Even limited cultural and organizational change creates some tension and anxiety within an educational institution. Those feelings intensify as the scale of change grows and more people become unnerved by adjustments to the status quo. In fact, big projects and massive shifts can wreak behavioral havoc. “Even people you think you know,” says John Carnaghi, senior vice president of finance and administration, Florida State University (FSU), Tallahassee, “may become overwhelmed by anxiety and emotion, and begin doing or saying things that seem out of character.”

Efforts on the part of a university to start, acquire, or incorporate into its operations something as significant as a medical school certainly qualify as disruptions of a dramatic degree. For insights into the challenges—and rewards—of such massive change, Business Officer talked to representatives of three institutions that have undertaken transformative initiatives related to their medical schools and discovered prescriptions for success.

CASE I: THE EXPANSION

Florida State University’s plan to start a medical school nearly ended before it began: The state university system’s board of regents voted 13 to 0 against the idea. A different attitude prevailed in the state legislature, where numerous elected officials—including the speaker of the house—supported the establishment of a fourth medical school in Florida.

The political standoff necessitated neutrality among FSU’s senior leadership. “We couldn’t question the regents’ decision, yet we couldn’t ignore what the legislature wanted to do for us,” notes Carnaghi. “One side or the other would ask for financial information to support its position, and I’d have to provide it.”

The debate spilled into the local media, with numerous letters to the editor questioning the need for another medical school. Many of the letters came from the medical community, which had concerns about 120 more doctors graduating each year. But, some came from FSU faculty members and staff, who publicly worried about how the university’s expansion would affect the overall budget and their departments’ funding in particular.

On the last day of its spring 2000 session, seemingly against the odds, Florida’s legislature granted FSU a line-item appropriation to launch a medical school.

No Time to Spare
Remarkably, in the summer of 2001, FSU welcomed the first class to its college of medicine. Building on existing strengths is what enabled the university to move so quickly. And, the fact that a first-year medical program already existed within its curricula bought some time to add a new facility to house the full-blown institution.

“From 30 years, we’d had a first-year medical school program at FSU,” explains Deborah Coury, who recently retired as chief financial officer at the FSU College of Medicine. “Students went on to complete their medical training at the University of Florida. So, we already had some enrolled students, a number of faculty involved in medical education, and an anatomy lab.”

The new medical school, however, didn’t have a budget, an accounting sys-
tem, a full faculty, or a building to call home. Coury, who served as director of FSU’s University Business Administrator program prior to assuming her role in the medical school, had to make educated guesses about how much money, how many people, and how much space a medical school really needed. She opted to use the same financial and human resources system already in place at FSU, and she adopted all of the university’s administrative policies and procedures as well.

"Because we were starting from scratch, we didn’t deal with the change management issues that surface when you replace something that has [existed] for 20 years," Coury says. "Still, we had to resolve administrative issues unique to a college of medicine—such as how to appoint and pay hundreds of community faculty who only teach once a year."

Approvals Needed
With a first-year class already enrolled, FSU also had to move fast to gain accreditation. Because FSU’s medical school was the first to open in the United States in nearly 25 years, the accrediting body needed additional time to review and update its guidelines, compressing the timetable even more. "It wasn’t an easy accreditation," Carnaghi reports, but FSU corrected the deficiencies identified to become partially accredited in 2002 and fully accredited by 2004.

Finding space for the medical school proved another challenge. Although Florida’s legislature eventually allocated $60 million for a new building, that funding came over three years. FSU’s leaders decided to physically integrate the medical school into the main campus by erecting it on the site of a K-12 school that had recently relocated. As a cycle of demolition and new construction unfolded, the college of medicine’s faculty and staff kept moving—from FSU’s nursing school, to temporary trailers, to portions of the old K-12 school, and eventually to the new building.

As bothersome as these relocations were, Carnaghi believes they helped smooth the acceptance and integration of the medical school into the FSU culture. He says, "The trailers not only broke down barriers between the new people but also with the folks who were worried about the medical school. Seeing the newcomers working in that situation, they realized the medical school personnel weren’t so different after all."

The Right People
Looking back, Coury identifies one thing she would have done differently. Early on, she would have assembled a cross-university team to address the countless financial issues that accompanied FSU’s expansion.

"We did just that on an ad hoc basis, but having a small group of decision makers that met regularly would have improved communication, relieved some stress, and reduced frustration," Coury says. "If, for example, we always had someone present from budgeting, from purchasing, and from the controller’s office, we would have spent less time chasing down information and working through problems."

With its college of medicine now operating at 87 percent of the full capacity of 480 students, FSU has begun to see the benefits it had envisioned more than a decade ago. The medical school encourages its students to consider practicing in rural and urban areas, where Florida has traditionally been short on doctors, and several communities are paying some students’ tuition as an added incentive.

"Medical schools also attract a lot of research dollars and a lot of donations. In the early 1990s, we didn’t have that," adds Carnaghi. "Now, because of the medical school, we have the opportunity to compete for research grants—which are starting to roll in—and we have received some very nice gifts."
Survival Skills

The difference between mastering change and muddling through it may rest in following these recommendations offered by several business officers.

Call on the experts. "If your management team doesn’t have expertise in a particular venture, use experienced consultants," advises John Carnaghi of Florida State University (FSU), Tallahassee.

"We didn’t have a clue what was required to establish a medical school, so we put a retired dean of medicine on the payroll for a couple of years. He helped us anticipate the issues we’d face, identified pitfalls along the way, and guided us through the accreditation process," says Carnaghi, who also asked for advice from fellow business officers at other Florida medical schools.

Similarly, Johns Hopkins University (JHU) and Johns Hopkins Health System (JHHS), Baltimore, hired financial consultants to determine the feasibility of jointly adopting a new enterprise resource planning system. Based on the firm’s findings and input from a trustee advisory committee, the two institutions developed a project budget that included the costs of all hardware, software, and personnel and assumed a 10-year return on investment.

Deal with the details. Because everything that happens on a campus circles back to money, business officers can’t escape the myriad issues associated with a large-scale operational change.

"Many times, business officers don’t want to get their hands dirty," says Thomas Elzey of Drexel University, Philadelphia. "But, to do something big, you have to get deeply involved so you know exactly what is going on throughout the organization—you can’t do this from the 10,000-foot level."

Communicate often and well. Ron Werthman, of Johns Hopkins Health System, observes, "If you’re going to embark on a huge change with cultural impact, you can never communicate enough. Ever."

The HopkinsOne project undertaken by JHU and JHHS had its own formal communication plan, developed by representatives from both institutions. Through vehicles such as print articles, e-mail discussion lists, and frequently asked questions posted on a Web site dedicated to the project, the team prepared employees for changes ranging from which longterm systems would no longer exist to how different their pay stubs would look.

"It’s easy to get caught up in the project itself and forget that other people, both internally and externally, need to know what’s going on," adds Carnaghi. Faced with vocal and local opposition, FSU often held town meetings and sent an army of speakers into the community to talk about why it was using its resources to establish a medical school—and how citizens would benefit. To address internal concerns, FSU senior staff provided updates on the medical school every time the deans or campus business officers had a meeting. Remember that time heals. John Carnaghi’s own physician publicly denounced FSU’s plan to establish a medical school; that same doctor now works with FSU medical students. After eight years, Carnaghi observes, "The medical school has become just another FSU program as well as part of the community."

When Drexel University acquired a bankrupt college of medicine, not all of its employees cheered. "The rest of the university didn’t want any resources that they were currently getting to be reallocated to help support a struggling medical school," says Jeffrey Eberly of Drexel’s college of medicine. "That attitude changed once the other departments realized that they did not lose any resources. Plus, the medical school has been showing a profit for the past five years."

Keep the project in perspective. "Big projects and massive change cause people to behave in unusual ways," says Carnaghi. "It’s the business officer who must keep a balanced perspective for everything to turn out well in the end."

right, however, Drexel signed an agreement with Tenet Healthcare to manage them.

"The expectation was that Drexel would eventually take over the medical school, which had a lot of heritage and a solid curriculum. Connecting the two would enable Drexel to continue its growth and further advance its prestige," says Jeffrey A. Eberly, chief financial officer and associate dean of operations at Drexel University College of Medicine. "But first, Drexel wanted to reduce its risk."

Fitter and Trimmer At the time of its bankruptcy, the medical school was losing approximately $80 million a year. Drexel’s president set a goal to reach the break-even point within three years. In FY00, the first full year that Drexel managed the medical school, losses totaled $44 million; the next year, losses had dropped to $9 million. And, by the time Drexel acquired the medical school in July 2002, it was indeed breaking even.

Drexel didn’t achieve this success by chance. Before the initial management agreement went into effect, its business officers had forecast the medical school’s financials for three years and developed a
list of what could—and couldn’t—be done to rein in the deficit.

"To save money, we consolidated various functions within the medical school, created interfaces between our system and theirs, reduced duplication, and restructured so we could meet payroll on a regular, uninterrupted basis," explains Thomas J. Elzey, Drexel University’s senior vice president for finance, treasurer, and CFO. "Because we were methodical in how we merged and integrated the administrative functions, there were no big surprises."

Drexel also instituted these changes to the medical school’s operations:

Reduced the size of the clinical faculty. Rather than employ all of the pediatricians working at a children’s hospital, the medical school retained only those it needed for academic purposes. This change alone saved $16 million annually.

Negotiated a reduction in the space rented by the medical school. "Because we were reducing faculty, we were able to consolidate and realign the space needed to house people," says Eberly. In the first three years after Drexel began managing the medical school, its rented space dropped from 800,000 square feet to less than 600,000 square feet.

Scaled back the medical research program. With the loss of research faculty after the bankruptcy, research spending dropped by $22 million. While this actually helped the institution from a financial perspective (since the research program had been losing money for the college), the school’s reputation and research ranking suffered.

Today, Drexel’s medical school has returned to the health system’s prebankruptcy level of research spending—$50 million annually. Says Eberly, "An initiative to focus on specific areas of research in which we have expertise, such as HIV, infectious disease, and spinal cord research programs, will continue to help increase funding for those areas."

All for One
Eberly was among the staff who remained with the medical school after its assimilation into the university. He says Drexel alleviated a lot of anxiety by ensuring that the medical school offered the same type of benefits and salary program as those of its main campus.

To shield the university’s corporate assets from liability concerns, the college of medicine operates as an affiliate of Drexel. For Elzey’s staff, that means producing two sets of financial statements, two cash reports, and two endowment reports—all of which are ultimately presented in a consolidated financial statement. Through a service agreement, Drexel handles all of the medical school’s treasury functions, accounts payable, and payroll, which enables Eberly to concentrate on business development, planning, and analysis.

"We have a very good system for financial planning and modeling, so we can better understand the potential implications of various changes within the institution," says Elzey. "For example, we do five-year profit-and-loss statements, cash-flow statements, and balance sheets. Our board appreciates those."

The board also thought highly of the smooth way Drexel integrated the medical school into its operations and started building profits as well as prestige. In fact, the change begat more change. Drexel’s board approved the establishment of a law school, which will graduate its first class in 2009. And, just recently, Drexel opened the doors of its graduate center in Sacramento, California, which offers classes leading to a master’s degree.

As Elzey observes, "The medical school was a big milestone—and it was just the beginning."

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CASE III: THE INTEGRATION

Johns Hopkins University (JHU) and Johns Hopkins Health System (JHHS), Baltimore, shared the same beginning. But, the two entities, created in 1867 by Baltimore businessman Johns Hopkins and funded through a bequest he left them, always operated separately and independently. Over the years, each evolved its own business processes and administrative systems.

By 2002, despite numerous upgrades, the legacy systems used by JHU and JHHS had started showing their age. "The systems weren’t integrated well, so integrity of the data was a concern," says Ron Werthman, vice president of finance for JHHS. Werthman wanted to move to a fully integrated enterprise resource planning (ERP) system in which data are entered once and are available to all parts of the system.
About the same time, Jim McGill, JHU’s senior vice president for finance and administration, had reached a similar conclusion. Acknowledging that some crossover exists between JHU and JHHS, the leadership of the two organizations decided to join forces. “Our motivators were efficiency, productivity, compliance, and service,” says McGill. “It simply made no sense for two entities that work very closely together to operate from two different administrative systems.”

And, so began HopkinsOne—a multiyear project that ultimately streamlined and standardized the two institutions’ financial, administrative, and human resources systems.

**Assembling the Team**

“The change involved two very different cultures that hadn’t always cooperated well in the past,” McGill notes. For example, the health system operates more hierarchically and in a centralized fashion. The university favors a decentralized approach; it doesn’t distribute resources at the president’s level and encourages deans to act as entrepreneurs.

“Those cultural differences aren’t going away,” emphasizes McGill. “We didn’t set out to change the cultures but to recognize that the systems we chose would have to support both the higher ed and the health care businesses.”

McGill and Werthman served as co-chairs of HopkinsOne, which began with a one-year feasibility study conducted by a consulting firm. The two used that year to build consensus within their own institutions, then began recruiting a full-time project team that drew personnel equally from JHU and JHHS.

“These people were taking a professional risk, leaving jobs with which they were comfortable to do something at which other universities have tried and failed,” says McGill. “As an incentive, we bumped their salaries immediately and also provided a bonus for those who stayed until the team’s work was complete, about five years later.” At its peak, HopkinsOne employed more than 200 people (including consultants) on various functional, cross-functional, and business-process integration teams.

HopkinsOne also had the assistance of a trustee advisory committee composed of people who had experience in or with the information technology industry. Werthman says, “Many of these people had implemented major systems worldwide, and their advice was invaluable. They helped us avoid some mistakes they’ve made or have seen others make.”

**Widespread Engagement**

Werthman and McGill believe they did at least two things right: They didn’t underestimate the difficulty of orchestrating major change, and they involved a broad array of constituents before making significant decisions. For instance, the HopkinsOne team sought feedback from hundreds of JHU and JHHS employees before selecting a vendor to determine the varied requirements the application would need to support and to finalize criteria for testing the software.

Coming from organizations with different recruitment, retention, and pay practices—to name just a few variations—everyone didn’t always agree. “But, we listened and communicated and rationalized the right approach, which often meant compromising,” says Werthman. JHHS, for example, had historically processed travel reimbursements through the payroll system but now does so through accounts payable.

**YOUR THOUGHTS?**

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A major change for both institutions came with the establishment of seven shared service organizations to process all transactions related to accounts receivable, accounts payable, sponsored projects, project systems, supply chain, human resources, and benefits, and payroll. The new ERP software replaced nearly 40 existing systems—and the changeover occurred all at once, in what Werthman and McGill refer to as the “Big Bang.”

“On the day we flipped the switch, everyone was on a new, level playing field, and that was quite unsettling for people who had been here for a long time,” acknowledges Werthman. “But, had we taken the module-by-module approach, we would constantly be introducing change.”

Adds McGill: “Our rationale was that it’s hard to make change. So, let’s just do it all at once and get it over with.”

When the switch occurred in January 2007—only six months later than originally planned—both institutions received plenty of complaints from end users, as anticipated. Equally expected was the eventual acceptance, even enthusiasm, for the new system.

Werthman and McGill say the university and the health system will continue improving the ERP system to address changes within the regulatory and compliance environments. So, the changes aren’t over yet—but neither is worried. “Hopkins is populated with bright, talented people, so we knew they would step up to handle the huge amount of change—and they did,” reports McGill. “Now, after nearly two years, we are letting go of the past and can begin to get the full productivity out of these systems.”

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