Uncomposed, edited manuscript published online ahead of print.

This published ahead-of-print manuscript is not the final version of this article, but it may be cited and shared publicly.

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Title: Returning to Growth: One Academic Medical Center’s Successful Five-Step Approach to Change Management

DOI: 10.1097/ACM.0000000000004116
Academic Medicine

DOI: 10.1097/ACM.0000000000004116

Returning to Growth: One Academic Medical Center’s Successful Five-Step Approach to Change Management


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Acknowledgments: The authors wish to thank all of those who contributed to this transformation
and success for the University of Alabama at Birmingham School of Medicine (UAB SOM):
board members, department chairs, center directors, institute directors, health system leadership,
hospital leadership, and university leadership. The authors also acknowledge the visionary
leadership of Dr. Will Ferniany, CEO of the UAB Health System, for his tremendous support of
our efforts in the UAB SOM. Additionally, the authors wish to acknowledge the staff personnel
who were vital to implementing many of the changes outlined in the manuscript.

Funding/Support: None reported.

Other disclosures: Reported as not applicable.

Ethical approval: Reported as not applicable.

Disclaimers: None reported.

Previous presentations: None reported.

Data: Reported as not applicable.
Abstract

The University of Alabama at Birmingham academic medical center (UAB AMC) had achieved great success and growth during the 50 years since its founding. However, the challenging and more competitive environment of the 2000s left the UAB AMC on a downward trajectory. The UAB AMC had to overcome difficult internal cultural and structural barriers that stood in the way of the transformational change needed to remain competitive. Competition rather than collaborative and strategic financial investment were the primary cultural barriers for the UAB AMC, while people were the primary structural barrier. Leadership identified 5 steps that were critical for the transformation that occurred between 2013 and 2018: alignment of leadership; creating a compelling and credible shared vision; identifying cultural and structural barriers; creating a thoughtful, data-driven intervention; and improved communication and accountability. Following these enabled the UAB AMC to transform its institutional structure and culture. As a result, the UAB AMC thrived, returning to substantial growth in research and clinical care. UAB AMC School of Medicine grew by $100 million in National Institutes of Health funding and moved up 10 spots in ranking. In 2018, UAB Hospital had 10 specialties ranked by *U.S. News & World Report*, 7 more than in 2013. This article outlines the approach taken and provides a conceptual framework for other AMCs eager to transform their structure and culture and position themselves for growth.
In 2006, less than 50 years since its inception, the University of Alabama at Birmingham School of Medicine (UAB SOM) had exceeded $130 million in research funding. However, the environment around the UAB academic medical center (AMC) was changing. The great recession of the 2000s, a more competitive research funding environment nationally, and shrinking budgets demanded a new approach to remain competitive, but with a decentralized leadership structure and limited institutional investment in research, UAB’s growth stagnated. By 2013, the UAB SOM had fallen to 31st in National Institutes of Health (NIH) funding, the lowest in over a decade.\(^1\)

Clinical reputation also suffered. In 2013, the UAB health system only had 3 adult specialties ranked by *U.S. News & World Report*, a low among its peers. The UAB AMC needed to adapt to succeed, which was achieved by these 5 steps:

- Alignment of leadership
- Creating a compelling and credible shared vision
- Identifying cultural and structural barriers
- Creating a thoughtful, data-driven intervention
- Improved communication and accountability

As a result of this effort, the UAB SOM moved from 31st to 21st in NIH ranking within 5 years. Among public medical schools, UAB SOM now ranks 8th in NIH funding, with an increase in total NIH dollars from $132.9 million to $234.4 million (as of September 30, 2018). The number of funded principal investigators (PIs) has grown nearly 26% since 2013, growing from 258 to 329 PIs as of October 2018. This growth has continued with NIH funding of $269.7 million and 349 PIs as of October 2020.
With this success, UAB joined an elite group of only 8 AMCs that have experienced growth greater than $100 million in net NIH funding in a 5-year period.* Among this group, UAB had the second highest percent of growth, at 75%. Consistent with previous findings showing a close relationship between clinical and research success,² the number of ranked specialties in the *U.S. News & World Report* at UAB increased to 10, more than any other AMC in the Deep South, except Duke University Medical Center.

**The UAB AMC Change Management Strategy**

Multiple change management models have been proposed for large-scale transformation at AMCs.³⁴ Some reflect influential theories on change such as Lewin’s change management model,⁵ Kotter’s 8-step process for leading change,⁶ and McKinsey’s management strategies.⁷ Across all these models, there is a key constant: fostering a sense of urgency and shared conviction is critical. For UAB AMC, this meant developing a compelling vision and aligning leadership in support of that vision. In a conversation with the author of *Mastering the Challenges of Leading Change*, the dean and senior vice president for medicine identified 6 key strategic focus areas critical for transformation: culture, people, organizational structure, programs, infrastructure, and financial investment. This framework ignited the transformation at UAB; however, through a retrospective review we identified 5 fundamental steps that made UAB’s exponential growth possible.

**Alignment of leadership**

The UAB AMC is a partnership among a faculty practice plan, health system, and medical school. Although the leaders of these entities were in general agreement about a desire for

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* These are the AMCs associated with Northwestern University Feinberg School of Medicine, Columbia University School of Medicine, Icahn School of Medicine at Mount Sinai, Keck School of Medicine of University of Southern California, University of Wisconsin School of Medicine and Public Health, Washington University School of Medicine in St. Louis, and New York University Grossman School of Medicine.
growth, they lacked specific shared goals. As a result, efforts at organizational change and improvement were unaligned and uncoordinated, and often resulted in conflict. The first step toward fundamental change was ensuring that leadership of the AMC components agreed not only on the need for change but also how to achieve it. What the UAB AMC needed was horizontal alignment across its components.

The former dean of the SOM and former chair of the Health System Board started the movement toward greater alignment and began to explore ways for the AMC components to develop collaborative leadership and support each other. This was enacted under a new comprehensive AMC 21 Strategic Plan, (UAB Medicine’s strategic plan to become the preferred academic medical center of the 21st century through the pillars of engagement, quality, finance, and advancement of knowledge), led by the CEO of the UAB health system. The SOM dean/health system board chair was appointed president of UAB in 2013, when building on these early efforts became the primary responsibility of the new dean of the SOM, also the senior vice president for medicine.

In collaboration with select faculty and the president of the Health Services Foundation faculty practice plan, and with the support of the UAB president, the CEO began to build on the earlier work to position UAB AMC to compete in the present and prepare for future growth. Achieving horizontal alignment required frank conversations among the 3 leaders of the AMC entities about the structure of the AMC, the flow of funds for both the clinical and academic missions within and among them, and how shared goals could benefit them all. This alignment required each entity to compromise. The practice plan could no longer serve in isolation and became more integrated with the SOM; the dean now served as chair of the practice plan board. The president of the practice plan would be the chief physician executive and also serve as senior associate
dean for clinical affairs, reporting to the dean of the SOM. The health system had to increase the contribution to the academic enterprise in an amount that was commensurate to other regional academic peers. For the SOM, the dean could no longer solely focus on the academic mission; he had to now serve as the voice for promoting the value of clinical service. With the senior leadership of the AMC components in agreement that change was necessary, the next step was to clearly articulate the vision and goals that would anchor this change.

Creating a compelling and credible shared vision

To ensure the UAB AMC vision for change was compelling, credible, and shared by all constituents, the process of developing it had to be inclusive and institutionally relevant. The dean and his leadership team spent 6 months in 1-on-1 conversations and meetings with the Board of Trustees, the university president, hospital and SOM leadership, and department chairs, while also holding faculty meetings and town halls. Each stakeholder was given the opportunity to define success for the UAB AMC. Proceeding in this way built trust that the change process would be inclusive, not imposed from above, and would consider the individual missions of each unique entity and unit comprising UAB AMC.

The vision that resulted was to make UAB AMC “the preferred academic medical center with growth in top rated clinical programs and to reach the status of a top 20 NIH-funded school of medicine by 2024.” Key stakeholders agreed that by achieving this unified vision, the education and service missions would also thrive. With this credible, shared vision in place, UAB AMC then had to identify and address the barriers standing in the way of achieving it.

Identifying the cultural and structural barriers

Embedded within any organizational culture are expectations about power, finances, leadership hierarchy, and domains of influence. To navigate these delicate relationships, UAB relied on a
combination of external data and reviews, intentional and thoughtful communication, and continual reminders of our shared vision.

To avoid concerns about bias, we commissioned a series of external reviews and reports that examined the structure and culture of the institution in order to define required changes and identify invisible barriers. We commissioned the Association of American Medical Colleges (AAMC) to collect institutional data, analyze our infrastructure, and offer recommendations based on their knowledge of comparable AMCs. Consultants from Mannatt were enlisted to evaluate our organizational culture. Using data from these external reviews enabled us to remove individual personalities and organizational history from the dialogue and arrive at a shared understanding of barriers to success.

**Cultural barrier: Competition rather than collaboration.** UAB’s decentralized culture was marked by a strained relationship between research and clinical care. Clinical faculty sometimes viewed research as a costly intrusion into their time and space and an activity that should be funded solely by grants. On the other hand, researchers often perceived the clinical enterprise as overly cumbersome to work with and uninterested in collaboration.

**Cultural barrier: Strategic financial investment.** An AAMC study found that every external research dollar requires approximately $0.53 in institutional funds to support the management of the grant and maintain the infrastructure to support future grants. The UAB research enterprise, however, was largely operating as though state and grant funding was self-sustaining. Compared to its peers, the UAB AMC had a comparable clinical revenue stream, but it was the only top 35 NIH-funded medical school that did not have a dedicated clinical revenue stream to support the research mission, often known as a dean’s tax.
Alongside this issue, many of the other challenges faced by the UAB AMC, such as recruitment and retention, implementation of new programs, and bridge funding, lacked a financial commitment. To address this, UAB AMC created an “obligated group” structure between its various stakeholder components. This structure created a strong financial entity by improving overall bond rating and enabling the entity to borrow and bond at lower interest rates. In addition to improving the financial position of the AMC, this change also reduced restrictions on funds transfers between AMC components, allowing for the implementation of a “funds flow” system to provide financial support for our change initiatives. Aided by contributions from the university-run health plan, this model allowed more clinical dollars to flow from departments in support of shared initiatives.

**Structural barrier: People.** As determined by an external AAMC audit, with only 3.5 FTE (18–20 fewer FTE than our peer competitors), the dean’s office had limited capacity to drive change and growth. Restructuring and expansion were needed.

The AAMC audit also determined that there was a general sense at the departmental level that recruitment was not strategic and retention efforts were minimal. An informal and unstructured approach to faculty development, combined with the other institutional challenges, led to undesired faculty turnover. Our challenge was to design and implement a robust and strategic recruitment strategy, supported by a comprehensive faculty development plan.

**Creating thoughtful, data-driven interventions**

Armed with our shared vision and an understanding of the barriers to overcome, UAB formed a series of task forces corresponding to the challenge areas the external reviews and internal conversations had identified. The task forces were charged with providing recommendations for achieving cultural and structural change.
We compiled and analyzed internal data on research funding, faculty recruitment and retention, clinical outcomes, and revenue. We collected data on comparable AMCs, both regionally and nationally, and analyzed their budgets, leadership staffing levels, funds flow models, faculty composition, and recruitment methods. These data provided a touchstone to which we could return when facing fear, resistance, or controversy.

**UAB AMC interventions.** Having improved alignment across the AMC, the Board of Trustees, and president’s office through purposeful collaboration, and in collaboration with department leadership, faculty, and staff through our vision and goals planning process, we set about developing and implementing a plan to fundamentally alter the way the UAB AMC conducted business. The task forces recommended interventions that would create the structural and cultural environment necessary to foster transformation. See Figure 1 for a timeline of this process.

**Alignment and strategic centralization.** Our primary vehicle for structural reorganization and strengthened horizontal alignment of the medical school, practice plan, and health system was Organizing for Success (OFS), a strategy based on recommendations from an external consulting company. As part of OFS, we established the Joint Operating Leadership Council (JOLC), comprising the senior vice president for medicine and dean of the SOM (who serves as chair), the CEO of UAB Medicine, the president and chief physician executive of the Health Services Foundation, and 4 department chairs. The JOLC advises and governs the direction of the AMC to ensure alignment across the 3 missions areas, and is able to make swift and strategic decisions at the highest level. To strengthen communication between the hospital and SOM leadership, we also began regular joint cabinet meetings including health system executive leadership and SOM senior associate deans. These advisory groups and meetings provide a setting for the most senior
leaders to address all mission areas, which enables them to execute strategy and initiatives in an aligned manner.

**From competition to collaboration.** Data from other institutions had shown that research and clinical care could grow together and reinforce each other. To this end, we broadly publicized that the academic mission and the clinical enterprise are mutually inclusive, as demonstrated by the significant overlap between the top 20 *U.S. News & World Report* hospitals and the top 20 NIH-funded institutions.

We also implemented a comprehensive, all-missions annual review of all SOM departments (both clinical and basic science) to provide the accountability necessary to achieve our AMC 21 vision. All senior associate deans and health system executive leadership attend these meetings, which are co-led by the dean and the health system CEO. Each department is required to detail its contributions to and challenges in all 3 mission areas. Faculty mentoring, leadership development, and faculty diversity and compensation are analyzed and discussed. Additionally, the financial and infrastructure investments are reviewed thoroughly, as well as the upcoming year’s recruitment plan. These meetings offer senior leaders a robust understanding of how each department contributes to each mission area in order to achieve the AMC 21 vision.

**Strategic financial investment.** Transparent communication and early engagement, as well as a tiered implementation model, were key to garnering buy-in from the department chairs in creating the dean’s tax, which is one of the main contributors to the Academic Enrichment Fund (AEF). The AEF currently provides up to $55 million per year, invested across the SOM to support institutional strategic priorities. This has enabled the school to use pooled funds to support recruitment of department chairs, reinvestment into departments, creation and support of institutes and centers, and strategic investments that no single department could make alone.
Monies were invested strategically to a multitude of units, depicted in Figure 2. To fulfill our promise of transparency, we share where AEF dollars have been invested with all SOM stakeholders annually.

**People.** As noted earlier, the dean’s office itself needed fundamental restructuring. We hired a senior associate dean for diversity and inclusion. We have made progress toward greater diversity and inclusion, especially for medical students, moving from ∼8% for traditionally underrepresented minorities in medicine to ∼16% for 2019 and 2020—a step of critical importance for a state whose population is 26.8% African American.

Another key change was the creation of a shared financial officer between the SOM and the health system, creating greater transparency and communication. We also created new senior leadership roles dedicated to clinical affairs, basic science, and leadership development, among others. Figure 3 illustrates the transformation of the dean’s office to better reflect institutional priorities.

Culture is created, transformed, and sustained by leaders at all levels of an organization. The UAB president and UAB health system CEO realized that achieving the desired cultural and structural change required investment in recruiting senior leaders at the department chair level. Under the leadership of the new associate dean for strategic planning, the dean’s office developed a structured protocol for search and selection, formalizing what had largely been an informal process. For the first time, recruitment became focused on the goal of securing outstanding leaders to advance the strategic priorities of the AMC, versus “big” or “quick” hires. To date, we have hired 22 new leaders, 17 from outside the state of Alabama, to advance our efforts toward becoming the preferred AMC of the 21st century.
Communication and accountability

To measure and communicate overall progress toward the shared vision, we chose 2 external metrics: Blue Ridge Institute for Medical Research NIH rankings and *U.S. News & World Report* rankings of clinical specialties. NIH ranking, while not the most nuanced measure of the health of an AMC, is a widely recognized general ranking that is easily understood by stakeholders and the public. The same is true of *U.S. News & World Report* rankings of clinical programs.

Internally, however, we focused on indicators we could measure in real time: research dollars, grants submitted and awarded, and the number of PIs on the research side; and outpatient clinical encounters, discharges, surgery cases, net patient revenue; and, most important, quality of care on the clinical side.

We substantially improved our communications by holding regular meetings with clinical and research faculty and department chairs. Leadership committed to visiting all 27 departments annually to present timely updates on our progress and address faculty concerns through open question and answer sessions. The dean, CEO, and their executive cabinets were held accountable by making a portion of their salaries dependent on progress toward achieving 8 pillar goals that span the 3 mission areas (Table 1). Department chairs were held accountable by the CEO and dean through annual departmental reviews and individual performance evaluations. Goals were set after each review/evaluation and were evaluated regularly. Inability to consistently meet goals or strategically lead the department could result in being asked to step down or reduced reinvestment into the department. Department chairs were responsible for holding their division directors and faculty similarly accountable.
Annual awards for excellence in research, mentoring, education, service, and diversity for junior and senior faculty improved faculty recognition. Along with new, large, extramural awards, faculty are now acknowledged with a personal note from the dean, and key successes are highlighted in regular messages to the SOM and AMC. We also created an AMC21 research fund to support development of multi-PI proposals that have potential for extramural funding such as large program project/center or research cooperative (P or U series) awards.

**Concluding Remarks**

Achieving this level of success prompted leadership to review the actions of the previous 5 years to determine the fundamental steps that allowed this growth trajectory. This lookback gave confirmation that the original foundation of the 6 key focus areas for strategy served as a framework and driver for this transformation. Additionally, the retrospective review revealed that 5 fundamental steps were taken to realize this success. UAB leaders affirm that these steps can be taken by leaders at any complex organization to achieve cultural transformation.

Leadership also identified 3 key principles that were and will continue to be fundamental. First was broad agreement within the organization about both the need for change and the methods to achieve it is vital. Throughout our change process, we asked of each decision, each expenditure, and each hire, does this advance the mission and help achieve the shared goals we agreed upon? This ensures all stakeholders are working toward the same goals, at all times, for all strategic initiatives. Second, change must be driven by data. Data-based change, firmly guided by a shared vision, helps remove politics and personalities from the process and fosters trust and collaboration. Third, credit for success must be shared broadly, because it is earned broadly.
While leadership may organize change, success depends on department chairs, division directors, faculty, and staff who are willing not just to accept the idea of change, but to actively engage in shaping it.

Every AMC is unique in its status, goals, and barriers. What we believe is transferrable in the changes UAB made and the success we experienced are the process and principles we identified as critical to our success. We have shared the 5-step process outlined here to enable and empower other AMCs to support and cultivate remarkable transformation.
References


Reference cited only in the table

Figure Legends

Figure 1
Timeline for University of Alabama at Birmingham academic medical center’s transformation through intentional change, depicting major steps.

Figure 2
Major contributors to and utilization of the AEF, or dean’s tax. Triton represents Viva Health, the insurance plan for the UAB health system and UAHSF refers to the practice plan. A major portion of the funds used for department chair, regional dean, and reinvestment packages were used for recruitment and retention of faculty (people), center and institute packages (programs), capital renovations (infrastructure), internal funding opportunities (people), and other (includes dean’s office infrastructure).
Abbreviations: AEF, academic enrichment fund; UAB, University of Alabama at Birmingham; UAHSF, University of Alabama Health Services Foundation.

Figure 3
Comparison of University of Alabama at Birmingham School of Medicine dean’s office organizational charts in 2013 and 2018.
<table>
<thead>
<tr>
<th>Goal</th>
<th>Metric</th>
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<tr>
<td><strong>Clinical indicators</strong></td>
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<td>Satisfaction</td>
<td>• Overall patient experience for inpatients as measured by Press Ganey HCAHPS 0–10 top box score</td>
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<tr>
<td></td>
<td>• Overall patient experience for ambulatory clinics as measured by Press Ganey CGCAHPS 0–10 top box score</td>
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<tr>
<td></td>
<td>• Employee engagement (as measured by Press Ganey)</td>
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<td>• Faculty engagement (as measured by Press Ganey)</td>
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<tr>
<td>Quality</td>
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<td>• Sepsis mortality</td>
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<td>• Improve ambulatory access</td>
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<tr>
<td>Finance</td>
<td>• Financial health of UAB Medicine as measured by operating EBITDA</td>
</tr>
<tr>
<td></td>
<td>• Aggregate documentation scores</td>
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<td>• Length of stay</td>
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<td><strong>Academic indicators</strong></td>
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<tr>
<td>Satisfaction</td>
<td>• Engagement of fourth-year medical students as measured by Association of American Medical Colleges graduate experience¹⁰</td>
</tr>
<tr>
<td></td>
<td>• Faculty engagement (as measured by Press Ganey)</td>
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<td>Quality</td>
<td>• Professional readiness as measured by United States Medical Licensing Examinations pass rates and residency match rates</td>
</tr>
<tr>
<td>Finance</td>
<td>• Expand research portfolio as measured by grant expenditures, grant submissions, and NIH grant funding</td>
</tr>
<tr>
<td>Advancement of knowledge</td>
<td>• Increase in high-impact research as measured by number of NIH funded principal investigators</td>
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</tbody>
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Abbreviations: UAB, University of Alabama at Birmingham; HCAHPS, Hospital Consumer Assessment of Healthcare Providers and Systems; CGCAHPS, Clinician and Group Consumer Assessment of Healthcare Providers and Systems; EBITDA, earnings before interest, taxes, depreciation, and amortization; NIH, National Institutes of Health.
Figure 2

AEF contributors
- Triton
- Hospital
- UAHSF
- Baptist Health
- School of Medicine
- Medical West
- UAB
- Callahan Eye Hospital

AEF utilization
- Chair packages, regional dean packages, and reinvestments
- Center and institute packages
- Capital renovations
- Internal funding opportunities
- Other