. The university’s total operating revenues exceed $1.2 billion, with research expenditures of more than $233 million and climbing.

The Feinberg School of Medicine is located on the Chicago campus. It employs some twelve hundred full-time and sixteen hundred contributed services faculty, educating more than seven hundred medical students and three hundred graduate students, training eleven hundred residents, and conducting basic and clinical research. The school’s operating revenues totaled $270
million in FY2002. Research expenditures reached nearly $122 million. Unlike many institutions, Northwestern does not own a medical practice plan or hospital. Rather, with five affiliated hospitals and three major practice plans, all separately incorporated, Feinberg has one of the most complex hospital-practice–medical-school relationships among U.S. medical schools. Therefore, the university and the medical school have far less control over the decisions and assets of affiliated organizations than do most universities that own a hospital or practice plan.

The School's Strategic Plan

Feinberg's strategic plan, published in March 1997, contained this strategic vision statement: “To become one of the nation’s preeminent medical schools, as measured by the excellence of our faculty and students, the innovative nature of our research and educational programs, and the quality of clinical care we provide to patients.”

To implement this vision statement, the school adopted a series of ambitious plans, including:

- Substantial growth of the medical school by adding more than 100 (later changed to 150) faculty over a ten-year period and building the research, library, and administrative infrastructure needed to accommodate such growth
- Becoming a top twenty research medical center over ten to fifteen years
- Adding more than 250,000 net assignable square feet of research space over the same period, beginning with construction of a $200 million medical research building
- Increasing the breadth and depth of programs in key areas
- Moving from a regional to a national presence in patient care by attracting and retaining top physician faculty and leveraging clinical care with research activity
- Attracting the best (instead of just very good) students and expanding graduate programs in life science to bridge the worlds of research and education
- Reducing the size of the medical school class by 20 percent to better ensure that an outstanding clinical education is provided to all students
- Doubling external support for the medical school in order to finance the plan, with special emphasis on greater affiliate organization and endowment support
- Exploring a new financial relationship with the university
- Committing to regularly budgeting funds to maintain facilities, even if the investment constrains the school’s rate of growth

In addition, the plan called for accountability and fiduciary responsibility becoming shared values, and the organization becoming more tolerant of
and capable of change by redesigning incentives and expectations to enhance partnering and accountability. Developing indicators and benchmarks to measure the school’s success in achieving its plans was also recommended.

**Northwestern’s Strategic Plan**

The school benefited as Northwestern University updated its strategic plan at the same time the school was developing its own plan. This enabled the school to suggest specific strategic directions to university leadership, and to receive definitive responses. For example, when the school was considering how much it needed to expand its research activities and how large its new medical research building should be, university and board leadership both encouraged medical school leadership to increase the size of the building beyond its initial scope and committed resources to this effort. This was in keeping with two of the themes in the university’s evolving plan: to grow the research mission on both campuses and to target the Feinberg School of Medicine as an area for expansion and improvement.

In addition, the university’s decision to close its dental school allowed a major repositioning of university assets to help support the future of the medical school. The university was able to reallocate shared medical school and dental school endowments and assets (including the net revenue from two parking garages) to the medical school and reallocate dental school space to the medical school to house a portion of the new faculty to be recruited.

**Laying the Foundation for the School’s Plan**

Taken as a single event, development of the school’s strategic plan looks fairly similar to that of many strategic planning efforts. For example, the plan was developed through the efforts of a steering committee of which a subset comprised the executive committee, five working groups, an external advisory committee, fourteen topical task forces, and advisory panels (from the five affiliate hospitals, the university itself, and students and alumni). However, it is both the events leading up to development of the plan and those following adoption of the plan that portend much of the success of the plan to date.

For many years prior to adoption of the strategic plan, the executive associate dean for management regularly published and presented comparative and longitudinal data on the medical school compared to other medical schools and to university trends. With the assistance of the director of strategic planning and management, an annual fact book and other analyses were published. They provided longitudinal and comparative data on department and school rankings in research and were based on national norms, trends in funding sources available to the school compared to other medical schools, and trends in university support. Regular presentations
on national rankings of departments and other measures were made to the dean’s council and departments requesting such presentations. Despite the typical complaints about the quality of comparative data, the school grew comfortable over time with comparative data and understood that data matter. Increasingly, the school understood how data could and should inform the decision-making process.

This openness to data and willingness to embrace the results of environmental scanning helped shape a number of the specific strategic thrusts. For example, the plan to become a top twenty research medical center and recruit more than one hundred additional faculty over ten years was supported by analysis showing how Feinberg’s research funding compared to the top twenty research-intensive medical centers as a percentage of overall revenue and what it would require, in the way of faculty and resources, to become a top twenty medical center. Additional analyses showing that the school had a productive but relatively small basic science and clinical research faculty informed the decision to increase the size of the faculty.

Similarly, comparative analysis showed that medical school revenues nationally had increased in absolute terms, but only medical services (practice plan) revenues had increased in relative terms. The results of the environmental scan also showed that medical services revenue was not likely to continue to increase at the current rate because of a medical delivery system that had become more market-oriented. This helped lead to the recommendation to diversify funding sources over time.

A great deal of the success to date in implementing the strategic plan is probably due to its emphasis on a decision-making process informed by data. A number of other factors leading to its success are described here.

**Developing and Implementing the Plan**

Four factors noted by Anderes (1996) were instrumental in reaching consensus on the school’s strategic plan: (1) active leadership from the top, (2) broad participation in developing the plan, (3) regular forums to share information on the plan and its development, and (4) clear intention to link planning outcomes into budget development and allocation.

The university and its board of trustees were active supporters during development of the plan. Much of this was because the individual in the medical school who was leading the strategic planning efforts not only knew planning but could communicate effectively with university leadership and the board of trustees. The executive associate dean for management, who is now the senior executive associate dean and chief operating officer of the medical school, had come from state government and possessed the professional background, relationships, and credibility to deal effectively with the business leaders who served on the board. He also encouraged broad participation in developing the plan within the medical school.
Another factor in the plan’s success has been the detailed analyses of the plan’s financial viability and development of strategic financial management tools. Detailed financial analyses suggested that the current level of funding would not be enough to support the strategic plan. Therefore, various changes in the school’s revenue mix and funding level were modeled, leading to recommended new financial strategies for the school. Development of a new financial relationship with the university and use of some of the revenue to fund a portion of the plan together are one of two key financial strategies emanating from the plan. The other financial strategy—diversification of revenue sources through greater support from affiliate hospitals—resulted from comparative analyses showing that affiliates were contributing substantially less in proportion to the medical school than peer institution affiliates were.

Two other elements had a measurable effect on the success of the plan. The first involved including agreed-on departmental performance indicators in the annual budget and planning process. These measures show each department’s performance compared to both the school as a whole and where schoolwide performance ought to be, in such areas as research funding per faculty member and research funding per net assignable square foot of space.

The second factor involved continuously updating the plan on the basis of new information. For example, the recommendation to reduce class size by 20 percent was abandoned when it became apparent that the loss of tuition revenue would only weaken the school’s ability to fund the overall plan. Similarly, the number of faculty to be recruited was increased from 100 to 150 when the former dental school space became available, and when the projected costs and revenues associated with each new faculty member were modeled. This is why, as Sevier (2000) says, strategic planning must be a series of conscious, explicit, proactive, and ongoing decisions.

However, changed financial relationships between the university and the school, and between the medical school and its departments, had the most profound effect on the ability to fund the strategic plan.

The New Financial Relationship

The shared strategic vision both parties had for the medical school sparked openness toward changing the financial relationships among the university, the school, and its departments. Nonetheless, the school had to make the formal case for a changed financial relationship with the university and then flesh out the details. School-department relationships under a new financial model also had to be defined before the overall financial change could be implemented.

The Case for Change. As has been noted, financial analyses during the strategic plan’s development showed a level of revenue insufficient to fund the strategic plan even when reasonable inflationary increases were
included. The university’s appropriation to the school, in particular, was
growing at a rate of only 3 percent a year, and increases much beyond that
rate were not feasible. On the other hand, the school had been experienc-
ing double-digit growth in sponsored research funding since the early
1990s, while gaining only limited sharing of facilities and administrative
(F&A) cost recovery revenue. Since both the university and the school
wanted to grow the research enterprise, the return of all facilities and
administrative revenues to the school seemed logical. Further, the school
felt that building incentives into budgetary allocations to departments
would further stimulate research growth. The school looked at the various
revenue streams the university controlled and was convinced that it should
become a “tub on its own bottom”—keeping all of the revenue it earned and
paying for the university services it received.

Several other factors led to the decision to forgo an annual appropria-
tion from the university. First, the individual appropriations that some
departments received made little sense. Some large departments with sig-
nificant research and education responsibilities received little appropriation
compared with smaller departments with significantly less in the way of
research and education responsibilities. These patterns, inconsistent with
the new strategic plan, were largely the result of incremental budgeting.
Second, the school hoped that by surrendering the appropriation it could
demonstrate to the affiliate hospitals and donors that their support would
further the research and education mission of the school (rather than sub-
sidizing the university), thus leading to increased contributions. This was
important because the hospitals had historically expressed concern that
increased support from them could lead to a lower medical school appro-
priation from the university. Increasing affiliate hospital and donor support
was another key financial objective of the strategic plan.

The university agreed to explore options for a decentralized financial
management structure for the medical school.

**Key Elements of the Change.** The university’s associate vice president
for budget planning and the executive associate dean of the medical school
were charged with recommending a decentralized financial management
structure that would work for both parties. These two individuals and their
staffs reviewed the decentralized financial structures in place at other institu-
tions and visited three of them to learn more about their structures.
Ultimately, the team chose to emulate one that had been in place at Vanderbilt
University for more than twenty-five years. The Vanderbilt model was selected
because the two universities are comparable in both size and mix of programs,
including medical schools, and the model was mature enough that most of
the issues and problems had been fixed over time. Furthermore, the associ-
ate provost at Vanderbilt agreed to provide consultation.

Table 7.1 shows the handling of key revenue and expense streams rec-
ommended by the review team to university and medical school leadership.
Both parties concurred, with the university adding two refinements. First,
it was agreed that neither the medical school nor the university would be disadvantaged financially in the short run (first year), allowing the university sufficient time to transition to the new structure. Second, the university built a president’s “tax” into the financial model from the medical school equal to 12.5 percent of facilities and administrative revenue, separate and distinct from the charge the school would be bearing for university services received. The university felt this tax was necessary to give the president sufficient strategic capital to fund university priorities. In part, this was the result of advice received from other decentralized institutions that had failed to build such contributions into their models and subsequently regretted it. Medical school leadership agreed, since the school would be eligible to compete for such funds.

Although both parties relied heavily on data in making their decisions, substantive unknowns still existed at the time the parties agreed to this new financial relationship. First, even though the general methodology of the model had been adopted, no one could predict exactly how much the charge for university services would be, nor the impact on the university of lost endowment earnings now earmarked for the school. Second, neither the school nor the university fully understood the extent of any deferred maintenance obligations the school was assuming. The fact that the change was agreed to, in spite of these unknowns, shows the level of trust that existed between the two parties, and it underscores why trust is viewed as essential to a change of this magnitude (Sanaghan and Napier, 2000).

**Decisions Shaping the School-Department Model.** The school also needed to determine how to implement a changed financial model internally. The executive associate dean and director of strategic planning and management conducted additional analyses and decided that critical decisions involved:

- How much of the new revenue available to the school would go to departments as opposed to staying at the school level
- Which costs under the new model would stay at the school level instead of going to departments
• Clarifying financial responsibility for strategic growth of the medical school
• Funding the school’s educational function
• Funding the medical school’s administrative costs

\textit{Splitting Revenue, Allocating Costs.} Of the three major new sources of revenue (tuition, facilities and administrative revenue, and centrally held school endowments), the first two are generated by departments. It was clear from the outset that a major portion of these revenues should be returned to the departments, to replace the appropriations they previously received from the university and to help create some incentives to support the school’s growth. The question then became, “How much of these revenues should be returned to departments?” This question could not be answered until it was decided how to handle the new costs to the school associated with the financial model. These costs included paying the university for medical school space, services received from the university, and the president’s tax.

The space question was relatively easy to answer. It was decided to pass space costs on to departments to help influence their decision regarding how much space they really needed. A related decision involved using only one rate for all types and quality of space to simplify the allocation procedures.

However, deciding how to allocate the costs of services received from the university was complicated by the fact that the model for assessing costs to the school had not yet been fully developed; nor had the total cost been determined. The school had to make some assumptions about what the total costs would likely be. The costs were modeled using the school’s share of university administrative costs that the latter provided to the school, as reported on the annual financial survey submitted to the medical school accrediting body. The other related decision was whether to pass these costs, as well as the cost of medical school administration and the president’s contribution, on to the departments, thus showing full costs at the department level. Use of a full-cost model would have helped the departments understand their real costs, but it was felt that the burden of additional transactions on an outdated university accounting system was not worth the benefits that would be derived. Furthermore, these were not costs that departments could control. Therefore those costs were taken off the top using a tax rate structure before distributing remaining revenues to departments.

\textit{Responsibility for Growing the Enterprise.} A decision on how to fund the 150 new faculty and related needs called for in the strategic plan was another consideration factored into the internal model chosen. Analyses showed that the clinical departments had substantial revenue available to them from the transfer of practice plan revenue and from endowments provided by grateful patients. It was also clear that the basic science departments did not have similar resources available.
A model was constructed to estimate the average expected costs and revenues for new faculty hires—incorporating start-up costs, ongoing support for a portion of salary, expectations about revenue generation, and the like. This model was based on the school’s own experience and survey results of experiences at other medical schools. The analysis showed that most clinical departments could afford to finance the cost of new faculty, but basic science departments and a few clinical departments could not. Therefore it was decided to allocate a portion of new revenue for the strategic growth of the medical school using the tax rate structure already noted.

**Funding the Education Function.** At Feinberg, basic science departments bear primary responsibility for educating medical students during their first two years. These departments previously received the largest appropriations from the university; they were the only medical school departments with tenure and the financial guarantees associated with it. Because they did not have the same diversity of resources available to them as did the clinical departments, they had the most to lose under the new financial model. On account of the university’s financial guarantee to tenure and the lack of other resources, it was decided to fund a portion of each tenure-track faculty member’s salary from the tuition dollars now available to the school. However, guaranteed financial support for faculty was ramped down over a three-year period, from 50 to 45 to 40 percent of salary, and then stabilized at that rate to give departments time to grow their research function.

Tuition funds also were distributed to departments to support their education function, with a specific allocation model developed by the executive associate dean for education in collaboration with the school’s Education Council. Since there are few national norms in this area, development of the model has proven difficult and thus far has not received widespread support. In its current and most simplistic form, it is designed to accomplish two objectives: (1) allocate funds to departments to support the educational administrative roles they perform using a standardized rate; and (2) allocate funds in proportion to the actual teaching performed by the department, with separate weightings by course type.

Medical student financial aid was historically provided from endowments and a university appropriation to the school. Since the school would no longer receive a financial aid appropriation, the medical school tuition revenue stream was deemed the most appropriate funding source for the portion not funded from endowments.

**Funding Medical School Administration.** The cost of medical school administration was historically funded from the university appropriation, school endowments, and support from the medical school’s practice plan. A new funding mechanism was needed to support the lost appropriation as well as fund additional administrative costs associated with new space and other infrastructure needs. These costs were built into the tax rate structure as well.

**The Final School-Department Model.** Many analyses were conducted—for example, of the amount departments would receive under
various scenarios compared to previous appropriations, how much would fund medical school administration, and so on—to create the model shown in Figure 7.1. This illustrates how the two primary revenue streams (medical tuition and facilities and administrative revenue) are being taxed. The one cost missing from this model is the required president’s tax, which is being funded from the endowments transferred to the school.

As the internal school-department model was developed, several objectives drove specific decisions, among them a desire to:

- Understand the costs (space, services, administration) and their relationship to the tax rate structure
- Create incentives for growth and optimal use of resources at the department level
- Support strategic goals of the school by requiring all departments to participate in funding the strategic capital needed to grow the enterprise
- Move authority, responsibility, and decision making down to the department level on matters such as faculty productivity and space management
• Make the model as rational as possible by having funds flow proportionally to activities that generate them

**Implementation Phase.** The implementation phase consisted of three components: (1) determining the methodology for the university shared services assessment, (2) deciding when and how to move to the new financial relationship between the university and school, and (3) selecting an implementation strategy within the school.

**Shared Services Assessment.** Early in the process, the university and school agreed to use revenue rather than expense as the basis for determining the school’s proportional share of university services costs. This decision was reached largely by default. The alternative would have involved determining the percentage of effort expended by each administrative office on medical school activities; this was viewed as too cumbersome, too subjective, and probably too unstable to support sound management year to year.

Three major efforts were required to build this model: (1) allocating the various university revenue streams to the proper school, college, or administrative unit; (2) netting noneconomic activity out of university administrative expenses to ensure that shared services expenses were allocated fairly; and (3) determining which revenue streams were the appropriate basis for setting the medical school’s share of expenses. Shared services rates developed from the ratio of medical school to university revenues were applied to the applicable university administrative costs to determine the medical school’s share of university services costs. Information flowed freely between the two parties during development of the model, and the medical school was a major player in determining which revenue streams were appropriate in determining our share of expenses. Table 7.2 shows the percentage of university services costs that the medical school paid in FY2002.

**Pulling the Trigger.** When and how to implement the new financial model was the subject of much debate between the university budget and planning office and the leadership of the medical school. The school in particular worried that other university goals and priorities would take precedent over the new model if it were not implemented within a year of agreement having been reached. The budget office, on the other hand, worried that it did not have the necessary infrastructure in place to implement the new model. A compromise was eventually reached whereby the two parties agreed to:

• An overall control number that the medical school was allowed to budget for FY2001, based on a very conservative estimate of facilities and administrative revenue, real likely space costs, and an estimate of the likely university shared services assessment.
• Distribution of only part of the endowment funds and none of the parking garage income that were to come to the school under the new
The university was bearing the full cost of closing the dental school, and this was part of the strategy to hold the university harmless in the first year of the transition.

- Agreement to make no major changes in the university’s accounting system for FY2001 as a result of the change. This required the school to run its own shadow system to ensure that it was earning an amount at least equal to the control number.
- Agreement to fully reconcile revenues and expenses under the model following FY2001. The school would receive any additional revenue earned above the control number but would also be responsible for any shortfalls.

**The School’s Implementation Plan.** The school needed to accomplish two objectives in its implementation of the new financial model: first, develop a strategy to ease in departments that would have fewer resources than when they received direct appropriated funds; and second, develop a budget strategy for FY2001 yielding departmental allocations equal to the agreed-on control number. These objectives were interrelated, but the need to grant the basic science departments a longer transition period was recognized early on, given their heavier reliance on the university appropriation. As has already been noted, the reserved education pool allocation to the basic science departments was structured so that support of faculty salaries would decrease from 50 to 45 to 40 percent over a three-year period. Further, it was decided to hold all departments harmless during the first year (and only the first year) of the new model to give them time to adjust to the new realities.

To finalize the department budget allocations, the school relied on the tax structure developed to allocate revenue streams to departments and used the earned education pool allocations developed by the executive associate dean for education. Two other decisions were required. The first was how

### Table 7.2 Summary of FY2002 Shared Services Assessment Calculation ($ in Thousands)

<table>
<thead>
<tr>
<th></th>
<th>NU Total Cost</th>
<th>FSM Share</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>$15.96</td>
<td>$3.18</td>
<td>19.9%</td>
</tr>
<tr>
<td>University services</td>
<td>5.36</td>
<td>1.14</td>
<td>21.3%</td>
</tr>
<tr>
<td>Business and finance development</td>
<td>17.57</td>
<td>4.81</td>
<td>27.4%</td>
</tr>
<tr>
<td>University relations</td>
<td>2.87</td>
<td>0.81</td>
<td>28.2%</td>
</tr>
<tr>
<td>Enrollment</td>
<td>7.73</td>
<td>0.33</td>
<td>4.3%</td>
</tr>
<tr>
<td>Student affairs</td>
<td>10.93</td>
<td>0.41</td>
<td>3.7%</td>
</tr>
<tr>
<td>Research administration</td>
<td>8.84</td>
<td>3.54</td>
<td>40.0%</td>
</tr>
<tr>
<td>Graduate studies</td>
<td>1.99</td>
<td>0.16</td>
<td>8.1%</td>
</tr>
<tr>
<td>University library</td>
<td>20.75</td>
<td>0.15</td>
<td>0.7%</td>
</tr>
<tr>
<td>Recreation (Evanston)</td>
<td>3.67</td>
<td>0.00</td>
<td>0.0%</td>
</tr>
<tr>
<td>Information technology</td>
<td>—</td>
<td>2.04</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td>$104.99</td>
<td>$19.19</td>
<td>18.3%</td>
</tr>
</tbody>
</table>
to fund the “hold harmless” provision for all departments losing under the model. The second concerned distribution of resources under the control number between departments and the dean’s administration. It was decided to fund the hold-harmless provision by reducing the net new revenues available to advantaged departments by 50 percent. Thus new phrases were coined: “stop-loss” and “stop-gain” provisions. It was decided to furnish the remaining funds to the dean’s administration even though it represented a loss for FY2001 compared to the previous appropriation. This was viewed as acceptable, since it helped build departmental acceptance of the new model. The dean’s administration also had other resources available to temporarily offset the loss. Also, beginning in FY2002, the school would be receiving additional endowment income and proceeds from the parking garages that had been withheld in FY2001.

**Implementation Problems Experienced.** The problems experienced are grouped here under three broad categories: (1) technical, (2) conflicting roles and responsibilities, and (3) communication.

**Technical.** Regarding technical problems, the university lacked the fund and account structure to transition easily to the new financial model. The school’s need to see the revenue earned against budget in real time challenged the university’s conventional ways of doing business, and it required difficult changes in the university’s outdated accounting system. Even with these changes, it was hard to manage the day-to-day operations of the school’s finances, since the system required a larger number of accounting transactions and redundant shadow fund information. The lack of a muscular reporting tool or data warehouse at the university level further compounded the problems; some of the deficiencies of the university’s transactional accounting system could have been overcome by having more readily available and flexible reports.

Another major problem has been integrating data from the student information system and the financial accounting system to give the school the necessary input on tuition earned and financial aid costs by program and student. Nowhere has this problem been more pronounced than in the graduate programs. Although much progress has been made in this area, more still needs to be done.

**Conflicting Roles and Responsibilities.** With the exception of the associate provost from Vanderbilt who helped build the model for calculating the university’s shared services assessment, all of the work involved in moving to the new financial model fell on individuals with ongoing roles and responsibilities. This is significant because Northwestern has always prided itself on having a lean administrative staffing structure. Many individuals find it difficult to devote time to the analytically complex issues that must be addressed in developing and implementing the new model, while keeping daily operations functioning smoothly.

Time constraints also led to a delay in finalizing agreements about the shared services assessment and other model components. These problems
were not insurmountable, but it is essential that such ground rules be written so that they are explicit and understood when, for example, the players change.

**Communication.** Although the vice presidents and deans of other university administrative units were informed of the change in the financial relationship between the university and the medical school, it is not clear that they fully understood the implications for their areas. Perhaps the essential aspects of the change were not reinforced frequently enough to become transparent. It is clear that the heads of other areas have not fully understood how the shared services assessment model works; as a result the associate vice president for budget and planning had to intervene.

Similarly, the school has had some internal communication challenges. As noted earlier, the school’s model for distributing earned education pool funds to departments has not been well received. This is due in large part to using two models and four major weighting changes in three years, resulting in large fluctuations in department budgets. However, there has also been insufficient communication and understanding of the earned education pool model. For FY2004, there has been a pronounced improvement in communication with departments regarding the model. This has gone a long way in reducing the noise level. But some problems are likely to remain until there is a more stable model.

One of the tenets of the new financial model is to openly share information about the financial status of the enterprise, but because of time constraints this has not occurred as soon or frequently as desired. Thus departments have engaged in debate over resources that might have been minimized had more information been shared.

**Capital Planning**

Under the new financial model, the school has complete financial responsibility for building, renewing or replacing, and maintaining its physical assets. A key component of the strategic plan involved building a new $200 million medical research facility to accommodate many of the 150 new faculty to be hired under the plan. With a $40 million lead gift, this building is now under construction and is expected to be 100 percent funded from philanthropy, as is all new construction at the university. It is not practical to present details about the capital plan here, but capital planning has been integrated and concurrent with the strategic planning and budgeting initiatives described in this chapter.

**Linking Strategic Planning and Budgeting**

Since the late 1990s, medical school departments had been doing all fund budgeting, whereby the revenues and expenses of all entities supporting the departments were reported, including those of the practice plan and affiliated hospitals.
Medical school administration took this all-funds-budgeting approach further by developing a more comprehensive set of multiyear financial projections that encompassed, for example, revenue and costs of strategic actions, the new debt service required under the capital plan, revenue and expense associated with renewal and replacement, and depreciation (explained later). The revenues and expenses associated with the 150 new faculty positions were calculated using the model described previously, with projections shown through FY2011, the year the school will be at steady state—with new faculty generating the expected level of grant as well as facilities and administrative revenue.

The projection model is flexible enough to determine whether the revenue available is sufficient to fund the nonrecurring and recurring costs of new basic science faculty, and whether the clinical departments are able to fund their share of new faculty. It is also possible to adjust the mix of faculty as well as other assumptions in the model, to estimate their projected impact.

Higher education institutions do not typically record depreciation expense for buildings and capitalized equipment on their balance sheets; it was important for the medical school do so since it is totally responsible for funding its own capital plan. Furthermore, the affiliate hospitals from which the school sought continuing contributions do include such costs on their balance sheets.

An analysis is currently being completed of unrestricted fund balances across the medical school, including expendable endowments. This information should enable school administrators to know the level of contingency funds available to fund unexpected needs or meet unanticipated shortfalls.

The development of a financial projection model covering both operating and capital needs has done what Jones (1995) suggests a good strategic budgeting process should do: give university leaders a tool for ensuring the long-term adequacy and integrity of institutional assets. The model and resulting bottom line have been instrumental in gaining university support for debt financing of $50 million for the capital plan. They have also been important in seeking additional ongoing and unencumbered support for research and education from the affiliate hospitals. As noted previously, the affiliate hospitals extend less support on average than do hospitals at counterpart institutions. Their support would do much to wipe out the negative bottom line that the model is currently projecting.

The new financial model and financial projection model have been powerful incentives and tools. The financial model explicitly sets aside budgeted funds for priorities established in the strategic plan. Using a multiyear financial projection model expands horizons and allows the school’s leadership to determine which components of the strategic plan are doable, and when, and with what tradeoffs. Departments are now in control of their own destiny.
and can increase their staffing and budget according to their own effort. This constitutes the direct tie-in of unit budgets and activities advocated by Knepp (1992).

**What Are the Outcomes of Strategic Planning?**

George Keller (1999–2000) has suggested that strategic planning is increasingly about organizational learning and creativity, and that there is a need to change radically existing structures and processes. The Feinberg School of Medicine has seen evidence of “organizational learning” since its new financial model was implemented:

- Grant activity and facilities and administrative revenue are up, with F&A revenue 18.5 percent higher in the first year of the change and 15 percent higher in the current year.
- Adoption of an incentive compensation plan for basic science faculty in FY2002 helped increase the percentage of faculty salaries on grants in basic science departments, lessening the burden on departmental budgets.
- Department chairs are making tough decisions, such as returning unproductive space and encouraging early retirements.
- Departments are becoming more selective in their faculty hiring decisions, looking at prospective faculty members' likely research output and how well they fit with the priority areas of the strategic plan.
- It has been easier to recruit department chairs under the new financial model.
- Departments are increasingly using their own resources for faculty recruitment, and in some cases sharing the cost of recruitment packages with innovative payback mechanisms.

The school is at a critical phase of implementing its strategic plan. The medical research building comes online early in 2005, and another large amount of space will be put in service in 2004. The school has recruited thirty-three net new faculty of the 150 targeted. Recruitment needs to ramp up substantially to fill the new space. Fundraising for the new building has slowed down substantially, owing to the downturn in the stock market and continued fallout from September 11, 2001. Negotiations are at a critical stage with our affiliate hospitals regarding a continuing, unencumbered contribution.

There are always challenges such as these to be overcome. The medical school can adapt, using the skills shown during development of the strategic plan and the change to the new financial model:

- Embracing the results of environmental scanning
- Continually updating the plan and assumptions on the basis of new information
• Taking a multiyear approach to implementation of the plan
• Taking advantage of opportunities when they present themselves, and always remaining flexible
• Continuing to furnish incentives to achieve the objectives of the strategic plan

Recent results of an environment scan are leading the school to question the planned mix and number (150) of new faculty, with the thought that recruiting fewer faculty at higher ranks may be an effective alternative. Ideas such as this will be debated across the enterprise. One notion that is likely not to be debated, however, is that data matter.

References


