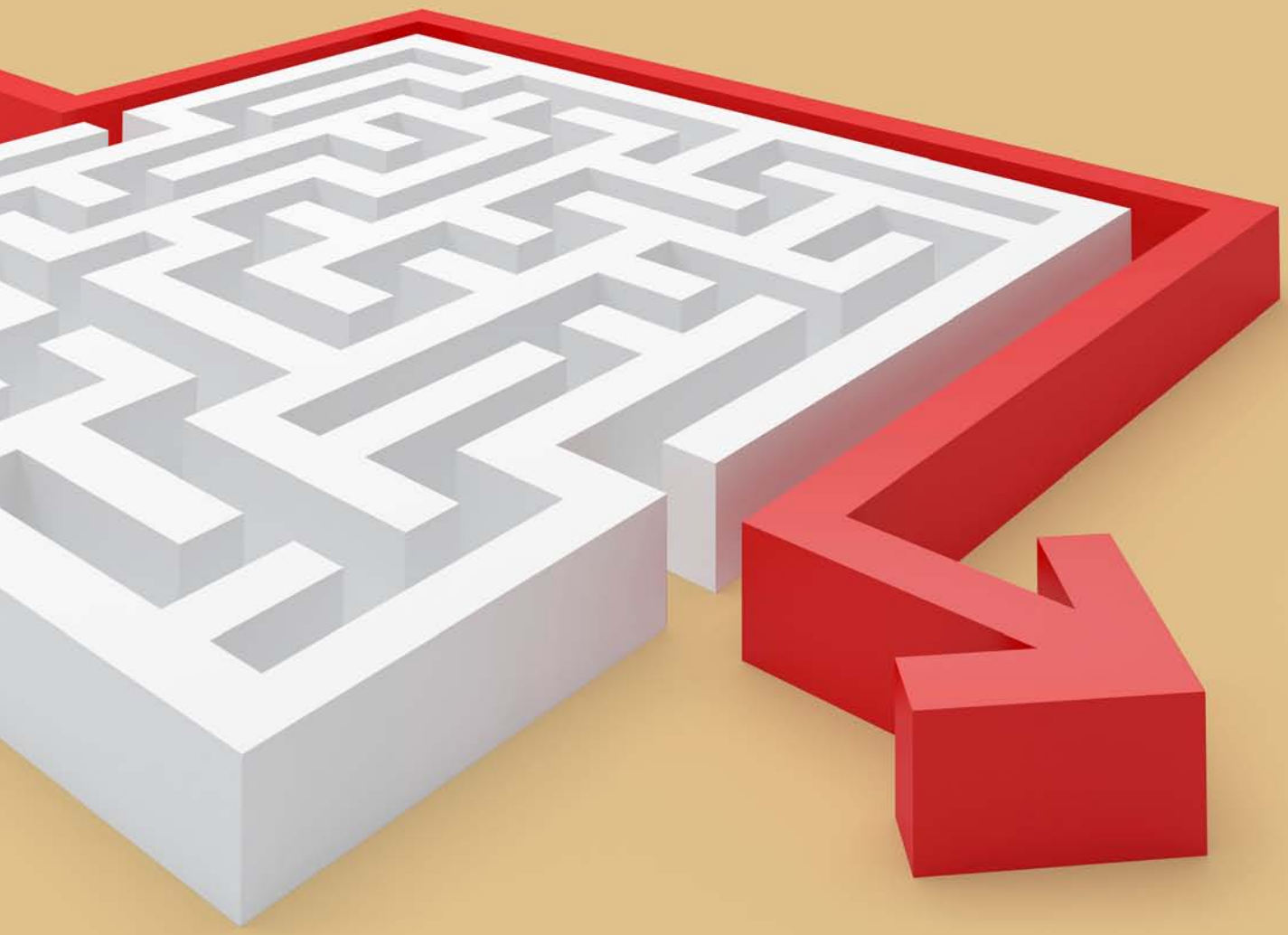

Essentials of Strategic Planning in Healthcare

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This book is dedicated to my parents, Richard and Gloria, whose encouragement and enthusiastic support were real motivators during the creative process. I am forever indebted to them for my success.

BRIEF CONTENTS

DETAILED CONTENTS

PREFACE

Essentials of Strategic Planning in Healthcare is intended to be the primary textbook for introductory courses in healthcare strategic planning. The textbook includes a comprehensive case study that students can use to work through the entire strategic planning process. Study questions and realistic exercises in each chapter are linked to the case study and give students an opportunity to work with healthcare data.

Healthcare research shows that the most successful organizations create an organizational culture that fosters creativity, innovation, and transformational leadership. A strong case can be made that effective strategic planning depends on leaders' commitment to create an organizational culture that supports change management. Part I of the book includes *Chapter 1: Leadership and Strategic Planning*, *Chapter 2: Mission, Vision, and Culture: The Foundation for Strategic Planning*, and *Chapter 3: Transformational Leadership Maximizes Strategic Planning*. These chapters show the important role leadership has in strategic planning and in creating an organizational culture that fosters successful strategic planning.

Part Two demonstrates essential strategic planning techniques for the healthcare industry. It proposes a framework that emphasizes the importance of positioning the

healthcare organization relative to its environment to achieve its objectives and ensure its survival. *Chapter 4: Fundamentals of Strategic Planning* begins the strategic planning process with an analysis of the external environment and organizational factors critical to strategic planning. *Chapter 5: Strategic Planning and SWOT Analysis* focuses on the strengths, weaknesses, opportunities, and threats facing healthcare organizations and their importance in developing strategic plans.

Part Three focuses on the data that must be collected before a strategic plan can be developed, analytical tools that support strategic planning, and essential components of a strategic plan. *Chapter 6: Strategic Planning and Health Information Technology* identifies key data sources available to strategic planners in healthcare. *Chapter 7: Strategic Planning and the Healthcare Business Plan* discusses financial tools used to inform healthcare strategic planning. Finally, *Chapter 8: Communicating the Strategic Plan* emphasizes the importance of effectively communicating the strategic plan to multiple stakeholder groups.

Part Four focuses on the development of strategic planning initiatives across the continuum of healthcare services. These developments include business initiatives in physician group management, long-term care, and other joint venture initiatives. *Chapter 9: Medical Group Planning and Joint Ventures* stresses the strategic advantage hospitals can achieve through linking with physicians. *Chapter 10: Strategic Planning and Long-Term Care Services* explores strategic planning opportunities in inpatient rehabilitation, skilled nursing, hospice, and other post–acute care services.

Part Five is written from a futurist perspective and discusses issues relevant to new developments in healthcare strategic planning. *Chapter 11: Strategic Planning in Health Systems* discusses the growth of national and international health systems and the increasing rate of integration among healthcare organizations. *Chapter 12: Strategic Planning and Pay-for-Performance* addresses the importance of pay-for-performance initiatives in maximizing an organization's income and quality of care. Finally, *Chapter 13: The New Value Paradigm in Healthcare* emphasizes high-quality healthcare at low costs as the healthcare value consumers are seeking today.

Each chapter of the book includes definitions of key terms, and the references included at the end of the text can also serve as a recommended reading list. Chapters 9 through 13 are modular, enabling the instructor to exclude chapters or change their order according to individual preference or classroom requirements. Instructor resources, including PowerPoint presentations and a test bank of multiple-choice and true/false questions, are available to instructors who adopt this book. For information on accessing these files, send an e-mail to hap1@ache.org.

I hope you find that *Essentials of Strategic Planning in Healthcare* provides the knowledge and tools necessary for future organizational success.

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Jacksonville, Florida

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I also acknowledge the behind-the-scenes work necessary to bring a book to publication. I thank my mother, Gloria Harrison, who helped edit the initial drafts of each chapter; Jeri Van Meter for her outstanding work in developing the PowerPoint presentations included in the instructor's manual; and my professor Jerry Norville and classmate Richard Bracken for the time they invested in reviewing earlier drafts of the book. Finally, I thank the staff at Health Administration Press. They were a pleasure to work with and were there every step of the way in the publication process.

COASTAL MEDICAL CENTER COMPREHENSIVE CASE STUDY

Introduction

This comprehensive case study is used as a basis for the exercises included throughout the book.

Coastal Medical Center (CMC) is a licensed, 450-bed regional referral hospital providing a full range of services. The primary service area is a coastal city and three counties with a total population greater than 825,000, located in the Sun Belt. This tri-county area has had one of the fastest growth rates in the country for the last five years. According to the local Health Planning Council, the tri-county population is projected to increase by 15 percent from 2009 to 2015. Appendix A at the end of this case study provides detailed population statistics for the city and tri-county area.

The population growth rate for households (families) has been one to two percentage points higher than the overall population growth. The high percentage of population growth below age 44 shows a young and growing community. Per capita (i.e., per person) income in the tri-county area is high, although growing unemployment is a concern. As the population of the tri-county area increases, the need for

healthcare services is anticipated to increase. The area's economy is largely supported by manufacturing, with service companies and agriculture accounting for 35 percent. Unemployment is typically 6 percent, although it ranges from 5.5 percent to 7.5 percent. The overall poverty rate is 12.4 percent. A recent study revealed that 40,000 city residents are below 125 percent of the established federal poverty level.

Healthcare Costs

Healthcare costs in the region are high in comparison to healthcare costs in most other areas in the state. In response to what they feel are excessively high healthcare costs, county businesses recently formed a business coalition, hired a full-time executive, and publicly stated their intent to achieve reduction in healthcare costs. The local press has expressed its concern about the high cost of healthcare in the local community and consistently bashes the area's hospitals and physicians. The coalition refused to allow the three major medical centers in the area to join, despite that each is a major employer.

The Competition

Full-time equivalent (FTE)
the total number of full-time and part-time employees, expressed as an equivalent number of full-time employees

Adjusted occupied bed
the number of inpatient occupied beds, adjusted (increased) to account for the bed occupancy attributed to outpatient services, partial hospitalization, and home services

Profit margin
the difference between how much money the hospital brings in and its expenses

CMC has two major competitors. Johnson Medical Center (JMC) is the largest of a two-hospital for-profit healthcare system, and Lutheran Medical Center (LMC) is the largest of a two-hospital faith-based not-for-profit healthcare system. JMC is located less than two miles from CMC and is a 430-bed tertiary care facility. JMC owns four nursing homes, two assisted living facilities, a durable medical equipment company, a wellness center, an ambulance service, and an industrial medicine business. These facilities are located in the tri-county area and are within a 30-minute drive of the main CMC facility. JMC's parent company, Johnson Health System, also owns one small hospital in the region.

JMC has 1,920 **full-time equivalents (FTEs)**, which translates to 5.2 FTEs per **adjusted occupied bed**. JMC recently used a consultant to reduce FTEs, flatten its structure, broaden its control, and improve its operations in general.

JMC has been averaging an occupancy rate of 74 percent. Outpatient revenues are 40 percent of total revenues and have grown at about 6 percent per year for the past two years. JMC had a bottom line (i.e., net income) of $15 million last year. Bottom lines for the two years prior to last year were $11 million and $14 million. **Profit margins** have exceeded 5 percent or better the past three years. In essence, JMC is a major strong competitor. The organization is reported to have a "war chest" of reserves exceeding $70 million.

LMC is a 310-bed acute care hospital located outside the city limits but within the tri-county area. It does not offer tertiary, intensive services to the extent that CMC and JMC do, but it is a highly regarded general hospital that enjoys an occupancy rate of 75 percent. It is especially strong in obstetrics, pediatrics, general medicine, and ambulatory care. It attracts well-insured patients from the affluent suburban area.

LMC has 1,180 FTEs and typically operates at 6.1 FTEs per adjusted occupied bed. LMC provides a great deal of indigent care and, in accordance with the philosophy of the church, its budgets are set to generate only a 2 percent annual profit margin.

Highlights of Coastal Medical Center

As a referral center, CMC offers almost every level of care, including a number of tertiary care services, with the exception of neonatology and severe burn unit services. Many of its patients require high-intensity services. For this reason, its costs are the second highest in the entire state. The average length of stay of a patient at CMC is 9.2 days, compared to a statewide average of 6.4 at hospitals of similar size and services. This difference is probably attributable to the intensity of services CMC offers. CMC's expenses per patient day are also the highest in the state, with the exception of two large university-affiliated teaching medical centers. Its FTEs per adjusted occupied bed (7.5), paid hours per adjusted patient day (35.20), and paid hours per patient discharge (238.5) all greatly exceed those of competitors and the norms of comparable facilities. CMC is presently authorized 2,240 positions but actually employs 2,259 FTEs. Salary expenses per adjusted discharge and adjusted patient day are $2,760 and $491, respectively.

A recent one-year market share analysis for the broader eight-county region revealed the data presented in Exhibit Case.1.

CMC has market advantage in substance abuse, psychiatrics, pediatrics, and obstetrics. JMC has a decided market advantage in adult medical and surgical care.

At a recent administrative meeting, the following CMC utilization figures were reviewed:

- Admissions are down 14 percent for the year.
- Medicaid admissions are up 11 percent for the year.
- Ambulatory care visits are down 10 percent for the year.
- Surgical admissions are down 6.7 percent for the year.

Exhibit Case.1
One-Year Market Share Analysis

Facility	Discharges	Percentage of Total
CMC	7,819	18%
JMC	8,989	21%
LMC	6,820	16%
All others	19,546	45%
Total	43,174	100%

A recent auditor's report included the following notes:

- A significant adjustment was required at year-end to correctly reflect contractual allowance expense (i.e., the amount of money spent in hiring outside contractors). (The data used at the beginning of the year to estimate contractual allowance expense was grossly inaccurate.)
- Insurers were not billed for services by certain hospital-based employed specialists ($7 million for the past year) as a result of incompetence on the part of the hospital billing staff.
- A total of $1.7 million of Medicaid reimbursement was not authorized. No follow-ups were done and no claims were resubmitted.

Historical Perspective

CMC was founded just after World War II using a Hill-Burton grant (see Highlight Case.1) and funds raised locally. From a modest beginning with 100 beds and a limited range of acute care service offerings, the medical center has grown to its present size of 450 beds and now offers a full range of services. Credit for the major growth and past success of CMC has

HIGHLIGHT CASE.1 Hill-Burton Act

In the mid-1940s, many hospitals in the United States were becoming obsolete because they did not have money to invest in their facilities after the Great Depression and World War II. To combat this lack of capital and help states meet the healthcare needs of their populations, senators Lister Hill and Harold Burton proposed the Hospital Survey and Construction Act, also known as the Hill-Burton Act. This act provided federal grant money to build or modernize healthcare facilities. In exchange, hospitals receiving the grant were obligated to provide uncompensated (free) care to those who needed care but could not pay for it.

The Hill-Burton Act expired in 1974, but in 1975 Congress passed Title XVI of the Public Health Service Act. Title XVI continues the Hill-Burton program by providing federal grant money for healthcare facility construction and renovation but more clearly defines requirements the facility must meet. For example, facilities receiving grant money must prove they are providing a certain amount of uncompensated care to populations that meet particular eligibility requirements.

been given to Don Wilson, who served as chief executive officer (CEO) from 1990 until his retirement in early 2008. Wilson was a visionary and was successful in transforming the medical center to its present status as a tertiary care facility offering high-intensity care including open-heart surgery and liver and kidney transplants.

Wilson's successor was Ron Henderson. During the past two years, Mr. Henderson practiced a loose, informal style of management. He seemed to sit back and enjoy himself while others ran the medical center. He was often characterized as a caretaker. The medical center made $15.4 million in 2008 following Mr. Wilson's retirement (due to an excellent revenue stream and a strong balance sheet), so he was not pressed to make major changes. Mr. Henderson encouraged the board of trustees, medical staff members, and his administrative staff to submit new ideas for improved community healthcare services using CMC as the focal point for delivery. An avalanche of ideas was submitted during the first two years of Mr. Henderson's tenure. He moved quickly on these ideas and established himself as a person who made swift decisions on new ventures and kept things rolling. He simply let other executives "do their thing" and neither discouraged nor evaluated their work. His strategy was apparently rapid growth and diversity in new businesses. He made major fund commitments to new ideas, but he did little to evaluate the ideas with respect to their compatibility with CMC's mission and its strategic direction, and he usually did not consider the financial implications of these ventures. His approach was "let's do it."

Before 2008, CMC was in good financial shape and faced few financial problems. In 2008, however, expenses began to skyrocket while utilization and revenues failed to keep pace. In addition, a hospital census indicated that, on average, 58 percent of CMC's patients were Medicare patients and 18 percent were Medicaid patients. As a result, the medical center suffered from reductions in reimbursement. Notable among CMC's excessive costs are labor, material, and purchased services. The chief financial officer (CFO) is convinced that a major part of this problem is the presence of three unions, including unionized employees in support services and unionized employees throughout nursing services. Added to this cost burden is the more than $5 million being transferred to subsidize other CMC subsidiary companies.

During the second year of his tenure, Mr. Henderson began to receive criticism from the board of trustees. Henderson had added 127 new positions despite solid evidence that utilization was experiencing a steep decline. His reasoning was that the declines were temporary and that business would soon be back to normal.

In late 2009, the medical center suffered a deficit of $8.6 million (see Appendix B). Surprised by this major loss, the board of trustees fired Mr. Henderson. They contended that they should have been informed of these serious problems. They felt that there should have been a better strategic planning process in place for the selection of projects, on which millions of dollars had been spent. The board of trustees could not understand how overall corporate net income could drop to a loss of $8.6 million when $15.4 million in profit had been made the previous year.

Governing Board

CMC's governing board has 27 members. All of its trustees are prominent, influential, and generally wealthy members of the community. The board is self-perpetuating. The same chair has served for ten years. Average tenure on the board is 17 years. Committees of the board are detailed in Exhibit Case.2.

One physician-at-large is also included on the board. The chief of staff and the CEO attend all board meetings but are not allowed to vote on board decisions. There are no minority members despite that racial minorities account for about 12 percent of the service area population. Only one of the 27 members of the board is a woman. The average age of the trustees is 66.

Parent Corporation

The parent corporation of CMC is Coastal Healthcare Incorporated. This parent board was created through corporate restructuring several years ago, but its role has never been clear. The parent board is made up of "friends" of the most powerful among the trustees of the CMC board. In essence, when corporate restructuring was the "in thing" to do,

Exhibit Case.2
Committees of the Coastal Medical Center Board

Committee	Size	Meeting Frequency
Executive	16	Monthly
Joint Conference	24	Monthly
Finance	13	Monthly
Budget	18	Quarterly
Executive Compensation	9	Annually
Construction	13	Monthly
Strategic Planning	16	Monthly
Quality Assurance	9	Monthly
Patient Care	11	Monthly
Ambulatory Care	11	Monthly
Public Relations	9	Monthly
Personnel	11	Monthly
Material and Equipment	11	Monthly
Audit	9	Quarterly

this holding company was formed. By appointing a few CMC trustees to also sit on the parent board and by appointing friends of present CMC trustees, it was believed that the two boards would function as one happy family. However, there has been constant conflict from the beginning regarding the relative powers and roles of the two boards.

The parent company board has 19 members, all of whom are white and male. Backgrounds of the parent board of trustees tend to mirror those of the medical center trustees in that they are prominent and mostly wealthy. Membership includes bankers, attorneys, business executives, business owners, developers/builders, and prominent retired people.

Committees of the Coastal Healthcare Inc. (parent) board are detailed in Exhibit Case.3.

The following are some of the conflicts that have occurred between these two boards over the years:

- The parent board refused to approve the appointment of a new hospital CEO selected by the CMC board.
- In 2006, the two boards hired separate consultants to develop a long-range strategic plan. Two plans were produced but were never integrated and never really implemented.
- Various committees from the parent board often request information about functions of the medical center, which creates conflict because the parent board has a tendency to micromanage CMC's routine operations.
- Separate committees of both boards have worked more than two years trying to revise CMC's mission statement.

Medical Staff

The medical staff at CMC has historically been a difficult group when it comes to cooperation with the board and administration. Patient length of stay is excessively high in most specialties, yet the physicians refuse to be educated on reimbursement and the need to reduce length of stay, excessive tests, and so on. Approximately 90 percent of the medical staff also has privileges at one or more competing hospitals in town.

Committee	Size	Meeting Frequency
Executive	11	Monthly
Finance	11	Monthly
Strategic Planning	11	Quarterly

Exhibit Case.3 Committees of the Coastal Healthcare Inc. Board

A number of the medical staff members have set up their own diagnostic services, especially the radiologists and neurologists, despite that they have been granted exclusive service contracts at CMC.

In recent years, there has been considerable dissatisfaction among the specialists who represent the majority of the medical staff. They complain that their referrals are decreasing or flat and that CMC is not doing enough to help them establish and maintain a sufficient number. Hospital admissions for specialty services are declining drastically. To compound the problem, the competing medical centers are courting these specialists aggressively with attractive offers, such as priority scheduling in surgery and other special arrangements, all of which are legal.

The medical staff also rated various aspects of medical center operations unsatisfactory in a recent survey. The subjects of their complaints were across the board and included key areas such as the following:

- Dissatisfaction with nursing services and especially the nurses' attitudes (Nurses have formed themselves into shared governance councils and are taking issue with both physicians and administration regarding their autonomy.)
- Excessive delays in every aspect of operations (e.g., late starts in the operating room, lack of supplies or equipment when it is needed, excessive patient processing time [for example, over three hours for pre-surgical testing for outpatient surgery])

The medical staff also feel they should have more voice in both financial and operational matters, especially in capital budgeting. They feel they are asked to provide free services too frequently (e.g., by committees), and many have refused to serve without compensation to offset the practice income they have lost.

There are also quality problems. Two physicians probably should have their privileges revoked, three apparently have substance abuse problems, and several are obsolete in their practices and should be asked to retire. The problem is getting their peers to act in these cases. It has also been difficult to get physicians to hold elected offices and accept committee responsibility. Payment of honoraria has helped, but support is still difficult to procure. Over $200,000 is being paid out to entice doctors to serve on committees.

Subsidiary Companies

Including CMC, there are 24 subsidiary corporations of Coastal Healthcare Inc.:

- **Medical Enterprises** is a for-profit joint venture with physicians. The company is developing computers that enhance imaging services. Thus far, CMC

has invested $18 million in this company. No cash flow is expected for three to four years.

- Coastal Healthcare Inc. has **three nursing homes**. Collectively, these long-term care facilities are losing almost $1 million annually. **Debt service** on two of them is very high. Only one is within patient transfer distance of CMC. The second is 70 miles away, and the third is 82 miles away. All three have unions. Almost all of the residents of the two facilities losing the greatest amount are Medicaid patients; there are only a few self-pay patients.

Debt service
cash required over a given period for the repayment of interest and principal on a debt

- **CMC Management Services** was formed to sell management and consulting services. The company lost $360,000 last year, which was its third year of operation.
- **Regional Neuroimaging** is a joint venture with physicians. The company lost $920,000 its first year of operation. Capital invested by the hospital to date totals $9 million.
- **American Ambulance** is a local ambulance company. Financially, it breaks even, but it does increase admissions to CMC, especially through trauma pick-ups.
- **Home Health, Inc.** provides home health care services in an eight-county area. Its operating loss last year was $290,000. The company has considerable difficulty attracting and retaining professional personnel, especially nurses and physical therapists.
- **Industrial Services Inc.** provides health services to industrial companies throughout the state. Only one of the six operating locations is close enough to generate referrals. None of the operating sites is making a profit despite that the company is five years old.
- **MRI Enterprises** is a successful mobile magnetic resonance imaging (MRI) joint venture with a physician group. It has a consistent, positive bottom line.
- **Textile Enterprises** is a large, high-tech laundry completed three years ago. It was intended to serve the medical center and many other companies in the region. Because of its debt service, union wages, and remote location, the laundry has yet to break even. After three years, it still does not have its first non-CMC service contract.
- Coastal Healthcare Inc. owns **three hospitals**: **Caroleen Hospital** (60 beds), **Grant Hospital** (74 beds), and **Ellenboro Hospital** (90 beds). All are small

rural hospitals purchased to feed patients to CMC. All are unprofitable. Collectively, the three of them require $2.5 million in subsidies annually.

- **Health Partners** is a health maintenance organization joint venture with 20,000 subscribers. After three years of operation, its costs are still rising. Last year, it required $2 million in subsidies.
- **Northeast Clinic** is a large multispecialty group of 11 physicians who were fed up with government red tape and sold out to CMC last year. CMC now employs these physicians and is responsible for all medical group operations. It is too early to determine the success of this venture.
- **Imaging Venture** is a recently formed radiology joint venture. Until/if it becomes successful, it will cost just under $1 million in debt service annually.
- **North Rehabilitation**, a 60-bed inpatient rehabilitation facility, was just opened. It is expected to be successful because CMC will refer all of its rehabilitation patients to this facility and there is no other rehabilitation facility in the region.
- **Center for Pain** has been a successful outpatient facility and is expected to remain successful. Its space is leased. Overhead is kept low. The physicians are salaried.
- **Coastal Wellness**, a fitness and wellness center, was developed five years ago at a cost of $10 million. It is located in a coastal community and is intended to attract those from the wealthy areas. A significant number of CMC employees and their family members use Coastal Wellness at a lower monthly rate, which is subsidized by CMC. Coastal Wellness is currently underutilized, so CMC subsidizes it with $220,000 annually.
- **Central Billing** was formed to attract patient billing contracts from health facilities and physician groups. It has been moderately successful and reached the break-even point this past year.
- **City Contractors**, a separate, small general contracting company, was just formed. It will require about $200,000 annually in subsidy.
- **Bay Enterprises** is a land acquisition and holding company.

Executives and Middle Management

CMC employs 20 executives. (*Executives* are defined as positions above the administrative director level.) Total annual executive compensation is $2.2 million. Each executive has an

executive secretary. The annual average compensation among the 20 secretaries is $35,000, which amounts to an executive-level support cost of $700,000.

Each of the other 23 subsidiary companies also employs executives and support personnel in addition to regular employees. This executive overhead is a drain on CMC because many of the subsidiary companies do not break even and thus must be subsidized.

CMC employs 15 administrative directors, who function between vice president and department directors. Their principal purpose is to handle problems at the department level so these problems do not escalate to the vice president.

There are also 67 director-level positions in the organization. Directors are responsible for a particular department or function. Managers are the next level down the line of supervision. There are 31 managers. Collectively, these managers have 68 supervisors working for them.

The compensation and benefits policy of CMC appears to deviate substantially from industry norms. For example, the directors' annual salaries range from $85,000 to over $170,000.

Corporate Staff

The parent corporation consists of the following offices:

- Office of the CEO, who has five "assistants to the president" (i.e., an administration, board, ethics, community, and staff assistant)
- Office of the senior vice president for finance (three people)
- Office of the senior vice president for corporate affairs (four people)
- Office of the senior vice president for corporate development (three people)
- Office of the vice president for legal affairs (five people)
- Office of the vice president for medical affairs (two people)
- Office of the vice president for marketing (two people)
- Office of the vice president for strategic planning (two people)

The corporate staff serve as advisers and coordinators, oversee their functional areas at CMC, and, where needed, oversee the various subsidiary companies.

Total FTEs for the parent company corporate staff are 29. Total costs of corporate overhead are $2.3 million annually. In addition, during the past year the corporate officers of the parent company purchased the consulting services listed in Exhibit Case.4.

Exhibit Case.4 Consulting Services Purchased by Parent Company

Consultant Purpose	Cost
Conduct board retreat	$35,000
Prepare restructuring recommendations	$65,000
Write organization history	$60,000
Provide policy advice	$25,000
Lobbying	$50,000
Compensation (wage/salary) study	$72,000
Labor negotiations	$120,000
Management development	$90,000
Managed care study	$47,000
Total	$564,000

Duplication of Functions

Throughout CMC, functions were duplicated as the organization grew. For example, there are three education departments and three transportation departments. There is both an inpatient and outpatient pharmacy, each with its own director. CMC and 12 of the larger subsidiary companies have separate human resources management functions.

There are 24 boards, one for each subsidiary company, and each board has a large number of committees. Executives from CMC and the parent corporation sit on these boards and their committees.

Service/Professional Contracts

CMC contracts with many service providers. Service contracts include housekeeping, food service, record transcription, biomedical maintenance, security, and many others. These contracts are renewed regularly with the same firms. CMC also contracts with countless health professionals. For example, the contract for coverage of CMC's pediatrics clinic by two physicians is $380,000, and CMC furnishes the facilities and professional and support personnel. Numerous physicians have negotiated arrangements through which they regularly receive checks for committee service, advice, and so on. Many of these negotiations are not documented in written contracts.

The hospital-based specialists' contracts are based on a percentage of gross earnings, with no provision for any type of adjustments to the gross. Several of these arrangements are long-standing but unwritten agreements.

Material Management

CMC is organized traditionally, meaning there is no centralized material management function. Purchasing is done throughout the organization from a large number of vendors. The pharmacy, laboratory, and other services do their own ordering, arrange contracts, and handle other supply and equipment matters. For example, the laboratory recently purchased a large computer software package without the knowledge of the purchasing agent or the information services department.

Large stores of inventory can be found throughout the facility. CMC also harbors excessive and obsolete equipment. Central storage occupies a huge amount of space and carries what appears to be an overabundance of many items.

Special Projects

Fifty-three "special projects" in various stages of progress are underway at CMC, ranging from the addition of a new education center to renovation of the food service department. A large number of start-ups are also under development. For example, CMC is considering a joint venture with physicians to build an ambulatory surgery center offering the latest robotic surgery technology. Analysis of the projected costs of these projects, and of the working capital many of them will need before they become profitable, if they ever do, revealed that the organization will suffer severe financial distress if these projects continue. Moreover, there is considerable uncertainty regarding the financial feasibility of many of them. Finally, these projects have not been centrally coordinated, nor has their potential impact on the organization's mission and strategic direction been discussed. These projects were simply developed on the basis of individual interests of various executives and managers. By his inaction and lack of leadership, Mr. Henderson gave everyone free rein to do their own thing—and they did.

New CEO Arrives

CMC hired an executive search firm specializing in healthcare to look for a new CEO. After a nationwide search, the board of trustees decided to hire Richard Reynolds. Mr. Reynolds appeared to be a no-nonsense CEO who had the knowledge and skills to determine the problems at CMC and resolve them. During his first few weeks in the new position, Mr. Reynolds did an exhaustive analysis of CMC with the assistance of a transition consultant and the executives and managers of the organization. The following list highlights his findings:

1. Compared to national personnel standards, a large percentage of the departments at CMC are grossly overstaffed. More than 100 new positions were

added during the most recent fiscal year, despite that utilization did not justify these positions. The overall administrative structure is top-heavy.

2. Fifty-eight general contracts were identified, many of which are standing contracts with consultants who appear to be receiving large monthly retainers but are not providing services. In addition, a total of 121 contracts with physicians were identified. Again, these physicians appeared to be providing few services. The prior CEO apparently made numerous agreements to subsidize various physicians and pay them large sums for performing administrative services that are normally done on a voluntary basis by members of the medical staff.
3. Fifty-three major new service projects in the planning or construction phase were identified. An analysis indicated that they would require over $100 million in future commitments, and Mr. Reynolds was not sure that CMC would be able to service the necessary debt. No project priorities existed and no feasibility studies had been done for most of the projects, so there was no way to project the financial impact of these "innovative ideas" on the organization.
4. A large number of duplicate departments were identified. Mr. Reynolds pinpointed many departments and services that could be consolidated.
5. Sixty-six "special" programs are collectively accounting for a $6 million outflow of cash from CMC. These programs are not directly related to CMC's tertiary care mission. CMC seemed to have developed every type of program conceivable from one end of the care continuum to the other without considering whether the programs supported its mission or generated a positive cash flow.
6. In material management, Mr. Reynolds found nearly $8 million in "unofficial" inventory stored throughout various facilities of the medical center. There is no centralized material management system for purchasing, storage, distribution, and accountability of materials.
7. While the median operating margin for medical centers of similar size and service was about 2.5 percent the past year, CMC had experienced a multimillion-dollar loss. In addition, the medical center's return on equity was a major problem. The number of **days accounts receivable** (i.e., average number of days it takes to collect payments that clients owe to the organization) in other medical centers averaged 68 days during the past year; CMC's accounts receivable days were far greater. Most alarmingly, CMC's cash on hand at any given time represented only 22 operating days. Finally, the hospital's major bond issue was recently downgraded to the lowest credit rating.
8. Medicare has just notified the CFO that recovery of $4 million is forthcoming due to past errors in the Medicare Cost Report.

Days accounts receivable
average number of days an organization takes to collect payments on goods sold and services provided, calculated as follows: average accounts payable (in dollars) × 365 (days per year) ffi sales revenue (The "normal" average range is 40 to 50 days. A number significantly greater than 50 days indicates that the organization is having difficulty collecting payments from its clients; a number significantly lower than 40 indicates that the organization has overly strict credit policies that might be preventing it from taking in higher sales revenue.)

9. The business coalition is becoming well established and intends to aggressively pursue discounted services through direct contracting.
10. The parent company (Coastal Healthcare Inc.) is not structured nor functions as a local healthcare system. Clinical services and administrative support are not integrated. For this reason, Coastal Healthcare Inc. does not meet the classic definition of a healthcare system provider.
11. Nationally, capitation payment arrangements have not been successful for many hospitals. CMC is not in a favorable position to become an accountable health plan. To become an accountable health plan, CMC would have to partner with primary care and specialty physicians to meet the total healthcare needs of a defined patient population.
12. No value-oriented efforts have been initiated at CMC (e.g., continuous quality improvement, benchmarking).
13. There has been no leadership development for the board of trustees, medical staff, and administration.
14. No formal strategic planning process is in place at the CMC or Coastal Healthcare Inc. (holding company) level.
15. There are no existing physician–hospital organizational arrangements.

General Conditions

Mr. Reynolds also quickly learned that he had taken a position in an organization with a governing board that was generally content to approve anything the previous CEO recommended. The medical staff appears no better in that they are principally focused on their own self-interests and show little interest in the affairs of the medical center.

Control systems are lacking, and CMC does not have a comprehensive information system. Moreover, quality of care appears low; a large number of legal cases against the medical center are pending.

With respect to material management, several suppliers have refused to deliver supplies because of delays in accounts payable. Mr. Reynolds summed up the medical center's situation by reporting to the members of the board that there is an immediate cash flow problem, people-related expenses are far too high, material-related expenses are well above those expected, plant-related expenses are excessive, contract amounts are excessive, and accounts receivable are too high. He also remarked that CMC seems to have no sense of direction or overall corporate strategy.

With the help of his transition consultant, Mr. Reynolds surveyed and interviewed his department heads. Given the financial situation and the results of the survey, Mr. Reynolds knew he faced a difficult challenge.

Mr. Reynolds concluded that the prior CEO had engaged in the "one man rule" concept and had failed to build necessary knowledge and management skills among the vice presidents. Thus, when difficulties occurred in the organization, inertia set in. The reaction of executives and managers was that of indecisiveness and unwillingness to take risk for fear of compromising their job security. He also reported that there are an excessive number of administrative positions.

An examination of CMC's balance sheet (see Appendix C), financial ratios (Appendix D), and structure led Mr. Reynolds to conclude that the corporation was over-expanded, over-leveraged, and over-dependent on a narrow market. The organization is too expensive to operate, bloated with bureaucracy, inefficient in its services, and unimaginative in its approach to strategic planning and change.

From his discussion with the leadership team and other hospital staff, Mr. Reynolds believes there is no clear organizational mission and that there is considerable dissatisfaction among the leaders. To confirm his beliefs, he had the transition consultant administer a brief leadership survey. Appendix E reports the results of this survey, providing detailed information on corporate culture and job satisfaction. Mr. Reynolds has already decided to do a similar survey of all hospital staff within the next six months to obtain more baseline data on the organization's corporate culture and its ability to deal with the changes he knows are coming.

New Business Initiatives

To expand its physician staff, CMC has constructed a hospital-owned medical office building in a growing community five miles from the hospital. This effort has been successful and has attracted a prominent group of orthopedic physicians who are now referring their surgical procedures to the hospital. As part of this expansion and with the growing orthopedic workload, CMC is exploring the financial feasibility of opening a physical therapy clinic at this new location.

On the basis of current physician referral patterns, CMC anticipates $250,000 in outpatient physical therapy net income at the new location during the upcoming 12 months.

Conclusion

As Mr. Reynolds ponders the many problems he had uncovered upon arrival at CMC, he wonders what other problems might be beneath the surface. Every day he uncovers additional major problems. At this point, Mr. Reynolds is so overwhelmed by the problems that he is unsure of how to proceed. He does know, however, that priorities need to be

set, the deteriorating situation needs to be turned around, and a strategic plan needs to be developed to chart the future of the organization.

Exercises

Assume you are Mr. Reynolds. Being new to the position, you are faced with major challenges.

The questions and exercises listed at the end of each chapter provide an opportunity to gain leadership experience in managing change in a healthcare organization. Most important, you will gain experience in developing a strategic plan.

Appendix A: Population and Household Data

	Riverside County	Metro City	Rural County	Ocean County
POPULATION AND HOUSEHOLD				
Square miles	609	775	601	485
Population density per square mile	214	1,028	245	111
Population 1992	83,829	672,971	105,986	28,701
Population 2004	129,832	794,569	146,739	53,506
Population 2009	148,289	842,179	163,082	63,543
% Population growth 1992–2004	54.88%	18.08%	38.45%	86.43%
% Population growth forecast 2004–2009	14.22%	5.10%	11.14%	18.76%
Households 1992	33,431	256,772	36,664	11,882
Households 2004	52,322	310,603	52,448	22,904
Households 2009	59,895	331,539	58,623	27,305
% Household growth 1992–2004	56.5%	20.97%	43.05%	92.76%
% Household growth forecast 2004–2009	14.5%	6.75%	11.77%	19.21%
Average household size	2.48	2.57	2.8	2.34
Families	35,793	205,123	40,907	16,766
% Urban population	56.5%	98.7%	59.6%	59.9%
% Rural population	43.5%	1.5%	40.4%	40.1%
% Female population	51.2%	51.5%	50.7%	51.5%
% Male population	48.8%	48.7%	49.3%	48.5%
% White population	91.1%	67.4%	88.6%	87.9%
% Black population	6.5%	28.5%	7.3%	9.5%
% Asian population	1.4%	3.8%	3.0%	1.6%
% Hispanic origin population	2.7%	4.3%	4.4%	5.2%
Other population	1.4%	2.1%	3.1%	2.3%
% Population 0–5 years	6.5%	8.7%	8.0%	4.9%
% Population 6–11 years	8.1%	9.1%	9.6%	6.0%
% Population 12–17 years	8.2%	8.7%	10.2%	6.7%
% Population 18–24 years	6.4%	8.9%	7.2%	4.4%
% Population 25–34 years	9.7%	14.4%	11.6%	7.3%
% Population 35–44 years	17.8%	18.1%	18.7%	12.9%
% Population 45–54 years	17.0%	14.6%	15.9%	14.3%
% Population 55–64 years	10.2%	7.7%	8.9%	14.4%

% Population 65–74 years	8.8%	5.7%	5.6%	17.2%
% Population 75 years and over	7.3%	5.1%	4.3%	11.9%
Median age	41.3	35.5	36.8	50.5
INCOME AND EDUCATION				
Total household income ($US)	$5,145,536,895	$20,994,962,608	$3,656,788,183	$1,650,526,132
Median household income ($US)	$49,103	$41,410	$49,270	$42,975
Per capita income ($US)	$39,632	$26,423	$24,920	$30,847
High income average ($US)	$474,930	$430,207	$348,177	$450,993
Education—% less than high school (age 25+)	11.2%	13.6%	11.5%	12.6%
Education—% high school (age 25+)	31.6%	33.9%	35.4%	36.6%
Education—% some college (age 25+)	25.5%	26.9%	29.9%	27.1%
Education—% college (age 25+)	22.1%	19.3%	16.8%	15.4%
Education—% graduate degree (age 25+)	9.6%	6.4%	6.5%	8.3%
EMPLOYMENT AND OCCUPATION				
Males employed (age 16+)	35,604	201,461	40,722	12,093
Females employed (age 16+)	29, 337	169, 863	30,949	9,654
Total employees (age 16+)	64,941	371,324	71,671	21,747
% White-collar occupations	62.9%	63.1%	61.8%	57.3%
% Blue-collar occupations	22.8%	23.6%	25.9%	27.5%
% Service occupations	14.3%	13.3%	12.4%	15.2%
% Local government workers	7.6%	7.0%	7.4%	7.7%
% State government workers	3.2%	2.4%	2.2%	1.6%
% Federal government workers	1.8%	3.5%	6.3%	0.9%
% Self-employed workers	9.0%	5.2%	6.3%	9.2%
CONSUMER EXPENDITURES				
Annual expenditures per capita ($US)	$18,211.60	$16,580.10	$16,226.00	$18,322.00
Healthcare expenditures per capita ($US)	$2,347.20	$2,183.90	$2,105.70	$2,390.30
Healthcare insurance expenditures per capita ($US)	$428.00	$385.00	$370.00	$482.20
COST OF LIVING				
Consumer price index	147.1	147.1	147.1	147.1
Medical care consumer price index	211.3	211.3	211.3	211.3

Appendix B: Coastal Medical Center: Statement of Income (in thousands of dollars)

	2008	2009
Operating revenue		
Inpatient	130,775	131,470
Outpatient	28,923	31,211
Other operating revenue	2,604	2,225
Gross operating revenue	162,302	164,906
Less provisions for allowances		
Third-party reimbursement programs	(31,422)	(42,081)
Doubtful accounts	(5,112)	(7,320)
Charity care	(2,705)	(2,993)
Total provision for allowances	(39,239)	(52,394)

Net operating revenue	123,063	112,512
Expenses		
Salaries, payroll taxes, and fringe benefits	61,757	64,858
Dietary, pharmaceutical, and other supplies	17,450	18,534
Purchased services	12,971	14,306
Depreciation and other capital costs	7,281	7,929
Medical specialists	4,091	5,893
Insurance	3,112	3,722
Interest expense and amortization of financing costs	2,408	2,560
Utilities	2,257	2,268
Other	2,336	2,203
Total expenses	113,663	122,271
Income from operations	9,420	(9,759)
Nonoperating revenue		
Interest income	1,268	1,040
Other	81	58
Total nonoperating revenue	1,349	1,098
Net income	10,769	(8,661)

Appendix C: Coastal Medical Center: Balance Sheet (in thousands of dollars)

	2008	2009
ASSETS		
Current assets		
Cash and cash equivalents	2,337	2,964
Accounts receivable	23,781	25,345
Inventories	2,251	2,638
Current portion of assets	3,030	3,947
Prepaid expenses and other assets	1,678	1,729
Total current assets	33,077	36,623
Facilities and equipment		
Land and land improvements	3,209	3,279
Buildings and improvements	44,053	46,369
Equipment	36,024	38,400
Construction	4,389	15,774
Less accumulated depreciation	(36,036)	(41,222)
Total facilities and equipment	51,636	62,600
Assets of limited use		
Funds held by trusts	40,475	29,469
Assets segregated for capital purposes	970	10
Donor restricted funds	2,045	2,049
Investment in deferred compensation annuities	6,058	6,212
Total assets of limited use	48,545	37,740
Less assets of limited use and required for current liabilities	(3,030)	(3,947)
Total assets of limited use	45,516	33,793

Other noncurrent assets		
Deferred financing costs	2,740	2,536
Due from affiliated organizations	1,587	1,865
Other	326	1,417
Total other noncurrent assets	4,653	5,818
TOTAL ASSETS	134,882	138,833
	2008	2009
LIABILITIES AND FUND BALANCES		
Current liabilities		
Current portion of long-term debt	1,156	1,073
Advance from donations	2,405	5,155
Accounts payable	2,440	6,690
Accrued expenses	3,030	3,947
Payroll and related fringe benefits	7,647	7,926
Interest payable	2,600	2,228
Other liabilities	1,302	3,074
Total current liabilities	17,549	26,148
Other liabilities		
Deferred compensation	5,056	6,212
Estimated malpractice liabilities		
Deferred reimbursement program liabilities	1,978	1,669
Retirement incentive liabilities		
Subtotal	7,034	7,881
Long-term debt, less current portion	53,717	52,745
Commitments and contingencies		
Donor restricted fund balances	2,045	2,049
Unrestricted fund balances	54,537	50,010
TOTAL LIABILITIES AND FUND BALANCES	134,882	138,833

Appendix D: Coastal Medical Center: Financial Ratios

	2008	2009
Liquidity ratios		
Current ratio	1.885	1.401
Days in patient accounts receivable	70.5	82.2
Average payment period ratio	42.7	58.3
Days cash on hand	10.9	13.3
Capital structure ratios		
Equity financing ratio	0.404	0.360
Long-term debt to equity	0.985	1.055
Fixed asset financing ratio	0.613	0.508
Times interest earned ratio	5.47	(2.38)
Debt service coverage ratio	5.74	0.503
Cash flow to debt ratio	0.657	0.413

Activity ratios		
Total asset turnover ratio	1.203	1.188
Fixed asset turnover ratio	3.143	2.634
Current asset turnover ratio	4.907	4.503
Profitability ratios		
Deductible ratio	24.55	32.20
Markup ratio	1.42	1.34
Operating margin ratio	0.077	0.087
Return on assets	0.08	0.062

Appendix E: Coastal Medical Center Leadership Survey

Perceived Corporate Culture

Item	Positive %	Neutral %	Negative %
1. Leadership	28	9	63
2. Structure	22	14	64
3. Control	66	20	14
4. Accountability	20	7	73
5. Teamwork	26	7	67
6. Organization identity	31	17	52
7. Work climate	17	17	66
8. Risk taking	15	9	76
9. Conflict management	24	24	52
10. Perceived autonomy	51	12	37
11. Results oriented	29	20	51
12. Mutual trust	36	8	56
13. Communication	24	7	69
14. Team spirit	7	21	72
15. Attitudes	21	22	57
16. Vision	19	5	76
17. Reward system	36	27	37
18. Group interaction	20	45	35
19. Value of meetings	26	7	67
20. Faith in organization	28	6	66

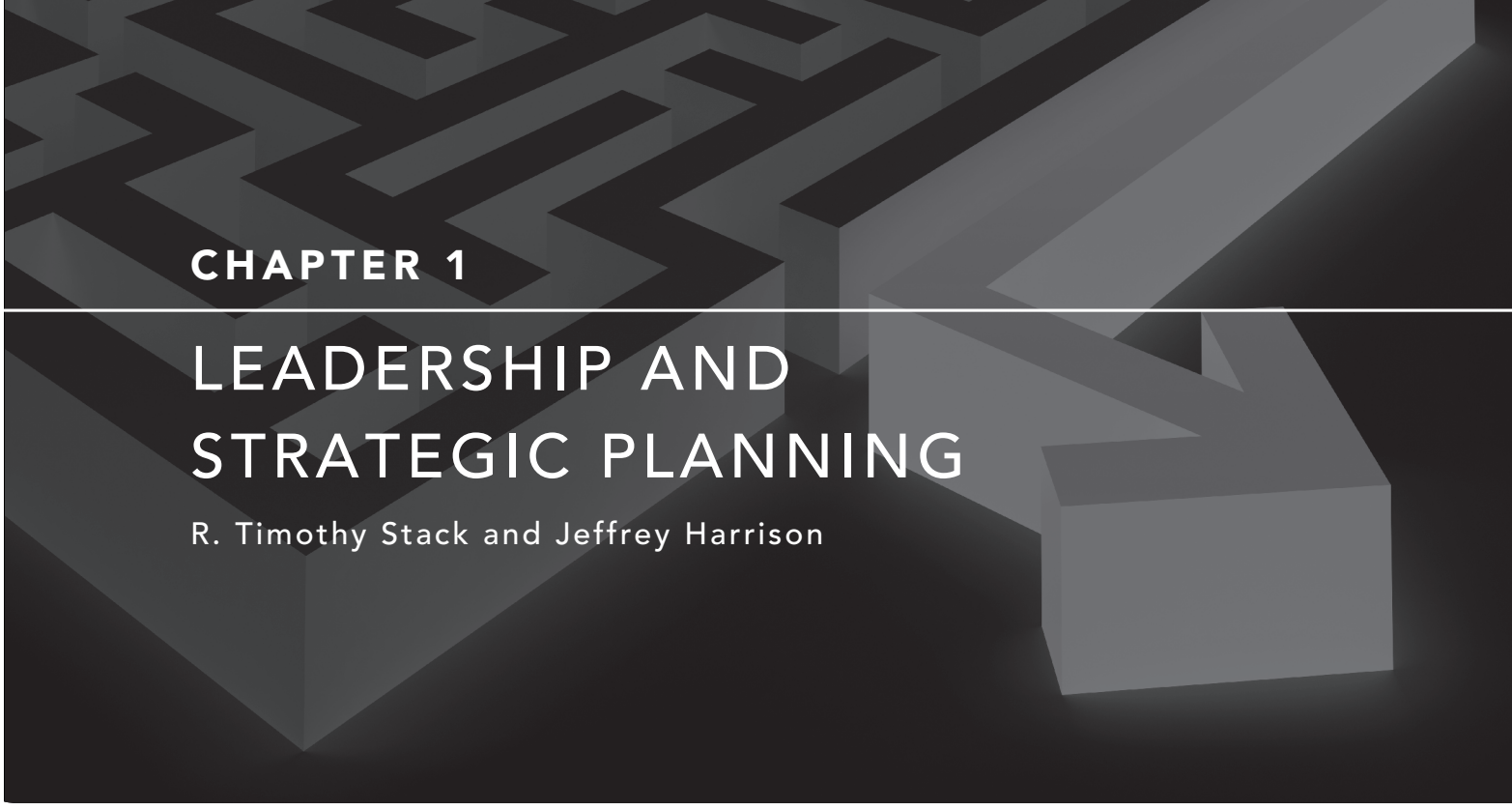
Self-Evaluation of Position

Item	True %	Partly true %	Not true %
1. Sufficient decision-making authority	34	50	16
2. Clear understanding of role	43	30	27
3. Clear understanding of performance expectations	26	44	30
4. Fully use training and experience	27	33	40
5. Mix of management and routine is correct	33	30	37
6. Amount of work is reasonable	28	32	40
7. Work offers challenge, satisfaction, and growth	30	30	40
8. Performance is recognized	38	32	30
9. Compensation is satisfactory	45	35	20
10. Quality work is recognized and rewarded	29	41	30
11. Upward communication is effective	21	40	39
12. Downward communication is effective	17	50	33

13. Cross communication is effective	15	55	30
14. Operations problem solving is timely and thorough	17	43	40
15. Strategic decisions are timely and effective	26	30	44

Appendix F: Hospital Compare Quality Data

CMS ID	11111X	22222Y	33333Z	State	National
HospitalName	CMC	JMC	LMC	average	average
Accreditation	Yes	Yes	Yes		
EmergencyService	Yes	Yes	Yes		
HeartAttackPatientsGivenACEInhibitororARBforLeftVentri	78%	82%	91%	82%	83%
HeartAttackPatientsGivenAspirinatArrival	92%	97%	100%	91%	94%
HeartAttackPatientsGivenAspirinatDischarge	95%	98%	96%	94%	95%
HeartAttackPatientsGivenBetaBlockeratArrival	90%	91%	97%	85%	86%
HeartAttackPatientsGivenBetaBlockeratDischarge	92%	97%	93%	92%	94%
HeartAttackPatientsGivenPCIWithin120MinutesofArrival	49%	52%	66%	65%	68%
HeartAttackPatientsGivenSmokingCessationAdviceCounseling	83%	98%	98%	98%	99%
HeartAttackPatientsGivenThrombolyticMedicationWithin30Mi	63%	33%	100%	40%	50%
HeartFailurePatientsGivenACEInhibitororARBforLeftVentr	81%	82%	89%	73%	75%
HeartFailurePatientsGivenanEvaluationofLeftVentricularS	93%	97%	96%	92%	93%
HeartFailurePatientsGivenDischargeInstructions	46%	37%	58%	39%	49%
HeartFailurePatientsGivenSmokingCessationAdviceCounseling	71%	78%	100%	87%	97%
PneumoniaPatientsAssessedandGivenInfluenzaVaccination	58%	59%	77%	43%	45%
PneumoniaPatientsAssessedandGivenPneumococcalVaccination	44%	60%	83%	39%	49%
PneumoniaPatientsGivenInitialAntibioticswithin4HoursAf	53%	61%	81%	72%	73%
PneumoniaPatientsGivenOxygenationAssessment	98%	98%	99%	98%	99%
PneumoniaPatientsGivenSmokingCessationAdviceCounseling	76%	77%	100%	92%	95%
PneumoniaPatientsGiventheMostAppropriateInitialAntibiotic	75%	81%	90%	81%	85%
PneumoniaPatientsWhoseInitialEmergencyRoomBloodCultureWa	80%	85%	81%	80%	90%
SurgeryPatientsWhoReceivedPreventativeAntibioticsOneHou	62%	75%	74%	80%	81%
SurgeryPatientsWhosePreventativeAntibioticsareStoppedWi	62%	75%	74%	80%	81%



CHAPTER 1

LEADERSHIP AND STRATEGIC PLANNING

R. Timothy Stack and Jeffrey Harrison

Lead, follow, or get out of the way.

—Thomas Paine

Key Terms and Concepts

- Board of directors
- Chief executive officer
- Chief financial officer
- Chief information officer
- Chief nursing officer
- Credentialing
- Fiduciary
- Health information technology
- Incentives
- Infrastructure
- Internal data
- Leadership
- Magnet hospital designation
- Medical staff
- Stakeholder
- Systems approach
- The literature
- Turnover

Introduction

Healthcare spending in the United States in 2006 rose 6.7 percent from the previous year, to $2.1 trillion. This figure equates to an expenditure of $7,026 per person and 16 percent of the gross domestic product. During this same period, prescription drug spending increased 8.5 percent (Catlin et al. 2008). Healthcare costs are increasing at a significant rate, and the industry needs leaders who can allocate resources more efficiently. Research shows that hospitals are one of the largest employers in the country and are critical to attracting new business to a geographic area. The healthcare industry also contributes to the United States' economic and social well-being; the Bureau of Labor Statistics (2007) reported 13.6 million Americans were employed in the healthcare industry in 2006. As noted in Exhibit 1.1, the U.S. hospital industry comprises a wide range of hospitals of varying size.

Infrastructure
an underlying foundation or basic framework

Incentive
a reward that motivates someone to take action or perform, such as a bonus payment awarded for achieving a goal

Growth is important to an organization's future success. It helps the organization recruit physicians and provides for greater economies of scale (see Highlight 1.1), which can result in increased profitability. To grow, organizations need effective **infrastructures**, high-performance work processes, and skilled personnel, and they must provide their employees with appropriate **incentives**. Most important to growth is good strategy development, which is a product of excellent leadership and diversity of individuals and expertise (Goldman and Dubow 2007). Strategic planning is an effective way for organizations to improve their allocation of resources (see Highlight 1.2). Resources need to be allocated in a way that allows organizations to provide healthcare services as efficiently as possible. Research has shown that the efficient allocation of healthcare resources in the production process is linked to improved quality (Harrison and Coppola 2007). The following section discusses the role of hospital leaders, particularly their function in strategic planning.

Exhibit 1.1
U.S. Hospitals by Category and Bed Size

Total number of hospitals: 6,348

	Number of Beds				
	0–99	100–199	200–299	300–399	400+
Government, nonfederal	879	256	117	74	109
Not-for-profit	1,393	743	456	279	333
For-profit	948	340	119	45	28
Government, federal	100	45	31	20	33

Source: AHA (2005).

HIGHLIGHT 1.1 Economies of Scale

The principle of *economies of scale* is based on the premise that an organization will be able to achieve greater savings if it is providing for a large number of patients (and employing a large number of providers) rather than just a few. A larger number of patients corresponds to a need for a greater number of supplies. As the number of supplies an organization needs increases, it becomes possible to buy those supplies in bulk instead of individually. When an organization buys in bulk, the average cost it will have to pay per unit usually decreases. For an everyday example, you experience economies of scale if you buy your soda in a 12-pack rather than individually—you might spend $4.99 for 12 cans (or $0.42 each) rather than $1 for one can in a vending machine.

HIGHLIGHT 1.2 Allocation of Resources

Allocation of resources is the phrase used to describe how an organization plans to spend its money as well as how it will focus the efforts of its employees and use its other resources. Because the resources of every organization are limited, the leadership team must decide which projects are most important and which are not important enough to invest in. For example, a hospital might have to choose which is more important: implementing an electronic medical record (going paperless) or buying new equipment for the radiology department.

Definition of Leadership

Leadership
the ability to guide, influence, and inspire individuals to meet organizational goals

At the most basic level, **leadership** is the ability to guide, influence, and inspire individuals to meet goals (for purposes of this book, organizational goals). Competency models that focus on leadership in the healthcare industry have been developed by many organizations, including the Healthcare Leadership Alliance and the National Center for Healthcare Leadership (see Highlight 1.3). Based on the most current research, these models identify behaviors and technical skills (competencies) that characterize outstanding leadership performance.

HIGHLIGHT 1.3 The Healthcare Leadership Alliance and the National Center for Healthcare Leadership

The Healthcare Leadership Alliance (HLA) is a group of professional organizations that use their combined knowledge and experience to improve the field of healthcare management. These organizations are

- the American College of Healthcare Executives (ACHE),
- the American College of Physician Executives (ACPE),
- the American Organization of Nurse Executives (AONE),
- the Healthcare Financial Management Association (HFMA),
- the Healthcare Information and Management Systems Society (HIMSS), and
- the Medical Group Management Association (MGMA), along with its standard-setting division, the American College of Medical Practice Executives (ACMPE).

The National Center for Healthcare Leadership (NCHL) is a nonprofit organization dedicated to improving leadership in healthcare organizations. Through research, publications, benchmarking, and formation of leadership networks, NCHL strives to improve the abilities of healthcare leaders to in turn improve healthcare in the United States.

Stakeholder
one who is involved in or affected by an organization's actions

Board of directors
the governing body appointed to hold fiduciary responsibility for the organization

Chief executive officer (CEO)
the highest-ranking executive in an organization, responsible for strategic planning, hiring senior leadership, and managing operations

Fiduciary
An individual or a group who acts for and on behalf of another in a relationship of trust and confidence

In this rapidly changing healthcare industry, strategic planning is becoming increasingly important to overall organizational success. Strategic planning involves the development of organizational objectives (i.e., what the organization wants to accomplish), the management of action plans, and the measurement of ongoing performance. Key to strategic planning is the development of relationships with key **stakeholders**, such as patients, physicians, employers, insurers, community groups, and government agencies (Griffith and White 2005).

In healthcare organizations, the **board of directors** and the **chief executive officer (CEO)** are at the top of the leadership structure. The *board of directors* is the governing body appointed to hold **fiduciary** responsibility for the organization. (An example of Piedmont Healthcare's (Atlanta, Georgia) board of directors is illustrated in Exhibit 1.2.) As part of this responsibility, the board makes policy decisions, which guide the future of the organization. An essential area of the board of directors' responsibility is the development of a strategic plan consistent with the organization's mission and vision.

Many believe that an organizational culture that embraces continuous quality improvement (see Highlight 1.4) is necessary for long-term success and that the board of directors should focus on measuring performance to ensure healthcare quality. The Institute

HIGHLIGHT 1.4 Continuous Quality Improvement

Continuous quality improvement (CQI) is the idea that no process or service is perfect and that an organization must continually strive to eliminate errors from its system to get closer and closer to perfection. The study and championing of CQI has taken many forms in many industries and has become an important aspect of healthcare management.

Healthcare organizations often use CQI to measure their performance. A hospital will collect data about one of its processes and compare these data to the data of other hospitals in the area and around the country. For example, a hospital will keep track of how often its patients are given the wrong medicine or the wrong dose of a medicine. It then compares its results to national standards. If the hospital has a higher frequency of errors than the national standard, the hospital might implement a CQI program to try to improve the statistic. Such a program would involve studying the processes that lead to errors, making recommendations to improve the process, implementing the changes, and then collecting the data once again to measure it against the national standards to see if the improvement has been achieved. The main principle behind CQI is that quality should be constantly under investigation and, thus, the organization is always working to improve.

of Medicine (IOM) (see Highlight 1.5) believes that improving the healthcare industry will require changes to the structure and processes of the delivery system, as well as a focus on coordination of care across all services (IOM 2001). In addition, successful delivery of healthcare in the future will depend on the use of **health information technology**, such as electronic medical records.

Health information technology
information and communication technology in healthcare, such as electronic health records, clinical alerts and reminders, and decision support systems

The *CEO* is the highest ranking executive in an organization and is responsible for strategic planning, hiring senior leadership, and managing operations. The CEO is often a member of the board of directors and is a key interface between the board and operations. The CEO also represents the organization to key stakeholders, including regulatory authorities and community groups. A competent CEO emphasizes organizational transformation by envisioning, energizing, and fostering change. Analytical thinking, a community orientation, innovative thinking, and strategic planning are essential to this focus. At the execution level, CEOs must demonstrate an ability to manage change, communicate, influence staff, and measure performance. They also need to demonstrate excellent people skills; they must build relationships, uphold professional ethics, develop talent, and lead teams (Calhoun et al. 2008). Most important, CEOs should focus on organizational values, direction, and performance expectations.

HIGHLIGHT 1.5 Institute of Medicine

The Institute of Medicine (IOM) was founded in 1970 as a nongovernmental, nonprofit organization that would provide impartial information and advice about healthcare in the United States. It is part of the National Academies. According to IOM's website, "IOM asks and answers the nation's most pressing questions about health and health care. [IOM's] aim is to help those in government and the private sector make informed health decisions by providing evidence upon which they can rely" (IOM 2009).

IOM publishes studies on the state of healthcare that historically have drawn a lot of attention; in 2000 it disclosed the high number of medical errors occurring in hospitals in its report *To Err Is Human* and in subsequent reports continued to identify the health industry's progress on quality. Most recently, IOM issued reports on priorities for a national vaccine plan, the redesign of continuing education for health professionals, and early detection of biological threats.

EXHIBIT 1.2
Sample Board of Directors

Board of Directors	*Number*
Physician directors	6
Chief executive officer	1
Community directors	8
Treasurer (chief financial officer), ex-officio	1
Government, federal	1

The Board of Directors' Role in Strategic Planning

Research shows that hospitals with high-performing governing boards perform better and are more profitable. In particular, outstanding hospital boards have a demonstrated commitment to the strategic planning process (McDonagh 2006). A major challenge for governing boards is keeping current with new business strategies and the changing healthcare environment (Pointer and Orlikoff 1999).

HIGHLIGHT 1.6 Service Lines

Service lines are specialty areas of care provided by a healthcare organization—for example, cardiology, oncology, orthopedics, or transplant services. Organizations may provide full-service care or they may specialize in just a few service lines and strive to excel in those areas. In general, some service lines, such as cardiology, are lucrative; other service lines—emergency rooms in an area with a high uninsured population, for example—may be unprofitable.

Excellent working relationships between boards and senior leadership are necessary to enhance corporate governance (Nadler 2004). Also important is the board's relationship to the community. A collaborative, community-oriented board stays in touch with the needs of the local population and develops new services to meet those needs. Such services can improve the health and well-being of the community as well as enhance the reputation of the healthcare organization.

Board participation in the strategic planning process helps build consensus among senior leadership and staff about the organization's future direction (Zuckerman 2007). Board involvement in subcommittees, board meetings, and strategic planning retreats can all increase the board's participation in strategic planning.

Planning for CEO succession is one of the board's most important responsibilities. Leadership development should be based on future needs of the organization, as identified through the strategic planning process (Garman and Tyler 2004). Because the board has an integral part in the strategic planning process and in defining the organization's mission, logic dictates that it should be involved in leadership development to ensure future success. Additionally, the board should evaluate leadership's recommendations for new service lines (see Highlight 1.6) and monitor the quality of care provided by the organization (Christman 2007).

The board plays a key role in challenging assumptions made during the strategic planning process and ensuring new business initiatives align with the organization's mission and goals. As of 2005, in response to the increasing complexity of the healthcare industry and the changing healthcare environment, 59 percent of hospital boards had appointed a strategic planning committee and 49 percent of board chairs believed that knowledge of the strategic planning process is important in trustee selection (Orlikoff and Totten 2006).

The CEO's and Leadership Team's Roles in Strategic Planning

A senior leadership team is an important asset to an organization and can give it a competitive advantage in the marketplace. The leadership team should use its technical knowledge and stakeholder relationships to help make the organization's decisions (Grant 1996). Research shows that high-performing senior leadership teams use formal management processes to improve efficiency and enhance quality. Like high-performing boards, they are also committed to strategic planning (Liu and Lin 2007).

Turnover
the departure and replacement of personnel

The CEO **turnover** rate among U.S. hospitals is approximately 16 percent, leading to approximately 700 CEO transitions annually (Cirillo 2006). A competent CEO is critical to the future success of the organization, so the board should help a new CEO develop team-building skills and the financial knowledge necessary to support the strategic planning process. In addition to maximizing performance, effective team building ensures that everyone in the organization is on the same page and that transitions to new leadership are smooth.

The CEO, in consultation with the board, is ultimately responsible for creating and implementing the strategic plan. The strategic planning process should also include physicians and other staff in the organization (Sollenberger 2006).

Other Key Leadership Roles

The Role of the Chief Financial Officer

Chief financial officer (CFO)
executive responsible for planning, organizing, and directing all financial activities

The **chief financial officer (CFO)** is responsible for planning, organizing, and directing all financial activities, including budgeting, cost accounting, patient accounting, payer relations (see Highlight 1.7), and investing. The CFO normally reports directly to the CEO.

HIGHLIGHT 1.7 Payer Relations

Healthcare in the United States is an unusual service industry in that a single transaction of care usually involves three parties: the person receiving the care (i.e., the patient); the person or the organization providing the care (i.e., the physician or nurse, or hospital or physician practice); and the party paying for the care (i.e., the payer). The payer may be an insurance company, a health plan, or even the government (e.g., Medicare or Medicaid).

Payer relations is the term used to describe the interactions of the healthcare provider with the payer. The provider's activity can include negotiating contracts regarding the amounts to be paid for specific procedures, educating payers about new procedures, and building and maintaining good relationships with payers.

The CFO is critical to the development of the strategic plan because of his or her responsibility for projecting workload and providing financial data. Key data include growth projections, market share, departmental budgets, and performance measures. Thus, the CFO needs to understand financial modeling (see Highlight 1.8) (Kaleba 2006). Gathering and providing accurate and timely information are often the most difficult parts of the strategic planning process. In a small hospital, the CFO also often functions as the project manager for strategic planning.

The Role of the Chief Nursing Officer

The **chief nursing officer (CNO)** is responsible for planning, organizing, and directing all nursing activities, including policy development, implementation of nurse staffing models (see Highlight 1.9), and ongoing quality improvement efforts. The CNO normally reports to the CEO.

Chief nursing officer (CNO)
executive responsible for planning, organizing, and directing all nursing activities

Nursing leaders are important participants in the organization's decision-making processes and should be involved in strategic planning. Their involvement provides a perspective on resource allocation, the marketing of new services, and quality enhancement (Phorman 2004). Research conducted in 2003 found that 10 percent of chief nursing executives had voting membership on their organization's board of directors (Phorman 2004). To achieve **magnet hospital designation**, hospitals must document the nurse executive's role in the senior leadership decision-making process (Havens 1998).

Magnet hospital designation
a status awarded by the American Nurses Credentialing Center to hospitals whose nursing staff meets certain criteria based on quality

HIGHLIGHT 1.8 Financial Modeling

Financial modeling is the construction of a formula or program, either by computer or on paper, to predict what might happen if certain financial decisions are made. By plugging different numbers into the formula to see how they change the results, a financial modeler can better decide the best course of action for an organization.

For example, say the CFO of a hospital wants to know what the financial impact would be if the facility's surgical staff increased the number of operations it performed per week. The CFO would construct a financial model that takes into account the additional costs—more staff, more supplies, more wear-and-tear on the equipment, more patients in the recovery rooms—and the additional revenue—more operations and therefore more money collected. On the basis of the calculation, the CFO would be able to make an informed decision as to whether increasing the number of operations would be profitable for the hospital.

HIGHLIGHT 1.9 Nurse Staffing Models

How many nurses are needed to staff a hospital unit? This question is tricky; the answer is not simply a ratio of patients to nurses. Nurse staffing models are guidelines a hospital unit uses to determine how many and what kind of nurses are needed to care for the patients on that unit. Nurse staffing models take into account

- the number of patients on the unit,
- how sick each patient is,
- what kind of technology and other aids are available to help the nurses perform their work, and
- the nurses' and other caregivers' level of training.

The mix of the above factors affects how well patients recover from their illnesses. A mix that is deficient in some way can even cause hospitalized patients to become more ill. This potential illustrates the importance of a proper nurse staffing model.

Chief information officer (CIO)
executive responsible for planning, organizing, and directing all information systems within the organization

The literature
a changing body of published information on healthcare that typically appears in peer-reviewed journals

Internal data
information and facts that can be gathered from sources within an organization

The Role of the Chief Information Officer

The **chief information officer (CIO)** is responsible for planning, organizing, and directing all of the organization's information systems (e.g., enterprise information systems, clinical information systems, and electronic medical records) and often manages the organization's telecommunication systems. From a strategic planning perspective, the CIO has an important role in systems design and analysis. In some cases, the CIO reports to the CFO; however, the authors believe it is more appropriate for the CIO to report to the CEO.

The CIO's role is critical because the strategic planning process hinges on the management of information and the use of information systems. Data collection is essential to strategy development and includes gathering both internal and external information. Sources of data include **the literature**, internal databases, community surveys, focus groups and interviews with community leaders, and physicians. **Internal data** are particularly important because they highlight an organization's strengths and weaknesses (Kaleba 2006).

From a clinical perspective, the contemporary practice of medicine should be guided by evidence-based medicine (EBM) (see Highlight 1.10) to reduce the variability of clinical care and optimize the patient's health. Effective practice requires physician

HIGHLIGHT 1.10 Evidence-Based Medicine

Evidence-based medicine (EBM) is the application of scientific evidence to medical practice. Physicians who practice EBM base the care they provide on treatments that have been shown to be scientifically most effective.

EBM dictates that decisions about patient care should be governed by (1) the physician's expertise, (2) the patient's values, and (3) the best current evidence in scientific research. The goal of EBM is to reduce variation in the outcome of care and to optimize the patient's health.

support of EBM and the use of electronic databases to monitor the outcomes of care, as well as hospital leadership's commitment to allocating the resources necessary to implement information technology (Chervenak and McCullough 2003).

The Role of Consultants

As discussed previously, research shows that the healthcare industry is one of the most complex industries. As a result, the need for highly skilled technical professionals is increasing. Many healthcare organizations fill this need through the use of consultants. Because consultants are external to the organization, they can review data objectively, challenge the status quo, conduct in-depth research on highly technical topics, and obtain candid opinions from stakeholders.

A wide range of stakeholders and other individuals can help in strategic planning. For example, the use of an outside consultant to facilitate the strategic planning process may contribute to improved results. The outside consultant can provide a national perspective on the healthcare industry as well as be an unbiased observer on issues associated with strategic planning (Sollenberger 2006). Consulting firms can aid in the strategic planning process and can participate in working groups in the organization that focus on key areas of operation (Christman 2007).

On the negative side, consultants come and go, so the organization has access to their technical skills only for the period of their contract. For continuity and stability, many organizations decide to develop the skills of existing employees or recruit these consultants for permanent staff positions.

Physician Involvement in Healthcare Strategic Planning

The Role of the Chief Medical Officer

The *chief medical officer (CMO)* is responsible for planning and implementing programs to improve the quality of patient care. The CMO also participates in **medical staff** meetings, **credentialing**, and medical staff recruitment. In larger hospitals, the CMO is usually a full-time employee who reports to the CEO.

CMOs and other physician leaders (also called *clinical leaders*) develop strategic competencies by combining management theory and practical experience to address the healthcare challenges of the twenty-first century. They must be adept at strategic planning, allocating resources, and developing new clinical services. A primary goal is to create value for stakeholders. The most important competencies for physician executives to have include strong leadership skills, technical expertise, innovation, and a **systems approach** to problem solving (Spevak 2003).

Under the CMO's direction, senior clinical leaders can improve treatment outcomes by supporting innovation in clinical practice and interdisciplinary collaboration among members of the healthcare delivery team (Liu and Lin 2007). Physicians are key stakeholders in the organization and play an essential role in developing and marketing new clinical services. Even more important, physicians should be part of the feedback loop in monitoring quality of care (Grube 2007).

In response to persistent and systematic shortcomings in quality, IOM published a report in 2001 titled *Crossing the Quality Chasm: A New Health System for the 21st Century,* which called for fundamental change in healthcare. The report identified six aims: safety, effectiveness, efficiency, patient-centered care, timeliness, and equitability, all of which are important to strategic planning. Research has shown, however, that 50 percent of physician care provided in the United States is not based on best clinical practice (see Highlight 1.11) (McGlynn et al. 2003), suggesting that the CMO should support the development of new clinical services that improve healthcare quality.

Medical staff
full- and part-time physicians and dentists who are approved and given privileges to provide healthcare to patients in a hospital or other healthcare facility; may be employed by the facility or granted admitting privileges to practice

Credentialing
process used to evaluate a physician's qualifications and practice history

Systems approach
management that emphasizes the interdependence of elements inside and outside an organization

HIGHLIGHT 1.11 Best Clinical Practice

Best clinical practice (or simply *best practice*) is the most effective method for treating a disease or an illness as determined by available evidence (studies and case reports). To provide the best care to patients, physicians need to keep up to date on the latest treatment guidelines.

The Role of the Medical Staff

Physicians and hospital leaders are co-fiduciaries for the patients' welfare. To be a *fiduciary* for a patient means possessing the knowledge needed to promote the patient's well-being and being committed to using one's own expertise for the patient's benefit. This healthcare concept of co-fiduciary draws on organizational ethics as well as a sense of morality (Chervenak and McCullough 2003).

The management of physician relationships is important and is becoming more complex as the healthcare industry evolves. Physician managers must make strategic decisions regarding the employment of primary care physicians, hospitalist physicians, and clinical specialists. For example, hospital emergency rooms need physician coverage, and on-call specialty physicians are needed to support trauma centers. Strategy decisions are also influenced by the increasing competition between hospitals and physician-sponsored outpatient services and other lucrative product lines (Ginsburg 2007).

Because physicians are major stakeholders in the healthcare system, they should be involved in business planning regarding the implementation of new clinical services. An outstanding physician reputation is fundamental to developing successful clinical service lines (Ginter and Swayne 2006). Therefore, the strategic planning process should include physician input and foster physician support of the organization. To ensure medical staff support, Richard Kaleba, principal consultant with PRISM Consulting Services Inc., recommends physician involvement on committees responsible for the review and approval of new business initiatives. He also believes physician involvement in financial planning and medical staff development is necessary to ensure long-term success (Kaleba 2006).

Unfortunately, as a result of increasing workload and administrative responsibilities, many physicians lack the time to participate in hospital-sponsored meetings, making physician participation in the strategic planning process problematic.

Summary

In today's rapidly evolving healthcare industry, a leader is one who promotes changes. The literature and organizational theory provide clear evidence that outstanding leadership is associated with increased organizational performance and future success. Effective leadership and strategic planning can significantly enhance the quality of patient care.

In the current environment of healthcare reform, healthcare leaders must uphold professional ethics and operate from a foundation of trust, honesty, and integrity in their dealings with patients and stakeholders. At all levels of the organization, leaders need to demonstrate ethics and honesty to gain employees' support.

The authors strongly encourage you to review the "Ten Concepts for Effective Leadership" included as an epilogue at the end of the text. By incorporating these concepts into your leadership behaviors early in your career, you will position yourself and the organization for future success.

Review Questions

1. Evaluate the statement that the board of directors has fiduciary responsibility for organizational resources. Provide an example from your own experience that illustrates the impact a board can have on organizational performance.

2. In healthcare organizations' attempt to enhance their leadership, what is the role of the board of directors, senior leaders, and physicians?

Coastal Medical Center Case: Exercise 1

According to Chapter 1 and the Coastal Medical Center case that appears at the beginning of the text, how effective has the board of directors been in providing oversight for the organization? From an operational perspective, how have the CEO and senior leadership team provided the oversight necessary for Coastal Medical Center to move forward on a new road to success?

Questions

1. Discuss the role of the board of directors in providing oversight to the organization. Has the board met its fiduciary responsibility?

2. Does the hospital board regularly monitor performance? If so, how, and how often?

3. Does the board hold management accountable for achievement of the strategic plan? If so, how?

4. Recommend changes to the role of the board of directors as well as new membership to the board of directors.

5. In the comprehensive case study, the original CEO provided leadership to a highly successful healthcare organization for over 20 years and was considered a visionary. Develop a list of five areas in which you think the original CEO's performance was particularly outstanding.

6. Does the quality of the new leadership at Coastal Medical Center set the stage for future success?

CHAPTER 2

MISSION, VISION, AND CULTURE: THE FOUNDATION FOR STRATEGIC PLANNING

Setting an example is not the main means of influencing others; it is the only means.

—Albert Einstein

Key Terms and Concepts

- Acute care hospital
- Balanced Budget Act (BBA) of 1997
- Culture
- For-profit hospital
- Goals
- Inpatient
- Joint venture
- Mission
- Not-for-profit hospital
- Organizational culture
- Outpatient
- Servant leadership
- Values
- Vision

Introduction

Balanced Budget Act (BBA) of 1997 legislation implemented in 1997 to reduce Medicare reimbursement rates

Organizations, like people, have personalities. This personality develops over time and is shaped by the organization's history, the environment in which it operates, and the beliefs of its key individuals. These factors are reflected in the organization's mission, vision, and culture.

The healthcare industry changes constantly. As a result, healthcare organizations, like individuals, must continually adapt to survive and prosper. They must develop a culture that supports change and periodically evaluate their mission, vision, and values to make sure they are relevant in the current environment. This evaluation provides a foundation for the strategic planning process.

By the late 1990s, competition in the hospital industry was intensifying. In 1997, Congress passed the **Balanced Budget Act (BBA)**, which reduced the rates at which Medicare (see Highlight 2.1) reimbursed hospitals for the services they provided. Together, these factors reduced hospitals' operating margins and lowered their profits.

HIGHLIGHT 2.1 Medicare

Medicare is a health insurance program offered by the U.S. government to certain portions of the population. It is run by the Centers for Medicare & Medicaid Services, which is part of the Department of Health and Human Services.

To be eligible to receive Medicare, you must be aged 65 or older, younger than 65 but disabled, or any age and suffer from end-stage renal disease (a condition requiring kidney dialysis or a kidney transplant).

There are four parts to Medicare, each of which offers slightly different benefits to participants:

- Part A is hospital insurance. It covers overnight hospital stays (if certain conditions are met). Participants generally do not have to pay a premium (i.e., a monthly fee to participate) if they have worked for ten years and paid Medicare taxes.
- Part B is medical insurance. It covers services provided on an outpatient basis and other types of care, such as home health services for homebound patients who need skilled nursing care. Participants usually pay a premium for this coverage.
- Part C is often referred to as *Medicare+Choice* or *Medicare Advantage* because it lets participants receive their benefits through private insurance plans (although they often have to pay more). Part C offers coverage for services that Parts A and B do not include.
- Part D is prescription drug coverage. Participants have to pay a premium for this coverage, which is provided through private insurance companies contracted by the government.

Inpatient
a patient who stays in the hospital for treatment for one or more nights

In the 1980s, earlier, conventional healthcare insurance plans began to be replaced by health maintenance organizations (HMOs) and preferred provider organizations (PPOs) (see Highlight 2.2). By the end of the 1990s, enrollment in HMOs and PPOs had skyrocketed. To attract these enrollees, hospitals needed to contract with these organizations. HMOs and PPOs used this dependency to their advantage and began to reduce the amounts they paid to hospitals for the services they provided. To offset this decrease in income, hospitals had to find ways to maintain their profit margins. They began to emphasize shorter hospital stays for **inpatients**. If their HMO was reimbursing them at a flat rate regardless of how long the patient stayed in the hospital, shorter stays equated to higher profits. For example, say the HMO was reimbursing the hospital $20,000 for a particular treatment. If a two-day inpatient stay for this treatment cost the hospital $10,000 and a three-day stay cost the hospital $15,000, the hospital would make $10,000 if it limited the patient stay to two days, but only $5,000 if the patient stayed for three days. This pressure to reduce length of stay is even greater for hospitals with low occupancy rates. Unable to adapt and maintain profits in this changing environment, many independent hospitals have been forced into bankruptcy, closure, merger with more successful hospitals, or acquisition by another company (Harrison et al. 2003).

HIGHLIGHT 2.2 Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs)

HMOs and PPOs are both managed care organizations—that is, insurance providers that are structured to control costs and improve care by using certain strategies, such as providing incentives to providers that keep their costs of care down and do not prescribe unnecessary treatments.

HMOs contract with hospitals, physicians, and other caregivers to provide care to their clients. In exchange for providing customers for the contracted providers, the HMO is assigned a group of providers who have agreed to abide by the HMO's treatment guidelines. To receive coverage, clients of HMOs must see providers who are part of that HMO's network. In 1973, the U.S. government began to require all employers of at least 25 people to offer an HMO option to their employees.

Groups of providers contract with PPOs to provide care at reduced rates to the PPO's clients. Unlike HMOs, PPOs cover services rendered by out-of-network providers, but at a lower reimbursement rate than that offered for the services of an in-network provider.

After enactment of the BBA, healthcare providers pressured Congress to undo its payment reforms. In response, Congress passed the Balanced Budget Refinement Act of 1999 and made other modifications that increased the rates at which Medicare reimbursed hospitals for the services they provided. By the middle of the first decade of the twenty-first century, hospitals had achieved greater efficiency, which in turn reduced the costs of providing care. This greater efficiency, combined with the Balanced Budget Refinement Act's improved Medicare reimbursement rates and other factors, helped hospitals increase their profitability (Evans 2007a). In addition, many healthcare organizations sold or closed unprofitable business lines to boost their earnings. Growth in the use of **outpatient** services and in the number of emergency room visits also prompted increased revenue. During 2006, hospitals reported the highest profit margins since the BBA was passed. **Acute care hospitals** realized a record-high $35.2 billion in profits out of the $587 billion they took in that year—a 20 percent increase over 2005 (Evans 2007a).

Outpatient
a patient who visits a clinic or other healthcare facility for treatment but is not hospitalized overnight

Acute care hospital
a hospital that provides medical services to all people seeking care or treatment, regardless of their ability to pay

Unfortunately, many U.S. hospitals still operate at a loss. Worker shortages drive up costs by forcing hospitals to raise wages to attract medical professionals (Kraman and Sewell 2005). To compete, hospitals are investing in health information technology, such as the electronic medical record (see Highlight 2.3). While this technology in the long run will lead to improved productivity, fewer medical errors, and lower staff turnover—all of which help to increase profits—hospitals must spend a considerable amount up front to acquire it and train employees to use it.

HIGHLIGHT 2.3 Electronic Medical Record (EMR)

An EMR is a computerized version of a patient's history and treatment (legal medical record). The source of care (e.g., the hospital) creates, maintains, and owns EMRs.

The advantages to having the patient records in electronic rather than paper form include greater accuracy and, therefore, quality of care (physicians' orders can't be misread because of illegible handwriting) and greater efficiency (information is stored in the EMR and need not be reentered multiple times). EMRs also help prevent errors; they can be set up to flag orders or procedures that might be harmful to the patient. For example, if a physician mistakenly prescribes a drug that conflicts with a patient's other medications, a warning message would display on the EMR when the physician places an order for the prescription.

Mission
a written statement of an organization's basic purpose

Goals
written objectives that can be measured to assess performance

Not-for-profit hospital
a hospital designated as a 501(c)(3) organization by the Internal Revenue Service and eligible for tax-exempt status

The Impact of Mission, Vision, and Culture on Profits and Strategic Planning

Mission

The **mission** of an organization is the fundamental purpose of its existence. In healthcare, an organization's mission is partially determined by ownership status. A hospital may be a not-for-profit organization, a for-profit organization, a government-operated organization, or a joint venture, and this designation will shape its mission. Differences in mission reflect different motivations and **goals**, and these differences influence the type of strategic plan an organization develops.

Not-for-Profit Hospitals

Not-for-profit hospitals are considered 501(c)(3) organizations by the Internal Revenue Service (IRS; see Highlight 2.4). The 501(c)(3) designation identifies an organization as "any corporation that is organized or operated exclusively for religious, charitable, scientific, public safety, literary, or educational purposes" (Gapenski 2003). The promotion of health is considered a charitable activity that relieves the government from having to provide healthcare services (Chestek 2000). As a result, not-for-profit hospitals receive favorable treatment from the government. They may apply for tax-exempt status, provided they operate exclusively for the welfare of the public, do not have a profit motive, and provide appropriate levels of charity care. In addition to exemption from federal taxes, exemption from property tax, and exemption from tax on bond interest, 501(c)(3) organizations enjoy many benefits, including bad debt write-off. Further, any donations a 501(c)(3) organization receives are tax deductible (Ferris and Graddy 1999). (See Highlight 2.5 for an explanation of these tax concepts.) Large, not-for-profit health systems in the United States include Ascension Health, Kaiser, and Mayo Clinic.

HIGHLIGHT 2.4 Internal Revenue Service (IRS)

The IRS is the U.S. government agency that collects taxes from citizens and corporations and enforces tax law. The IRS has been appointed by Congress to enforce the Internal Revenue Code, which includes complicated tax guidelines for citizens, for-profit corporations, and not-for-profit and charitable organizations.

For-Profit Hospitals

For-profit hospital an investor-owned hospital that must pay federal and state taxes on its profits

For-profit hospitals are organizations owned by investors, or *shareholders*. In contrast to not-for-profit hospitals, their mission is to generate profits for their shareholders. For-profit healthcare organizations must pay federal and state corporate income taxes and local property taxes and should generate appropriate returns for stockholders.

The modern for-profit healthcare industry was born in the late 1960s with the creation of Hospital Corporation of America (HCA, Inc.) by Dr. Thomas Frist and Jack Massey. Today, HCA operates 178 hospitals in the United States and additional hospitals abroad.

One major advantage of for-profit health systems is their ability to make money through the sale of stock. As a result, they can expand rapidly (build or acquire hospitals), renovate their facilities, and purchase new technology. Building or acquiring new hospitals creates economies of scale (see Chapter 1, Highlight 1.1), which can improve efficiency and

HIGHLIGHT 2.5 Tax Exemption, Tax Deduction, Bond Interest, and Bad Debt Write-Off

- Tax exemption: The hospital does not have to pay federal or property taxes.
- Charitable contributions: Any money given to a charitable hospital can be deducted—that is, the person who gives the gift can claim the money on his taxes, and the donated money is subtracted from that person's total taxable earnings for the year. Lower taxable earnings means that person pays less income tax. This arrangement motivates people to donate to the charitable hospital, and the hospital thus acquires money.
- Exemption from bond interest tax: Buyers of bonds issued by a charitable organization do not have to pay taxes on the interest earned on those bonds. An organization might issue bonds if it wanted to raise funds for new construction or to fund new technology, for example. A bond is purchased for a certain price, and the purchaser receives regular interest payments from the amount invested. After a certain period, the purchaser receives the entire amount back, plus the interest he has been collecting over that period. The exemption from bond interest tax encourages people to purchase such bonds, and the charitable organization thus raises money.
- Bad debt write-off: A hospital's *bad debt* is money that other organizations or individuals owe the hospital that will never be paid. The hospital is able to write off the amount of bad debt as an expense to the organization (rather than income as it was originally recorded).

lead to lower costs. The four largest for-profit hospital chains in 2006 were HCA in Nashville, Tennessee; Tenet Healthcare Corp. out of Dallas, Texas; Triad Hospitals out of Plano, Texas; and Community Health Systems out of Franklin, Tennessee (Anonymous 2007b).

Government Hospitals

Government hospitals are operated by state, local, and federal governments to meet specific missions. For example, some states and municipalities operate acute care and psychiatric hospitals for low-income patients. The U.S. Department of Defense, U.S. Department of Veterans Affairs, U.S. Public Health Service, and U.S. Department of Justice all operate hospitals. Government hospitals are funded through a process that does not depend on the healthcare market (Harrison, Coppola, and Wakefield 2004). Funding for the construction of government hospitals is exempt from many of the governmental regulations over the healthcare industry, including the National Health Planning and Resources Development Act of 1974 and Certificate of Need (CON) review (see Highlight 2.6).

Joint Ventures

Joint venture
a partnership formed between two organizations that draws on their combined resources to accomplish a specific purpose

In healthcare, a **joint venture** is a partnership formed between two or more provider organizations with different missions for purposes of accomplishing a unified mission that draws on their individual strengths. Through joint ventures, healthcare organizations can pool their resources (such as management expertise), attract new customers, adopt new technologies, spread costs and risks, and/or meet a community's need for new healthcare service. Joint ventures also provide opportunities for improved relationships between hospitals and physician groups (Harrison 2006). Instead of competing with each other, hospitals and physician groups can combine their resources to produce mutually beneficial outcomes. Additionally, a joint venture may streamline the patient care experience. For example, say Physician Group A operates independently of Hospital B. A patient of Physician Group A has a need that Physician Group A can't fulfill. Hospital B, however, has the resources to fulfill that need, so Physician Group A refers the patient to Hospital B. Physician Group A's record-keeping system is different from that of Hospital B, so the transfer of information between hospitals is unlikely to be smooth. Further, Physician Group A will not profit from referring a patient elsewhere. If Hospital B and Physician Group A formed a joint venture, they could adopt a mutual record-keeping system, allowing for seamless transfer of patient information. Further, Physician Group A would not have to direct its business elsewhere. As a partner with Hospital B, it, too, would profit from the services performed by Hospital B.

Joint ventures are located in communities that have more elderly patients, lower unemployment, and fewer HMOs than average. They also offer more clinical services and have a higher patient occupancy rate, a higher average patient length of stay, lower

HIGHLIGHT 2.6 Two Regulations: National Health Planning and Resources Development Act of 1974 and Certificate of Need (CON) Review

These two regulations were created in response to the rising costs of the U.S. health services system and the inequity of access to healthcare across the nation. Before these regulations, healthcare providers would be reimbursed (by Medicare and other insurers) even for inefficient or failed care, so they had few incentives to keep costs down. Some areas of the country had too many hospitals and healthcare options, which resulted in duplicate costs (money would be spent building and maintaining a hospital when there already was a facility a few blocks away) and uncoordinated care. Other areas (often rural areas) had no options for reasonably priced healthcare.

The first of these regulations, the National Health Planning and Resources Development Act, was passed in 1974 to enforce more careful planning of health services. Among other things, the National Health Planning and Resources Development Act created regional health services agencies and assigned them the responsibility of collecting data so they could identify the needs and deficiencies in the area, develop long-range plans to correct the deficiencies, and provide technical and financial assistance to implement the plans.

Certificate of Need (CON) regulations, which require health services planners to obtain approval from state or federal government to build a new healthcare facility, were implemented to give a structure to the National Health Planning and Resources Development Act. Initially, all 50 states were required to develop a structure through which all new facility proposals had to pass to obtain approval. The CON requirements are aimed at reducing healthcare costs and controlling the building of new, potentially unnecessary facilities. The mandate was repealed in 1987; however, 36 states still have a CON program, and the remaining 14 states have some type of regulation over duplication of services (NCSL 2010).

long-term debt, and a greater number of managed care contracts. Most important, joint ventures can have a positive financial impact on U.S. hospitals; joint ventures provide an opportunity to implement new healthcare services in the local community while allowing the partners to combine their money, people, and facilities for the maximum benefit of all (Harrison 2006).

Vision
a short, inspiring statement of what a group intends to achieve in the future

Culture
a collection of values and norms shared by a group of individuals

Values
the social principles, goals, and standards of an organization

Specialty Hospitals

Not-for-profit hospitals, for-profit hospitals, and joint ventures are further broken down by specialty, which further affects their mission and, hence, strategic planning process. Exhibit 2.1 provides information on the types of specialty hospitals in the United States and the ownership of those hospitals.

Vision

An organization's **vision** is a short, inspiring statement of what it intends to achieve in the future. A vision statement should be broad and forward thinking and should specify goals it wishes to accomplish over time. A hospital's senior leadership team should create a vision that is meaningful to staff and describes the state of affairs to which the organization aspires.

Culture

Culture is a collection of **values** and norms shared by a group of people. Similarly, organizations have cultures composed of values, customs, and traditions that reflect their ethical beliefs. Senior leadership teams base their decisions on these tenets, and these decisions affect their organization's performance.

Exhibit 2.1
Breakdown of U.S. Hospitals by Specialty and Ownership

Total number of hospitals: 6,346

	Owner				
Specialty	County, city, state government	Not-for-profit	For-profit	Federal government	Total
General medical and surgical	1,132	2,762	732	205	4,831
Psychiatric	205	85	161	10	461
Obstetrics and gynecology	1	9	9	0	19
Eye, ear, nose, and throat	0	6	0	0	6
Rehabilitation	14	63	155	1	233
Orthopedic	0	5	18	0	23
Children's hospital	18	103	17	0	138
Other	68	135	424	8	635

Source: AHA (2005).

At the most basic level, society is composed of families who share genetic material and have developed similar values to cope with changes in their environment. Some species, such as *Tyrannosaurus rex*, have become extinct, and some societies, such as that of the Incas, have disappeared, suggesting that people, species, and societies must adapt to survive. Like people, organizations progress through a life cycle that includes birth, growth, maturation, and regeneration/renewal or death. Their culture and values dictate how they deal with change as they move through this cycle. In a dynamic, complex industry like healthcare, an organization's culture must support change if it is to successfully evolve over time.

Organizational culture shared beliefs among individuals in an organization

Organizational culture is an expression of shared beliefs among individuals in an organization. Culture is important because it ensures healthcare professionals are working toward common goals. The development of organizational policies and practices sets these goals in motion. Furthermore, organizational culture should give staff members the authority they need to do their jobs and hold them responsible for their actions. An empowering organizational culture is associated with improved team morale, enhanced healthcare quality, and higher levels of patient satisfaction (Hann et al. 2007).

Eric Williams, associate professor of healthcare management at Culverhouse College of Commerce and Business Administration at the University of Alabama, proposed that changing an organization's culture may improve patient safety (Williams et al. 2007). In particular, he and his colleagues found that a cultural emphasis on quality can play a key role in improved clinical outcomes. Healthcare organizations should provide a positive working environment for clinical providers because physicians and other clinicians who are stressed or dissatisfied with their jobs have a greater incidence of providing suboptimal patient care.

The development of core behaviors that support a common purpose is crucial to achieving improved quality and clinical outcomes (Pawar 2007). Organizational culture needs to focus on improving clinical processes rather than blame individuals for suboptimal care. When members of the healthcare team focus on the clinical process, they can clearly see their roles in it. When there is no confusion about roles, team members will communicate more effectively with each other. In addition, a focus on the clinical process instead of blame encourages the team to think from a position of curiosity and innovation rather than fear and anxiety.

Strategic Planning

Strategic planning is an ongoing process, not a onetime project, based on an organization's mission, vision, and values. In many healthcare organizations, this process begins with an off-site retreat during which the board of directors and senior leadership revisit the organization's mission, vision, and values to ensure they are still valid. The board retreat also serves as a forum in which senior leaders and other stakeholders build consensus on the action to be taken and clarify how they will contribute to and support the planning effort.

A hospital's mission, vision, and strategy must be in sync with the way it allocates its money. Healthcare organizations have limited financial resources, so a hospital's mission, vision, and strategy need to guide its investments. If an organization fails to link its strategic plan to its financial decisions, organizations may invest in inappropriate technology, equipment, or facilities and end up depleting their resources (Fine and Bacchetti 2004).

When organizations link their strategic plan to their spending behaviors, their investments benefit them over the long term. They may build new facilities, renovate existing facilities, or invest in appropriate new information technology. Historically, many financial decisions were driven solely by physician requests. Unfortunately, many of these decisions had a short-term impact rather than a long-term, lasting effect on their organizations' development.

When an organization's vision lines up with its strategic plan, it maximizes its return on investment (see Highlight 2.7). By balancing its mission and its need to maintain a competitive advantage, an organization can adjust its strategy to ensure that profitable business initiatives are able to fund unprofitable mission-based activities and to determine when to invest in new programs or close others. The vision, mission, and values statement of Piedmont Healthcare, a large not-for-profit health system in Atlanta, Georgia, is shown in Exhibit 2.2.

HIGHLIGHT 2.7 Return on Investment

Return on investment (ROI) is the financial return you expect to receive from an investment. There is a simple formula to express it: net profit (money gained minus money invested) divided by money invested. The solution to the formula is expressed as a percentage:

ROI = (Money gained from investment – Money invested) ÷ Money invested.

A positive result indicates a positive return on your investment; a negative result indicates a loss. For example, if you buy 5 lottery tickets at $1.00 each, and win $15, the formula would be: ROI = ($15 – $5) ÷ $5, or 2 (200%). You have a positive return on investment. If, however, you win only $3, the formula would be: ROI = ($3 – $5) ÷ $5, or –0.4 (–40%). The ROI is negative—you've lost money.

An organization's mission, vision, and values should be guideposts in assessing organizational performance, and compliance with the organization's values should be a factor in annual employee performance evaluations. In support of the values, the organization should have annual goals and objectives, and part of the performance measurement process should be based on the organization's progress toward their fulfillment.

According to the American Hospital Association (2006; see Highlight 2.8), an organization's mission and vision should describe its commitment to the community. They should be documented and shared with leadership, physicians, and staff, as well as with patients and their families. Organizational leaders should meet regularly with community partners to assess the delivery of healthcare in the community and, on the basis of their evaluation, plan initiatives to improve the community's health status.

Finally, an organization's mission in healthcare must include a commitment to quality and patient safety. The concept of **servant leadership** is crucial to this commitment. In a culture that embraces servant leadership, relationships are based on communication and listening. Leaders serve as mentors and teachers to ensure that their staff members become wiser and more autonomous. At the same time, these leaders are followers in that they continually learn from individuals in the organization. Servant leadership creates a culture in which employees are considered partners in the organization's mission, not a disposable resource (Yanofchick 2007).

Servant leadership
a culture in which employees become partners in fulfilling the organization's mission

EXHIBIT 2.2
Sample Vision, Mission, and Values

Vision
Piedmont Healthcare, a growing community of excellence dedicated to providing you the best patient care and services

Mission
Healthcare marked by compassion and sustainable excellence in a progressive environment, guided by physicians, delivered by exceptional professionals, and inspired by the communities we serve

Values

- Compassion: Caring for every person every day with dignity and respect
- Commitment: Dedicating ourselves to improving the lives of others
- Service: Providing a safe and supportive environment to ask, learn, and heal
- Excellence: Leading in quality through expertise, innovation, and technology
- Balance: Using resources efficiently and effectively

HIGHLIGHT 2.8 American Hospital Association

The American Hospital Association (AHA) is a national association for hospitals and healthcare networks. Healthcare organizations as well as individuals can become members of AHA. The main functions of AHA include the following:

1. Advocacy—AHA represents and lobbies for the concerns of healthcare facilities in Washington, DC, whenever an issue comes up in Congress or the Senate that will affect hospitals.
2. Research: AHA researches healthcare trends and publishes its findings in many newsletters and periodicals.
3. Information: AHA provides information about healthcare to providers and the public.

Within AHA are 11 membership groups for specialists in different aspects of healthcare administration, including affiliated societies for human resources professionals in healthcare and healthcare marketers.

The Impact of Ownership on Profits and the Strategic Planning Process

Reduced operating margins affect a healthcare organization's ability to raise capital for replacement facilities, adopt new medical technology, and participate in joint ventures. As healthcare reimbursements decline and the requirement for costly healthcare technology grows, many healthcare organizations, driven by financial need, are using the strategic planning process to explore merger or acquisition, which could lead to a change in ownership status.

Research shows that healthcare organizations are improving efficiency and quality through consolidation and integration of services. Although health systems in the United States continue to acquire hospitals, not-for-profit health systems have reduced their acquisitions over the past five years. As a result, for-profit health systems acquired 76 percent of all hospitals purchased in 2005—a significant increase over previous years. The largest acquisition of a not-for-profit healthcare organization to date took place in 2003, with HCA, Inc.'s purchase of Health Midwest in Kansas City, Missouri, for $1.13 billion (Galloro 2006a).

Not-for-Profit Strategy

Not-for-profit healthcare systems are experiencing improved operating margins, but a gap is growing between the haves and have-nots as a result of increased costs, greater market competition, and the increasing number of people without health insurance.

Dr. Dennis McDermott, emeritus associate professor of marketing at the Virginia Commonwealth University School of Business, found that the amount of money not-for-profit hospitals spent on charity care was greater than the amount they received in tax benefits. (To ensure that they meet their charity obligations, the Internal Revenue Service audits not-for-profit hospitals' levels of charity care.) He also found that the sum of money for-profit hospitals spent on community contributions and taxes combined exceeded not-for-profit hospitals' spending on charity care by a small amount. He believes that high-cost hospital treatment for low-income patients should be shifted to lower-cost delivery systems (McDermott 2007).

Supporting McDermott's idea, Cinda Becker, former bureau chief of *Modern Healthcare* magazine's New York office, believes that, to improve healthcare quality, not-for-profit healthcare organizations should adopt organizational structures and practices normally associated with for-profit organizations, including greater use of information technology (Becker 2007). A case could also be made that not-for-profit hospitals need to improve their financial performance because they do not participate in the stock market (Anonymous 2002). Not-for-profit hospital executives are challenged to link their strategic planning to the current environment to ensure the survival of the organization and, at the same time, ensure that the hospital fulfills its mission (Harrison and Sexton 2004).

For-Profit Strategy

While significantly smaller than the not-for-profit hospital sector, the for-profit hospital industry is rapidly growing in size and market penetration. A focus on new clinical services and an increasing presence in developing communities have prompted this growth. Additionally, many for-profit hospitals are evaluating closing duplicate, unprofitable clinical services as part of the strategic planning process.

Government Hospital Strategy

While most government hospitals provide care to a predetermined population, they still need to participate in strategic planning to meet the changing needs of their patients and foster an organizational culture that supports change. For example, the Veterans Administration operates 153 medical centers and numerous clinics that provide comprehensive care to 5.5 million veterans annually. Recognizing that the Sunbelt states are experiencing a growing veteran and retired military population, the Veterans Health Administration has

redistributed its resources and is funding major construction projects in Florida, California, Texas, North Carolina, South Carolina, and Arizona (U.S. Department of Veterans Affairs 2009).

Research has shown that federal hospitals have become more efficient in providing both inpatient and outpatient services. In some communities, however, demand for inpatient services has decreased as a result of the aforementioned migration of the veteran population to the Sunbelt. Consequently, occupancy levels have decreased in the federal hospitals located in these communities (Harrison, Coppola, and Wakefield 2004). This development has made these facilities potential targets for closure. To prevent closure, the federal hospital system should explore ways these hospitals could use their excess hospital beds and resources. For example, the services the federal government purchases from local markets, such as skilled nursing care and ambulatory care, could be provided by these facilities instead (Harrison, Coppola, and Wakefield 2004).

Joint Venture Strategy

The number of freestanding (i.e., independent) hospitals is decreasing as more and more hospitals join multi-hospital systems (McCue and Diana 2007). Many not-for-profit healthcare organizations are only marginally profitable, and their aging facilities need major renovations. As a result, they are considering joint ventures with for-profit companies as a method of acquiring additional financial resources.

From the perspective of a for-profit company, a joint venture with a not-for-profit organization is advantageous because (1) a not-for-profit organization is less expensive to purchase than another for-profit company, (2) the for-profit company can gain increased market share (in other words, the not-for-profit organization's customers will likely become customers of the new joint venture), and (3) the community will look favorably on the for-profit organization for partnering with a not-for-profit organization. From the perspective of a not-for-profit organization, a joint venture with a for-profit organization is advantageous because (1) together, they have a greater pool of resources (financial and other) and (2) the not-for-profit organization will not have to give up all its power and will continue to have a say in operational decisions. At the health system level, joint ventures are one way a corporation can extend its network and gain resources. A lesser-known organization also can achieve instant recognition by joining with an organization whose products and services carry a trusted, well-known brand name (Galloro 2006b).

In response to a rapidly changing healthcare environment, joint ventures are an opportunity for hospitals, physicians, and other healthcare organizations to work together to meet community healthcare needs. Faced with rising costs, decreasing reimbursement from insurers, and global competition, hospitals and physicians may use joint ventures to combine clinical and financial resources, claim a greater share of the market, and gain a better strategic position. To remain in a position of competitive advantage, organizations

that pursue joint ventures must create a culture of trust between hospitals and physicians. In most cases, such a relationship requires a change of culture to see a joint venture as an opportunity rather than a threat. Physicians may view joint ventures as a threat because joint ventures often require them to give up their autonomy (e.g., the joint venture requires the physician to refer patients only to the joint venture, whereas before the partnership was formed, the physician could refer patients to a number of different hospitals with which he was affiliated). Despite that joint ventures promise to benefit both partners profitwise in the long run, some hospitals initially view joint ventures as a threat because joint ventures require them to share profits that they previously collected for themselves only.

One goal of physician–hospital joint ventures should be to increase the value of healthcare services to patients while providing a win-win situation for the hospital and physicians. When planning a joint venture, the two parties need to share information, develop a shared vision, and focus on improving efficiency in the healthcare process. As a result, the joint venture will foster a sense of shared ownership (Cohn, Friedman, and Allyn 2007).

Implementing Organizational Change

The survival strategies discussed thus far require comprehensive organizational change. For change to occur smoothly and result in successful outcomes, everyone in the community needs to be involved in the strategic planning process, including the community's leaders, the organization's leaders and staff, and the organization's patients. The organization must share its mission, vision, and values with the community and encourage all stakeholders to develop alliances. Such an approach strengthens the organization's links with the external environment. Organizations whose culture emphasizes alliances, ongoing evaluation of change, wide participation from all stakeholders, and creativity are more likely to achieve successful outcomes. As will be discussed in Chapter 3, a transformational leadership approach that fosters a high level of staff involvement encourages innovation as part of the change process (Viens et al. 2005).

Summary

The healthcare industry in the United States is experiencing a growing shortage of financial resources. An inability to adapt to this changing environment has forced many hospitals into bankruptcy, closure, merger with one or more hospitals, or acquisition by another company.

To survive, many healthcare organizations are using strategic planning to position themselves for future success. Strategic planning is an ongoing process, not a onetime project, based on an organization's mission, vision, and values. These statements help organizations

focus their investments and allocate their resources and provide the foundation for implementing appropriate change.

An organization's mission, vision, and values are shaped by its ownership status. Organizations may be not-for-profit, for-profit, government-operated, or joint ventures. Differences in mission reflect different motivations and goals, and these differences influence the type of strategic plan an organization develops.

Top organizations focus on their mission, monitor performance, participate in continuous quality improvement, and maintain relationships with patients, physicians, staff, and community stakeholders. Such organizations provide higher-quality care, have lower costs, are more profitable, and report higher rates of employee satisfaction.

Review Questions

1. Adequate reimbursement levels are an important consideration in the strategic planning process. Discuss the recent trends in HMO and PPO development and the impact they have on strategic planning.

2. An organization's mission is the fundamental purpose of its existence. Discuss the types of hospital ownership in the United States and how they may influence an organization's strategic plan.

3. *Culture* is a collection of values shared by a group of people. Discuss important attributes of organizational culture in the healthcare industry.

Coastal Medical Center Case: Exercise 2

According to Chapter 2 and the Coastal Medical Center case, how effective has the Center's board of directors and senior leadership team been in developing a clear mission and vision?

Exercises

1. Write clear and concise mission and vision statements for Coastal Medical Center.

2. Develop some written organizational goals and objectives for Coastal Medical Center that support the mission and vision.

3. Develop a performance measurement process that Coastal Medical Center could use to evaluate its progress toward fulfilling its goals and objectives.

CHAPTER 3

TRANSFORMATIONAL LEADERSHIP MAXIMIZES STRATEGIC PLANNING

Suzanne Wood, M. Nicholas Coppola, and Robin Satterwhite

The most successful leader of all is one who sees another picture not yet actualized. He sees the things which belong in his present picture but which are not yet there.... Above all, he should make his coworkers see that it is not his purpose which is to be achieved, but a common purpose, born of the desires and the activities of the group.

—Mary Parker Follett

Key Terms and Concepts

- Charisma
- Code of ethics
- Demographics
- Ethics
- External rewards
- Groupthink
- Institutionalism
- Internal rewards
- Morale
- Process changes
- Situational leadership
- Social exchange theory
- Structural changes
- Transactional leadership
- Transformational leadership
- Western leadership

Western leadership
a traditional model of leadership that emphasizes separation between leader and follower and leader command of the follower group

Situational leadership
model of leadership based on the idea that the most effective leadership style to use depends on the case or issue in question

Transactional leadership
model of leadership that emphasizes giving rewards for good performance or taking corrective action for poor performance and that followers are motivated only by this expectation of reward or threat of punishment

Transformational leadership
model of leadership that emphasizes a common purpose among group members, putting the self aside to work for the good of all involved, and motivating one another to maximize individual and group potential

Introduction

M. Nicholas Coppola, program director and associate professor of clinical practice management in the School of Allied Health Sciences at Texas Tech University, has suggested that there are as many definitions of leadership as there are researchers studying it (Coppola 2004). New definitions of leadership are introduced in the literature every year. Keith Thurgood, commanding general and CEO of Army & Air Force Exchange Service, has noted that leadership is not based on any one experience, theory, or historical study (Thurgood 2009). It is a quality that develops out of the integration of many factors. The education and development of a leader requires a broad perspective that emphasizes leadership as both an art and a science.

The definitions and cultural interpretations of leadership are constantly changing. A century ago, Theodore Roosevelt said that "the best executive is the one who has sense enough to pick good men to do what he wants done, and the self-restraint to keep from meddling with them while they do it" (Maxwell 1998). When the famed American Indian and cavalry fighter Geronimo was asked to describe what made him a good leader, he replied, "the ability to ride a strong horse." Anthropology, archeology, social anthropology, political science, business, communication, health administration, and other disciplines have all contributed to the foundations of leadership theory and practice. There are traditional models of **Western leadership**; Asian styles of leadership; and **situational, transactional,** and **transformational models of leadership**, among others (see Highlight 3.1).

HIGHLIGHT 3.1 Different Models of Leadership

The concept of leadership is given tremendous consideration in executive training programs, yet is often misunderstood. This misunderstanding stems from the different assumptions on which different models of leadership are based. Furthermore, the application of leadership in corporate settings is often limited to behavior modification techniques and employee evaluation practices, and organizations tend to rely too much on external rewards (e.g., financial compensation) to motivate their employees.

Many studies of great leaders have centered on U.S.-based (also called *Western*) models, which traditionally emphasized dualism—in other words, either/or thinking. A person is either a leader or a follower, not both. Leaders command and direct others, make decisions, run meetings, and make sure things get done (Omatsu 2003).

The *situational leadership* model contends that different scenarios demand different leadership styles. Leaders must adapt their leadership style as required by their followers' needs; some situations may call for a directive approach, while in others, a supportive approach might

(*continued*)

HIGHLIGHT 3.1 Different Models of Leadership

(*continued*)

be more effective (Northouse 2001). The approach the leader takes depends on the task that needs to be accomplished and the leader's assessment of the competence and commitment of the employee assigned to that task.

The *transactional leadership model* emphasizes rewarding employees for successful completion of a task, as well as corrective action for performance that does not meet expectations. It assumes that employees are motivated by self-interest, namely the promise of a reward and the threat of punishment (ChangingMinds.org 2009).

The *transformational leadership model* places importance on a shared vision; motivating others to become the best they can be; and collective, values-based rewards. This chapter focuses and elaborates on this model as the approach most suitable for leaders in healthcare.

Some leadership styles are more effective in an environment experiencing high rates of change. As discussed in Chapter 2, healthcare is a dynamic industry. Faced with rapidly changing technology and **demographics**, and under pressure to improve clinical care, healthcare organizations need leaders capable of motivating employees, managing change, and unifying everyone in the organization through a common cause. For these reasons, the fluid model of transformational leadership is best suited for the healthcare environment. This chapter provides an overview of this complex and exciting topic.

Demographics
the characteristics of populations, expressed in statistical terms

Social exchange theory
the idea that exchanges between two people occur or do not occur depending on the rewards or benefits each party expects to gain for himself/herself

The Concept of Transformational Leadership

The transformational leadership model was introduced by James MacGregor Burns in 1978. Burns described transformational leadership as a process in which leaders and followers (e.g., employees, volunteers) raise one another to higher levels of motivation. Transformational leadership also incorporates principles of **social exchange theory**, which states that individuals engage in social interactions with the expectation that they will give and receive a benefit or reward.

The transformational leadership model uses transactions and interpersonal relationships to bring about change in a political, social, or economic environment experiencing a crisis requiring radical reform (Northouse 2001). John Paul Jones,

EXHIBIT 3.1
The Effect of Transformational Leadership on Followers

Bernard Bass, founding director of the Center for Leadership Studies at Binghamton University, built on Burns' work and proposed a theory of transformational leadership that is measured in terms of the leader's effect on followers. He attested that followers of a transformational leader (Bass 1985)

- trust the leader (they know that the leader has their best interests at heart),
- admire the leader (they see the leader's capabilities as standards for their own professional development),
- are loyal to the leader (they see the leader as a "parent" and a member of the "family" unit), and
- respect the leader (they recognize the leader as holder of a legitimate office, achieved through credentials and experience).

Transformational leaders motivate their followers to do more than expected by making followers more aware of the importance of the outcomes of the tasks they complete and inducing them to put their self-interest aside for the sake of the team. In healthcare, transformational leaders create an environment in which individuals provide their best efforts because they believe in the mission of the organization and recognize the value of their contribution to improved patient care.

EXHIBIT 3.2
Skills and Traits of Transformational Leaders

Bernard Bass's theory of transformational leadership stated that transformational leaders use the following behaviors to motivate their followers:

- **Charisma:** Transformational leaders exert influence by provoking strong emotions and loyalty in their followers.
- **Intellectual stimulation**: Transformational leaders increase their followers' awareness of problems and get them to view the issues from a new perspective.
- **Individual consideration**: Transformational leaders support and encourage their followers and provide them with developmental opportunities.
- **Inspirational motivation**: Transformational leaders communicate an appealing vision using symbols to focus their followers' efforts and model appropriate behavior.

Personality characteristics of transformational leaders include intelligence, self-confidence, a positive self-image, excellent communication skills, and the ability to empathize with followers (Nahavandi 2002). Research also suggests that transformational leaders have a need for power, a strong moral conviction, and elevated energy levels, all directed toward goal attainment.

Eleanor Roosevelt, Winston Churchill, Dr. Martin Luther King, Jr., Paul "Bear" Bryant, Tecumseh, and Lee Iacocca could all be considered leaders who used a transformational approach to prompt dramatic change. Transformational leaders focus on linking their goals and values with their followers by developing a common cause (Sullivan and Decker 2000). When they do so successfully, they become motivators, facilitators, educators, and visionaries. Their followers develop a high degree of confidence in their direction and a sense of loyalty toward them. As discussed in Chapter 2, the organization's vision should be widely accepted throughout the organization and be congruent with the leader's vision. Followers often internalize the leader's values and moral convictions, which results in a perceived need for change. As a result, they are motivated to pursue goals that are higher than those that could be accomplished individually (Yukl 2001). See Exhibit 3.1.

Leadership is demonstrated when leaders use their human resources (e.g., employees, volunteers) to meet their goals in a way that simultaneously satisfies the ambitions of those employees/volunteers (Burns 1978). For example, say the leader of a radiology department needs to hire an intern on a temporary basis to complete miscellaneous tasks that the department's staff cannot handle under its current workload. Radiology students apply for the position because they wish to gain experience in the radiology field. When the leader hires the intern and the intern completes the miscellaneous tasks, the leader and department get done what they need to get done and the intern gains the experience he or she was seeking.

However, motivation differs among individuals and may stem from external or internal sources, which are often related to situational or organizational factors, values, and ideals. For example, the transactional model of leadership (see Highlight 3.1) assumes that leaders and followers are motivated by **external rewards** and that they strive to maximize their own individual gains (e.g., the leader wants to make money for himself/herself; each follower wants to earn money for himself/herself). Conversely, transformational leaders tend to focus on values and **internal rewards**—for example, the leaders' and followers' reward is a feeling of accomplishment or a sense of belonging to a community. Common internal motivation techniques include the use of personal **charisma**, individual attention to the follower, intellectual stimulation through assignment of tasks, and emotional appeal (see Exhibit 3.2).

External rewards
incentives outside an individual that motivate him or her to perform, such as money, gifts, or threat of punishment for nonperformance

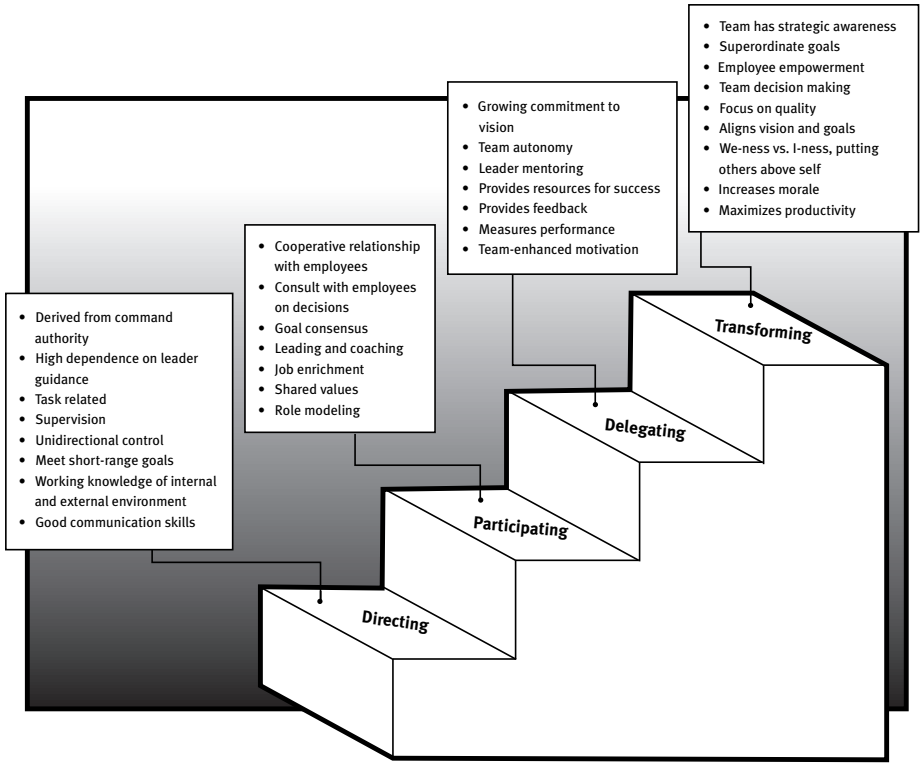
Internal rewards
feelings that arise out of performing an activity that motivate an individual to perform, such as the enjoyment that comes from creating a work of art or playing a sport

Charisma
leadership charm that provokes strong emotions and loyalty in followers

Exhibit 3.3 depicts a hierachy of leadership components, with a directive style at the bottom and transformative style at the top.

As noted in Exhibit 3.3, leadership could be considered a hierarchy. At the bottom of the hierarchy is the *directing leadership* style. Leaders who take a directive approach use authoritative command to communicate with and motivate their subordinates. The second level of the hierarchy is the *participating leadership* style. Leaders who take a participatory approach coach their subordinates and serve as role models. The next level up is the *delegating leadership* style. This leadership style affords subordinates some independence and self-direction, and teams exchange activities for the purpose of improving performance. At

EXHIBIT 3.3
The Transformational Leadership Model



Morale
positive emotions and sense of common purpose among members of a group

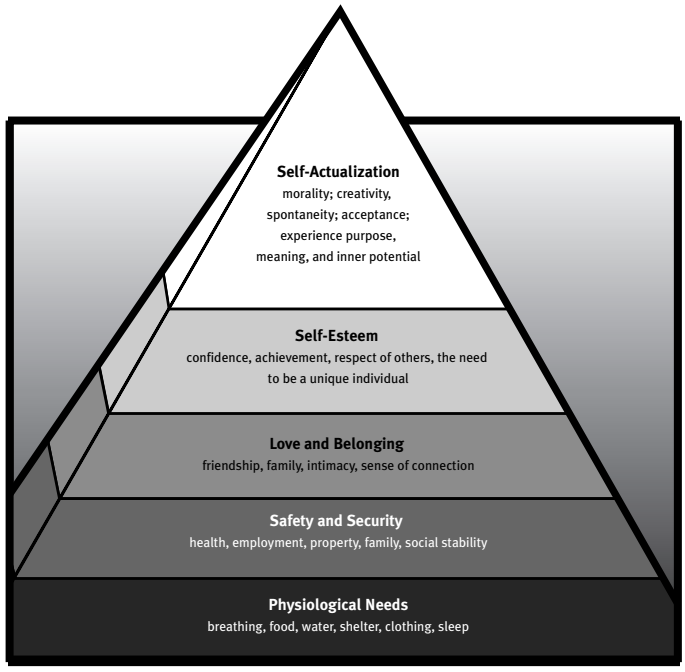
the top of the hierarchy is the *transformational leadership* style, which empowers the group and heightens subordinates' awareness of the organization's vision, mission, values, and goals and the role of these factors in the organization's strategy. Higher strategic awareness can lead to increased **morale** and greater productivity.

Transformational leadership originates from Maslow's hierarchy of needs (see Highlight 3.2), incorporating esteem, autonomy, and self-actualization. Specifically, transformational leaders are believed to motivate followers in three ways. First, transformational leaders motivate their followers by making them more aware of the importance of the outcomes of the tasks they complete (esteem) and empowering them to promote change (autonomy). Second, transformational leaders encourage their followers to think and act beyond their self-interest to meet organizational goals. Third, transformational leaders foster an environment of team decision making in which individuals work together to improve organizational performance (Bass 1985; Burns 1978).

The transformational leadership approach is considered highly effective in situations—whether they be organizational, political, economic, or social—in which followers

HIGHLIGHT 3.2 Maslow's Hierarchy of Needs

In his 1943 paper "A Theory of Human Motivation," American psychologist Abraham Maslow proposed a hierarchy of human needs. At the bottom of this hierarchy are basic human needs (e.g., food, clothing) and at the top, higher needs relating to one's identity and purpose in life, such as fulfillment of creative potential. Maslow proposed that a human being is unable to concern himself with higher-level needs until he has satisfied his lower-level needs. For example, as illustrated in the following chart, humans cannot focus on social stability (level 2) until they have a consistent source of food, lodging, and so forth (level 1).



are frustrated, stressed, or unhappy with the current state of affairs (Howell and Costley 2000). It is also effective in crisis situations. If an individual is able to emerge from the group to represent its desires and needs in such situations, that individual is likely to become a leader. From this position of authority, the leader is able to influence the course and direction of events to bring about change, often with revolutionary results (Nahavandi

2002). Leaders such as Genghis Khan, Cyrus the Great of Persia, Gandhi, and the Roman Emperor Constantine I are examples of individuals who stepped up in this manner and won the hearts and minds of followers and radically changed the world.

Why Is Transformational Leadership Important to Study?

Transformational leadership is important to an executive's success and a critical resource in an organization's ongoing strategic planning process. No well-known leader of our time has become successful or has led an organization to success without first understanding the principles of leadership—particularly transformational leadership.

To thrive in the highly dynamic field of healthcare, organizations must engage in careful strategic planning. To maximize the success of their strategic plans, organizations need to tap their greatest resource—their people. Transformational leadership leverages this resource by motivating individuals in the organization to adopt goal-oriented behavior that supports the organization's mission and vision.

Does Today's Multinational Workforce Challenge the Effectiveness of Transformational Leadership?

Many studies of great leaders have centered on U.S.- or Western-based models (see Highlight 3.1). In today's global community, however, greater focus is being placed on international applications of leadership. This globalism has forced the study of leadership to look outside traditional boundaries for better ways to train, teach, and evaluate leaders.

All healthcare executives lead people and manage resources. Leaders need to understand that their human resources are composed of people with vastly different education, training, and experience. While leadership vision is a universal attribute of the transformational style, the manner in which it is expressed and communicated varies greatly across cultural boundaries. Therefore, culturally specific transformational styles may be needed to appropriately address the values and societal norms that exist within different cultures (Martinez and Dorfman 1998; Den Hartog et al. 1999; Nahavandi 2002).

Many researchers believe that some aspects of transformational leadership appear to apply to most contexts; however, transformational leadership is not equally effective in all situations (Yukl 2001). The culture of the follower may determine his or her openness to a particular leader. As a result, activities and behaviors developed in one society may need to be altered in order to be effective in another. For example, American society recognizes leadership regardless of age, race, or gender and judges leaders on their own merits. However, Asian and Middle Eastern societies place heavy emphasis on age and gender as precursors to leader recognition.

Ethics as a Foundation for Leadership and Strategic Planning

Although a comprehensive discussion of **ethics** is beyond the scope of this book, it is important to note that ethics is central to leadership and strategic planning and crucial to engaging followers to accomplish mutual goals consistent with the organization's values (Northouse 2001). An organization's failure to uphold business ethics often leads to a disastrous future (or, in some cases, no future at all). Episodes of corporate misdoing, such as the Enron and the Bernie Madoff scandals, highlight the importance of corporate ethics. In the healthcare arena, examples of corporate ethical problems include HealthSouth's 2003 accounting scandal and Pfizer Pharmaceuticals' 2009 case involving off-label promotion of drugs (SEC 2003; O'Reilly and Capaccio 2009).

Ethics
moral duty, values, and obligation

Ethical Considerations of the Healthcare Leader

Transformational leaders must be careful to focus on the societal culture in which they are functioning. There are many ethical models, and the ethical model upheld by one culture may differ from the one upheld in another. For example, perspectives on healthcare issues such as access to care, abortion, genetic engineering, and euthanasia vary from organization to organization (Iannone 2001).

In an attempt to regulate corporate ethical behavior, the federal government and other organizations have enacted laws and established principles of ethical conduct. In 2002, Congress passed the Sarbanes–Oxley Act in reaction to a number of major fraud cases involving large U.S. corporations. In healthcare in particular, numerous organizations have established their own codes of ethics. For example, as part of its credentialing process, the American College of Healthcare Executives (ACHE) requires that healthcare executives maintain the highest level of ethical behavior. The preamble to ACHE's ***Code of Ethics***, which provides standards of conduct and ethical behavior for healthcare executives, appears in Exhibit 3.4.

Code of ethics
a guide to professional conduct and decision making

Following the preamble, the ACHE *Code of Ethics* provides healthcare executives with specific guidance on professional conduct and addresses the importance of honesty, integrity, respect, and fairness. The *Code of Ethics* goes on to delineate the healthcare executive's responsibilities to patients, the organization, employees, and the community. As is common among professional codes of ethics, it also provides clear guidance on a healthcare executive's responsibility to report violations of the *Code of Ethics* (ACHE 2009).

The Role of Transformational Leaders in Managing the Strategic Planning Process

Current initiatives in healthcare reform show that the healthcare industry is subject to rapid change. In such an environment, transformational leaders draw on the expertise of their staffs to maximize the success of the strategic planning process and chart the organization's course

EXHIBIT 3.4
American College of Healthcare Executives *Code of Ethics*

Preamble

The purpose of the *Code of Ethics* of the American College of Healthcare Executives is to serve as a standard of conduct for affiliates. It contains standards of ethical behavior for healthcare executives in their professional relationships. These relationships include colleagues, patients or others served; members of the healthcare executive's organization and other organizations; the community; and society as a whole.

The *Code of Ethics* also incorporates standards of ethical behavior governing individual behavior, particularly when that conduct directly relates to the role and identity of the healthcare executive.

The fundamental objectives of the healthcare management profession are to maintain or enhance the overall quality of life, dignity and well-being of every individual needing healthcare service and to create a more equitable, accessible, effective and efficient healthcare system.

Healthcare executives have an obligation to act in ways that will merit the trust, confidence and respect of healthcare professionals and the general public. Therefore, healthcare executives should lead lives that embody an exemplary system of values and ethics.

In fulfilling their commitments and obligations to patients or others served, healthcare executives function as moral advocates and models. Since every management decision affects the health and well-being of both individuals and communities, healthcare executives must carefully evaluate the possible outcomes of their decisions. In organizations that deliver healthcare services, they must work to safeguard and foster the rights, interests and prerogatives of patients or others served.

The role of moral advocate requires that healthcare executives take actions necessary to promote such rights, interests and prerogatives.

Being a model means that decisions and actions will reflect personal integrity and ethical leadership that others will seek to emulate.

Source: ACHE (2009).

through difficult periods. Transformational leaders understand that their staff members are most knowledgeable about the factors often overlooked in strategic planning and that the entire team's support is necessary to operationalize the strategic plan. Such operational support is essential to the success of new business initiatives and the long-term well-being of the organization.

To manage organizations most effectively, transformational leaders must do three things (Herb and Price 2001):

1. They must communicate values and goals in a way that everyone in the organization will understand.

2. They must focus on interaction to unify the people working in the organization.
3. They must be able to rejuvenate the organization on a continuous basis to adapt to a highly complex and dynamic environment.

These three requirements are similar to the four critical strategies that Warren Bennis, a pioneer in the field of leadership studies, presented in 1985 (Thurgood 2009):

1. A leader must create attention through vision (i.e., create focus).
2. A leader must create meaning through communication (i.e., create a vision that fosters enthusiasm in his followers).
3. A leader must demonstrate that he is someone who can be trusted.
4. A leader must develop positive self-regard and self-respect and continuously improve his skills.

In general terms, a leader must establish close relationships based on trust, explicit communication, and shared values with the members of the organization (Kumle and Kelly 2000). This task is extremely difficult and requires a great deal of leadership talent.

Defining the goals of the organization is a key component of strategic planning. Organizational goals must meet three basic conditions with regard to organizational standards:

1. The goals must be consistent with and directly related to the standards of the organization.
2. The goals must have specific information that explains their relation to institutional standards.
3. The goals must specify actions that will be taken to meet the standards of the institution.

Goals must be clearly measurable, ensure accountability, and be attainable. For any organization, clear and measurable goals are the primary prerequisite to achieving success. An organization's staff must not only understand the goals of its leaders and institution but also embrace them as fundamental principles supporting change in the organization (O'Neill 2000). Successful transformation of any organization depends on its leaders' ability to articulate these goals and get everyone in the organization motivated to achieve them.

Transformational leaders need to maintain a delicate balance between using and relaxing their direction and authority. Leaders cannot (and should not) do and be all things. The energies and talents of the different members of the organization all contribute to the transformation effort. One of the critical activities of the transformational leader is developing a leadership team—the topic of the following section.

Establishing the Leadership Team

The first step in developing a leadership team is to identify employees who think, act, and respond in a manner that supports the organization's goals. It is important to develop a team with attitudes and ideals that will propel the team into a synergistic and more functional leadership group.

Groupthink
a concept introduced in 1972 by social psychologist Irving Janis that refers to a mentality that develops in groups as a result of deterioration of "mental efficiency, reality testing, and moral judgment" caused by pressures among group members (Janis 1972)

While leaders want to include high-performing employees on the team, intelligent, driven individuals can be difficult to manage (Walls 2002). Because of their individuality, however, nontraditional thinkers may prevent **groupthink** from developing among team members. Effective transformational leaders are able to manage a highly skilled and diverse group of individuals in a manner that is most effective for the organization and keep it focused on results.

Transformational leaders inspire followers to adopt the values and missions of the organization and boost teams to maximum levels of performance (Kirby, Paradise, and King 1992). They do so by communicating a belief in teamwork, by using an exceptional level of charisma, by stimulating team members' intellects, and by considering the individual (Nur 1998). Transformational leaders are able to manage a team by striking a balance between leading the team themselves and transforming their followers into leaders. The relationship between team members and the transformational leader alters the environment of the organization instead of forcing it to conform to environmental demands.

Transformational leaders naturally emerge as the most effective team leaders in any organizational setting. They understand that they must remain open to the input and direction of their team members and are most adept at promoting effective interaction among them. Through delegation and empowerment, the transformational leader allows others to embrace the direction and operations of the organization.

Organization Transformation as a Competitive Advantage

The healthcare literature is full of examples of organizations that have successfully leveraged their knowledge, processes, and resources to gain competitive advantage in the marketplace. Kaiser Permanente, Mayo Clinic, Cleveland Clinic, Intermountain Healthcare, and Piedmont Healthcare are just a few organizations fitting this description. One common characteristic of these organizations is their transformational leaders' ability to gain employee support of their mission, vision, values, and goals.

For any organization to survive, the organizational entity must adopt the personality characteristics of the transformational leaders who guide it. All organizations eventually do so if they are managed appropriately. For example, when we think of IBM, white shirts and black ties typically come to mind. When we think of Microsoft, more relaxed images of unbuttoned collars usually come to mind. These formal and informal dress codes indicate that the leaders of these companies have translated their vision into a corporate culture that is visually recognizable by outside stakeholders.

Various U.S. presidents have had a national impact on organizational values. For example, the Kennedy presidency is often characterized as inspiring the Civil Rights movement and a manifest destiny toward space. There is a story that Kennedy, during a visit to a NASA site, asked a janitor to describe his job, and that the janitor replied, "I am helping to put a man on the moon" (Ipsos 2009). President Kennedy was successful in transforming the perceptions of the janitor to view his job not only as a task but as one part of a greater, shared vision of space exploration.

Although both were transformational leaders, Reagan and Kennedy developed different transformational leadership styles. Reagan's transformational style incorporated a network of ardent supporters who helped communicate a consistent message over time. Reagan was so successful in establishing a transformational vision that rejected any dissention toward traditional family-based values that many Americans embrace Reagan-based principles to this day. In contrast, Kennedy was able to emotionally stir individuals from grassroots America to form networks of like-minded populations that all embraced a similar agenda. He broke down barriers of race, gender, and socioeconomic status and made people feel as though they were being personally addressed. This personal approach to transformational leadership was effective; however, some believe Kennedy's message and legacy have failed to maintain the same legitimacy over time as the Reagan transformational approach has.

President Bill Clinton also engaged the American public with a strong message that healthcare is an inalienable right for all citizens and not an entitlement for those who can pay for it. Before the Clinton administration, healthcare was largely viewed as an individual responsibility. President Clinton transformed the nation's views associated with healthcare and made transforming the healthcare system a national priority in the minds of Americans. Clinton was successful by appealing to a value natural in most people—that providing care for children, the infirm, and the elderly was the "right thing to do."

All three of these presidents had an ability to sway populations of individuals toward a shared vision; however, each employed different transformational techniques and skills to communicate his message. Their success in advancing agendas, swaying populations, and reorienting individual and group values is undeniable. Not all students of transformational leadership will naturally have the skill sets these presidents had, but they can study and use their strategies to bring about change.

Factors Affecting Organization Transformation

Structure and Process

Organizational transformation is based on both structural and process changes. Structural factors are elements in the physical environment that are tangible and usually visible. They include signs, factories, facilities, employee dress, and even organization leaders.

Structural changes
changes made to the physical environment for purposes of producing different outcomes

Process changes
changes made to procedures for purposes of producing different outcomes

Structural changes can be an important transformational tool. In 2001, for example, Army Chief of Staff General Erik K. Shinseki ordered all Army personnel to wear black berets instead of their old garrison caps. This structural change was General Shinseki's way of signaling an Army transformation, namely the reengineering of heavy, Cold War–era combat forces into a lighter, more maneuverable Army that could be more easily deployed worldwide.

Process changes are alterations to procedures that are made to create different outcomes. For example, streamlining administrative procedures by updating billing software is a process change that can inspire customer service loyalty and increase a hospital's return on investment.

Offering after-hours or weekend appointments at a primary care clinic or local pharmacy is another example of a process change. Even small process changes such as this offer can place a clinic or pharmacy into a position of competitive advantage over similar clinics or pharmacies that do not offer such hours. For example, this change in operating hours may attract a new population of working parents who work 9 am to 5 pm and cannot leave work early to take their children to a primary care clinic that closes at 5 pm.

Institutionalism

Institutionalism
the belief that established ways of doing things work well and need not be changed

Perhaps the greatest threat to organizational change and gaining a competitive advantage is **institutionalism**. Fear of change is a powerful motivator in long-standing organizations. Many organizations' strategy is, "What worked yesterday will work tomorrow." Such was the case with the company Smith Corona. In the twentieth century, Smith Corona typewriters were a standard office machine. However, by the dawn of the new millennium, the Smith Corona typewriter had become little more than a movie prop and an oddity found at flea markets, and competitors such as Hewlett-Packard, Dell, Gateway, and Apple had come to dominate the market for word processors. Smith Corona lacked the vision to transform itself and use its resources to develop a personal word processor that would survive the dawn of the computer age.

Organizations must avoid institutionalism and be able to sense when structural and process changes are needed, not only to maintain a competitive advantage but also to simply survive. One such example in healthcare was the formation of walk-in and retail clinics. Realizing that many people do not want to wait for weeks to get an appointment for a routine procedure or to pay exorbitant prices for routine services, healthcare entrepreneurs introduced mini-clinics in local drugstores and other convenient locations to attract this clientele.

Summary

The rapidly changing field of healthcare demands leaders who can continuously reinvent strategy and successfully use their resources—human and other—to achieve and remain in a position of advantage in the marketplace. Of the different types of leadership, the transformational model seems best suited for this objective. Transformational leaders are motivators, facilitators, educators, and visionaries who focus on unifying their desires and goals with those of their followers. The transformational leadership model differs from narrow, prescriptive models of leadership in that it considers the sociocultural environment in which it operates. Although some aspects of transformational leadership appear to apply to most contexts, leadership techniques that work in one culture will not necessarily work in another. The transformational model also differs in that it motivates followers through internal (i.e., values-based) rather than external (e.g., money-based) rewards. Followers of a transformational leader aren't driven by selfish aims; for them, a sense of accomplishment or community is a reward in itself. Transformational leaders uphold strong ethics, work against institutionalism, and know when structure and process changes need to be made to keep their organizations vital and competitive.

Review Questions

1. Why do organizations adopt transformational characteristics?

2. How do organizations use transformational leadership to manage change and gain a competitive advantage?

3. In what ways are the situational, transactional, and transformational models of leadership similar? In what ways are they different from each other?

4. How might leadership ethics apply to the healthcare industry? Provide examples.

Coastal Medical Center Case: Exercise 3

According to Chapter 3 and the Coastal Medical Center case, does Coastal Medical Center operate under the transformational leadership model?

Exercises

1. Is there information in the case study suggesting that at one time Coastal Medical Center embraced transformational leadership? If so, why is this no longer the case?

2. Develop a plan or process by which transformational leadership might be implemented at Coastal Medical Center.

3. Assess the level of leadership ethics currently in place at Coastal Medical Center. Address any problems you see and propose potential solutions.

CHAPTER 4

FUNDAMENTALS OF STRATEGIC PLANNING

Look before, or you'll find yourself behind.

—Benjamin Franklin

Key Terms and Concepts

- Ambulatory surgery center (ASC)
- Benchmarking
- Dashboard
- Efficiency frontier
- Gap analysis
- *Healthy People 2010*
- Medicare Payment Advisory Commission (MedPAC)
- Preventive care
- Safety-net providers
- Strategic planning

Introduction

Strategic planning brings leaders and stakeholders together to successfully position an organization in an environment of uncertainty. Organizations engage in strategic planning to reduce costs, improve quality and service, and ensure access to care (Alexander 2006). An innovative, efficient strategic planning process also helps an organization allocate its resources more effectively.

Definition

Strategic planning
a process of defining and managing actions that will shape an organization; the development of organizational objectives and measurement of ongoing performance

Strategic planning is the process by which a healthcare organization determines its overall direction for future years (Nowicki 2004). It is also a process of defining the actions that will shape an organization (Kaleba 2006). The strategic planning process involves gathering information about the internal and external environment and having meaningful discussions about the future of the organization.

The critical components of the healthcare strategic planning model are illustrated in Exhibit 4.1. These elements are discussed in the sections that follow.

Analysis of the Internal Environment—Inside the Organization

Internal data on the organization includes financial data, key assets, and information on quality of care. A thorough analysis of internal data reveals an organization's strengths and weaknesses, both of which affect its ability to meet its mission (Kaleba 2006).

Mission, Vision, and Values

The essence of leadership is having a vision (Zuckerman 2006); a leader cannot plan if there is no future state to which he or she aspires. As discussed in previous chapters, an organization's mission, vision, and values provide the foundation on which the strategic plan is built. A clear link and consistency between the vision, values, and mission enhance the strategic planning process and increase the likelihood that the organization's performance will improve.

Culture

The distinctive beliefs that organizations develop provide a framework for their behavior. Social values in their surrounding communities shape these behaviors. People want access to healthcare to be a right, not a privilege, and patients want to be an organization's first priority. Incorporation of these social values in organizational culture is important to healthcare strategic planning (Ginter and Swayne 2006).

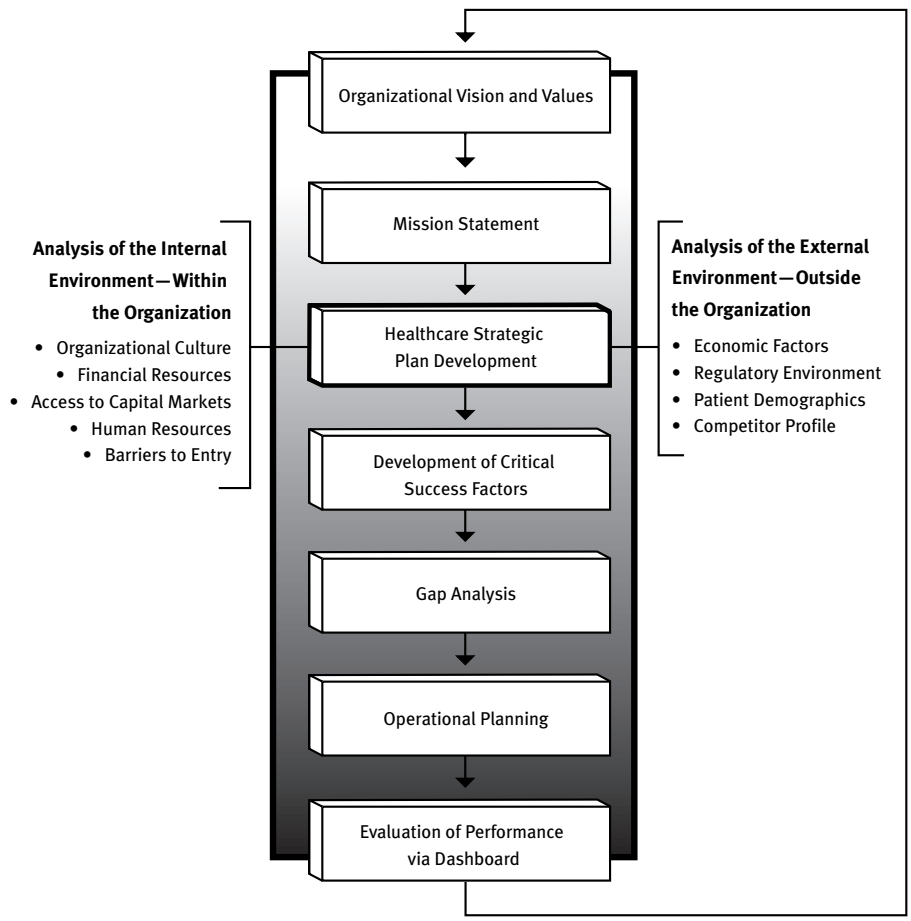


EXHIBIT 4.1
Healthcare Strategic Planning Model

Culture also guides an organization's decisions about allocating resources and establishing priorities. For example, consumers and health professionals want access to the best technology available. An organization that emphasizes innovation and technological advancement needs to carefully allocate its resources to be able to fund this costly priority (Anderson, Tang, and Blue 2007).

GOALS AND STRATEGIES

Quint Studer, named one of the "100 Most Powerful People in Healthcare" by *Modern Healthcare* magazine in 2008, proposed a foundation for the development of organizational goals in his book *Hardwiring Excellence*. He calls this foundation the "Five Pillars of Excellence." The five pillars are (Studer 2003)

- service,
- quality,
- people,
- finance, and
- growth.

Donna Sollenberger, named one of the "Top 25 Women in Healthcare" by the same magazine in 2007, proposed that an organization needs to adopt the following four goals to position itself for success in the healthcare industry (*Modern Healthcare* 2009; Sollenberger 2006):

- Preeminence in some clinical service areas
- Improved quality of care and patient access
- Efficient allocation of healthcare resources
- Strong financial performance

In their 2006 article in *Frontiers of Health Services Management*, Peter Ginter, professor and chair of the Department of Health Care Organization and Policy at the University of Alabama, and co-author Linda Swayne believe no organization can successfully achieve a large number of goals simultaneously and recommend pursuing three to five goals at any given time (Ginter and Swayne 2006).

Critical Success Factors

An organization's strategic plan needs to address the following core areas:

- Improvement of healthcare quality
- Increased patient access
- Improved employee retention
- Differentiation in the market
- Improved alignment of resources

Successful strategic planning is contingent on the following factors (Sollenberger 2006):

- Collaboration among physicians, leaders, and employees
- Acquisition of information through external groups
- Use of outside consultants as facilitators
- Focus on organizational competency and prioritization of business initiatives
- Investment in employee training to ensure the right people have the right skills
- Revision of the strategic plan at least every three years

Analysis of the External Environment—Outside the Organization

The healthcare strategic planning process is subject to considerable outside control and rapid change. Federal and state legislation, physician involvement, third-party payers' actions, and competitors' actions all affect an organization's operations. As a result, healthcare organizations need to focus on the external environment and future changes to the industry (Ginter and Swayne 2006). By gathering information from external sources, healthcare organizations increase their likelihood of achieving success.

External information includes market position; data on local demographics, competitors, and payers; and information on the local business environment. Such data are available through online databases maintained by hospital associations, regional health planning groups, the U.S. Census Bureau, and the Department of Health and Human Services.

Trends in the External Environment

Hospitals engaging in strategic planning today need to be mindful of trends influencing the direction of the healthcare industry. Major trends include growth in the following areas:

- Managed care
- The uninsured population
- Participation in healthcare systems
- The number of specialty hospitals
- The number of ambulatory surgery centers

Each of these trends is discussed in the sections that follow.

The Growth of Managed Care

Preventive care actions taken to prevent diseases or injuries before they occur

The growth of managed care (i.e., contracting with HMOs and PPOs) has instigated price competition among hospitals, resulting in lower prices and reduced profit margins. Increased competition has also led hospitals to increase their focus on quality; the higher the quality of services a hospital provides, the more likely it is to attract patients. As a result of this increased quality, mortality rates among hospital patients have decreased. Research has found that mortality rates are also lower in areas that have a large number of HMOs (Rogowski, Jain, and Escarce 2007). HMO coverage is more affordable, so in areas with a large number of HMOs, more people have insurance and obtain **preventive care**, which leads to prolonged life.

The Growth of the Uninsured Population

Saftey-net providers providers that deliver a significant amount of care to uninsured, Medicaid, and other disadvantaged patients

The number of uninsured Americans reached 45 million in 2007, or roughly 17 percent of the U.S. population (Robert Wood Johnson Foundation 2009). As a result, a large segment of the U.S. population is dependent on **safety-net providers**, such as public hospitals, not-for-profit hospitals, community health centers, and local health departments. With this large number of people lining up for safety-net care, the uninsured may have to wait for a significant amount of time before they are able to access care. Faced with long waiting times, an increasing number of uninsured are choosing to go without care.

Increased Participation in Healthcare Systems

Faced with lower Medicare reimbursement rates and a growing uninsured population, independent hospitals are experiencing weak profit margins and a growing need for capital. As a result, they are under increasing pressure to become part of healthcare systems (Evans 2007b). Some of the benefits of system membership include lower interest rates on loans, greater negotiating power with third-party payers, and savings through group purchasing. However, in evaluating the benefits of system membership, independent hospitals should consider maintaining fiduciary control as well as local involvement in the strategic planning process to ensure that the strategic plan prioritizes and meets consumer needs in the community.

The Impact of Specialty Hospitals

Healthcare policymakers continue to debate whether physician-owned specialty hospitals that provide heart, orthopedic, and surgical services are desirable. Research suggests that specialty hospitals are driving up costs without improving quality (Berenson, Bazzoli, and Au 2006).

According to the **Medicare Payment Advisory Commission (MedPAC)**, the number of specialty hospitals is increasing (MedPAC 2006). As of the end of 2007, approximately 125 specialty hospitals were operating in the United States (Roy 2007). In its 2006 report to Congress, MedPAC found that physician-owned specialty hospitals did not have lower costs than competitor community hospitals in their markets, although their patients had shorter lengths of stay, and specialty hospitals admitted less severe cases and fewer Medicaid patients than competitor community hospitals. Furthermore, MedPAC (2006) found that the number of physician-owned specialty hospitals increased the most in states that have no Certificate of Need (CON) requirement (see Chapter 2, Highlight 2.6) and are experiencing high population growth. (It is easier to open a specialty hospital in a state that has no CON requirement, and the population growth creates demand for specialty services.)

Medicare Payment Advisory Commission (MedPAC)
government agency established by the Balanced Budget Act of 1997 to advise Congress on issues that affect the Medicare program

In a 2007 study, economist Jean Mitchell of Georgetown University found that the number of people who undergo complex surgical procedures increases significantly when physician-owned specialty hospitals open. In particular, she studied the rates of spinal fusions performed in two urban areas in Oklahoma before and after physician-owned specialty hospitals opened in these areas. Before they opened, the market area utilization rate for complex spinal fusion was 1.93 per 1,000 back/spine cases. By 2004, this rate increased to 49 per 1,000 back/spine cases—close to a 2,439 percent increase in the market area utilization rate for complex spinal surgery (Mitchell 2007). This increase stems from a greater number of physician referrals; because physicians profit from the specialty hospitals they own, they are more likely to refer their patients to them for surgery.

Growth of Ambulatory Surgery Centers

The number of Medicare-certified **ambulatory surgery centers (ASCs)** grew from 3,028 in 2000 to 4,964 in 2007—a 64 percent increase (MedPAC 2008). Because patients can have surgery done at ASCs at a lower price than that charged by hospitals, the number of surgeries taking place in hospitals has declined in communities where ASCs have been opened. Most ASCs are for-profit and located in large metropolitan areas. Surgeons who own stock in an ASC can earn a profit not only from the professional fees they charge but also from the return on their investment in the ASC (Bian and Morrisey 2006).

Ambulatory surgery center (ASC)
facility at which outpatient surgeries (i.e., surgeries not requiring an overnight stay) are performed, often at a price that is less than that charged by hospitals

Gap Analysis

Gap analysis is a review of an organization's internal and external environments for purposes of revealing, as the name suggests, gaps. *Gaps* are differences between where the organization currently stands and where it needs to be in terms of performance. These gaps become the focal points that shape the strategic plan.

Gap analysis
a comparison of actual performance with potential performance

For example, say an organization's analysis of its internal environment reveals that its mission, vision, and values are not aligned. A primary strategic goal, then, would be to make these elements consistent with each other. Imagine that the organization finds that one of the critical success factors discussed in the previous section is not in place—for example, its staff lacks certain skills. Organizational strategy would need to include plans for employee training to get staff up to speed.

Two of the most important gaps organizations need to address today are found in the areas of information technology and diversity. These elements are discussed in the following sections.

Health Information Technology as a Competitive Advantage

Clinical information systems have the potential to improve the efficiency and quality of care in both the inpatient and outpatient medical delivery system. While documentation of medical records in the United States is still predominantly paper based, electronic medical records (EMRs) offer an opportunity for seamless exchange of clinical information. Electronic exchange prevents breakdowns in communication that place patient lives at risk (Harrison and Palacio 2006).

The use of EMRs can give an organization a competitive advantage in that they pass real-time information to multiple users and promote timely feedback. As such, healthcare quality can be improved more quickly. Also, information can be pulled from a centralized database to supplement evidence-based research on clinical treatments. EMRs also facilitate administrative decision making and the allocation of healthcare resources. For example, an EMR provides detailed information on patient services that have been provided and current payer mix. This information can be linked to billing software to project reimbursement levels and measure the profitability of new business initiatives.

To encourage the adoption of clinical information systems in the healthcare industry, the Health Insurance Portability and Accountability Act (HIPAA) designated a standard electronic framework for electronic claims submission (see Highlight 4.1). As part of the 2009 stimulus plan, President Obama has called for a nationwide EMR system to be implemented by 2014 (Privacy Rights Clearinghouse 2009).

As consolidation in the healthcare industry increases, more effective linkages are critical to the success of integrated delivery systems (Harrison et al. 2003). From a risk management perspective, EMRs and supporting clinical information systems have the potential to reduce medical malpractice costs. Disjointed communication and incomplete records could become a thing of the past.

Diversity in the Workplace

Demographic evidence shows that the U.S. population is becoming more diverse and multicultural. According to the Bureau of Labor Statistics, the U.S. hospital workforce

in 2008 totaled 6.2 million people, of whom 77 percent were women, 23 percent men, 15 percent African American, 8 percent Hispanic, and 7 percent Asian (Bureau of Labor Statistics 2008).

HIGHLIGHT 4.1 HIPAA and EMRs

The Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996 to protect the privacy and security of patient health information, particularly health information that can be used to discover a patient's identity, by

- setting national standards for the security of health information that has been stored electronically,
- permitting the confidential use of health information so that healthcare providers can analyze patient safety events and improve patient care, and
- affirming that patients own their health records and have the right to access their records.

Under HIPAA, all hospitals and healthcare providers must meet minimum information security and privacy requirements (standards). The standards allow data to be transferred between providers and other health-related entities, but the information must be coded securely and the parties doing the sharing must meet certain criteria.

The rules regulating information exchange are called "HIPAA Transactions and Codes Sets" and are based on electronic data interchange (EDI) standards. The rules apply to healthcare providers, retail pharmacies, health plans, healthcare clearinghouses (organizations that do not provide care but do standardize information for providers), and covered entities (separate healthcare providers that are under one ownership). HIPAA has set rules for many types of transactions, including

- submitting claims to payers (e.g., insurance companies),
- requesting information about a patient's eligibility for certain treatments and responding to such requests,
- obtaining referrals for additional care from a specialist and authorization to ensure the additional care will be covered by the payer,
- enrolling members in a health plan, and
- supplying information on patient demographics, diagnoses, or treatment plans for a healthcare services review.

Hospitals with higher levels of diversity in their workforce outperform less diverse organizations (Richard 2000). The American College of Healthcare Executives (2006) believes that diversity in healthcare management is an ethical and business imperative. Thus, to improve profitability and have a positive impact on the health status of the community, a sound business case can be made for healthcare organizations to incorporate diversity in their workforce. Such a cultural foundation should enhance the quality of healthcare delivered in diverse community populations. By integrating diversity in the strategic planning process, hospitals should be able to reduce health disparities in the communities they serve (Richard 2000).

Barriers to implementing diversity in the workplace include lack of diversity awareness, poor communication, and organizational constraints. For example, healthcare clinical protocols are frequently structured in ways that minimize gender difference and use the same clinical presentation for men and women. A better approach would be to develop separate clinical practice guidelines for men and women. There is a growing demand to improve clinical practice in this manner and to foster improved diversity within healthcare organizations.

Improved communication between providers and patients leads to improved quality of healthcare. Greater diversity among healthcare providers can minimize language barriers as well as cultural differences. Optimally, the diversity of a hospital's workforce should mirror the population it serves (Celik et al. 2008).

Strategic Planning Areas

As discussed in the earlier sections on goals, strategies, and critical success factors, strategic plans, at a minimum, need to address certain core areas. These core areas include

- financial planning,
- efficiency,
- management of healthcare personnel,
- current versus long-term strategy,
- product/service mix, and
- operational planning.

Each of these areas is addressed in the following sections.

Strategic Financial Planning

The healthcare environment has become more competitive, and healthcare leaders must improve their ability to manage resources and reduce costs. Faced with inadequate

reimbursement, greater price competition, and a growing shortage of professional staff, healthcare organizations are forced to improve financial performance to gain greater access to capital and remain competitive. Hospitals are responding to these challenges by trying to provide higher volumes of care within limited financial constraints. Additionally, many hospitals are **benchmarking** against outstanding organizations to improve internal operating procedures, to enhance their clinical services, and to maximize efficiency and profitability (Butros 1997).

Benchmarking
examination of a competitor's business practices and products for purposes of comparing and improving one's own company

Strategic planning needs to ensure that proposed new services will attract a sufficient volume of patients to support an investment in new facilities. Before a proposal is approved, a detailed study should be conducted to determine whether it will likely generate enough revenue to justify the investment. This study should clearly define the new service line to be implemented; accurately forecast the volume of patients who will use the new service; and project construction costs, revenue that will be taken in, operating expenses, and overall profitability. Poor forecasting of clinical workload can lead to the approval of unnecessary and unprofitable projects (Harris 2007).

As discussed in Chapter 2, an organization's status—for-profit or not-for-profit—affects its strategic financial planning. In general, not-for-profit hospitals have a lower return on assets, lower debt, higher occupancy rates, older facilities, and higher operating expenses per discharged patient. They also are larger and offer more clinical services. Although for-profit hospitals have higher long-term debt, they are more profitable because they use the money they borrow to invest in newer hospital facilities. Not-for-profit hospitals have lower levels of debt because they do not generally borrow money to fund facility improvements and technological advancements, most likely because they provide a significant amount of charity care and make less money and thus cannot hope to pay back debt (Harrison and Sexton 2004).

The strategic planning team should review key financial data as well as hospital operations data to ensure an efficient use of hospital resources, including personnel. Healthcare organizations can improve incoming cash flow by developing procedures for timely submission of clean claims, rapid review of claim denials, and compliance with the organization's policy on charity care. Specifically, healthcare organizations should review their policies on charity care to ensure they are consistent with their mission and then monitor the level of charity care provided on an annual basis. Additionally, healthcare organizations should perform an annual price analysis to confirm that the prices they charge for specific procedures are higher than authorized reimbursement rates so they at least receive the maximum authorized reimbursement. From a compliance perspective, healthcare organizations should implement an audit program that reviews the accuracy of their billing and coding systems (Fogel and Watt 2007). Such a program ensures the accuracy of financial information used in the strategic planning process.

Tony Sinay, professor and program director of healthcare administration at California State University, has proposed a cost model that evaluates hospital efficiency and

productivity by measuring payroll, supplies, bed size, case mix, and system affiliation. He found that organizations with poor efficiency were candidates for merger or closure (Sinay 2005). According to this model, healthcare leaders should consider reducing costs by reducing staff and closing beds when confronted with greater competition and declining patient volume.

Efficiency in the Strategic Planning Process

Efficiency frontier
the best use/combination of inputs (investment of resources) that will produce the best possible outputs (profits and outcomes of care)

As the population continues to age and more Americans become uninsured, the healthcare industry is under growing pressure to improve efficiency as well as profitability. *Efficiency* refers to eliminating sources of waste without worsening the outcomes of healthcare services (Cooper, Seiford, and Tone 2003). In an efficiency evaluation, organizations that share common characteristics should be compared, in both clinical and administrative areas. For example, a comparison of two not-for-profit hospitals would be appropriate because they have similar missions. If efficiency across a group of similar organizations is measured, individual hospital performance can be benchmarked against the **efficiency frontier** of "best-in-class" facilities.

Managing Healthcare Personnel

Healthcare organizations should continuously monitor personnel costs and productivity against industry benchmarks. In particular, they should routinely perform salary surveys to compare their salary rates to local and state peers (Fogel and Watt 2007).

Hospitals require adequate numbers of well-trained and highly credentialed healthcare professionals. Unfortunately, the current shortage of highly skilled healthcare professionals is limiting the growing U.S. population's access to healthcare services. Results from a 2008–2009 American Nurses Association survey of approximately 15,000 nurses revealed that 72 percent of nurses were dissatisfied with the current nurse-to-patient staffing ratio on their unit (ANA 2009).

High-quality healthcare is provided by teams of physicians, nurses, and allied health professionals trained in more than 50 different medical specialties. Good communication and close collaboration are required to ensure that the 200+ professional interactions that occur during an average hospital admission result in high-quality care (Scott, Poole, and Jayathissa 2008). Research has shown that healthcare organizations with well-coordinated teams report lower morbidity and mortality. Patient satisfaction also improved when healthcare professionals communicated clearly, expressed empathy, and demonstrated good listening skills. Good communication skills can be taught, and healthcare organizations must foster an environment in which good provider–patient communication is a priority (Gremigni, Sommaruga, and Peltenburg 2008).

Current Operations Versus Long-Term Strategy

Excellent strategic planning is a key ability of healthcare organizations that have achieved financial profitability over the long term. Strategic planning provides a framework for integrating marketing, efficiency, personnel management, and outstanding clinical quality while ensuring financial performance. Key in this process is the development of process improvement teams and the use of real-time data to monitor performance on key metrics. Accurate data on community demographics, market share, payer mix, costs, and medical staff performance allow executives to make sound decisions. By comparing these internal data with competitor and industry-wide benchmarks, they can develop a sound strategic plan and financial targets. Good data enable them to accurately forecast future demand over the next five to ten years. Short-term performance also must be monitored to make sure it is consistent with the organization's long-term vision. Once new business initiatives become fully operational (typically 24 months after start-up), they should be evaluated to ensure they are fulfilling the objectives of the organization's strategic plan (Grube 2006). Performance measurement and evaluation will be covered in greater detail later in the chapter. In addition to performance measurement, creativity and a focus on community needs are important to long-range strategic planning.

Strategic Implication of Product Mix

Many hospitals located in growing communities are expanding their inpatient and outpatient capacity. At the same time, however, these organizations are forced to operate unprofitable services such as obstetrics, pediatrics, and emergency services. As a result, many of these hospitals are participating in joint ventures with physicians to improve clinical quality and develop a more varied product mix (O'Dell 2007). Healthcare organizations should routinely monitor their medical staff network to maximize clinical services while ensuring a profitable product line mix (Fogel and Watt 2007). Such an assessment should consider changing community demographics and needs and the product mix that competitors offer. Key information about changing community needs can be obtained from community leaders, board members, hospital employees, and physicians on the medical staff.

Joint ventures enable organizations to preserve capital, expand services, and better meet community healthcare needs. A healthcare organization seeking a joint venture should identify potential partners that demonstrate ethical, cultural, and quality of care factors that are consistent with its strategic plan. Once these model partners have been identified, the strategic planning process can pinpoint clinical areas where joint ventures may be most appropriate. Such areas could be new service lines; the development of facilities that are more convenient or easier for patients to access; or high-level services, which would enhance the hospital's reputation. Any new service should be financially profitable and provide long-term value to the organization. Value may take the form of increased

clinical volume, greater market share, or limited competition from other hospitals (Blaszyk and Hill-Mischel 2007). For example, by investing in new clinical services on an ongoing basis, a healthcare organization can meet the existing demand for services. If this demand is already met, potential competitor organizations would have little business and thus are unlikely to enter the market.

Operational Planning

Operating plans set strategic plans in motion and carry out the tasks they prescribe. Each operational plan should be assigned to a senior leader and linked to specific activities with deadlines. Operational responsibilities should be assigned to individual leaders who are held accountable for performance. By pushing operational goals down the ranks of the organization, the strategic plan becomes a reality for all staff and creates a unified endeavor (Zuckerman 2006). The strategic plan should prioritize operational goals according to the resources available to the organization at any given point in time.

Evaluation of Performance

Once strategic plans are in operation, results of strategic actions must be evaluated. Clear goals linked with measurement of outcomes are necessary to align behaviors. Organizations that are able to create such an alignment are more likely to be successful.

Dashboard
tool that links strategic goals to operating performance

One useful tool for linking strategic goals to annual operating performance is called a **dashboard**. Like the gas gauge, speedometer, and temperature gauge on a car dashboard, a hospital dashboard contains numerous indicators of performance. Just as the indicators on a car dashboard must all reflect good performance for the car to reach its destination, a hospital's strategic success depends on the collective performance shown by the indicators on its dashboard. An example of a hospital dashboard is shown in Exhibit 4.2.

Organizational performance should be monitored on a quarterly basis (Ginter and Swayne 2006). In other words, performance data should be collected for three months and then evaluated. Some recommended dashboard measures include quality of care (e.g., nosocomial infection rates[1] and 30-day readmission rates[2]), patient satisfaction, market penetration, operating efficiency (e.g., measured by average length of stay or cost per procedure), and financial performance (e.g., measured by return on assets and cash on hand). The dashboard should include visual cues, with green representing favorable performance, yellow representing areas of growing concern, and red representing areas of poor performance (Sollenberger 2006).

On the basis of these indicators, the organization can modify its strategy to improve areas of poor performance. For example, say a hospital wants to build a particular service

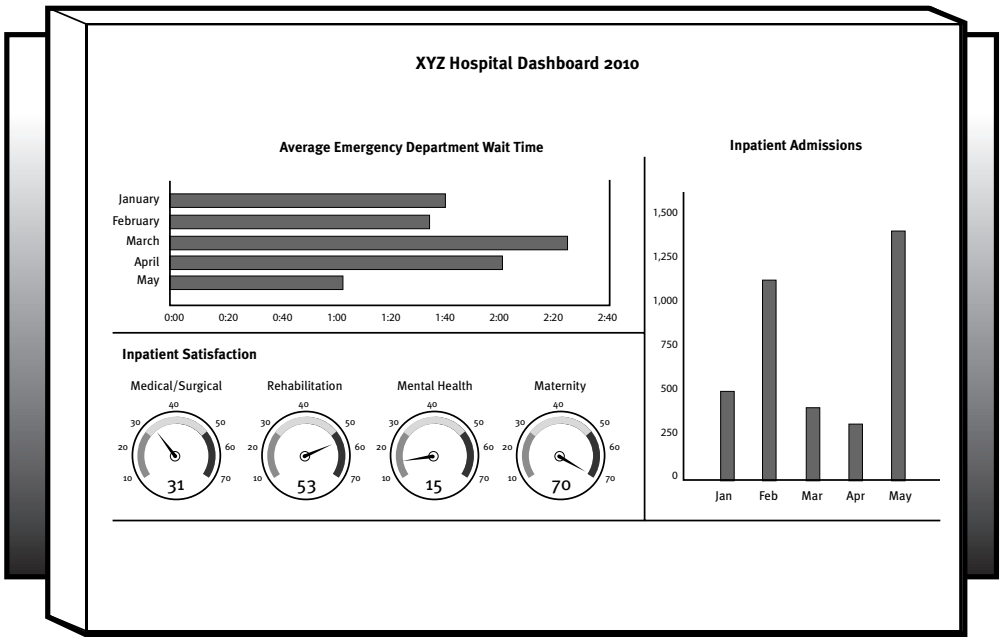


EXHIBIT 4.2
Sample Hospital Dashboard

line, but its dashboard shows that it does not have enough staff to do so. The hospital would then need to focus on recruiting and training additional staff while ensuring that it can afford to compensate the new staff and still make profits.

As shown in Exhibit 4.1, evaluation of performance ends the strategic planning cycle, but not the strategic planning process. Strategic planning is a continuous activity. In healthcare, change occurs rapidly, both internally and externally. Once a strategy has been implemented and evaluated, the cycle begins again. That strategy is modified as needed, re-implemented, and evaluated again, and new strategies are developed in response to the changing environment.

PLANNING AT THE LOCAL, REGIONAL, AND NATIONAL LEVELS

The following sections deal with healthcare planning at the local, regional, and national levels. Organizational planning at the local level is different from regional and national healthcare planning, which is usually done by government agencies.

Local Planning

In general, healthcare in the United States is a local commodity produced to meet local demand. For this reason, much of an organization's strategic plan is developed using local data. A good understanding of community needs is necessary for local health planning. More important, local governmental entities and other organizations in the community can provide additional funding and thus significantly influence the allocation of healthcare resources.

Joan Anderson, professor emerita in the school of nursing at the University of British Columbia, stressed the importance of moving healthcare decision-making authority from a national level to local or regional levels. Local healthcare planning can better allocate staff and financial resources to more effectively implement evidence-based clinical practice (Anderson, Tang, and Blue 2007). Local efforts to streamline healthcare will make the U.S. healthcare system more efficient as a whole.

Measuring the availability of physicians, allied healthcare providers, hospital beds, and long-term care resources in the local geographic area is a responsibility of the local health planning council. State government also assesses the economic status of the state's communities and its effect on the availability of healthcare services in those areas. Economic factors affect an individual's ability to pay for healthcare services, the number of uninsured, and, ultimately, the community's overall health. Common economic factors affecting local planning include per capita income and the percentage of unemployed in the community (Dahlgren and Whitehead 2007).

Regional Planning

As healthcare complexity increases in the United States, a case could be made for allocating healthcare resources at the regional (e.g., state) level. Such an approach could reduce costs through improved efficiency and ensure a consistently high level of healthcare quality.

Massachusetts formally launched a healthcare reform plan in 2006, making it the first state in the United States to have universal healthcare. The plan hopes to reduce healthcare costs by extending healthcare coverage to all Massachusetts residents. It allows all citizens earning less than 150 percent of the federal poverty level to enroll in a free government-funded health plan. Low-income families with a combined household income of up to 300 percent of the federal poverty level receive government subsidies to purchase healthcare coverage. In addition, all companies with 11 or more full-time employees must provide health insurance or establish employee healthcare accounts. Before this program was implemented, 10 percent of Massachusetts' population lacked healthcare coverage, obligating the state's providers to deliver uncompensated care. Such regional healthcare strategic planning initiatives are growing in importance (Anonymous 2007c).

The Massachusetts plan requires all companies in the state that do not provide health insurance for their employees to pay into the government health plan fund. Similar programs are under development in Maine, Vermont, Pennsylvania, and Illinois. Regional planning at the state level includes an analysis of population demographics and the development of mathematical models designed to determine the need for health services in local communities. These activities address a variety of questions associated with regional health planning, such as the location of hospitals; the number of hospital beds, hospitals with open-heart surgery units, ambulatory surgery centers, imaging centers, and nursing homes; and the availability of hospice programs.

National Planning

A framework for healthcare strategic planning at the national level is important. National healthcare reform is currently under debate and has garnered considerable support, but the United States does not have a national health plan. As such, much of the following discussion is theoretical.

National healthcare reform should stress the importance of developing national values and formulating a national strategic healthcare plan that integrates the priorities of key stakeholders, including patients, employers, plans, healthcare providers, and medical suppliers. The strategic plans would be developed by the federal government and then implemented by governmental authorities at the local and regional levels.

The United States has experienced significant improvement in the health status of its population over the past decade. However, research demonstrates that minorities suffer disproportionately from many diseases (Graham 2006). The federal and state governments are working to reduce these disparities through such projects as the ***Healthy People 2010*** report. Managed by the Office of Disease Prevention and Health Promotion (U.S. Department of Health and Human Services), this comprehensive analysis of the U.S. population's healthcare needs specifies healthcare improvement goals and measures by which progress toward those goals can be monitored. The report contains 498 objectives geared toward reducing or eliminating illness, disability, and premature death (Keppel 2007).

Healthy People 2010 a statement of healthcare objectives around which local and regional planning can take place, managed by the Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services

Many believe local communities have the greatest understanding of healthcare needs and therefore should have significant influence over healthcare planning decisions. As such, local communities should be included in the strategic planning process and in any national healthcare reform initiative (Green et al. 2007).

Summary

Strategic planning is a process by which healthcare organizations determine their future direction. An important part of strategic planning is the allocation of resources to maximize

the delivery of healthcare services. Research suggests that good strategic planning leads to lower healthcare costs, improved quality of care, and greater patient satisfaction.

Healthcare strategic planning is grounded in an organization's mission, vision, and values. Building on this foundation, the organization develops a strategic plan based on analyses of the internal environment of the organization and the external environment in which it operates.

As part of the process, organizations identify factors necessary to achieve outstanding performance and then complete a gap analysis designed to identify where improvement is needed. At the operational level, it is important that healthcare organizations develop programs and services that support the overall strategic plan and turn plan objectives into action. An effective tool for linking the strategic plan to operating performance is a dashboard analysis. Measurement of performance via a dashboard is part of an ongoing feedback process that drives future strategic planning. Programs are implemented, performance is measured, and any remaining performance gaps prompt the cycle to begin again. Programs are implemented to address the remaining gaps (and new gaps that have emerged), performance is measured, and so on, indefinitely.

Notes

1. *Nosocomial infections* are infections that are not caused by a patient's condition but that result from the treatment a patient receives in a hospital.
2. *Thirty-day readmission rates* are the percentages of patients who are treated for a particular condition and discharged from the hospital but who had to be readmitted to the hospital for the same condition within 30 days of the initial discharge.

Review Questions

1. What are the roles of the following groups in a healthcare organization's strategic planning process: board of directors, senior leaders, physicians, employees, and community organizations?

2. Evaluate the statement that healthcare organizations should monitor key business metrics throughout the year. Provide an example from the chapter that illustrates monitoring organizational performance.

3. Should a healthcare organization do a community health assessment as part of its strategic planning? Why or why not?

4. Does the diversity of a healthcare organization's staff have any impact on organizational performance?

Coastal Medical Center Case: Exercise 4

According to Chapter 4 and the Coastal Medical Center case that appears at the beginning of the text, does Coastal Medical Center have the organizational capabilities for future success?

Richard Reynolds is the newly hired CEO and has been actively investigating the declining performance of Coastal Medical Center. During the hiring process, the board of directors assigned him the responsibility of getting the organization back on track. Help Reynolds develop a strategic planning process that will place Coastal Medical Center on a new road to success.

Questions

1. The original CEO of Coastal Medical Center, Don Wilson, was termed a visionary and helped the Center grow and prosper for over 20 years. His successor, Ron Henderson, took the organization from profitability to significant financial losses within two years and was fired as a result. Name five areas in which Ron Henderson's performance was weak.

2. Did Coastal Medical Center have a plan for developing new business initiatives? Name five areas in which such a plan could improve performance.

3. Outline a strategic planning process appropriate for Coastal Medical Center.

4. Who should be involved in the strategic planning process, and at what point do you involve them?

5. How will you know if the strategic plan is a success?

6. What do you see as the future of strategic planning at Coastal Medical Center?

7. What industry do you see Coastal Medical Center focusing on in the future?

8. How is Coastal Medical Center positioned relative to its competitors?

9. On the basis of your answers above, what do you see as potential areas for future growth? What should be targeted first in these areas?

10. Does Coastal Medical Center have a process for measuring the performance of its business units?

11. How should Coastal Medical Center generate new and innovative approaches to meeting community needs?

CHAPTER 5

STRATEGIC PLANNING AND SWOT ANALYSIS

I skate where the puck is going to be, not where it has been.

—Wayne Gretzky

Key Terms and Concepts

- Force field analysis
- Opportunities
- Strengths
- SWOT analysis
- Threats
- Weaknesses

Introduction

Healthcare organizations must continually make adjustments to maintain optimal function (Christiansen 2002). A number of different techniques can be used to determine where adjustments need to be made. One essential technique involves a discussion of an organization's **s**trengths, **w**eaknesses, **o**pportunities, and **t**hreats, commonly called *SWOT analysis*. SWOT analysis has been used extensively in other industries but has not been widely used in healthcare (Kahveci and Meads 2008).

SWOT analysis is a precursor to strategic planning and is performed by a panel of experts who can assess the organization from a critical perspective (Gibis et al. 2001). This panel could comprise senior leaders, board members, employees, medical staff, patients, community leaders, and technical experts. Panel members base their assessments on utilization rates, outcome measures, patient satisfaction statistics, organizational performance measures, and financial status. While based on data and facts, the conclusions drawn from SWOT analysis are an expert opinion of the panel.

Definition

SWOT analysis
an examination of an organization's internal strengths and weaknesses, its opportunities for growth and improvement, and the threats the external environment presents to its survival

SWOT analysis is an examination of an organization's internal strengths and weaknesses, its opportunities for growth and improvement, and the threats the external environment presents to its survival. Originally designed for use in other industries, it is gaining increased use in healthcare.

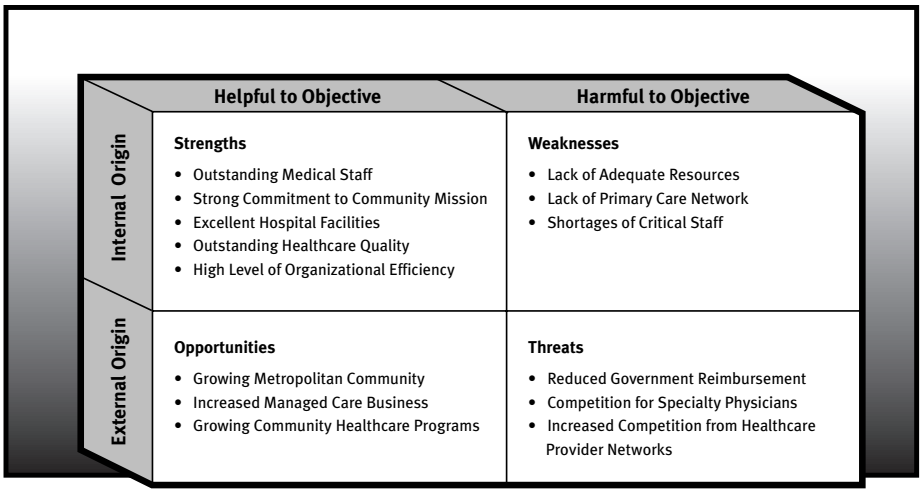
Steps in SWOT Analysis

The primary aim of strategic planning is to bring an organization into balance with the external environment and to maintain that balance over time (Sackett, Jones, and Erdley 2005). Organizations accomplish this balance by evaluating new programs and services with the intent of maximizing organizational performance. SWOT analysis is a preliminary decision-making tool that sets the stage for this work.

Step 1 of SWOT analysis involves the collection and evaluation of key data. Depending on the organization, these data might include population demographics, community health status, sources of healthcare funding, and/or the current status of medical technology. Once the data have been collected and analyzed, the organization's capabilities in these areas are assessed.

In Step 2 of SWOT analysis, data on the organization are collected and sorted into four categories: strengths, weaknesses, opportunities, and threats. Strengths and weaknesses generally stem from factors within the organization, whereas opportunities and threats usually arise from external factors. Organizational surveys are an effective means of gathering some of this information, such as data on an organization's finances, operations, and processes (Carpenter 2006).

EXHIBIT 5.1
SWOT Matrix



Step 3 involves the development of a SWOT matrix for each business alternative under consideration. For example, say a hospital is evaluating the development of an ambulatory surgery center (ASC). They are looking at two options; the first is a wholly owned ASC, and the second is a joint venture with local physicians. The hospital's expert panel would complete a separate SWOT matrix for each alternative.

Step 4 involves incorporating the SWOT analysis into the decision-making process to determine which business alternative best meets the organization's overall strategic plan.

A practical example of Step 2 of SWOT analysis is illustrated in Exhibit 5.1.

Strengths

Traditional SWOT analysis views **strengths** as current factors that have prompted outstanding organizational performance. Some examples include the use of state-of-the-art medical equipment, investments in healthcare informatics, and a focus on community healthcare improvement projects. Other strengths might include highly competent personnel, a clear understanding among employees of the organization's goals, and a focus on quality improvement.

Strengths
current factors that have prompted outstanding organizational performance

Weaknesses

Weaknesses are organizational factors that will increase healthcare costs or reduce healthcare quality. Examples include aging healthcare facilities and a lack of continuity in clinical processes, which can lead to duplication of efforts. Weaknesses can be broken down further

Weaknesses
organizational factors that increase healthcare costs or reduce healthcare quality

to identify underlying causes. For example, disruption in the continuity of care often results from poor communication. Weaknesses also breed other weaknesses. Poor communication disrupts the continuity of care, and then this fragmentation leads to inefficiencies in the entire system. Inefficiencies, in turn, deplete financial and other resources.

Other common weaknesses include poor use of healthcare informatics, insufficient management training, a lack of financial resources, and an organizational structure that limits collaboration with other healthcare organizations. A payer mix that includes large numbers of uninsured patients or Medicaid patients can also negatively affect an organization's financial performance, and a lack of relevant and timely patient data can increase costs and lower the quality of patient care.

Opportunities

Opportunities
significant new business initiatives available to a healthcare organization

Traditional SWOT analysis views **opportunities** as significant new business initiatives available to a healthcare organization. Examples include collaboration among healthcare organizations through the development of healthcare delivery networks, increased funding for healthcare informatics, community partnering to develop new healthcare programs, and the introduction of clinical protocols to improve quality and efficiency. Integrated healthcare delivery networks have an opportunity to influence healthcare policy at the local, state, and national levels. They also have an opportunity to improve patient satisfaction by increasing public involvement and ensuring patient representation on boards and committees. Organizations that are successful at using data to improve clinical processes have lower costs and higher-quality patient care. For example, healthcare organizations with CMS Hospital Compare quality scores above the 90th national percentile are eligible for CMS pay-for-performance incentives. (See Chapter 6 for information on CMS Hospital Compare). The greater the number of organizations achieving such scores, the greater patients' access to quality healthcare. Such scores also enhance an organization's reputation in the community.

Threats

Threats
factors that could negatively affect organizational performance

Threats are factors that could negatively affect organizational performance. Examples include political or economic instability; increasing demand by patients and physicians for expensive medical technology that is not cost-effective; increasing state and federal budget deficits; a growing uninsured population; and increasing pressure to reduce healthcare costs.

Force Field Analysis

Healthcare organizations' responsibility to implement change that is beneficial to the patient, staff, and organization is increasing. The primary areas driving change in healthcare include quality improvement, customer satisfaction, improvement of working conditions, and diversification of the healthcare workforce.

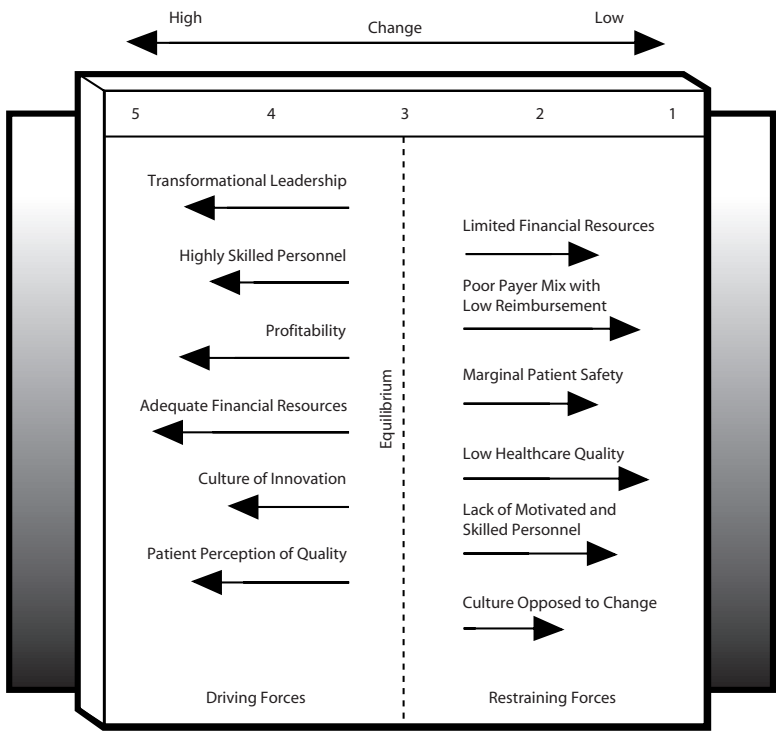


EXHIBIT 5.2
Healthcare Model for Force Field Analysis

Force field analysis (see Exhibit 5.2) takes SWOT analysis a step further by identifying the forces driving or hindering change—in other words, the forces driving its strengths, weaknesses, opportunities, and threats. Forces that propel an organization toward goal achievement are called *helping forces*, while those that block progress toward a goal are called *hindering forces*. After identifying these positive and negative forces, organizations can develop strategies to strengthen the positives and minimize the negatives. For an organization to achieve success, the driving forces must outweigh the resisting forces (Baulcomb 2003). When this state is reached, organizations are able to move from their current reality to a preferred future.

Force field analysis an examination of the forces driving or hindering organizational change

Effective force field analysis considers not only organizational values but also the needs, goals, ideals, and concerns of individual stakeholders. A case can be made that individuals who promote change are driving forces, whereas those who resist change are restraining forces. As a result, it is important to understand individuals, their attitudes, and the culture of the organization. It is also important to identify the key stakeholders in an issue and to develop a plan to gain their support. Kurt Lewin, the renowned psychologist often recognized as the founder of social psychology, stressed the importance of counteracting organizational inertia to maintain the status quo (the resisting forces) and creating

an environment that proactively supports future change (the driving forces) (Lewin 1951). Such change is accomplished by modifying current attitudes ("unfreezing" an organization's perspective on a particular issue), emphasizing the positive aspects of change, and then incorporating the new attitudes in the organization's processes ("refreezing" the new attitudes so that they and their associated behavior patterns become entrenched in the institution).

Many believe that a participative management style that solicits input from within the organization is important in implementing change. It also fosters the development of consensus within work groups, which helps to refreeze the new behaviors in the organization.

Gap Analysis

To further refine planning decisions, SWOT analysis can be supplemented by gap analysis (see Chapter 4). Research shows there are significant gaps in healthcare practice and that these gaps cause providers to make inaccurate assessments of patients' conditions and provide the wrong types of care. The result is poor clinical outcomes. Gaps in healthcare include lack of knowledge, lack of motivation, poor access to information, variations in patient culture and education, lack of resources, and system barriers that limit teamwork. In one study, Robert Fleetcroft, honorary senior lecturer in primary care for the School of Medicine at the University of East Anglia, and his colleagues used gap analysis to measure the quality of healthcare services at 8,407 medical practices in England. Their research found significant gaps in clinical practice, quality indicators, and patient satisfaction across a wide range of outcome measures. Their research was important because the United Kingdom provides pay-for-performance payments to providers based on these critical indicators. In many cases, performance gaps exceeded 25 percent, and there was evidence to support increased mortality as a result of poor performance among some of the outcome measures (Fleetcroft et al. 2008).

Gaps also exist between the public's expectation of high-quality care and situations in which they receive low-quality healthcare. Characteristics of low-quality healthcare include lack of responsiveness, marginal competence, unreliability, weak communication skills, and breaches of confidentiality. Performance variations also result from trade-offs in the allocation of healthcare resources (Wicks and Chin 2008). For example, some healthcare organizations may lack the financial resources to purchase new equipment or hire additional staff when experiencing increased demand because they have allocated their resources for another purpose; as a result, patients experience excessive waiting times.

The complex nature of the healthcare industry necessitates a unified, systems approach to performance enhancement. For example, many patients receive only episodic care during periods of acute illness because they do not have a primary care physician. A system that requires patients to have a primary care provider would coordinate and give continuity to a patient's healthcare services. Other recommended changes include the

implementation of evidence-based medicine in clinical processes (see Highlight 1.10), the creation of multidisciplinary healthcare teams, and the implementation of a continuous quality improvement process (Braithwaite et al. 2007).

Summary

SWOT analysis is a precursor to the strategic planning process. Ideally, SWOT analysis includes a comprehensive review of the healthcare literature, in-depth data analysis, and input from a panel of SWOT analysis experts. Findings from the analysis are sorted into four categories: strengths, weaknesses, opportunities, and threats. Force field analysis supplements SWOT analysis by identifying the forces driving the strengths, weaknesses, opportunities, and threats. To refine these analyses even further, gap analysis may be performed to determine where deficiencies exist in an organization's delivery of care. Such analyses promote (1) a better understanding of barriers to change, innovation, and the transfer of knowledge to practice; (2) improved outcomes; and (3) more efficient allocation of healthcare resources.

Review Questions

1. How does SWOT analysis set the stage for strategic planning?

2. Discuss the use of force field analysis in promoting change in a healthcare organization.

3. Provide examples of how gap analysis can be used to improve the quality of healthcare services.

Coastal Medical Center Case: Exercise 5

Using the four steps of SWOT analysis discussed in Chapter 5, create a panel of experts and perform a SWOT analysis for Coastal Medical Center. Use SWOT analysis to identify key factors necessary to get Coastal Medical Center back on track and moving forward on a new road to success.

CHAPTER 6

STRATEGIC PLANNING AND HEALTH INFORMATION TECHNOLOGY

The difference between what we do and what we are capable of doing would suffice to solve most of the world's problems.

—Gandhi

Key Terms and Concepts

- Clinical information systems
- E-health
- Health information technology (HIT)
- Healthcare data warehouse
- Regional health information organization (RHIO)
- Telehealth

Introduction

The annual leadership survey conducted by the Healthcare Information Management and Systems Society (HIMSS) addresses the use of **health information technology (HIT)** in strategic planning. The 2009 survey found that 70 percent of chief information officers (CIOs) are on the executive committee of their healthcare organization and involved in the development of strategic plans. Additionally, 84 percent of CIOs reported a high level of integration between HIT strategy development and overall organizational strategy. Thirty-seven percent indicated that their HIT strategic plan is a component of the organization's overall strategic plan. The survey also found that the following HIT investments were considered priorities for the upcoming year:

Health information technology (HIT)
computer hardware, software, and networks that enable healthcare information, data, and knowledge to be stored, retrieved, shared, and used for communication and decision making

- Clinical information systems (indicated by 50 percent of the CIOs)
- Electronic medical records (EMRs) (indicated by 31 percent of the CIOs)
- Patient safety systems (indicated by 24 percent of the CIOs)
- Focus on ambulatory systems, including practice management and EMR (indicated by 11 percent of the CIOs)

According to HIMSS Analytics, healthcare organizations spent 2.27 percent of total operating expenses on IT in 2008, and the majority of organizations anticipate increases to expand IT capabilities (HIMSS 2009).

The Institute of Medicine's (IOM) report *To Err Is Human* (2000) estimated that 44,000 to 98,000 Americans die annually as a result of preventable medical errors in U.S. hospitals, at a cost to the U.S. healthcare system of between $37.6 billion and $50 billion. The report proposed that HIT could be used to prevent errors by monitoring events and correcting those that are inconsistent with best clinical practice. A study published in 2005 in the *Journal of the American Medical Association* found that the use of clinical information systems improved practitioner performance in 64 percent, and improved patient outcomes in 13 percent, of the cases studied (Garg et al. 2005).

Definitions

E-health emerged early in the twenty-first century and is an all-encompassing term for the use of electronic information and communication technology for clinical, educational, research, and administrative purposes in the health sector (Cashen, Dykes, and Gerber 2004). According to HIMSS, *e-health* is "the application of Internet and other related technologies in the healthcare industry to improve the access, efficiency, effectiveness, and quality of clinical and business processes utilized by healthcare organizations, practitioners, patients, and consumers to improve the health status of patients" (Griskewicz 2002). The

E-health
an all-encompassing term for the use of electronic information and communication technology in the health sector

use of e-health has enhanced networking, facilitated global thinking, and improved healthcare on local, regional, and national levels (Cashen, Dykes, and Gerber 2004).

Regional health information organization (RHIO)
a group of healthcare organizations in the same geographic area that exchange electronic health information

A **regional health information organization (RHIO)** is a group of healthcare organizations in the same geographic area that exchange electronic health information. Each organization maintains its own data and uses software to interface with the electronic data of the other organizations in the group.

Healthcare data warehouse
database that integrates multiple types of data, such as patient demographic information, comprehensive clinical information, and resource utilization data

Healthcare data warehouses integrate multiple types of data, such as patient demographic information, comprehensive clinical information, and resource utilization data to provide a foundation for decision making. For example, clinical data from all Veterans Health Administration (VA) sites are maintained in Austin, Texas. Because the data they contain are comprehensive and voluminous, data warehouses allow strategic planners to efficiently collect and evaluate data on large patient populations.

Clinical information systems
technology that provides information on patient outcomes and practitioner performance and includes clinical alerts, reminder systems for disease management, and medication administration systems

Clinical information systems provide information on patient outcomes and practitioner performance and include clinical alerts, reminder systems for disease management, and medication administration systems (Garg et al. 2005). These systems are important because they use HIT to standardize clinical practice. By integrating multiple systems, they improve decision making and communication among an organization's healthcare staff.

As described in Chapter 1, Highlight 1.10, *evidence-based medicine* (EBM) is the process of systematically finding, appraising, and using research as the basis for clinical decisions. Clinicians who practice EBM are linked to the best clinical literature to determine efficient and effective medical treatment protocols (McQueen 2001).

Telehealth
the use of telecommunications to deliver health services and information that support patient care, administrative activities, and health education

Telehealth is the use of telecommunications to deliver health services and information that support patient care, administrative activities, and health education (Dixon, Hook, and McGowan 2008). It is particularly valuable in rural communities where access to healthcare is limited. Telehealth plays an important role in the management of chronically ill patients because it establishes and maintains an ongoing connection with the clinical care team. It also helps to coordinate care among primary care and specialty physicians and to prevent unnecessary office visits and costly hospitalization. Research has found that the use of telehealth can reduce unnecessary emergency room visits by 65 percent (Moore 2009).

Strategic HIT Initiatives

E-Health Initiatives

The use of health information technology can help improve quality and efficiency in the healthcare industry (Harrison and Lee 2006). For example, the Internet provides patients with self-care tools, and patients and providers can search for health information online. As such, e-health encourages patients and providers to be partners in health management.

Under healthcare reform, hospitals and other providers face growing pressure to improve efficiency and enhance the movement of patients through the continuum of care. The creation of health information networks and the use of standardized data systems improve communication, which leads to better integration of healthcare providers and improved quality of care for patients. In particular, e-health can link ambulatory care, hospital care, skilled nursing care, and home care through regional data exchanges and telemedicine.

Future innovations in e-health could include communication by nano-sensors, which are capable of monitoring the status of individual cells. This technology would enable patients and health professionals to collect information at the cellular level. Such data could significantly improve treatment processes (Bushko 2009).

As noted in Exhibit 6.1, 4,638 hospitals reported the use of health information technology systems in 2007. Additionally, 2,030 hospitals budgeted to purchase new HIT systems. On average, installation of a new HIT system takes 12 to 24 months.

Clinical Information Systems

Health information systems improve coordination of care, and better coordination of care leads to improved medical outcomes. HIMSS' (2009) EMR Adoption Model measures the level of clinical information systems adoption in U.S. hospitals. It rates

Exhibit 6.1
HIT Systems Planning

Variable	
Hospitals with HIT systems in operation	4,638
Hospitals budgeting for new HIT system	2,030
Hospitals proposing adoption of new HIT system	1,459
Projected months to installation of HIT system	12 to 24 months
Hospitals with an information systems plan	2,167
Chief information officer has responsibility for biometric technology	7%
Chief information officer has responsibility for telecommunications technology	38%

Source: HIMSS (2007).

hospitals' level of adoption on a scale of stages 0 to 7, where Stage 0 indicates the lowest level of adoption and Stage 7 indicates the highest level of adoption (i.e., a complete inpatient and outpatient EMR, data warehousing, a medication administration system, computerized physician order entry [CPOE], and clinical protocols). In 2009, HIMSS research found that, of the 5,235 hospitals reporting, 50.9 percent were at Stage 3, which indicates that all ancillary services, such as lab, pharmacy, and radiology, have been installed, as well as clinical decision support, clinical documentation, and a picture archiving and communications system (PACS). Unfortunately, less than 1 percent of hospitals were at Stage 7.

As noted in Exhibit 6.2, a significant number of U.S. hospitals are investing in clinical information systems. The most widely used systems included laboratory, radiology, and computerized physician order entry.

Electronic Medical Records

The VA is the largest integrated U.S. healthcare system. It consists of 153 inpatient medical centers and numerous outpatient clinics and provides comprehensive healthcare to over 5.5 million veterans each year. The VA uses an EMR called VistA, which stands for *Veterans Health Information System and Technology Architecture*. Within VistA is the Computerized Patient Record System (CPRS), which is an integrated, comprehensive suite of clinical applications that work together to create a display of a veteran's EMR over time. CPRS

Exhibit 6.2
Use of Hospital Clinical Information Systems

System	Number Responding	In Use	Percentage
Laboratory	2,815	663	23.6%
Radiology	2,815	653	23.2%
Computerized physician order entry (CPOE)	2,815	561	19.9%
Computerized data repository (CDR)	2,815	329	11.7%
Chart deficiency	2,815	295	10.5%
Electronic attestation	2,815	209	7.4%
Other	2,815	105	3.7%

Source: HIMSS (2007).

capabilities include a real-time order checking system, a notification system that alerts clinicians to clinically significant events, and a clinical reminder system. By using VistA and adopting performance measures, the VA has reduced costs and errors and increased safety, efficiency, and patient satisfaction. According to a study by the RAND Corporation, a nonprofit research institution, the VA outperforms other sectors of U.S. healthcare across 294 measures of quality in disease prevention and treatment (RAND 2005). According to the American Customer Satisfaction Index, the VA's inpatient care outranks inpatient care in the private-sector healthcare industry (Miles 2006).

The federal government has made the computer source code for VistA available as free operating software. As a result, some rural critical access hospitals, Indian Health Service hospitals, and nursing homes have implemented it. For healthcare organizations with limited financial resources, the adoption of open-source EMR software is a viable alternative.

Evidence-Based Medicine

IOM's report *Crossing the Quality Chasm* (2001) identified EBM as one of ten characteristics essential to the redesign of healthcare systems in the twenty-first century (Johnson 2004). EBM is an ongoing process that categorizes and validates clinical research. It is estimated to take more than 20 years for clinical research to be accepted into medical practice; EBM can speed up this process (Ho et al. 2004).

Clinicians who practice EBM review the medical literature (i.e., online libraries, archives, and databases) comprehensively to discern the best clinical approach to treatment of a patient's condition (Evidence-Based Medicine Working Group 1992). EBM is not simply diagnosing a problem and then searching the literature to determine the best course of treatment, however. Clinicians must have extensive clinical knowledge to accurately identify the patient's condition and an ability to research the literature and apply the research findings.

Other components of EBM include the use of clinical practice guidelines and care maps, also called *clinical* or *critical pathways*, developed on the basis of a systematic literature review (see Highlight 6.1). Care maps also provide a basis for identifying best practice benchmarks (McQueen 2001).

The process of gathering information before making important decisions also applies to healthcare management, where it is called evidence-based management (Kovner, Fine, and D'Aquila 2009).

Strategic Planning for HIT

The American Recovery and Reinvestment Act of 2009 (ARRA) made available $12 billion to modernize the healthcare system by promoting and expanding the adoption of

HIGHLIGHT 6.1 Care Maps (Clinical Pathways)

Care maps, also called *critical pathways* and *clinical pathways*, are plans for treatment of a particular health condition. Care maps include the goals for the patient and a sequence of treatment and time frames for each item in the sequence. Healthcare providers use care maps to reduce the costs of care by making sure all patients with a particular diagnosis are treated the same way and no unnecessary or extra resources are used. Care maps are also thought to improve the quality of care by requiring that caregivers follow a plan that has been determined to produce the best results. The care map is a document, often a chart, used by all of a patient's caregivers, including doctors, nurses, and therapists.

HIT. It is estimated that this investment in healthcare information systems will reduce federal healthcare costs by over $12 billion over the next ten years. The ARRA HITECH (Health Information Technology for Economic and Clinical Health Act) grants will fund approximately 70 health information technology regional centers to help doctors and hospitals use EMRs.

According to one 2009 study, 89 percent of organizations have an IT steering committee and 86 percent have an information systems strategic plan. Recognizing the importance of information technology in ongoing healthcare operations, 83 percent of organizations have an IT disaster recovery plan (Harrison and Radcliffe 2010).

As mentioned previously, the VA has implemented digital technology in its clinical practice. It has a systemwide EMR for its 1,234 healthcare facilities, which include medical centers, outpatient clinics, nursing homes, readjustment counseling centers, and domiciliaries (U.S. Department of Veterans Affairs 2010). Clinicians can access pharmacy, radiology, nursing, and laboratory applications and place orders for services and medications via the EMR. The EMR also provides source data for administrative and financial databases, which are used in strategic planning (Hynes et al. 2004).

Exhibit 6.3 is an example of a HIT checklist that healthcare organizations can use to evaluate their progress in HIT planning and to benchmark against other organizations.

With the establishment of the Health Insurance Portability and Accountability Act of 1996, Congress expanded the use of HIT by requiring healthcare organizations, pharmacies, insurers, and other related entities to use electronic data interchange (see Chapter 4, Highlight 4.1). More recently, ARRA allocated $19 billion for HIT and made a commitment to invest $50 billion in HIT over the next five years.

EXHIBIT 6.3
HIT Checklist

HEALTH INFORMATION DASHBOARD

	Yes	No
Shared IT Vision	❒	❒
Structure of Consolidated IT Responsibility	❒	❒
Multidisciplinary IT Planning Committee	❒	❒
Integration of IT Systems	❒	❒
Data Warehouse in Place	❒	❒
Electronic Linkage to Patient, Physicians	❒	❒
Evidence-Based Medicine in Use	❒	❒
CPOE* in Use (>50% orders)	❒	❒
High-Quality IT Staff and Technology	❒	❒
Sufficient Capital Investment in IT (3%)	❒	❒
Community IT Health Initiatives	❒	❒
Biomedical Research Investments	❒	❒

* Computerized physician order entry

HEALTHCARE INFORMATION DATABASES

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

CMS (www.cms.gov) is a federal agency whose primary responsibility is to provide health insurance to U.S. citizens aged 65 or older. As part of this responsibility, CMS maintains extensive data on annual Medicare and Medicaid expenditures, the Children's Health Insurance Program, and national healthcare expenditures.

FedStats

FedStats (www.fedstats.gov) provides a full range of official statistical information produced by the federal government. The site provides links to more than 100 agencies that provide data and trend information on such topics as economic and population trends, crime, education, healthcare, aviation safety, energy use, and farm production.

NationMaster

NationMaster (www.nationmaster.com/index.php) is a massive statistical database compiled from such sources as the Central Intelligence Agency's *World Factbook*, United Nations, and Organisation for Economic Co-operation and Development, used to research and compare nations. NationMaster provides

- information on disasters, such as the extent of their devastation and the losses incurred by affected countries;
- economic information, such as gross domestic product, aid, per capita income, debt, inflation, trade balance, foreign investment, and government spending; and
- health statistics from countries around the world, including birth weights; smoking rates; incidences of HIV infection, cancer, and circulatory and other diseases; infant and maternal mortality; life expectancy; suicide rates; teenage pregnancy; and health expenditures.

U.S. Census Bureau

The U.S. Census Bureau (www.census.gov) provides extensive information from the American Community Survey (ACS), broken down at the zip code level. Instead of collecting census data every ten years as the decennial census does, the ACS collects population and housing data on an annual basis. The current information provided by the ACS helps communities determine where to locate services and allocate resources.

State Data

StateMaster

StateMaster (www.statemaster.com/index.php) is a statistical database that provides a multitude of different data on U.S. states. Healthcare data available through StateMaster

include state health status (in terms of such indicators as life expectancy and obesity levels) and comparisons of the health of residents by region. Its primary sources of data are the U.S. Census Bureau, the Federal Bureau of Investigation, and the National Center for Educational Statistics. In addition to numerical data, StateMaster displays data in visual formats, such as pie charts, maps, graphs, and scatterplots.

State Health Facts

State Health Facts (www.statehealthfacts.org/index.jsp) is a statistical database sponsored by the Kaiser Health Foundation. It contains extensive state-level demographic healthcare information, data on residents' income and employment, and other similar content.

Hospital Data

Agency for Healthcare Research and Quality

The Agency for Healthcare Research and Quality (AHRQ) is the health services research arm of the U.S. Department of Health and Human Services. AHRQ funds research in the following areas:

- Quality improvement and patient safety
- Outcomes and effectiveness of care
- Clinical practice and technology assessment
- Healthcare delivery systems
- Primary care and preventive services
- Healthcare costs and financing

AHRQ's website (www.ahrq.gov) provides links to research data, survey reports, and tools, including AHRQ's Healthcare Cost & Utilization Project (www.ahrq.gov/data/hcup).

GuideStar

GuideStar (www.guidestar.org) is a publisher of financial and other data on nonprofit organizations. Visitors to the site can view a nonprofit's recent Forms 990 or find out more about its mission, programs, and finances. Thanks to generous funding from a number of foundations, GuideStar's basic service is available at no charge.

Hospital Compare

Hospital Compare (www.hospitalcompare.hhs.gov) is a collaborative effort among CMS, the Hospital Quality Alliance, and the nation's hospitals to create and publicly report hospital quality information. The hospital quality measures show recommended care for some of the most common and costly conditions. The measures are based on scientific evidence about treatments known to produce the best results. Healthcare experts and researchers are constantly evaluating the evidence to make sure that the guidelines and measures continue to reflect the most up-to-date information.

California HealthCare Foundation

California has the largest state population in the United States. Its over 36 million residents represent 12 percent of the total U.S. population. In partnership with the University of California at San Francisco Philip R. Lee Institute for Health Policy Studies and the California Hospitals Assessment and Reporting Taskforce, the California HealthCare Foundation developed www.calhospitalcompare.org, a source of current data on quality in California hospitals. The 218 hospitals rated on this site account for 82 percent of hospital admissions in California, and the rated procedures (heart attack, heart failure, heart bypass surgery, pneumonia, and maternity) are the five most common conditions/treatments requiring admission to a hospital. The site also provides measures pertaining to surgery patients and patients admitted to intensive care units. Hospitals on this site are rated on quality and timeliness of care, overall patient experience, and adherence to recommended patient safety practices.

Medical Group Data

National Center for Health Statistics

The National Center for Health Statistics (NCHS) (www.cdc.gov/nchs), the nation's principal health statistics agency, compiles statistical information, mainly through surveys (e.g., the National Ambulatory Medical Care Survey), to guide health policy and improve the health of the population. NCHS's statistics document the health status of the population; disparities in health status by race/ethnicity, socioeconomic status, and region; and trends in healthcare delivery.

Florida Department of Health

Florida is one of the largest states in the United States. Its 17.7 million residents represent over 6 percent of the total U.S. population. The Florida Department of Health (www.doh.state.fl.us) provides a wide range of healthcare data on the state's providers and

residents through its databases, including annual vital health statistics data, public health data, information on hurricanes, Florida practitioner profiles, and professional licensure listings.

Nursing Home Data

Nursing Home Compare

CMS's Nursing Home Compare tool (www.medicare.gov/NHCompare/home.asp) evaluates nursing homes at the local, state, and national levels. CMS's Online Survey, Certification, and Reporting (OSCAR) database and Long-Term Care Minimum Data Set (MDS) Repository supply the information found on the site. OSCAR itself is populated with information documented from state nursing home inspections, which assess such factors as resident care, staffing levels, and living environment. The MDS Repository is populated with data on every resident in a Medicare- or Medicaid-certified nursing home. Information is collected on residents' health, physical functioning, mental status, and general well-being and compared to MDS quality standards.

Summary

Health information technology has important strategic value in the competitive healthcare environment. By implementing technology and processes that will improve patient care, healthcare providers can increase efficiency and profitability, enhance quality, and better coordinate care across the continuum of health services. As consolidation in the healthcare industry increases, HIT provides linkages necessary for the success of integrated healthcare delivery systems. From a risk management perspective, electronic medical records and supporting clinical information systems have the potential to reduce medical malpractice costs. HIMSS Analytics data demonstrate that healthcare delivery systems are increasingly implementing EMRs as a foundation for future use of clinical information systems.

E-health initiatives such as telehealth have the potential to improve the health status of patients at the local, regional, and national levels, particularly those in rural communities. E-health also promotes more efficient use of medical resources and helps reduce administrative costs.

Nearly 50 percent of physician-directed care in the United States is not based on best practice protocols (McGlynn et al. 2003). This statistic clearly documents the need for increased use of EBM. Technology is essential to keeping pace with the exponential growth of health information and applying this knowledge.

In the strategic planning process, healthcare leaders' support of healthcare informatics is essential. Particularly important are leadership support of IT steering committees and leadership involvement in the development of IT disaster recovery plans.

Review Questions

1. Discuss the role information plays in strategic planning in the healthcare industry.

2. Discuss how HIT can help healthcare providers adapt to the rapidly changing healthcare environment. Provide examples of several HIT systems experiencing significant growth.

3. Health information websites are an important source of information for patients and providers. Identify three websites that provide healthcare data, and describe the type of information they contain.

Coastal Medical Center Case: Exercise 6

According to Chapter 6 and the Coastal Medical Center case that appears at the beginning of the text, how can the information contained in the multiple databases be used to improve Coastal Medical Center's performance?

Questions

1. Coastal Medical Center failed to plan for investment in HIT. Develop a list of three health information technologies the Center should consider implementing and the impact they could have on the organization.

2. Develop an IT strategic plan for Coastal Medical Center.

3. Who should be involved in IT strategic planning, and at what point should you involve them?

4. How would you determine whether the IT strategic plan was successful?

CHAPTER 7

STRATEGIC PLANNING AND THE HEALTHCARE BUSINESS PLAN

The way to get started is to quit talking and begin doing.

—Walt Disney

Key Terms and Concepts

- Cost of capital
- Financial planning
- Healthcare business plan
- Horizontal integration
- Income statement
- Internal rate of return (IRR)
- Marketing plan
- Net present value (NPV)
- Payback period
- Pro forma financial statements
- Regression analysis
- Vertical integration

Introduction

Healthcare business plan
a methodology by which a healthcare organization evaluates future investment in a new business initiative

To compete in the healthcare market, providers must innovate. Healthcare organizations engage in business planning to (1) evaluate new business initiatives and ensure the initiatives are consistent with organizational strategy, (2) improve profitability, and (3) enhance the organization's reputation (Rovinsky 2002). Effective business planning is a formal, measurable process that evaluates resource allocation, performance, and the current business environment and forecasts potential demand for new services.

Definition

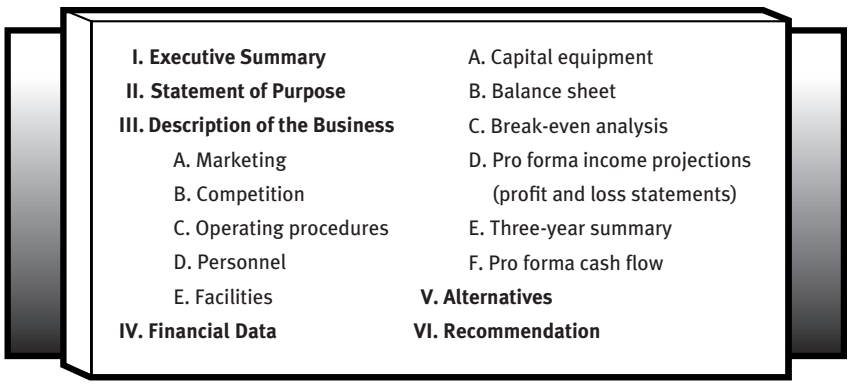
A **healthcare business plan** is a methodology by which a healthcare organization evaluates future investment in a new business initiative. To create a comprehensive business plan, a wide range of information must be gathered and future demand must be forecasted. A sample business plan outline appears in Exhibit 7.1. A business plan outline and examples of a written business plan also can be found on the U.S. Small Business Administration's website at www.sba.gov/starting/indexbusplans.html.

Healthcare Business Plan

An organization's healthcare business plan should be consistent with its overall mission and vision and should consider the competitive market. While the business plan is a written document, it is subject to change. Factors such as a shift in community demographics and competitors' actions will require an organization to revisit its plan and revise it as necessary.

The typical business plan includes a detailed discussion of the proposed healthcare service, identification of target markets, and financial projections. After the new service has been implemented, planners evaluate it over a multiyear period, usually three years.

Exhibit 7.1
Sample Business Plan Outline



The initiative's development can be monitored by setting targets and seeing whether those targets are met within that three-year time frame. Periodic evaluation over multiple years will return a fair, realistic assessment of the initiative's progress.

Horizontal integration expansion along existing lines of business, often through merger with other organizations and for purposes of increasing market share

Vertical integration expansion by means of a new line of business located somewhere along the continuum of care (e.g., a hospital that normally provides acute care may open a primary care clinic or acquire a skilled nursing facility)

Healthcare Business Plan Methodology

The healthcare business plan methodology is illustrated in Exhibit 7.2.

Introduction and Business Purpose

Corporate strategy depends on the *scope* of an organization—that is, the breadth and type of businesses it operates. For example, organizations can expand their current lines of business into new geographic areas (a strategy of **horizontal integration**), or they can choose to pursue new business initiatives, such as opening outpatient clinics, ambulatory surgery centers, or skilled nursing facilities, or acquiring and integrating physician group practices (a strategy of **vertical integration**) (Inamdar 2007).

Environmental Factors

Historically, healthcare has been less affected by economic factors than other industries have been. However, the economic recession of 2009 and unemployment rates of 12 percent in some areas of the United States are negatively affecting some local healthcare markets (Coleman 2010; Kalorama 2009).

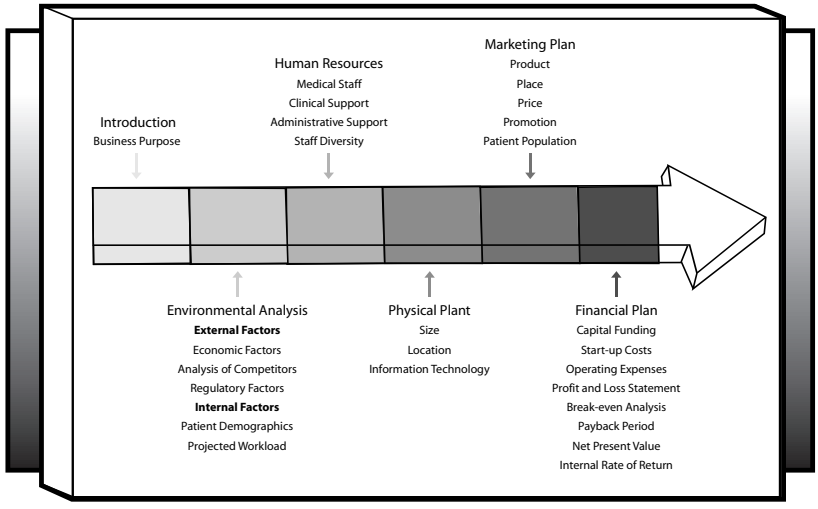


Exhibit 7.2
Healthcare Business Plan Methodology

Cost of capital
the rate of return an organization must achieve to make a capital budgeting project, such as building a new facility, worthwhile

Healthcare is delivered in local communities and is affected by market competition, making evaluation of current and potential competitors essential to the business planning process. A highly competitive market increases the vulnerability of a healthcare organization's strategic position by lowering profit margins and reducing operating capital. As market competition increases, healthcare organizations often consider mergers, acquisitions, or joint ventures to reduce costs, share risks, and enhance their reputations. Research suggests that consolidation can create economies of scale, help organizations maximize their use of resources in the local market, reduce administrative overhead costs, and lower the **cost of capital** (see Highlight 7.1). The resulting increased market share may also reduce operating costs and improve patients' awareness of the services an organization offers.

An analysis of for-profit healthcare competitors can be completed online using the competitor's name or stock symbol. On Yahoo! Finance (http://finance.yahoo.com), for example, analysts can enter the company's name or stock symbol and then select "profile" for a description of that company. Selection of other subheadings on the company's page will reveal stock price fluctuations based on corporate performance and other useful information.

HIGHLIGHT 7.1 Cost of Capital

When an organization has two investment opportunities of equal risk but must choose one, it hopes that the one it chooses will yield a greater rate of return. Say Hospital X can either open a new outpatient clinic or build a new parking lot. The hospital forecasts that it will earn a 7 percent return if it invests in a clinic and a 5 percent return if it invests in a parking lot, so it chooses to invest in a clinic. The 5 percent return the hospital "gave up" by choosing to invest in the clinic and not the parking lot is the *cost of capital*.

The interest on the funds used to make the investment also figure into the cost of capital. When an organization borrows money, it must pay back that money *plus interest*. Interest is a consideration even for organizations wealthy enough to not have to borrow money. The money that organization has in the bank is *earning interest*—for example, 3 percent. If it withdraws that money to make an investment, it will stop earning that 3 percent interest on that money. In both cases, the interest is part of the cost of capital, and the organization hopes that the return it will make on its investment will be greater than the interest it is paying (in the case of the organization that has to borrow money to make the investment) or not earning (in the case of the wealthy organization that is withdrawing money from its bank account to make the investment).

Regulatory Factors

When exploring new business initiatives, organizations must be mindful of government regulations pertaining to healthcare development. (See Highlight 7.2 for a discussion of the Stark laws, which regulate hospital partnerships with physicians.) Some states are subject to Certificate of Need regulations (see Chapter 2, Highlight 2.6), which require health services planners to obtain approval from state officials to build a new healthcare facility. The intent of these regulations is to limit the duplication of services in a geographic area.

HIGHLIGHT 7.2 The Stark Laws

The original Stark legislation—the Ethics in Patient Referral Act—took effect in 1992. The intent of this federal legislation was to reduce conflicts of interest regarding physician referrals and limit overutilization of healthcare services. The statute was expanded in 1995 under Stark II to prohibit physicians or their family members from referring Medicare patients to healthcare organizations in which they have a financial interest, including clinical laboratories and organizations that provide physical therapy, occupational therapy, radiology services, radiation therapy, durable medical equipment, home health services, and hospital services.

Stark III regulations went into effect on December 4, 2007, to institute exceptions to Stark II. These exceptions, called *safe harbors*, were designed to provide clear guidance in support of governmental healthcare policy. Under this revised legislation, for example, a physician can refer to a rural provider if 75 percent of the provider's patients come from a rural area. This safe harbor was designed to protect the healthcare infrastructure of rural communities and to encourage healthcare providers to practice in rural areas. Stark III also allows employed physicians to refer to other providers within their healthcare system. This modification helps bond independent physicians in the community to the healthcare system, which, theoretically, should promote better continuity of care.

In another effort to bond independent physicians to hospitals (and to each other) and promote continuity of care, the Internal Revenue Service issued a memorandum in May 2007 to allow hospitals to pay for (donate) up to 85 percent of the cost that community physicians would have to pay to obtain and use shared electronic medical record (EMR) software. The memorandum allowed hospitals to do so without being in violation of the Stark laws or losing their not-for-profit status. To qualify, the EMR software must have been certified by the Certification Commission for Health Information Technology within the previous 12 months (Raths 2008). The hospital's donation can cover the cost of the system software, system connectivity,

(*continued*)

HIGHLIGHT 7.2 The Stark Laws

(*continued*)

and training on the use of the EMR. The hospital cannot donate computer hardware, however (Sandrick 2008); the physicians have to pay for it on their own. According to the American Hospital Association's Center for Healthcare Governance, "For hospitals, a community physician EMR becomes a vehicle to bond the physicians more effectively to the hospital and provides the platform for real clinical integration with continuity of care. It also is an effective market defensive vehicle if the hospital is at risk of having referring physicians lured away by a competing hospital.... In some highly competitive markets, there can be a first-to-market phenomenon, where the hospital with the most attractive and cohesive community physician EMR initiative is more likely to lock in key physicians" (Duffy and Green 2007). CMS is planning on tracking hospital EMR donations through a detailed self-reported questionnaire and hiring independent contractors to review the questionnaires.

Violations of the Stark statutes are punishable by a $15,000 civil penalty, and any claim paid as the result of an improper referral is considered an overpayment, which the provider must pay back. Organized schemes to evade the statutes can be punished by a $100,000 civil penalty (Gosfield 2008).

Human Resources

Human resources are a critical factor in healthcare business planning and may determine the success of new business initiatives. Effective planning aligns human resources with organizational strategy and measures the status of human resources as part of the organization's balanced scorecard (see Highlight 7.3) (Fottler, Erickson, and Rivers 2006). For example, human resources could be measured according to the number and specialties of physician medical staff members, the level of certification held by clinical support personnel, and the overall diversity of the organization's staff.

To maximize organizational performance, effective leaders focus their efforts on recruiting the best individuals available. They start by identifying individuals who have a track record of success and who reflect the changing demographics of the population they serve (Hobby 2006). Once these individuals are on board and have demonstrated their knowledge and outstanding performance, they should be rewarded with appropriate financial compensation and other organizational recognition. Such recognition helps retain those who will lead the organization to future success.

HIGHLIGHT 7.3 Balanced Scorecard

The balanced scorecard is a strategy and management system that focuses an organization on several areas of performance measurement. Historically, in most cases, performance was measured on the basis of financial achievements alone. When Dr. Robert Kaplan and Dr. David Norton developed the balanced scorecard approach in the 1990s, they wanted to give management a more "balanced" approach to measurement.

The balanced scorecard shows, at a glance, an organization's goals and how it aims to achieve them. The scorecard is divided into several areas that the organization considers important to achieving its mission—for example, human resources, customer interactions, financial position, internal processes, and employee learning/growth. For each area, objectives are stated and specific measurements are identified that will demonstrate how the organization is progressing in that area. Target results are also listed to indicate what an organization hopes or expects to achieve. For example, the human resources section of the balanced scorecard might measure and list targets for employee turnover that include the turnover rate, cost per hire, length of employment, and so forth.

The balanced scorecard allows everyone in the organization to easily see what the organization's priorities are and which areas need improvement.

In a 2007 study on the recruitment and retention of nurses, Sabine Stordeur, researcher in the Department of Public Health at the Université Catholique de Louvain in Brussels, Belgium, and William D'Hoore, professor in the Department of Public Health at the same university, evaluated employee turnover in healthcare organizations and found that individuals leave for better pay, for better working conditions, and because of problems with supervisors. They believe a management style that values employee contributions and supports team decision making will result in lower employee turnover. Organizations that exhibited an organizational culture of trust, respect, and employee recognition had the lowest turnover rates.

Physical Plant

The communities' evolving healthcare needs should justify investments in new facilities. Successful organizations develop a facility master plan that incorporates high-performance work processes and the latest technology. Development of new processes is even more

critical for organizations with old facilities because their existing processes may be inappropriate for new facilities. Organizations planning for replacement facilities should consult process improvement experts to maximize organizational efficiency (Lauer 2007).

The first step in facility planning is a community needs assessment to identify current and future healthcare needs. Using this information, hospital leaders can create a plan that adds facilities as they are required by the community. Many hospitals create master campus plans, which include facilities inside and outside of the main hospital. The plans can also incorporate smaller new initiatives, such as expanded outpatient services that do not require major facility expenditures. In addition to community needs, organizations should evaluate local community demographics, the ethnic mix of the surrounding population, market share, and payer mix (Lauer 2007). A master facility plan can improve patient care, enhance community health status, and have a positive impact on overall profitability.

Expenditures on health information technology should be a strategic priority. For example, investments in EMRs and medical informatics should be included in any facility expansion. By combining high-performance work processes and investments in new facilities with state-of-the-art technology, healthcare organizations can streamline clinical processes, improve patient care, and enhance the organization's reputation in the community. Because development of new processes and investments in technology affect both the administrative and the clinical domains of healthcare, both leaders and clinicians should be involved in the facility planning process (Davis and Adams 2007).

Marketing Plan

Marketing plan
a written document that guides marketing activities by considering the competitive marketplace, the healthcare organization's capabilities, and areas with the greatest economic potential; can include the development of websites, educational seminars, radio or television advertising, printed brochures, and other materials and activities to promote a new business initiative

Marketing is important to healthcare business planning and is necessary to ensure the success of new business initiatives. Development of a formal **marketing plan** is an important part of the business planning process. The marketing plan considers the markets in which an organization operates and is a written document that guides marketing activities. It takes into account the competitive marketplace, the healthcare organization's capabilities, and areas with the greatest economic potential. Marketing plans can include website development, educational seminars, radio or television advertising, and the distribution of printed marketing materials. Marketing plans also consider expenses; an appropriate level of funding must be available to fund the ongoing marketing costs (Curnow 2007).

The key characteristics, or *four Ps*, of a marketing plan include

- *product*—the type of healthcare service to be offered and the quality outcomes to be measured;
- *price*—the fee schedule or rate of reimbursement for the service, adjusted for payer mix;

- *place*—the location of the service, including the facility, parking, signage, and easy access to major highways; and
- *promotion*—the method of advertising to be used to appeal to physicians, patients, health plans, and local businesses.

Reflecting the complexity of healthcare, a fifth P, *patient population*, has been added to the marketing methodology in Exhibit 7.2. An analysis of patient demographics is important because the demand for new healthcare business initiatives is often a function of age, sex, culture, and economic status. When forecasting the profitability of a new healthcare business initiative, it is also important to evaluate payer mix and the level of charity care the new business expects to provide. The marketing plan should ensure an appropriate payer mix to maximize profitability. Specifically, a high percentage of patients with commercial insurance will increase the level of profitability for a new business initiative, whereas a high percentage of patients who are dependent on Medicaid reimbursement or who have no way to pay (charity care) will reduce profitability (Inamdar 2007).

Traditional marketing methods include the use of the Yellow Pages (72 percent); websites (71 percent); brochures (57 percent); newspapers, radio, and television (35 percent); and physician directories (42 percent) (Redling 2007).

Financial Planning

Financial planning
the analysis of financial information, such as the development and evaluation of pro forma financial statements, to demonstrate potential performance of a new business initiative

Organizations engage in **financial planning** to model potential performance with regard to a new business initiative. An important part of financial planning is the development of **pro forma financial statements**. Key to the use of these statements in evaluating new business initiatives is the accurate forecasting of clinical workload. Because accurate forecasts are often difficult to make, healthcare organizations frequently develop pro forma statements reflecting different scenarios of potential workload. A multiyear analysis of new business initiatives is appropriate because an ongoing cash flow is necessary to pay back debt and meet operating expenses.

Pro forma financial statements
statements prepared before a business initiative is undertaken to model the anticipated financial results of the initiative

Income Statement

Income statement
a summary of an organization's revenue and expenses over a certain period

An **income statement** is a summary of an organization's revenue and expenses over a defined period. A *statement of operations* is similar to an income statement, except it is used by not-for-profit organizations and reflects the fact that they do not generate profits for owners (Zelman et al. 2003).

A projected income statement for a new physical therapy clinic is shown in Exhibit 7.3.

EXHIBIT 7.3
Projected Physical Therapy Clinic Annual Income Statement

Physical Therapy Clinic Annual Income Statement	New Clinic
1010 PHYSICAL THERAPY REVENUE	$384,155
100 SALARIES—GENERAL	85,000
1585 FRINGE BENEFITS	9,750
3500 MED/SURG SUPPLIES	1,435
3800 MARKETING	5,000
4600 OFFICE SUPPLIES	175
4640 POSTAGE/SHIPPING	134
4800 MINOR EQUIPMENT	1,314
5550 SUPPLIES AND MATERIALS	1,306
5630 LINEN EXPENSE	1,232
5640 REPAIRS AND MAINTENANCE	366
7030 BUILDING DEPRECIATION	24,000
7060 EQUIPMENT DEPRECIATION	1,612
7600 LEASE/RENT—EQUIPMENT	2,336
9100 PROFESSIONAL DUES	495
TOTAL EXPENSES	134,155
NET INCOME	$250,000

Payback period
the amount of time it takes a new business initiative to recoup the cost of the original investment made to implement that initiative

Payback Period

Payback period is calculated to determine how rapidly a new business initiative will recoup an organization's original investment in it. The shorter the payback period, the more rapidly an organization is able to recover its original capital investment and redeploy its resources to new projects. When prioritizing new business initiatives, organizations often pick projects that will have the shortest payback period.

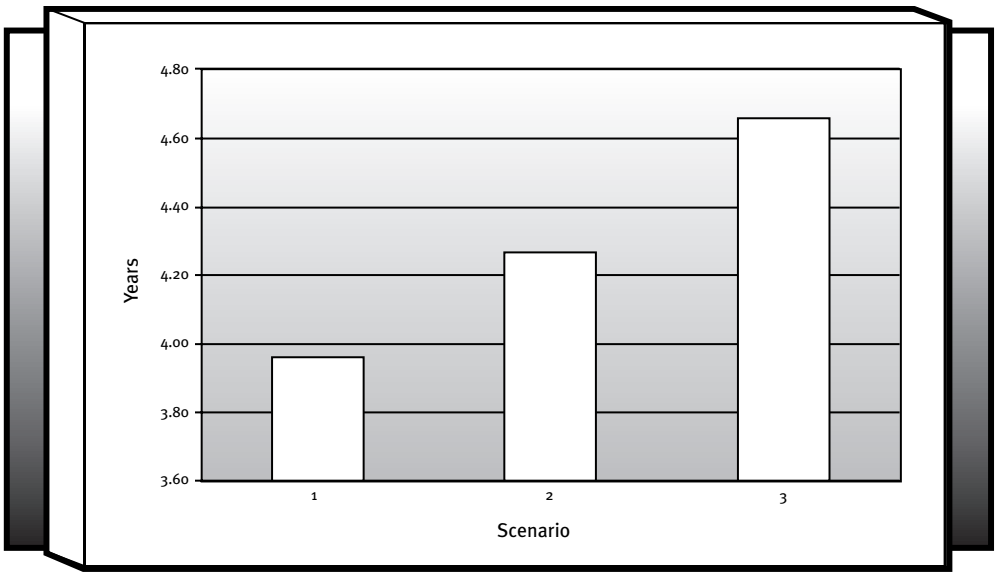


EXHIBIT 7.4
Projected Physical Therapy Clinic Payback Period

Exhibit 7.4 shows a payback analysis for the proposed physical therapy clinic featured in Exhibit 7.3. Note that it considers three scenarios, as discussed earlier in the Financial Planning section.

NET PRESENT VALUE

Net present value (NPV)
a figure calculated on the basis of discounted cash flow to evaluate the financial worth of a business initiative; the amount of money a business initiative is projected to earn minus the amount of money originally invested in it

Net present value (NPV) is a figure investors calculate to help them determine whether a capital project will be worth the investment. In basic terms, it is the amount of money a business initiative is projected to earn minus the amount of money invested in it. If NPV is greater than zero, the initiative is probably worth the investment; it will generate more money than the organization's original investment in it. If NPV is less than zero, the initiative is probably not worth the investment; it will not generate enough money to repay the investment in it. NPV uses *discounted cash flow*, which takes into account the fact that money loses value over time because of inflation and the cost of the capital invested in the project (see Highlight 7.4). A 12 percent cost of capital was used in the NPV calculations for the proposed physical therapy clinic in Exhibit 7.5.

HIGHLIGHT 7.4 Discounted Cash Flow

Discounted cash flow is used to determine the value of an amount of money over time. It revolves around the principle that a dollar today is worth more than a dollar tomorrow and uses a discount rate (also called a weighted average cost of capital) to calculate worth. The discount rate accounts for the change in value because of factors such as inflation and the return that could have been earned by investing the money.

The principle of discounted cash flow implies that an investment today is worth whatever amount it will earn for the investor in the future. For example, if you invest $1,000 today and expect it to earn another $100 in five years, the value of that money is actually $1,100. Put another way, the $1,100 that you have in five years is worth $1,000 today; thus, the discounted value is $1,000.

EXHIBIT 7.5
Projected Physical Therapy Clinic Payback Analysis

Physical Therapy Clinic Payback Period Scenarios (Cost of Capital 12%)

Payback Period 100% Volume

Cash Flows	Sq. Ft.	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Totals
Building Costs		$(750,000)	$ –	$ –	$ –	$ –	$ –	$ (750,000)
Net Income		$ –	$250,000	$255,000	$260,100	$265,302	$270,608	$1,301,010
Net Cash Flows		$(750,000)	$250,000	$255,000	$260,100	$265,302	$270,608	$551,010
Cumulative Payback		$ –	$ 250,000	$505,000	$765,100	$1,030,402	$1,031,010	
Cumulative Cash Flows		$(750,000)	$(500,000)	$(245,000)	$15,100	$280,402	$551,010	

Payback Period (Years) = 3.96 NPV = $183,787 IRR = 21.3%

Payback Period 90% Volume

Cash Flows	Sq. Ft.	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Totals
Building Costs		$(750,000)	$ –	$ –	$ –	$ –	$ –	$ (750,000)
Net Income		$ –	$225,000	$229,500	$234,090	$238,772	$243,547	$1,170,909
Net Cash Flows		$(750,000)	$225,000	$229,500	$234,090	$238,772	$243,547	$420,909
Cumulative Payback		$ –	$ 225,000	$454,500	$688,590	$927,362	$1,170,909	
Cumulative Cash Flows		$(750,000)	$(525,000)	$(295,500)	$(61,410)	$177,362	$420,909	

Payback Period (Years) = 4.27 NPV = $90,409 IRR = 16.7%

Payback Period 80% Volume

Cash Flows	Sq. Ft.	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Totals
Building Costs		$(750,000)	$ –	$ –	$ –	$ –	$ –	$ (750,000)
Net Income		$ –	$200,000	$204,000	$208,080	$212,242	$216,486	$1,040,808
Net Cash Flows		$(750,000)	$200,000	$204,000	$208,080	$212,242	$216,486	$290,808
Cumulative Payback		$ –	$ 200,000	$404,000	$612,080	$824,322	$1,040,808	
Cumulative Cash Flows		$(750,000)	$(550,000)	$(346,000)	$(137,920)	$74,322	$290,808	

Payback Period (Years) = 4.66 NPV = ($2,970) IRR = 11.8%

Internal Rate of Return

Internal rate of return (IRR)
the estimated rate of return of a project, taking into account the cost of the capital used in the project

Internal rate of return (IRR) is the estimated rate of return of a project, taking into account the cost of capital used in the project. In the same way that payback period may be used to prioritize projects (as discussed earlier in the chapter), an organization could choose the project with the highest IRR, thereby maximizing its overall profitability, and then continue down the list of projects. IRR for the projected physical therapy clinic, scenario 1, at 100 percent of projected workload (i.e., the amount of work expected to be completed by the clinic), is shown in Exhibit 7.5.

Planning Tools

Business Planning Software

A variety of software is available to assist business plan development. Most business planning software helps the business leader define the proposed product or service, identify the specific market(s) for that product or service, conduct market research, analyze the competition, determine the market position of competitors' products/services, describe the clinical care process, analyze financial performance, develop a staffing plan, and determine the legal structure (e.g., the legal structure could be a wholly owned for-profit or not-for-profit subsidiary corporation, a joint venture corporation owned partly by a healthcare organization, or a physician group).

Financial Analysis Tools

Microsoft offers a suite of financial planning tools within Excel that can be used for healthcare business planning. These tools, which can be accessed by clicking on "fx Insert Function" under the Formulas tab, can calculate IRR, payback period, NPV, and other values. Additional information on these capabilities can be found at http://office.microsoft.com/en-us/excel/FX100487621033.aspx.

Forecasting Tools

Development of accurate workload projections is another important part of healthcare business planning. Future demand for a new service can be estimated by looking at patient demographics in the market area. Age, sex, cultural diversity, per capita income, unemployment rate, and payer mix are all factors to consider in assessing the potential profit of a new business initiative. Consideration of referral information from physicians, health plans, and other healthcare organizations in combination with demographic data increases the accuracy of this estimate.

HIGHLIGHT 7.5 Regression Analysis

Regression analysis is a mathematical method of determining the relationship of one variable to another—for example, determining whether the number of visitors to the emergency department is related to the day of the month. To discover whether there is a relationship between these two variables, the analyst would gather data about both (the number of visitors to the emergency department and the calendar day) and graph the results. If a relationship is determined, a formula can be constructed that will allow a healthcare provider to predict the traffic to the emergency department on any given day.

Multiple regression analysis is the same as "basic" regression analysis, except in this case a greater number of variables are tested; for example, you might consider severity of illness and length of time spent waiting in the emergency department in addition to the number of visitors on certain days.

Regression analysis a tool used to determine the relationships between variables, usually the effect of one variable on another, such as the effect of a price increase on demand

Regression analysis (see Highlight 7.5) is a useful tool for forecasting changes in healthcare workload over multiyear periods. It provides an accurate estimate of future workload and can be adjusted to reflect seasonal fluctuations in the demand for health services. For example, healthcare organizations experience increased demand for services during flu season, which normally runs from October through February. While forecasting, it is important to consider the importance of both long-term trends and short-term variations in the healthcare business planning process. Examples of long-term trends in healthcare include a shorter length of stay for hospital inpatient care and the increased use of outpatient services. Several types of regression analysis can be performed in Excel, including linear regression, exponential regression, and multiple regression (Wan 1995).

Summary

Effective business planning enables integrated healthcare systems to allocate healthcare personnel, facilities, and information technology efficiently and deliver healthcare services to the local community in an organized fashion. To maintain a competitive position in the market, healthcare organizations are challenged to pursue new business initiatives. Successful business planning and accurate forecasts depend on the collection and analysis of historical data, input from clinical providers, patient demographic data, physician referral patterns, and competitors' market share. The use of forecasting tools such as regression

analysis increases the accuracy of forecasts by accounting for seasonal fluctuations in the demand for health services, short-term variations, and long-term industry trends.

The healthcare planning methodology discussed in this chapter is a model on which to base the business planning process. Part of this framework is the marketing plan, which is a written document that guides marketing activities. Preparation of the marketing plan requires a clear understanding of the competitive marketplace in which an organization operates as well as the organization's capabilities. When evaluating potential new healthcare services, the organization should focus on areas with the greatest economic potential. Another essential part of the business plan is the development of pro forma financial statements to document the profitability of new business initiatives. When analyzing these pro forma statements, profitability may be evaluated on the basis of financial indicators such as payback period, IRR, and NPV.

Review Questions

1. What is a healthcare business plan? What key sections are included in a healthcare business plan?

2. What are horizontal integration and vertical integration? How does vertical integration reflect a change of strategic direction for an organization?

3. Discuss the importance of financial planning in healthcare organizations. Describe several of the techniques used in the financial planning process.

Coastal Medical Center Case: Exercise 7

On the basis of the information provided in the Coastal Medical Center case and what you learned in Chapter 7, develop a healthcare business plan for a freestanding physical therapy clinic.

Questions

1. Who should be involved in developing the healthcare business plan?

2. How will you know if the healthcare business plan is a success?

3. What do you see as the value of the healthcare business plan for Coastal Medical Center's future success?

CHAPTER 8

COMMUNICATING THE STRATEGIC PLAN

You see things; and you say, "Why?" But I dream things that never were; and I say, "Why not?"

—George Bernard Shaw

Key Terms and Concepts

- Motivation

Introduction

Previous chapters of the book discussed the technical aspects of developing a strategic plan. To ensure it is implemented, the next step is to communicate it to the healthcare organization's stakeholders. These stakeholders include the board of directors, the leadership team, the medical staff, the nursing staff, administrative personnel, and key community leaders. Effective communication of the plan is essential to gaining their commitment and support.

Motivation

Motivation is a stimulus that energizes and drives people to achieve. This chapter addresses the importance of communicating in a way that motivates others to do things they normally would not do, to overcome barriers, and to perform to the best of their abilities (Schmid and Adams 2008). By communicating the strategic plan to stakeholders, an organization can generate grassroots support for new business initiatives and enhance their acceptance in the community. Internal communication of the strategic plan (within the organization) enables the board of directors, medical staff, nursing staff, and administrative personnel to become ambassadors for the organization and its new services within the community.

Motivation
the act or process of energizing people to overcome barriers and achieve outstanding performance

Presentation of the Strategic Plan

Communications pertaining to strategy can take many forms. Presentation of the organization's strategic plan to community groups, routine reporting of operational results following implementation of new healthcare services, and community education on accessing and utilizing new healthcare services are just a few examples. Regardless of form, effective presentations include certain critical components. These components are presented in Exhibit 8.1.

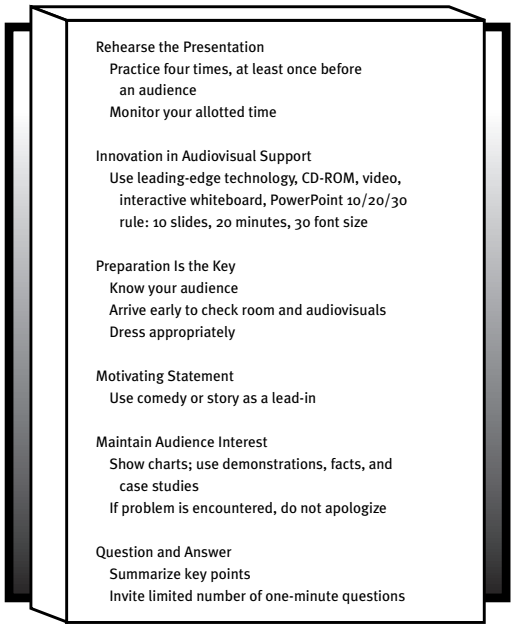
Improve Communications with Management

Effective internal communication positions an organization for success. Withholding or poorly communicating key information on finances, operations, or healthcare quality can have negative consequences. To improve communication with managers, leadership staff should avoid using technical jargon. They should educate department heads on accounting, finance, ratios, and benchmarks and make sure they have the financial reports they need to present the strategic plan and then measure operating performance over time. When they note deficiencies in communication, they should invest in self-help courses and books so that employees can improve their skills.

Preparation Is the Key

Presenters who know their audience can focus on meeting their needs. The purpose of a presentation is to influence an audience, so it must satisfy the audience's self-interest.

EXHIBIT 8.1
Components of Healthcare Presentations



Successful presentations answer questions, overcome objections, and present information previously not considered.

Early arrival to the site of the presentation is an important part of preparation. Presenters can test the audiovisual equipment, familiarize themselves with the room, and review the presentation. This extra time helps the presenter relax and reduces the chance that problems will occur (Baker 2004). Experienced presenters also have a back-up plan ready in case the equipment should fail.

The arrangement of both the room and audience can enhance or weaken the presentation. U-shaped seating is ideal for a workshop based on high audience participation. Classroom format (chairs in horizontal rows facing the front) may be suitable for informational presentations but limits audience participation. Boardroom seating (chairs around a table) works well for small groups and fosters discussion among the audience. Bistro seating (randomly placed tables) is another format that encourages discussion and is useful for group work. The objective is to make the audience comfortable, provide them with a clear view of the presenter, and facilitate participation (Bosworth 2005).

A speaker's credibility begins with preparation and appearance. Dress, body language, and the use of audiovisual support can create positive (or negative) perceptions. Good eye contact with the audience and good stature can convey confidence and professional expertise. Distracting gestures, such as jingling coins, clicking a pen, or adjusting clothing should be avoided. Monotone, mispronunciation, excessive pauses, and "uhs" and "ums" are also poor technique (Chaney and Green 2006).

Motivating Statement

A presentation comes to life with stories, facts, and examples. Humor targeted to the audience can be effective in engaging the group as well (Holliday 2007a). The challenge lies in integrating these elements.

When introducing a new healthcare business initiative, leaders can express the positive impact it will have on the local community, the potential for increased profitability, and the ways in which it will enhance quality. Appealing to the individual is also powerful when employees will be able to improve their job skills, make more money, or gain greater prestige in the community as a result of the new program.

Rehearse the Presentation

A presentation should be rehearsed at least four times. Family, friends, or colleagues can serve as an audience and provide honest feedback. The rehearsals should also be timed to ensure that you cover your presentation in the allotted time while allowing for a question and answer period at the end (Holliday 2007a).

Audiovisual Support

The use of technology can enhance presentation delivery. A presentation with visual support is five times more likely to be remembered. Microsoft PowerPoint, for example, is a widely popular presentation aid. To be effective, however, PowerPoint slides must be crafted carefully; otherwise, they will deflate your presentation and your audience will lose interest. Some follow the 10/20/30 PowerPoint rule, which recommends that a PowerPoint presentation contain 10 slides, last for 20 minutes, and use 30-point font for any text it includes. In choosing colors for the presentation's background text, keep the lighting in the room in mind. For example, in a light room, bright text on a dark background is recommended. Conversely, in a dark room, a light background with dark letters may work better. Most important, text should be kept to a minimum. The audience is there to hear the presenter speak. Slides featuring high-resolution photos can help the presenter tell a compelling story. If text is necessary, the software has a feature that enables the presenter to display information one bullet at a time to prevent the audience from reading ahead and losing track of what you are saying. Even more effective is to limit the text on each slide to five words. Alternatively, laser pointers can be used to emphasize items on a slide (Holliday 2007b). Finally, unless the speaker has a booming voice, a quality microphone is essential.

Videos, webcasting, and interactive whiteboards may also enhance a presentation. Electronic whiteboards offer presenters flexibility because notes can be presented directly from the board, or the audience can download the notes to storage devices. Electronic whiteboards can also link participants to each other and to the presenter via the Internet, facilitating presentations across the world (Baker 2004).

Maintain Audience Interest

Presenters can maintain an audience's interest by showing trends on charts, performing demonstrations, supporting statements with facts, relating anecdotes and case studies, and developing theories with visual diagrams and videos (Bosworth 2005). Key items should be arranged in groups of three to maintain focus and ensure the audience understands the information being presented. According to Aristotle (1992), an ancient mathematical law supports groupings of three. Examples in history include quotes by Julius Caesar—"I came, I saw, I conquered"—and the phrase "life, liberty, and the pursuit of happiness" found in the U.S. Declaration of Independence. Individuals more easily remember items in groups of three (Holliday 2007a). Audiences will not remember your groupings, however, if they are not engaged. Conversational, interactive presentations hold audiences' attention and keep them alert.

It is important to pause periodically to ensure that the audience understands the material. Such pauses can help a presenter establish rapport with the audience and provide an opportunity for participants to ask questions.

Question and Answer Session

Ending a presentation approximately ten minutes before the scheduled time gives a presenter an opportunity to summarize key points and invite questions from the audience. An effective method of managing expectations is to ask everyone in the audience with a question to raise his or her hand and then give each question an equal share of the remaining time. Doing so will limit the length of the question as well as the time for response. Questions should be repeated to the audience and answers kept to a maximum of one minute. If an expert in the audience has information relevant to one of the questions, he or she can also contribute. When faced with negative or inappropriate questions, listen carefully and respond in a manner relevant to the presentation. For example, rephrase a negative question in a more positive manner and then respond. For questions that are inappropriate or of no interest to the group, thank the individual for the question and tell him that you will address it with him after the presentation.

In conclusion, outstanding presentations result from understanding the audience, identifying the key items in the material, and finding the best method for delivery.

Summary

Effective communication of the strategic plan transfers knowledge to staff and stakeholders and garners support for new initiatives. Good presenters rehearse their presentation, know their audience, arrive early to evaluate the room, and ensure all equipment works. They engage their audience immediately with a motivating statement that captures the

importance of the topic, establish themselves as subject matter experts, and use audiovisual technology to support the delivery of their message. They avoid using technical jargon and acronyms, limit the number of main points, and integrate the key components listed in Exhibit 8.1. Finally, to wrap up the discussion, effective presenters summarize their key points and allocate time to respond to questions.

Review Questions

1. Who are key stakeholders in a healthcare organization? Provide an example of a motivating statement that might engage one of these groups.

2. Discuss the key components of a healthcare presentation. Highlight three items you think are most important.

Coastal Medical Center Case: Exercise 8

On the basis of the business plan you developed in Chapter 7 and the outline you created in Chapter 4, present a strategic plan for Coastal Medical Center as if you were addressing the Center's board and senior leadership.

Questions

1. Over the last two years, Coastal Medical Center has experienced declining performance. Develop a motivating statement that will generate support among the Center's employees to implement the strategic plan. Also, give three suggestions for making an effective presentation on the Center's financial data.

2. In the future, when Coastal Medical Center allocates its resources in the strategic planning process, which is most important: developing the strategic plan or communicating the strategic plan?

CHAPTER 9

MEDICAL GROUP PLANNING AND JOINT VENTURES

...I will continue with diligence to keep abreast of advances in medicine. I will treat without exception all who seek my ministrations, so long as the treatment of others is not compromised thereby, and I will seek the counsel of particularly skilled physicians where indicated for the benefit of my patient....

—Excerpt from *The Hippocratic Oath (Modern Version)*

Key Terms and Concepts

- Clinical integration
- Co-opetition
- Co-optation
- Equity-based joint venture
- Hospitalist model
- Integrated physician model
- Medical foundation model

Introduction

A positive relationship between hospitals and physicians is important to the success of the U.S. healthcare system, as hospitals and physicians can be both collaborators and competitors. Physicians play a key role because they function as patients' "agents" and direct clinical services. Physicians are responsible for major decisions, including whether to admit patients to a hospital, whether to perform procedures, and whether to use pharmaceuticals or other supplies. A case can be made that, directly and indirectly, physicians control 87 percent of all personal health spending (Sager and Socolar 2005).

Physicians work in a wide range of settings. In 2008, 32 percent of physicians worked in private practice or in two-physician practices, 15 percent worked in groups of 3 to 5 physicians, and 19 percent worked in practices of 6 to 50 physicians. Thirteen percent were employed by hospitals, and 7 percent worked in medical schools (Boukus, Cassil, and O'Malley 2009). Physicians also serve in leadership positions and have significant responsibility for the quality of care. Unfortunately, increasing economic pressures, advances in technology, and increasing use of outpatient care are straining the relationship between hospitals and physicians and forcing them to compete for patients (Gosfield and Reinertsen 2007). In addition, managed care organizations routinely bargain with hospitals and physicians separately, which only exacerbates the divide.

Clinical Integration

Through **clinical integration**, hospitals and physicians can bridge their separation and diffuse the competition between them. Clinical integration provides an opportunity to coordinate services through centralized scheduling, electronic medical records, clinical pathways (see Chapter 6, Highlight 6.1), management of chronic diseases, and innovative quality improvement programs (Burns and Muller 2008).

Clinical integration coordination of patient care between hospitals and physicians across the healthcare continuum

By pooling their resources, hospitals and physicians also benefit financially. Clinical integration facilitates access to expensive medical technology, allows for greater economies of scale (see Chapter 1, Highlight 1.1), and enables subsidization of unprofitable services.

Hospitals and physicians are inherently interdependent. The ability to recruit and retain quality physicians is critical to a hospital's reputation, market share, and long-term profitability. Most patients are admitted to hospitals because of physician referral. Therefore, hospitals seeking to increase their market share would be wise to focus on improving their relationships with physicians (Press Ganey 2008). Conversely, physicians rely on hospitals to provide facilities, state-of-the-art technology, and high-quality clinical staff.

As noted in Exhibit 9.1, hospital inpatient and outpatient services combined represented 46 percent of total healthcare spending in 2008, while physician services ranked second at 35 percent of healthcare spending and pharmacy third at 15 percent.

EXHIBIT 9.1
Components of Medical Spending (2008)

Component	Spending	Percentage
Physician	$5,435	35%
Inpatient hospital	$4,724	30%
Outpatient facility	$2,516	16%
Pharmacy	$2,302	15%
Other	$633	4%

Source: Milliman Medical Index (2008).

POTENTIAL STRUCTURES FOR PHYSICIAN–HOSPITAL INTEGRATION

Many healthcare leaders believe that physician–hospital alignment is one of the greatest challenges facing the U.S. healthcare system. Hospitals and physicians are faced with the task of finding innovative ways to collaborate while improving their joint economic interests. Development of a formal, board-approved physician–hospital alignment plan can help hospitals achieve this goal. At a minimum, physician engagement in strategic planning, development of an organizational culture that supports physicians, improved communication with physicians, increased emphasis on physician retention, and investment in physician leadership development are recommended objectives to include in an alignment plan (McGowan and MacNelty 2007).

Medical foundation model
an arrangement under which independent physicians sell their practices to a medical foundation and then contract with the foundation to provide professional services at the foundation's practice sites

MEDICAL FOUNDATION MODEL

A growing volume of research supports implementation of the **medical foundation model**, under which independent physicians sell their practices to a medical foundation and then contract with the foundation to provide professional services at the foundation's practice sites. This arrangement allows physicians to be more independent than hospital-employed physicians and is a strategy for improving physician–hospital relationships (Peregrine and Glaser 1995).

A foundation is typically a not-for-profit corporation affiliated with a hospital. The medical foundation model works well in states that prohibit the corporate practice of medicine because the physicians are not employed by the foundation; they only contract with it. Reimbursement for physician services is paid to the foundation, and the foundation then pays the physicians for their services.

Historically, medical foundations have been successful at recruiting physicians and establishing clinics. More recently, however, opposition to medical foundations is growing among individual physicians, small practices, and loosely affiliated independent practice associations. This opposition is growing because hospitals and physicians can jointly participate in managed care contracts under this model, thereby gaining greater market share and more business. This situation increases competitive pressures on individual physicians in small group practices because they have limited presence in the overall marketplace. Despite this resistance, the medical foundation model remains attractive to young family practice physicians just out of their residency training because it provides them adequate compensation and they do not have to make significant investments in facilities and technology because the clinics furnish these essentials.

Hospital-Owned Group Practices

Hospital acquisition of medical group practices began in the 1990s as healthcare organizations created integrated delivery systems. A primary motivator for acquiring medical practices was to gain market share in the local community. Primary care practices could drive a large number of referrals to a hospital, so these practices were the first type of physician group that hospitals sought to purchase. Today, hospitals may purchase a variety of practices, including cardiology groups, orthopedic groups, and neurosurgery groups. Hospitals that purchase medical groups can improve integration, expand patients' access to care, and foster long-term relationships with their physicians.

According to the Medical Group Management Association (2010), the number of hospital-owned medical groups has increased 25 percent from 2003 to 2008. As of 2008, hospital-owned medical groups account for 10 percent of all medical groups. Likewise, the average number of physicians included in a hospital-owned group has increased by 19 percent. Among other factors, this growth can be attributed to changes in operating costs. In 2008, operating costs for physician practices not owned by a hospital increased by 3.9 percent over the previous year, whereas operating costs for hospital-owned practices decreased by 7.6 percent.

Hospitalist model
an arrangement under which an inpatient physician assumes primary responsibility for managing a patient upon admission to the hospital and supervises all inpatient care until the patient is discharged from the hospital

Hospitalist Model

Under the **hospitalist model**, a patient's regular outpatient physician transfers complete responsibility for the patient's care to a dedicated inpatient physician when the

patient is hospitalized. This physician supervises all of the patient's inpatient care until discharge. Hospitalist physicians can be hospital employees or members of an independent hospitalist physician group. As of 2008, there were approximately 20,000 hospitalists in the United States. This number is expected to grow to more than 40,000 over the next ten years (Siegal 2008).

Use of the hospitalist model has had a positive impact on hospitals' profitability. According to a 2004 study, hospitals using the hospitalist model had a return on assets of 3.1 percent, whereas those not using the hospitalist model took a loss, with return on assets of –1 percent (Harrison and Ogniewski 2004). Additionally, use of a hospitalist program reduced average length of stay from 11.9 days for those without hospitalists to 6.5 days for those using hospitalists. Overall, 70 percent of organizations that have implemented a hospitalist program give it a positive rating and believe it enhances the quality of care they provide (McGowan and MacNelty 2007).

In choosing a physician model, strategic planners need to consider hospital size to determine whether a given model is appropriate or feasible. Hospitalists are more prevalent in large, complex hospitals that offer a wide range of clinical services. In this setting, hospitalist physicians may be critical to the coordination of care across multiple clinical service areas. Smaller hospitals offering fewer services may have a lesser need for hospitalists and may best operate under a different physician model (Harrison and Ogniewski 2004). On the other hand, hospitalists can help manage inpatient workload when a limited number of specialists are available to provide care, as may be the case in a smaller hospital.

Joint Venture Initiatives

As discussed in Chapter 2, joint ventures are created when two organizations create a legal entity to participate in an economic activity. Each party contributes money to the venture and shares in its profits. The combining organizations share control of the joint entity, and the joint entity gains a larger customer base through the combination of each organization's customers (patients), giving the joint venture a competitive advantage in the marketplace (Sanderson, Rice, and Fox 2008).

Before the 1990s, hospitals and physicians focused on their separate roles. However, as a result of the increase of managed care in the 1990s, hospitals and physicians began to enter into strategic ventures to increase profitability and to gain greater leverage with managed care companies. Instead of bargaining with physicians and hospitals separately and placing them in competition with each other, managed care companies bargain with the combined physician–hospital enterprise, diffusing this competition. Additional benefits include shared technology, collaborative research, shared expertise, and an increased market share. In the current economic environment, organizations and physicians have limited access to financial markets; by combining their money and customer base, strategic ventures gain greater access to capital and dominance in the market. Organizations can also expand their product lines through joint ventures and thereby increase organizational capacity (Walsh and Szabat 2002).

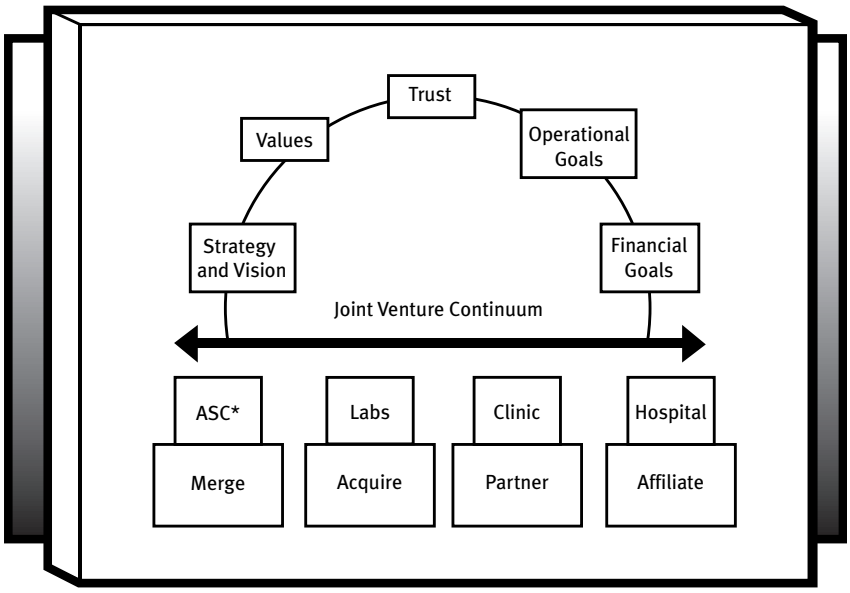


Exhibit 9.2
Hospital–Physician Joint Ventures

* Ambulatory surgery center

According to one survey by *Trustee* magazine, the Health Research & Educational Trust (an affiliate of the American Hospital Association), and the Center for Healthcare Governance, 50 percent of hospitals have begun or are planning joint ventures with physicians. Most of these joint ventures are for outpatient services, ambulatory surgery centers, medical office buildings, and specialty hospitals (Burns and Muller 2008; Anonymous 2007a). See Exhibit 9.2.

Equity-based joint venture
an organization whose ownership is divided between a hospital and physicians on the basis of their contributions to the enterprise

Equity-Based Joint Ventures

Equity-based joint ventures, which are based on a new model of business cooperation known as **co-opetition**, move beyond the traditional win-lose business mentality and focus on complementary relationships among physicians, hospitals, and suppliers. The concept of co-opetition is derived from **co-optation**, which is the absorption of new individuals into an organization for purposes of diffusing the threat of challenging groups.

Co-opetition
a model of business cooperation that focuses on complementary relationships among physicians, hospitals, and suppliers

Co-optation
the absorption of individuals into an organization for purposes of diffusing the threat of challenging groups

In equity-based joint ventures, ownership is divided between the hospital and the participating physicians. The hospital and physicians create a new organization and contribute funds, facilities, or services equal to their ownership proportion. For an equity-based joint venture to succeed, there must be positive relationships among the owners and mutual benefits. For physicians, joint ventures present an opportunity to gain ownership in an organization, to have a positive impact on the community, to increase their revenue, to engage in research, and to sustain their practices over the long term (Kittredge 2001). Many physicians find these benefits so attractive that they are willing to participate in

joint ventures with hospitals even in markets affected by high managed care penetration and the accompanying risks of capitated reimbursement mechanisms (Nichols et al. 2004) (i.e., the managed care organization reimburses for care provided only up to a certain amount, regardless of the cost of the services provided, so the physician risks bringing in less revenue).

From a hospital's perspective, a joint venture does not always have to generate a profit because other benefits may accrue to the organization. For example, the joint venture may enhance recruitment of physicians, increase hospital admissions, or improve access to managed care contracts. A case can be made that even for-profit hospitals are willing to participate in unprofitable joint ventures because they may increase revenue farther down the continuum of care or are able to increase their percentage of market share, which then becomes a barrier to potential new competitors.

Equity-based joint ventures between hospitals and physicians have demonstrated that they improve clinical treatment and enhance communication between hospitals and physicians. Where hospital and physician joint ventures have not succeeded, the greatest problems were lack of trust, unequal contribution of capital, and disagreement on overall control (Rovinsky 2000). To prevent such problems, all parties must agree on the goal, the strategic direction, and anticipated financial performance of the joint venture before embarking on it. Board regulation and hospital policy also deter such issues.

Joint Ventures and Profitability

According to a 2006 study, hospitals engaging in joint ventures with physicians had occupancy rates of 55 percent versus 53 percent for those not engaged in physician joint ventures. In terms of scope, hospital–physician joint ventures offered an average of 32 clinical services, whereas hospitals without physician joint ventures averaged 26 clinical services. In financial terms, hospitals with physician joint ventures had a return on assets of 2.5 percent versus 1.9 percent for those not participating in joint ventures with physicians (Harrison 2006).

Physician Employment

Instead of pursuing joint ventures or implementing one of the models discussed earlier, hospital strategists may opt for the direct hire of physicians. As employees, physicians are exempt from the Stark laws (see Chapter 7, Highlight 7.2) and therefore are able to refer patients for other services within the same hospital. Physician employees are more likely than independent physicians to stay with their employer hospital over the long term, which enables the hospital to staff a consistent workforce with critical clinical skills. Employed physicians' referral patterns are also more predictable. Disadvantages of physician

employment include the high cost of recruitment and increased costs for salary, fringe benefits, and graduate medical education.

Integrated Physician Model

An **integrated physician model** is the result of a series of partnerships between hospitals and physicians developed over time. Essentially, it is a joint venture that has become many joint ventures, and all of these joint ventures are connected through congruent goals. For example, an integrated physician model could include acute care hospitals, nursing homes, affiliated medical groups, primary care clinics, employed physicians, and independent medical groups.

Integrated physician model
a series of partnerships between hospitals and physicians developed over time

Physician Engagement in Strategic Planning

Hospital involvement of physicians in the decision-making process helps the hospital and physicians reach agreement on the values, ethics, and culture of the new business initiative (Blaszyk and Hill-Mischel 2007). Physician empowerment is key to increasing physicians' engagement in the hospital's future. Empowerment begins with physician participation on the hospital board of directors and on key board committees (Dadlez 2008). The president of the medical staff should be a voting member of the board, and physicians should be members of the strategic planning and finance committees. By soliciting their input, including them in focus groups about new business initiatives, involving them in the creation of the strategic plan and work schedules, and granting them the opportunity to become co-owners of the organization, hospitals can inspire physicians to commit to new business ventures. For example, if physicians are involved in the development of metrics to be used to evaluate the quality of care the organization provides, they will respond in a positive manner and not feel resentment if the data show a need for improvement.

Summary

The U.S. healthcare system is fragmented, and research suggests that the quality of healthcare is deteriorating. Many healthcare leaders believe that clinical integration and coordinated strategic planning between hospitals and physicians is necessary to improve this state of affairs. Large, integrated healthcare delivery systems will be better able to deal with future healthcare needs because they have greater access to capital and deliver clinically integrated care.

Hospital–physician integration can take many forms. Hospitals can contract with physician group practices and gain greater market share through managed care networks. Such relationships can lead to joint ventures, in which hospitals share ownership of the

enterprise with physicians. Finally, employment of physicians by hospitals and health systems is a growing trend. This arrangement frees physicians from the frustrations associated with managing a practice and allows them to focus on providing clinical care.

Review Questions

1. How does involving physicians in the strategic planning process help a hospital reach its goals?

2. Why is clinical integration important today?

3. Choose one of the potential models for hospital–physician integration discussed in the chapter and list the potential advantages and disadvantages for the hospital as well as the physician under this model.

Costal Medical Center Case: Exercise 9

According to Chapter 9 and the Coastal Medical Center case that appears at the beginning of the text, is adoption of the medical foundation model a viable strategy for Coastal Medical Center?

Questions

1. How should physicians be involved in strategic planning at Coastal Medical Center, and at what point should you involve them?

2. How would you assess physician engagement at Coastal Medical Center?

3. What do you see as the future of physician involvement at Coastal Medical Center?

CHAPTER 10

STRATEGIC PLANNING AND LONG-TERM CARE SERVICES

Twenty years from now you will be more disappointed by the things that you didn't do than by the ones you did do. So throw off the bowlines. Sail away from the safe harbor. Catch the trade winds in your sails. Explore. Dream. Discover.

—Mark Twain

Key Terms and Concepts

- Adult health daycare center
- Comorbidity
- End-of-life care (EoLC)
- Hospice
- Inpatient rehabilitation facility (IRF)
- Long-term care
- Post-acute care (PAC)
- Prospective Payment System (PPS)
- Skilled nursing facility (SNF)

Introduction

Long-term care
medical and personal services provided over an extended period to people who have chronic illness or disability

This chapter discusses trends and factors affecting strategic planning in the post–acute care industry. As the longevity of Americans increases and the number of baby boomers reaching retirement grows, the demand for post–acute care and other types of **long-term care** services will escalate. These developments pose strategic planning opportunities and business growth potential for a wide range of healthcare providers.

Conversely, these factors also have the potential to significantly increase federal expenditures on the Medicare program. The Centers for Medicare & Medicaid Services (CMS) is concerned that a fragmented long-term care system will increase costs and adversely affect the quality of care, so to work against increased expenditures and fragmentation, it is considering bundling the payment for all post–acute care services that a Medicare patient receives after being discharged from an acute care hospital. Such a bundled payment would require long-term care providers such as inpatient rehabilitation facilities, skilled nursing facilities, adult daycare centers, and hospice facilities to work closely together to be able to assume the risk associated with bundled Medicare payment for post-acute care—the risk of paying more to provide care than is received in reimbursement.

CMS views this bundling as a better approach to managing Medicare patients across the continuum of post–acute care services. A bundled payment approach also opens up opportunities for post–acute care providers to acquire, merge, or pursue joint ventures with other post–acute care providers.

Chronic conditions are the leading cause of illness, disability, and death in the United States and account for the majority of U.S. healthcare expenditures (IOM 2001). Although chronic diseases can affect people in any age group, there is a high incidence of such conditions among the elderly. As the U.S. population ages, more and more people will require chronic disease management and end-of-life care. In addition, due to advances in trauma care as well as improved medical practice, people often survive a number of major illnesses and live well into old age. As discussed in the *World Factbook* for 2010, the life expectancy in the United States ranks 49th in the world and increased to a record high of 78.11 years in 2009 (CIA 2010). As a result, chronic disease and a period of significant disability precede most deaths. Unfortunately, the U.S. healthcare system focuses on curing disease and prolonging life but is poorly designed to provide care at the end of life. This demographic shift supports the need for increased focus on long-term care planning.

Strategic planners look at their payer mix (entities that reimburse them for the services they provide) to determine whether a new business initiative will be financially profitable. For example, at current payment rates, reimbursement from both Medicare and Medicaid is often less than the amount the provider spent to deliver the services. Commercial insurance and PPO payment rates are higher.

Care for elderly patients in acute care hospitals, inpatient rehabilitation facilities, and hospice facilities is paid for by Medicare Part A. Medicare's reimbursement for skilled

nursing facility care is limited; its lifetime limitation is reimbursement for 100 days of skilled nursing care. In contrast, Medicaid has no such limitation, so the majority of the care for skilled nursing patients is paid for by Medicaid. Unfortunately, Medicaid's reimbursement rate is the lowest of all payers.

As part of its cost-cutting strategy, Medicare is attempting to shift post-acute care into less expensive outpatient treatment and hospice care options. In 1999 Medicare spent $25 billion on post-acute care, with a goal of improving elderly patients' function after hospital discharge. Expenditures on post-acute care increased to $42 billion in 2005—13 percent of total Medicare spending that year. Expenditures on skilled nursing care, which have been increasing at a rate of 9 percent annually, account for the largest proportion of Medicare spending on post-acute care (Hoover et al. 2008; Hoverman et al. 2008).

Definitions

This chapter focuses on **post–acute care (PAC)** services, which are healthcare services provided to a patient after he or she is discharged from an acute care hospital. Specifically, PAC services include inpatient rehabilitation, skilled nursing care, and hospice and home health care. Nursing home services are not included in this group; they are considered long-term care services. In most cases, PAC planning is a joint decision-making process involving the patient, the patient's family, the patient's physician, and a hospital discharge planner. The three patient groups with the highest rate of PAC utilization are stroke patients, patients with hip fractures, and patients undergoing joint replacement. In a 2005 study, these patients accounted for 7 percent of Medicare acute care hospital discharges and 25 percent of discharges to a PAC setting (Buntin et. al 2005). Other chronic conditions that frequently require PAC are cancer, pulmonary disease, congestive heart failure, liver disease, diabetes, renal failure, dementia, Alzheimer's disease, and Parkinson's disease.

Post-acute care (PAC) services provided after discharge from an acute care hospital

End-of-life care (EoLC) is care provided when a patient is not expected to recover from his or her condition and further treatment is futile. EoLC does not focus on life-sustaining treatments but is designed to maximize patient comfort. Such end-of-life treatment, also called *palliative care*, involves the use of medication as well as other medical and surgical procedures that can increase patient comfort. Key to this process is the involvement of a multidisciplinary clinical team that manages the treatment process according to the needs and desires of the patient and family. This type of management is considered a *family-centric approach* to EoLC (Coombs and Long 2008).

End-of-life care (EoLC) care provided to improve the quality of life of patients who are facing life-threatening disease or disability and are not expected to recover

EoLC includes hospice services, which focus on pain relief and help the patient and family cope during the time leading up to the patient's death. In addition to pain management, hospice offerings include a comprehensive mix of services, including bereavement counseling, home health care, hospital services, skilled nursing services, and other residential care services (Martin et al. 2007).

Demographics of an Aging Population

In the United States, the proportion of the population aged 65 or older is projected to increase from 12.4 percent in 2000 to 19.6 percent in 2030, or approximately 35 million to 71 million people. The number of Americans aged 80 or older is expected to increase from 9.3 million in 2000 to 19.5 million in 2030 (U.S Census Bureau 2008). The U.S. healthcare system is facing the challenge of meeting their need for chronic care.

Research conducted in 2008 found that women are more likely than men to use acute care hospitals, skilled nursing facilities, hospices, and home health services (Shugarman et al. 2008). Additionally, women's average expenditures for skilled nursing facility, hospice, and home health care were $1,900 greater than men's per year. Similarly, a 2007 study found that 53 percent of the population in large community hospices was female and that there is a high incidence of cancer and other chronic illnesses among elderly hospice patients (Harrison and Ford 2007). The primary clinical diagnoses of hospice patients were malignant neoplasm of lung (14 percent); Alzheimer's, presenile dementia, and senile dementia (9.9 percent); cerebrovascular disease (5.5 percent); and congestive heart failure (5.1 percent). Over half of the patients were older than age 75, indicating major growth in Medicare expenditures. Family members provided 68 percent of the care for hospice patients. For 34 percent of the patients, the patient's spouse served as the primary caregiver, followed by daughters (29 percent) and sons (15 percent).

Inpatient Rehabilitation Facilities

Inpatient rehabilitation facility (IRF)
a facility that provides restorative services for traumatic injury, acute illness, and congenital conditions

Inpatient rehabilitation facilities (IRFs) are growing in importance as the need for restorative services for traumatic injuries, acute illnesses, and congenital conditions increases. To qualify as a Medicare IRF, 75 percent of admitted patients must require intensive rehabilitation for one of ten specified physical conditions, such as stroke, spinal cord injury, head trauma, burns, hip fracture, and amputation. The growth of the elderly population and healthcare providers' increasing use of medical rehabilitation have caused Medicare costs for rehabilitation to increase significantly (Harrison and Kirkpatrick 2009).

Skilled nursing facility (SNF)
a facility that treats elderly patients with chronic diseases who need long-term nursing care, rehabilitation, and other healthcare services

In communities where IRFs are located, more PAC patients are admitted to an IRF than to a **skilled nursing facility (SNF)**. PAC services are offered in numerous settings, but physicians prefer to transition patients to IRFs because they provide a minimum of three hours of intensive rehabilitation therapy per day (Buntin et al. 2005).

IRFs are under increasing financial pressure to meet operations costs and invest in the latest healthcare technologies. They are also being forced to redefine their roles within the continuum of long-term care services as the requirement for quality rehabilitation services becomes a local and national concern (see Exhibit 10.1). Specifically, IRFs are evaluating expanding their service lines to include home health care, outpatient rehabilitation, and telemedicine to meet the healthcare demands of the growing elderly population in a cost-effective manner.

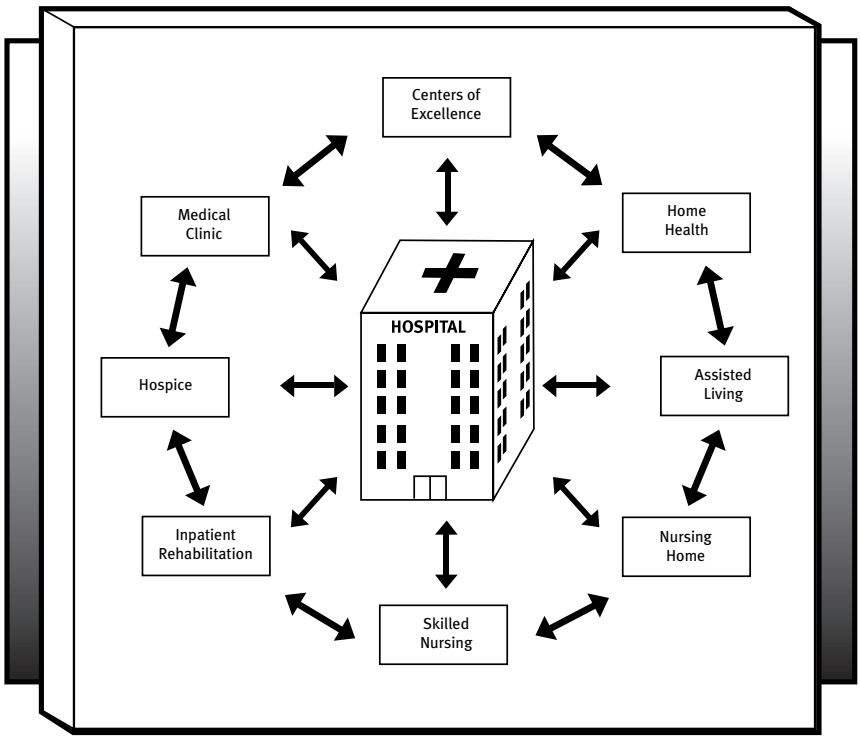


EXHIBIT 10.1
The Continuum of Long-Term Care Services

The largest provider of inpatient rehabilitation services is HealthSouth, a for-profit company that operates in 26 states and in Puerto Rico. HealthSouth provides care to more than 250,000 patients annually in 93 IRFs, 6 freestanding long-term acute care hospitals, 49 outpatient rehabilitation clinics, and 25 home health agencies. HealthSouth's net operating revenues in 2008 were approximately $1.8 billion (SEC 2008).

MEDICARE REIMBURSEMENT OF INPATIENT REHABILITATION FACILITIES

Medicare reimburses IRFs through its **Prospective Payment System (PPS)**. PPS motivates IRFs to control costs by offering a predetermined fixed payment per patient case, regardless of the costs the IRF incurs in rehabilitating the patient. PPS has established payment rates for 385 rehabilitation services, called *case-mix groups*. Patients are assigned to these categories on the basis of their diagnosis, age, level of functional or cognitive impairment, and **comorbidity**. The average IRF payment in fiscal year 2010 is $13,661 (Arkansas Medicare Services 2009). PPS incorporates the conversion factor, which adjusts payment levels on the basis of comorbidity, local wage rates, rural status, and income.

Prospective Payment System (PPS)
a reimbursement mechanism for inpatient healthcare services that pays a predetermined rate for treatment of specific illnesses

Comorbidity
the coexistence of one or more medical conditions in addition to the initial diagnosis

A 2005 study found that PAC provided by SNFs was less costly and that the outcomes were similar to those of Medicare patients rehabilitated by an IRF. A similar study conducted in 2008 compared the outcomes of cardiopulmonary patients in IRFs and SNFs following acute care hospitalization. They found that patients admitted to an IRF achieved greater functional improvement and had shorter lengths of stay than those admitted to an SNF. However, the superior outcomes carried a higher price tag, with IRF charges at $22,162 versus SNF charges of $10,873 (Vincent and Vincent 2008).

Rehabilitation Services in Acute Care Hospitals

In a 2006 study that evaluated changes in hospital services in California, researchers found that inpatient rehabilitation was the most frequently opened new clinical service in California acute care hospitals (Kirby et al. 2006). Specifically, 14.7 percent of acute care hospitals opened new inpatient rehabilitation units. These hospitals experienced significant improvement in their financial performance after opening these services. Their profit margin increased from 1.9 percent to 4.8 percent, and their net patient revenue increased from $206,495 to $552,178 per staffed bed.

Skilled Nursing Facilities

Trends in Skilled Nursing Facilities

While acute care hospitals are experiencing increasing pressure to reduce length of stay, SNFs are experiencing strategic opportunities. Specifically, SNFs have an opportunity to work collaboratively with acute care hospitals to place discharged patients. For example, these hospitals are increasingly discharging orthopedic surgical patients to SNFs for rehabilitation services. To meet this increased demand, the number of SNFs has been growing at a rate of 12 percent annually, increasing from 13,945 in 1995 to 15,632 in 2005. Additionally, Medicare expenditures for SNF services increased from $10.9 billion in 1999 to $15.7 billion in 2004. The data show that 67 percent of Medicare beneficiaries discharged from acute care hospitals go home, with the remainder discharged to PAC facilities. SNFs receive the largest number of PAC patients, specifically 13 percent of Medicare acute care hospital discharges (MedPAC 2005).

Hospice

Patients' Use of End-of-Life Care

Recognizing that a high percentage of total healthcare dollars are spent on EoLC, CMS created a unique hospice benefit designed to improve the quality of EoLC while also

reducing the cost. This benefit, combined with a growing elderly population, creates a significant strategic opportunity to expand hospice services across the United States.

Role of Hospice

A **hospice** is a healthcare organization that provides EoLC or palliative care services to a patient and his or her family when the patient is no longer responding to treatment. Hospice care contrasts with curative care because it is not designed to cure an illness or lengthen life but emphasizes the management of pain (Patrick et al. 2003). Hospice services help the patient and family members handle the emotional, social, and spiritual aspects of terminal illness and help preserve the patient's dignity.

Hospice
a healthcare organization that provides EoLC or palliative care services to a patient and his or her family when the patient is no longer responding to treatment

Most hospice programs are run by not-for-profit organizations. Some are affiliated with hospitals, nursing homes, or home health care agencies. The first hospice was established in 1974 in New Haven, Connecticut. As of 2005, there were 4,100 hospices in the United States; these facilities served 1.3 million patients in 2006 (Coile 2002; Weckmann 2008).

To be admitted into a hospice program, the patient must have a physician's referral and a life expectancy of six months or less. Most hospice care is provided in the home by a family caregiver; however, inpatient hospice care is available for pain and symptom management for periods of up to five days (Chrystal-Frances 2003). During the referral process, a member of the hospice staff meets with the patient's physician to talk about the patient's medical history, symptoms, and life expectancy. They also develop a plan of care for the patient and discuss the hospice philosophy and the patient's expectations.

The Medicare Hospice Benefit

The Medicare Hospice Benefit was established in 1982 and was designed to provide families with the resources to care for their dying loved ones at home. In 1986, the Consolidated Omnibus Budget Reconciliation Act extended the benefit to include nursing home care for hospice patients. Medicare covers hospice patients who are aged 65 or older or who have been disabled for more than two years. In 2005, Medicare reimbursed 82 percent of all hospice services. To be eligible for the hospice benefit, the patient must be eligible for Medicare Part A, be enrolled in a Medicare-certified hospice, and have signed a statement agreeing to receive hospice services. To qualify for Medicare certification, hospices must offer 16 separate core and non-core services. The core services include bereavement counseling, dietary services, physician services, and skilled nursing services. (Medicare's limitation on SNF services does not apply here because they are considered part of the hospice services.) Non-core services include home care, physical therapy, personal care, and household services (Tokarski 2004). The Medicare Hospice Benefit pays a daily rate

for all of these services. Medicare also reimburses the hospice for medications provided to hospice patients on an inpatient or outpatient basis.

Hospice and the Continuum of Care

Research shows that healthcare providers across the continuum of care benefit from cooperating with hospices to provide EoLC. Hospitals with a hospice program have higher occupancy and shorter lengths of stay and are more profitable. Furthermore, there is increasing evidence that use of hospice programs in acute and long-term care settings has led to quantitative and qualitative improvements in healthcare delivery. An effective hospice program can improve acute care hospital performance by decreasing length of stay, reducing ancillary charges, and preventing unnecessary inpatient utilization by reducing hospital readmission rates and emergency department visits.

A 2005 study evaluated the impact of hospice programs on U.S. hospitals and found that hospitals operating a hospice are located in communities with higher per person income and more elderly patients. They are also larger and more clinically complex than hospitals without a hospice program, averaging 205 beds versus 157 beds and 38 clinical services versus 27 clinical services (Harrison, Ford, and Wilson 2005).

From an operating performance perspective, hospitals that operate hospices had a 2.5 percent return on assets, in contrast to 1.52 percent for those without hospices. Hospitals with a hospice had an average length of stay of 10.5 days, while those without a hospice had an average length of stay of 12.8 days. These statistics show that hospitals without hospice programs may be missing an opportunity to reduce costs and improve efficiency. Additionally, it is clear that as hospital size, clinical complexity, and occupancy increase, the value of a hospice program also increases (Harrison, Ford, and Wilson 2005).

Cultural Diversity and Hospice Services

Of the patients who received hospice care in the United States in 2006, 80.5 percent were white, 14.3 percent were African American, and 1 percent were Hispanic (Harrison and Ford 2007). When compared to overall population rates, these statistics reveal an underutilization of hospice services among minority groups. Local initiatives, such as providing education on hospice services to culturally diverse groups, can increase hospice and other EoLC utilization rates among these populations (Meyers et al. 2008; Harrison and Ford 2007).

Adult health daycare center facilities that provide services to patients requiring long-term care and help family caregivers with their responsibilities

Adult Health Daycare Centers

Adult health daycare centers, which provide a combination of social and medical services, were designed to keep senior citizens in the community as long as possible, thereby reducing

admissions to nursing homes. These centers also provide services to patients who require long-term care and assist their family caregivers. For example, an adult health daycare center can provide meals, transportation, socialization, therapeutic activities, healthcare treatment, and health referrals. Services for caregivers include time to rest and self-esteem/family relations improvement programs, both designed to improve the caregiver's psychological attitude. To be effective, adult daycare centers need to incorporate activities and offer services specific to the culture of their patient/caregiver population (Park 2008).

Strategic planners would be well advised to consider the approaches that countries around the world are taking to deal with the growing elderly population. In Norway, for example, communities are required to provide a child care center within walking distance of parents' homes. This system has been replicated to provide adult health daycare centers in similar locations. Elderly people living at home with their families can walk to these senior centers during the day and engage in a wide range of activities.

What implications does the growth of such centers have for business planners in other types of senior care facilities? Despite that adult daycare centers were developed with the intention of reducing admissions to nursing homes, they currently pose no threat to nursing homes, which continue to have an average occupancy rate of 95 percent and waiting lists full of prospective patients.

Summary

Faced with a rapidly growing elderly population, healthcare providers have a strategic opportunity to position themselves as sources of long-term care. As the population ages and the prevalence of chronic disease increases, the need for PAC in IRFs, SNFs, adult daycare centers, and patients' homes will grow significantly. Further along the continuum of long-term care services, hospitals have an opportunity to develop and implement EoLC/hospice programs. When exploring any new business venture, strategic planners need to ensure up front that the reimbursement they will receive for providing services is high enough to make the venture profitable. Faced with the prospect of a bundled payment system, and because Medicare and Medicaid reimbursement for long-term care services is often less than the amount the provider will need to spend to deliver the services, this factor is especially important to consider when exploring long-term care ventures.

Review Questions

1. Many elderly patients are being discharged from acute care hospitals after undergoing procedures such as knee replacement surgery and need extensive rehabilitation services.

From a strategic planning perspective, investment in what type of PAC facility would be best to pursue, given these circumstances?

2. Research shows the number of elderly Americans with chronic health conditions is growing significantly. What strategic implications does the increasing demand for skilled nursing care have for the nursing home industry?

3. Looking at the demographics of the U.S. population, what do you see as strategic planning opportunities in the area of hospice services?

Coastal Medical Center Case: Exercise 10

What type of long-term care does Coastal Medical Center provide? What is its competition in this area?

Questions

1. Outline a PAC plan appropriate for Coastal Medical Center.

2. Who should be involved in strategic planning for PAC services, and at what point do you involve them?

3. How will you know if Coastal Medical Center's PAC plan is a success?

CHAPTER 11

STRATEGIC PLANNING IN HEALTH SYSTEMS

By a wide margin, the biggest threat to our nation's balance sheet is the skyrocketing costs of healthcare.

—President Barack Obama

Key Terms and Concepts

- Hospital acquisition
- Hospital merger
- Integrated delivery system (IDS)
- Virtual health system

Introduction

According to the American Hospital Association (2009), the number of U.S. hospitals operating as part of a health system has grown from 2,542 in 2000 to 2,868 in 2008—a 12.8 percent increase, or 57 percent of all U.S. hospitals. These data indicate that the majority of strategic planning in healthcare considers not just the individual hospital but the overall health system in which it operates. Likewise, the minority of independently operated U.S. hospitals must consider future health system affiliation as part of their long-term survival plan.

Integrated delivery system (IDS)
a network of hospitals that enables better use of staff and financial resources and promotes greater operational efficiencies across the continuum of healthcare services

Declining reimbursement and provider competition are driving this trend. Many medical groups are joining to form affiliations, confederations, or shared economic models, such as an **integrated delivery system (IDS)**. IDSs enable better use of staff, increase financial resources, and can lead to greater operational efficiencies. IDSs may also gain a competitive advantage by negotiating better reimbursement rates with insurers. Furthermore, IDSs bring together a wider array of clinical services and deliver them in a more coordinated manner than fragmented hospitals can. This chapter discusses the important role health systems have in positioning an organization in an environment of growing uncertainty.

Hospital Mergers and Acquisitions

In the 1990s, healthcare was characterized by the restructuring of hospitals, medical groups, and long-term care providers. These restructuring initiatives included the development of IDSs formed by a combination of acquisitions, mergers, joint ventures, and other alliances.

Hospital acquisition
the purchase of a hospital by another facility or multi-hospital system

A **hospital acquisition** is the purchase of a hospital by another facility or multi-hospital system. Hospital acquisitions began to decline in 1997, suggesting that acquiring healthcare organizations became more selective about the hospitals they purchased.

Not-for-profit health systems typically evaluate potential acquisitions on the basis of mission, outreach, services, and geographic location. In addition to these factors, for-profit systems evaluate opportunities to maximize profits—for example, purchasing a hospital when its sale price is below the net present value of its cash flow stream. For for-profit health systems, the advantages of acquiring a hospital include increased market share in the community, greater total revenue, and an improved referral base as a result of more patient volume. Potential disadvantages to acquiring a hospital include the major capital investment required for the purchase and the possibility of an antitrust violation caused by the increased presence in a local market (i.e., the system comes to monopolize the local market).

Hospital merger
a combination of two or more hospitals

A **hospital merger** is a combination of two or more hospitals, often through a pooling of interests. As a pooling of interests, a merger often requires no capital outlay.

An organization may choose to merge when low profits and weak markets do not support acquisition. In other words, many hospitals choose to merge with another hospital because neither hospital has sufficient financial resources to acquire an organization. By combining their resources, organizations can pursue business and other strategic opportunities together that they could not afford to pursue on their own.

Research shows that hospital mergers tend to be horizontal, meaning the merging hospitals are competitors looking for increased operating efficiency and improved market share. By combining their services, the merged entity can offer more services than each could independently, and with more services comes more revenue. Instead of drawing from one patient base, the combined entity draws from both organizations' patient base. Just as more services bring in more revenue, more patients bring in more revenue. Additionally, managed care organizations (i.e., healthcare insurance companies) tend to favor contracting with larger, more complex hospitals, forcing smaller hospitals to become part of a health system.

Additional reasons for merger are to eliminate unnecessary services, reduce overhead through consolidation, and provide a more rational mix of services designed to better meet the community's needs. For example, many mergers involve hospitals located in the same community. If both hospitals offer some of the same services—say, both hospitals provide obstetrics services—the merged hospitals can close the duplicated services at one site because it is more efficient to provide the service at a single location. While increased efficiency through consolidation benefits the merged organization as a whole, some staff may be adversely affected when, for example, administrative functions such as human resources are combined and streamlined, leading to involuntary reductions in staff.

In a merger, it is important that the mission, vision, and culture of the two organizations be similar. While organizational fit in an acquisition situation is preferable, it is not necessary because the purchase indicates which organization will have dominance, and the acquired entity's assets are transferred to the purchasing entity.

Integrated Delivery Systems

In 2006, 57 mergers/acquisitions took place in the United States, affecting 249 hospitals. In 2008, 60 mergers/acquisitions took place, affecting 78 hospitals. All of these mergers/acquisitions involved the expansion of a health system (Irving Levin Associates 2009). Examples of highly successful horizontally integrated systems include Partners HealthCare, University of Pittsburgh Medical Center, and Sutter Health, all of which have improved their financial performance as well as the quality of their health services through integration (Burns and Pauly 2002).

Ascension Health, headquartered in St. Louis, Missouri, is the largest not-for-profit health system in the United States. Ascension provides acute care, long-term care, psychiatric care, rehabilitation services, and residential care through a network of 67 acute

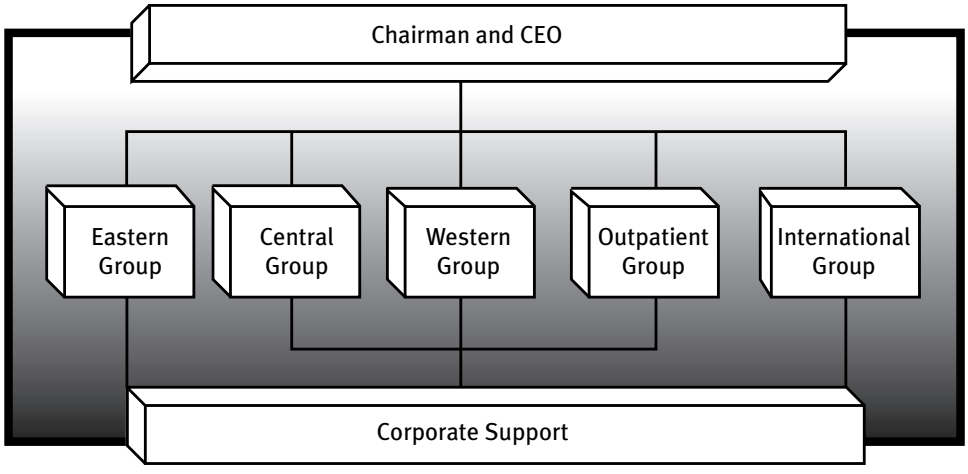
care hospitals, 2 long-term acute care hospitals, 3 rehabilitation hospitals, and 4 psychiatric hospitals. The system has 107,000 employees and 18,012 hospital beds. In fiscal year 2008, Ascension had assets of $18.3 billion, operating revenue of $13.8 billion, and income from operations of $478 million and provided $926 million of charity care (Ascension Health 2009). The largest for-profit-health system is HCA, headquartered in Nashville, Tennessee. In 2008, HCA was the leading provider of healthcare services in the United States, comprising 163 hospitals and 105 surgery centers in 20 states and England. That year HCA had revenue of more than $28 billion and assets of more than $24 billion and employed approximately 183,000 people (HCA 2008).

A sample health system organization chart is provided in Exhibit 11.1.

Strategic Planning at the Health System Level

Strategic planning at the health system level is different than planning at the individual hospital level. Health systems routinely evaluate the acquisition of hospitals or other smaller health systems with values in excess of $1 billion. The magnitude of these projects requires working with Wall Street banks and venture capital firms to negotiate capital financing packages, which are critical to determining whether these new business initiatives will be profitable. Most health systems have a dollar threshold of approximately $1 million for the local approval of new business initiatives. Any new business initiative that will cost in excess of this threshold must be approved by the health system's headquarters.

Exhibit 11.1
Sample Health System Organization Chart



At the headquarters level, these larger business initiatives compete with business initiatives across the entire health system and are prioritized in a strategic plan for the overall health system. The number of projects funded by the health system is determined by the level of cash flow generated throughout the health system as well as the cost and availability of capital from the Wall Street banks or the equity stock markets. Health systems attempting to expand their services also must work closely with state regulatory agencies and the U.S. Department of Justice. These agencies are responsible for ensuring that health systems do not approach monopoly status in a local community, which can have an adverse effect on competition in the marketplace. For these reasons, strategic planning at the system level requires a global perspective and additional technical skills that are not necessary when planning in local markets.

Not all systems are created equal, and many small systems (as well as some larger systems) don't really operate as a consolidated entity. These systems may comprise many facilities and have good public relations programs, but they are fragmented and do not act like a system. For example, in a small health system of five to eight hospitals distributed across a wide geographic area, there are limited opportunities for economies of scale (see Chapter 1, Highlight 1.1). The same is true for a large system of 20 hospitals located in separate parts of the world. To gain real economies of scale, multiple, large facilities need to be concentrated in one geographic area. For example, suppose a small hospital system needs to buy an x-ray machine. If the system's hospitals are in proximity to each other, there is no need to buy a machine for each facility. The system can buy one machine and place it in one of the facilities. If a physician at one of the other facilities orders x-rays for a patient, the patient can easily travel to the facility where the x-ray machine is located. If the system's hospitals were scattered around the country, it would have to buy a machine for each facility—an exorbitant expenditure.

By failing to leverage the economies of scale made possible by consolidated systems, fragmented systems are not in much better shape than the small, stand-alone rural hospital that lacks the technical expertise and facility infrastructure to operate in an increasingly complex healthcare industry.

Integration Across the Continuum of Care

Research suggests that, in the future, management of individual patients across the continuum of healthcare services will become increasingly important. Healthcare will be viewed as everything from the primary care visit to the hospital stay to post–acute care services. IDSs can offer all of these services to patients. Instead of receiving care from different hospitals, patients can do "one-stop shopping" in an IDS.

Affiliation and integration of care are also a strategy for achieving quality improvement goals. Health systems are in a position to manage variation across their facilities in both administrative and clinical areas. For example, the health system HCA, Inc., once had a billing office and a payroll department in each of its hospitals. Each hospital also

had a purchasing agent and central supply warehouse to meet its ongoing needs. This individualism led to a wide range of variation in performance. To reduce this variation, HCA has since regionalized its billing and supply chain operations. These regional centers leveraged consistency across the health system, improving quality and efficiency as a result.

HCA uses the same approach to clinical quality improvement. It calls on the best talent in the organization to transfer best practices across the enterprise. When protocols of care are standardized and implemented across a health system, quality scores improve, patient satisfaction increases, and fewer malpractice claims are filed.

Virtual Health Systems

Virtual health system a network of organizations created through the use of health information technology

Through **virtual health systems**, independent healthcare providers can link together without having to merge with or acquire other facilities. Participation in a virtual health system might be attractive to some independent hospitals because they can gain many of the advantages of health system membership without giving up operational control to the health system. Other candidates for participation in virtual health systems include independent rural hospitals that have a long history of financial losses, old facilities, and antiquated equipment. Strategic planners of health systems often consider these hospitals as "losers," and, as a result, they are not viable candidates for merger or acquisition. In such cases, the only possibility for affiliation these hospitals have is participation in a virtual health system.

Virtual health systems can also link hospitals with physician groups in the community or long-term care providers to enable smooth transitions for patients from facility to facility. To make transitions even more seamless, members of virtual health systems can create a shared electronic medical record so they all have access to the same information. Virtual health systems can't comprise all the linkages an IDS can, but they can emulate some of the important components of a "physical" health system.

International Health Systems

In recognition of the global market, many health systems are looking at providing international healthcare services. For example, high-profile organizations such as Johns Hopkins Medicine go into international communities and create relationships or linkages. They put up a clinic, provide some local healthcare services, and send inpatient referrals back to the flagship hospital in the United States. There is nothing wrong with this approach, but it is a modest enterprise. A bolder approach to international healthcare is to expand a system or create a new system in the foreign country and provide comprehensive healthcare.

When considering expansion into an international market, strategic planners of health systems must ensure there is an existing market for a new healthcare provider. This market is often driven by excessive waiting times for services or a perception of poor

healthcare quality among the population. Once the market demand has been validated, the international strategic planner should then determine whether a commercial health insurance program exists in the country to pay for services or if segments of the population have sufficient financial resources to pay for premium healthcare services.

Summary

From a strategic planning perspective, what opportunities are open to a small community hospital or a small system? What does their future look like? With limited resources, unaffiliated hospitals have few options. How will they fund new technology? How will they pay for the talent they need to move the organization forward?

These important questions are driving the growth in the number of independent hospitals joining health systems. IDSs are able to gain a competitive advantage in the market by negotiating higher reimbursement rates, offering a wider array of clinical services, and delivering these services in a more coordinated manner.

Also contributing to the growth of IDSs is the development of virtual health systems, a new model that allows organizations to participate in a loosely structured system without having to give up operational control. This model has the potential to offer many of the advantages of a "physical" health system without requiring the commitment of financial resources. Finally, there is increasing evidence that some U.S. health systems are participating in international healthcare initiatives as a way to expand their market.

Review Questions

1. Evaluate the statement that an integrated delivery system (IDS) is the wave of the future and is critical to future organizational success.

2. Identify the largest for-profit as well as not-for-profit health systems in the United States. Provide specific information about each, including the number of hospitals, the number of employees, and total revenue. Compare these health systems and discuss the ones you think will grow at the fastest rates.

Coastal Medical Center Case: Exercise 11

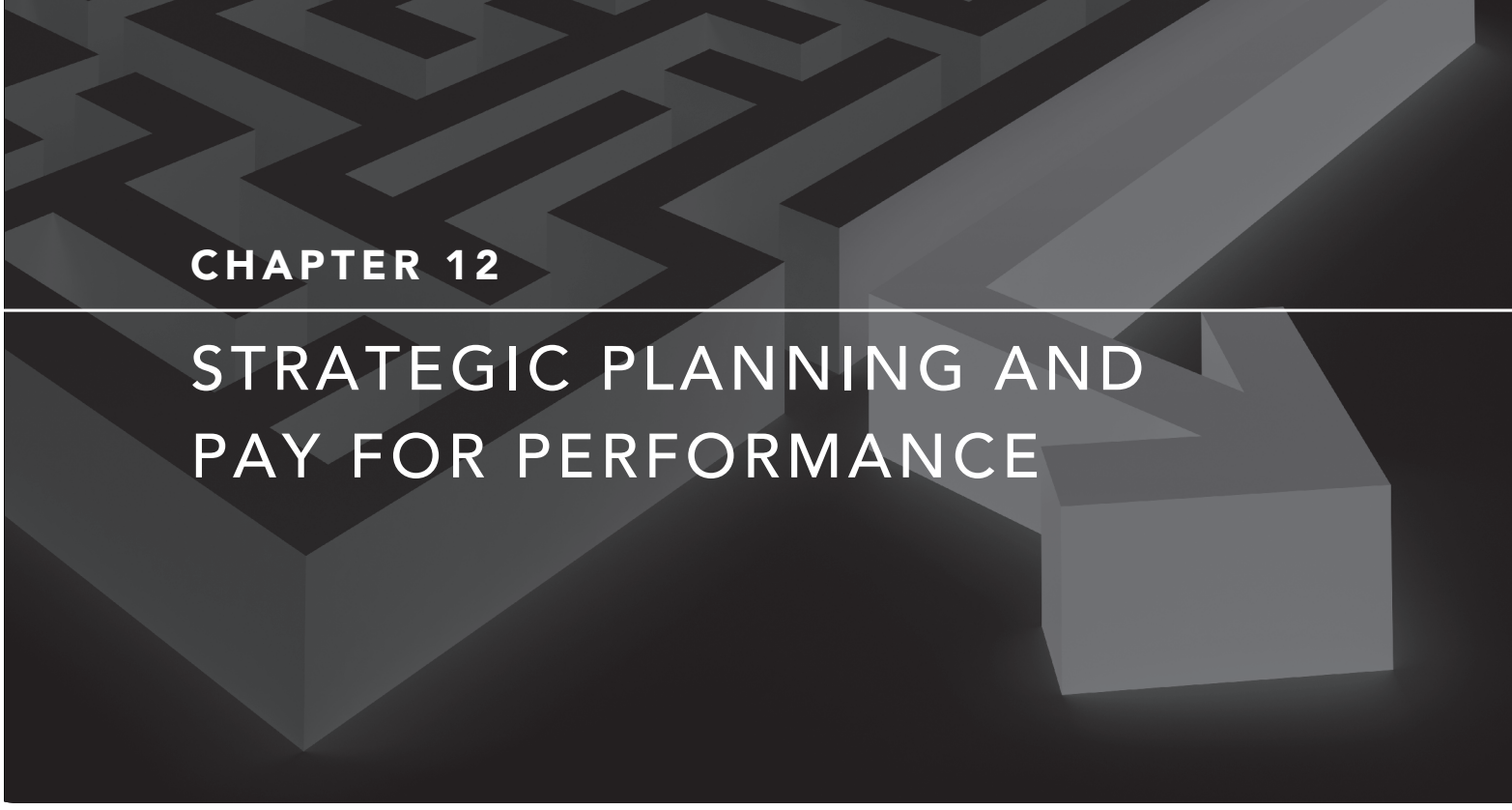
Would developing an IDS allow Coastal Medical Center to improve the efficiency and quality of its healthcare services?

Questions

1. Name five areas in which Coastal Medical Center has some components of an IDS in place. Next, develop a list of five new areas or activities that Coastal Medical Center could successfully integrate into a health system.

2. Will an IDS improve Coastal Medical Center's negotiating power with managed care organizations (i.e., insurers)?

3. From your perspective, does Coastal Medical Center need to develop an IDS, or does it just need a quick fix for its operational problems?



CHAPTER 12

STRATEGIC PLANNING AND PAY FOR PERFORMANCE

Knowing is not enough; we must apply.
Willing is not enough; we must do.

—Johann Wolfgang von Goethe

Key Terms and Concepts

- Intensivists
- Leapfrog Group
- Pay-for-performance (P4P) programs

Introduction

Pay-for-performance (P4P) programs initiatives implemented by the government, insurance companies, and other groups to reward providers for meeting certain performance targets in the delivery of healthcare services

According to The Commonwealth Fund (see Highlight 12.1), waste and medical errors add $100 billion to U.S. healthcare expenses and may cost 150,000 lives annually. To encourage quality improvement and more efficient delivery of healthcare services, the government, insurance companies, and other groups implement **pay-for-performance (P4P) programs**, which offer financial incentives to physicians, hospitals, and other healthcare providers in exchange for meeting certain performance targets. P4P initiatives can also reduce the payments providers receive if they commit medical errors, have poor quality outcomes, or incur excessive costs.

An awareness of P4P offerings is important in strategic planning. To maximize an organization's income and improve quality and efficiency in the delivery of care, strategic planners incorporate objectives into the strategic plan that are geared toward achieving P4P performance targets.

Medicare Pay-for-Performance Initiatives

As part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Congress directed the Institute of Medicine to identify ways to better align healthcare performance

HIGHLIGHT 12.1 The Commonwealth Fund

The Commonwealth Fund is a private institution whose goal is to improve access to care, quality of care, and efficiency of care in the United States. The Commonwealth Fund is especially interested in helping vulnerable people receive better care: the low-income population, the uninsured, minorities, young children, and the elderly.

To achieve these goals, The Commonwealth Fund supports independent research on how care could be improved. For example, The Commonwealth Fund has published reports on such topics as asthma outcomes in minority children and reasons for patient readmission to hospitals after discharge. It also publishes reports to inform the public, such as its analysis of the different healthcare reform bills proposed by the U.S. House of Representatives and Senate in late 2009. Many of its publications provide information and statistics about the current state of healthcare in the United States.

Financed by individuals and organizations that support its mission, The Commonwealth Fund grants money to tax-exempt organizations and public agencies to improve the provision of healthcare and to study and recommend policy changes that will improve the healthcare system. For example, some of its grants support programs that study the future of Medicare and the care of frail elderly adults.

with the Medicare payment system. The act required that performance measures be identified, that the Medicare payment system be used to reward performance, and that data and information technology requirements be addressed. It proposed P4P as a long-term incentive Medicare could use to improve the quality of the U.S. healthcare system.

Historically, Medicare (CMS) has supported initiatives to improve healthcare quality of care in physicians' offices, ambulatory surgery centers, hospitals, nursing homes, and home health care agencies. The basis of CMS's recent P4P initiatives is collaboration with providers to ensure that valid measures are used to achieve improved quality. CMS has explored P4P initiatives in nursing home care, home health care, dialysis, and coordination of care for patients with chronic illnesses (CMS 2005). Some of these initiatives are described in the sections that follow.

Hospital Quality Initiative

The Hospital Quality Initiative (HQI) was launched nationally in November 2002 for nursing homes and then expanded in 2003 to home health care agencies and hospitals. In 2004, it was further expanded to include kidney dialysis facilities that provide services for patients with end-stage renal disease. The HQI focused on a set of ten hospital quality measures. To benefit from this initiative, a hospital had to measure its level of quality in these ten areas and report these data to CMS. Hospitals that submitted the required data received full Medicare DRG payments. (See Highlight 12.2 for a discussion of diagnosis-related groups [DRGs].)

While the HQI has concluded, CMS currently has more than 375 measures in place to assess healthcare quality. These measures are designed to benchmark quality in

HIGHLIGHT 12.2 Diagnosis-Related Groups

Diagnosis-related groups (DRGs) are a patient classification scheme used by hospitals to identify the diseases they treat. Each disease is grouped with similar diseases and assigned a code so that physicians, billing departments, and payers (particularly Medicare) can easily identify the diagnosis. Assigned to each code is an amount of money the payer will reimburse a provider for treatment of that diagnosis. The amount of reimbursement is based on the average cost of providing care for that illness and includes the cost of in-hospital nursing care, room and board, diagnostic treatments, and any other treatments that might be necessary (routine) for that illness while a patient is in the hospital. The payment does not include the physician's fees.

(*continued*)

HIGHLIGHT 12.2 Diagnosis-Related Groups

(*continued*)

The amount a hospital receives in reimbursement is also influenced by such factors as the hospital's location (urban or rural), the number of low-income patients it treats, staff compensation (wage index), and the types of diseases it treats in a year (case mix). Reimbursement is greater if the hospital is a training site for medical school students.

The DRG system was developed in the 1980s to control costs and motivate hospitals to provide care more efficiently. The hospital is paid a predetermined rate, so it will try not to spend more than that rate in treating the patient. DRGs, of which there are about 500, are updated yearly by CMS.

the following healthcare settings: inpatient hospitals, physicians, nursing homes, home health, end stage renal disease, pharmaceuticals, and Medicare Advantage (CMS 2010b).

Linking the reporting of hospital quality data with P4P is an effective strategy for improving the U.S. healthcare system. Such a program will provide financial incentives to organizations that invest in quality improvement. A 2007 study found that hospitals scoring in the bottom quintile on quality performance measures improved by 16.1 percent after participating in the Hospital Quality Initiative (Lindenauer et al. 2007), clearly documenting the positive association between P4P and improved hospital quality. Furthermore, research shows that by increasing P4P payments to make them compose 15 percent of total compensation, providers would have greater incentive to invest in health information technology and other activities to improve quality so that they receive that full 15 percent (Damberg et al. 2009).

Premier Hospital Quality Incentive

In 2003, CMS announced a demonstration project called the Premier Hospital Quality Incentive, which paid bonuses to hospitals on the basis of their quality performance in five clinical areas: heart attack, heart failure, pneumonia, coronary artery bypass graft surgery, and hip or knee replacements. Hospitals that ranked in the top 10 percent for a specific condition received a 2 percent bonus on its medical payments, and hospitals in the next 10 percent received a bonus of 1 percent. The project lasted four years. In the final year of the demonstration project, hospitals with poor quality outcomes were financially penalized. Bonuses averaged $71,960 per hospital annually but were offset by financial

penalties for the hospitals in the bottom 20 percent (Premier 2010). The offset equaled the total amount by which the reimbursement for hospitals in the bottom 20 percent was decreased. This amount was divided up and paid to the hospitals with the highest quality, in addition to their bonuses.

Final results of the initiative found that participating hospitals improved their quality by an average of 17.2 percent over the four-year study period. The study estimated that the improvements saved the lives of an estimated 4,700 heart attack patients (Premier 2010). In total, CMS awarded over $36.5 million in P4P payments during the demonstration. Of this amount, $12 million was awarded during the last year of the project. An analysis of the study results found that if all U.S. hospitals were able to achieve the cost and quality improvements experienced in this project, 70,000 lives would be saved annually and hospital costs would be reduced by over $4.5 billion per year (DeVore et al. 2010).

More recent CMS initiatives to improve the quality of inpatient care require collecting data on 34 quality measures relating to five clinical conditions: heart attack, heart failure, pneumonia, surgical care, and asthma care. These quality measures were developed jointly by private healthcare organizations and government institutions. Hospital-specific performance is publicly reported on CMS's Hospital Compare website.

Physician Group Practice Initiative

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 mandated the first Medicare P4P initiative for physicians. This program, called the Physician Group Practice Demonstration, began in April 2005 and was designed to assess the impact of P4P on large medical groups. Specifically, it rewarded physicians for improving the quality and efficiency of healthcare services delivered to Medicare fee-for-service beneficiaries (patients). It encouraged coordination of Medicare Part A and Part B services, promoted efficiency in high-performance work processes, and paid physicians for improving clinical outcomes (CMS 2005). Originally intended to be a three-year demonstration, this project was extended to five years and continued until the end of March 2010 (CMS 2010a).

Ten large group practices of more than 200 physicians each participated in this demonstration. Together, these ten groups represented 5,000 physicians and a diverse group of over 220,000 Medicare patients. The physician group practices were eligible to earn performance-based payments after achieving savings greater than those achieved by a control group while maintaining quality scores (CMS 2005). The study found that these savings were generated by reducing unnecessary hospital admissions, preventing readmissions, and minimizing emergency room visits. The P4P bonuses were linked to 32 ambulatory care quality measures previously validated by the National Committee for Quality Assurance as part of HEDIS (see Chapter 13, Highlight 13.2). The demonstration project found that effective strategies for quality improvement included provider feedback from

individual profile reports, increased use of clinical protocols, and redesigned workflow processes that incorporate electronic medical records (CMS 2006).

Care Management Initiative

CMS's Care Management Performance Demonstration was a three-year physician P4P project designed to promote the use of health information technology to improve the quality of care for chronically ill Medicare patients. Initiated in July 2007, this project paid bonuses to physicians who exceeded CMS performance standards in clinical delivery systems and patient outcomes. In contrast to the Physician Group Practice Demonstration described earlier, this demonstration focused on small and medium-sized physician practices located in Arkansas, California, Massachusetts, and Utah (CMS 2009a).

Chronic Care Initiative (Medicare Health Support Program)

CMS's Chronic Care Initiative used a disease management model to manage chronically ill patients with congestive heart failure or complex diabetes. Participating organizations had to guarantee CMS a certain amount of savings. Reimbursement by CMS was contingent upon meeting quality measures and patient satisfaction scores. Participating organizations included Humana in South and Central Florida; XLHealth in Tennessee; Aetna in Illinois; LifeMasters in Oklahoma; McKesson in Mississippi; CIGNA in Georgia; Health Dialog in Pennsylvania; American Healthways in Washington, DC, and Maryland; Visiting Nurse Service of New York; and United Healthcare in Queens and Brooklyn, New York.

This program evolved into the Medicare Health Support program. The purpose of the program was to increase the use of evidence-based protocols, reduce unnecessary hospitalization, and minimize costs associated with chronic conditions. The program's P4P component was driven by quality improvement, Medicare cost savings, and improved patient satisfaction. Phase I of the program included approximately 100,000 chronically ill Medicare patients and officially ended August 31, 2008. CMS is currently evaluating the results and will submit a final report by February 2013 (CMS 2008).

Care Management for High-Cost Beneficiaries

This demonstration tests models of care management for Medicare patients who are both high cost and high risk. The payment methodology is similar to that implemented in the Chronic Care Improvement Program, in that participating providers are required to meet relevant clinical quality standards as well as guarantee savings to the Medicare program (CMS 2005). In 2009, CMS granted a three-year extension of this program. This initiative is important because it demonstrates that managing the care of high-cost Medicare beneficiaries can result in cost savings as well as improved quality (CMS 2009b).

Additional Initiatives in Pay for Performance

Commercial Payer Initiatives in Pay for Performance

CMS is not the only entity offering P4P incentives. U.S. health plans and other payers are also developing P4P programs to improve the quality of care and minimize future cost increases. As of 2005, there were more than 150 commercial P4P programs in operation (Baker and Carter 2005). Empire BlueCross BlueShield (headquartered in New York City) and Integrated Healthcare Association (headquartered in Oakland, California) are examples of two commercial organizations offering P4P programs.

Leapfrog Group

The **Leapfrog Group**, founded in 2000, is a coalition of more than 65 employers that purchase care for more than 34 million U.S. employees. The mission of the Leapfrog Group is to use employer purchasing power to improve the quality, efficiency, and affordability of U.S. healthcare. Employer members of the Leapfrog Group expect the healthcare organizations their employees use to meet a certain level of quality and efficiency. If Hospital XYZ, for example, does not perform up to these levels of quality, the Leapfrog Group can inform its employer members not to use Hospital XYZ. As a result, Hospital XYZ loses the business of these members' employees. As part of this work, Leapfrog provides P4P incentives geared toward improving patient safety and increasing the value consumers receive for their healthcare spending.

Leapfrog Group
an independent organization, developed by major employers, that uses purchasing power to improve the quality and efficiency of U.S. healthcare services

Leapfrog's hospital reporting initiative, implemented in 2001, assesses hospital performance on the basis of quality and safety measures developed by the National Quality Forum (NQF). Hospitals that meet or exceed NQF's benchmarks have been successful in reducing medical mistakes. Hospitals that participate in the reporting initiative are eligible for the Leapfrog Hospital Recognition Program, which is a hospital P4P program that offers financial benefits and public recognition for meeting Leapfrog's standards. As part of this recognition program, Leapfrog posts participating hospitals' scores on its website for use by employers and consumers (Leapfrog Group 2010).

Employers that join the Leapfrog Group agree to educate their employees about patient safety and hospital quality. They also agree to encourage their employees to seek care from hospitals that meet Leapfrog's safety standards; for example, employees who use those hospitals do not have to pay copayments. Such actions have been highly effective in moving patients to healthcare providers that meet Leapfrog's standards. Everyone benefits; patients are steered to safer hospitals and, as a result, hospitals receive more business. Conversely, Leapfrog removes hospitals from its register of approved providers if their quality and safety scores decline (Leapfrog Group 2010).

To date, much of Leapfrog's focus has been on computerized physician order entry (CPOE) and physician staffing in intensive care units. In an evaluation of 1,860 hospitals,

Leapfrog found that hospitals using CPOE have higher quality scores and lower mortality than those not using CPOE (Jha et al. 2008).

Intensivists
physician specialists who staff intensive care units

Leapfrog is also driving significant improvement in patient safety and quality of care through a program that focuses on staffing intensive care units with physician specialists called **intensivists**. The intensivists program is saving an estimated 20,000 lives annually. The bonuses Leapfrog provides in this program are funded through savings generated from reduced length of stay and fewer readmissions (Delbanco 2006).

Physicians' Attitudes Regarding Pay for Performance

Many physicians express a lack of trust in health plan and government initiatives imposing change. However, one of the first national surveys on physicians' attitudes about P4P, completed in 2005, found that 75 percent of responding physicians supported financial incentives for improved quality when the measures they were required to report were deemed as "accurate" by an authority on those measures. A much smaller percentage of physicians indicated support for public reporting for medical group quality performance. The survey also found that physicians who currently have financial incentives for quality were more likely to support future P4P programs (Casalino et al. 2007).

Growing Demand for Quality-Related Data

There is a growing demand for quantitative data on healthcare quality. P4P programs use these data to recommend quality measures, design financial incentives, and create measurement systems. Because chronic conditions account for 75 percent of medical costs, they stress the importance of gathering data on chronic care. They also stress the importance of using existing quality measures based on peer-reviewed national standards of care. The analysis of quality data can take more than a year, leading to delays in reporting on hospital quality and preventing timely P4P bonuses (Young and Conrad 2007).

Future Pay-for-Performance Initiatives: Paying for Value

Recommendations for future initiatives in P4P include incorporating the concept of "paying for value." From the patient's perspective, value includes high-quality healthcare at a reasonable price. *High quality* means excellent outcomes, patient-centric care, and high levels of patient satisfaction. Future paying-for-value initiatives will need to require physicians to limit the number of tests they order that do not improve morbidity or mortality. These initiatives will also need to mandate that physicians provide care based on clinical protocols developed using evidence-based research and approved by a professional association appropriate to the clinical area in which these protocols are to be used.

Incorporating Pay-for-Performance into a Strategic Plan

Current and past P4P initiatives have focused on improving quality and reducing costs—two key factors in gaining a competitive advantage. Therefore, it is important that hospital planners incorporate P4P initiatives into the strategic plan. Strategic planners should routinely monitor their CMS Hospital Compare quality scores to get them to the level needed to receive CMS's P4P incentives. If their scores are already at that level, they should focus on driving them up further to maximize the rewards and reimbursement CMS offers; the higher the quality, the greater the reward. Planners need to allocate money to invest in programs and new technology that will help the hospital increase its quality scores. In areas where quality is poor and unlikely to change, the strategic planner should consider closing the service so patient safety is not jeopardized. As a result, the hospital will be less likely to incur malpractice suits.

Mayo Clinic is an outstanding example of an organization that has incorporated P4P into its strategic planning process. It routinely evaluates new business initiatives that could enhance the quality of care it provides. Demonstrating its ability to prepare for the future well in advance, Mayo even benchmarks its quality and efficiency performance against P4P standards that have been developed but are not scheduled to be implemented until several years from now.

Summary

Federal healthcare policymakers and state regulators have legitimate concerns about the negative impact that reduced reimbursement for healthcare services, low hospital occupancy, and poor efficiency can have on the quality of healthcare. They also recognize that the aging population and high rate of inflation in healthcare will continue to drive up healthcare costs. By operating in a manner consistent with evolving healthcare policy and the quality standards set forth by P4P programs, hospitals can receive financial and other rewards (e.g., a reputation for excellence), all of which will place them in a stronger competitive position.

Review Questions

1. Evaluate the statement that P4P is the latest fad in healthcare reimbursement and will have little impact on the healthcare industry.

2. What do you see as the future of P4P in the healthcare industry?

3. Imagine you are a hospital executive and you want to improve your P4P situation with the Leapfrog Group. What areas do you need to improve?

Coastal Medical Center Case: Exercise 12

Coastal Medical Center has been experiencing declining performance. From your perspective, are Coastal Medical Center's problems related to efficiency or quality? What do you see as the responsibility of the board of directors and CEO to get the organization back on track? Should P4P be incorporated in Coastal Medical Center's strategic planning process?

Questions

1. Outline a process that will allow Coastal Medical Center to take advantage of future P4P initiatives.

2. Who should be involved in P4P planning, and what should their role be?

3. How will you know if Coastal Medical Center's P4P planning is a success?

4. In Appendix F of the Coastal Medical Center comprehensive case study, Hospital Compare data are provided for Coastal Medical Center and its competitors in the local market. How does Coastal Medical Center's quality compare to its competitors? Develop a list of five areas in which Coastal Medical Center's quality could be improved.

5. Access the Hospital Compare database for your community (www.hospitalcompare.hhs.gov) and find the state and national quality standards. On the basis of your analysis, how does Coastal Medical Center's quality compare? Should Coastal Medical Center expect to receive a P4P bonus for its quality scores?

CHAPTER 13

THE NEW VALUE PARADIGM IN HEALTHCARE

M. Nicholas Coppola, Jeffrey Harrison, and Larry Fulton

Price is what you pay. Value is what you get.

—Warren Buffett

Key Terms and Concepts

- Quality
- Therapeutic alliance
- Value
- Value frontier

Introduction

In 1973, President Richard Nixon signed the Health Maintenance Organization Act, which was intended to create incentives for healthcare organizations to offer services for a prepaid healthcare premium. The risks involved with this healthcare arrangement were twofold. One, would healthcare organizations offer value-added care after having received the premiums from the patients enrolled in the system up front? Two, how would the value of this new prepaid care be measured?

How has the U.S. healthcare system addressed these questions?

The Value Frontier

Value frontier
the linking of quality and efficiency data to identify optimum levels of healthcare performance

A paradigm shift from the efficiency frontier (see Chapter 4) to a **value frontier** is occurring in healthcare. The value frontier considers not only efficiency but also quality. Organizations on the value frontier are considered "best in class," and their levels of performance become benchmarks for improved performance in healthcare organizations throughout the industry.

What Is Quality Healthcare?

Quality
reflection of the goals and values currently believed in the medical care system and the society in which it exists

No single definition of healthcare **quality** exists, nor is there a single method of measuring quality in the healthcare industry. Numerous judgments of its meaning, measurement, and value have been made. As a result, quality is difficult to define, measure, and apply in a health services setting. While scholars agree on some of the underlying quality issues in healthcare, they differ dramatically in their ideas about where these issues stem from and how to address them.

Access to healthcare for all Americans is paramount in the quality literature. Concerns regarding access include having enough physicians for consumers and having a sufficient supply of physicians in rural areas. Before any discussion about quality can ensue, physicians and hospital beds need to be present in adequate numbers so that people have access to care.

The consumer's ability to choose the physician or the care setting to be used is another focal point. The literature considers whether consumer choice equates to quality, but there is general agreement that choice does not exist when there is a lack of healthcare facilities and a lack of trained healthcare providers. Therefore, choice does not equate to quality, but rather overall access may influence quality.

Healthcare's growth from 7.2 percent of the gross domestic product in 1965 to over 16 percent in 2006 (where it remains) points to a third point of emphasis in discussions about healthcare quality: cost (Kaiser Family Foundation 2006; Tamny

2010). How to provide access to affordable healthcare is an ongoing philosophical discussion in modern medicine. In healthy industries, competition is not based on cost but on **value**, which is the level of consumer benefit received per dollar spent. Where value rules, innovation is rewarded, providers prosper, and efficiency increases. As a result, customers buy better products and receive better services (Davidson and Randall 2006).

Value
a measure of the benefit a consumer receives from a service in relation to dollars spent on that service

Comparative Outcomes

In the early 1900s, Dr. Ernest Codman, a pioneer surgeon and advocate of healthcare reform, researched healthcare quality by measuring quality outcomes. His *end results theory* supported measuring patient care to assess hospital efficiency and identify clinical errors or problems. The American College of Surgeons adopted his theory as a minimum quality standard. On the basis of this theory, the College created the Hospital Standardization Program, which later evolved into The Joint Commission on Accreditation of Healthcare Organizations (now simply "The Joint Commission"). Codman also believed in public reporting of quality, a concept first taking hold today, a century later. The American Hospital Association also has encouraged providers to establish quality assurance programs to audit outcomes of care. The most comprehensive evaluation of hospital quality today is the CMS Hospital Compare report, which assesses hospital quality performance and measures changes in quality over time.

The initial purpose of measuring the quality of healthcare outcomes and processes was to help patients make informed healthcare decisions. However, studies show that healthcare organizations are not measuring criteria that patients or the healthcare industry consider significant. While research shows that Americans rate quality as the most important factor when choosing a health plan, studies also show that most do not understand their options well enough to make an informed choice. However, today's consumer is more informed and demanding than ever and considers the advantages and risks of recommended treatments. It is important for healthcare organizations to understand, define, and measure quality of care as well as gather data from the patient's perspective that can be used in decision making.

Public and private groups, such as the National Committee for Quality Assurance, have developed tools for measuring and reporting healthcare quality. The Consumer Assessment of Healthcare Providers and Systems (CAHPS; see Highlight 13.1) and the Healthcare Effectiveness Data and Information Set (HEDIS; see Highlight 13.2) are two examples. Many hospitals use CAHPS to assess patient satisfaction and HEDIS to measure clinical performance.

HIGHLIGHT 13.1 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a survey used to measure patient experiences with healthcare providers. Use of this standardized survey allows patient experiences to be compared with those of other patients across the country. All patients are asked the same questions, and all results are measured according to the same rating scale. Without a standardized survey, comparisons of quality of care would be inaccurate.

Healthcare organizations, purchasers, consumers, and researchers can use the information gathered by the survey to

- determine how patient centered the care is,
- compare different providers' performance, and
- improve the quality of care.

Originally called the Consumer Assessment of Health Plans Survey, CAHPS has grown and changed since its inception in 1995. The first phase of the initiative focused on developing questionnaires for consumers enrolled in health plans. The second phase focused on developing surveys for ambulatory care centers and other healthcare facilities. The third phase, begun in 2007, is focused on providing tools and resources to support the surveys already created.

CAHPS is funded by the Agency for Healthcare Research and Quality, but the surveys are developed through a joint effort of government agencies, such as the Centers for Medicare & Medicaid Services and the Centers for Disease Control and Prevention, and private agencies, such as Harvard Medical School and RAND Corporation.

Donabedian and Quality

Considered the father of quality assurance in healthcare, Avedis Donabedian (1966) defined *quality* as the reflection of the goals and values currently believed in the medical care system and the society in which it exists. This definition signifies that there is no one common criterion on which to measure healthcare quality. For this reason, Donabedian introduced a model of medical quality based on three criteria: structure, process, and outcomes.

Structure includes the environment in which healthcare is delivered, the instruments and equipment providers use, administrative processes, the qualifications of the

HIGHLIGHT 13.2 Healthcare Effectiveness Data and Information Set (HEDIS)

In 1991, the National Committee for Quality Assurance (NCQA) created the HMO Employer Data and Information Set (HEDIS) to help measure the quality of care at healthcare institutions. HEDIS has undergone four name changes while maintaining the same acronym; it was changed to "Healthcare Effectiveness Data and Information Set" in 2007.

According to NCQA, 90 percent of health plans use HEDIS to monitor quality (NCQA 2010). The tool identifies 71 measures of quality categorized in eight areas:

1. Effectiveness of care
2. Access to/availability of care
3. Satisfaction with the experience of care
4. Use of services
5. Cost of care
6. Health plan descriptive information
7. Health plan stability
8. Informed healthcare choices

Healthcare institutions are evaluated on how well they perform on the 71 measures. Examples include cancer screenings, weight assessment and counseling on nutrition and physical activity for children and adolescents, medication management, follow-up care for particular diagnoses, and frequency of certain procedures. NCQA collects the data from healthcare organizations and uses them to calculate national benchmarks and set standards for NCQA accreditation.

HEDIS is used by employers and consumers to compare health plans and identify those most appropriate for their needs. Because the measures reported to HEDIS are specific (all organizations report the same measurements), healthcare organizations across the nation can be easily compared.

medical staff, and the fiscal organization of the institution. Access to care may also be considered part of the structure component.

Process considers how care is delivered. For example, healthcare quality could be evaluated according to the appropriateness and completeness of information obtained through review of a patient's clinical history, physical examinations, and diagnostic tests; the provider's explanation of and reason for his diagnosis and recommended therapy; the physician's technical competence in the performance of diagnostic and therapeutic

procedures, including surgery; evidence of preventive management in health and illness; coordination and continuity of care; and acceptability of the care to the patient (Donabedian 1966). By studying the process indicators of quality, judgments can be made whether medicine was practiced appropriately and addressed the patient's needs.

Outcomes, the most discussed measure of quality, include recovery, restoration of function, and survival. These quality indicators are some of the most frequently reported and most widely understood. Other outcome indicators are patient satisfaction, physical disability, and rehabilitation. Although the latter are more complicated to assess, they remain the ultimate validation of healthcare quality (Donabedian 1966).

The three pillars of structure, process, and outcomes need to be addressed collectively to achieve optimum quality of care. Each aspect influences the others. For example, a patient with a broken bone needs access to a qualified physician and an appropriate facility for treatment, and the care he receives needs to meet preestablished standards. If any one of these aspects is lacking, the others are negatively affected and optimum quality is not achieved.

Technology

The discussion of healthcare quality is important as healthcare evolves and experiences technological advances that result in increasing cost to the consumer. Do increased costs limit access to healthcare (i.e., only those who can afford it have access)? Is there a return on investment for the price of technology?

U.S. Agency for Healthcare Research and Quality

The U.S. Agency for Healthcare Research and Quality (AHRQ) defines quality healthcare as doing the right thing, at the right time, in the right way, for the right person, with the best possible results. AHRQ (2001) identifies two measures that can be used to identify quality care: consumer ratings and clinical performance measures, both of which are obtained from outcomes research.

Patient Satisfaction

In general, patient satisfaction with healthcare has been used as an overall indication of the quality of care (Harris-Haywood et al. 2007), suggesting that the relationship between patient and provider encompasses the practice of medicine and the healthcare system as a whole.

Therapeutic alliance a partnership between patient and provider that involves collaboration and negotiation to arrive at mutual goals

A **therapeutic alliance** is a partnership between patient and provider that involves collaboration and negotiation to arrive at mutual goals. The Kim Alliance Scale was formulated to accurately assess the quality of the therapeutic alliance between patient and provider, as well as the level of patient empowerment. A study conducted in 2008 evaluated

the therapeutic alliance as a predictor of patient satisfaction and revealed that the quality of the therapeutic alliance between the healthcare provider and the patient accounted for 35 percent of the patient satisfaction score (Kim, Kim, and Boren 2008).

The literature suggests that patient satisfaction scores offer useful information about the quality of service a healthcare institution is providing. While patient satisfaction is not the only indicator of quality care, it is a significant goal (IOM 2001). Providers could achieve exemplary clinical outcomes but have negative patient satisfaction scores if they have poor interpersonal skills or lack sensitivity to cultural differences among their patients.

Patient Safety

In 2000, the Institute of Medicine (IOM) released *To Err Is Human: Building a Safer Health System*, which described the problems surrounding patient safety. In 2001, IOM issued a follow-up report that listed six aims designed to improve safety in healthcare.

IOM said that healthcare must be (1) safe, (2) effective, (3) patient centered, (4) timely, (5) efficient, and (6) equitable. These six aims underscore the fact that healthcare is a service delivered to a patient, who is also the customer. While some of the IOM aims, such as safety, effectiveness, and fiscal efficiency of services, can be statistically measured on the basis of mortality and morbidity rates, other factors, such as patient-centeredness, timeliness, and equitability, are best evaluated through research and patient satisfaction surveys.

Workforce

Healthcare is a labor-intensive industry. Research on workforce issues can help organizations determine the number of staff members, mix of expertise, and level of experience necessary to provide optimal care (West, Maben, and Rafferty 2006).

Employee Satisfaction

Employee satisfaction has also been validated as an indicator of healthcare quality. Satisfied employees contribute to the growth of an organization. Employee satisfaction is measured through in-house surveys that allow employees to communicate concerns, ask questions, or praise their employer.

Accreditation

Healthcare quality is also maintained through accreditation, which is a standardized method of ensuring that quality processes are consistent across the healthcare industry. Examples of accrediting organizations include The Joint Commission, which accredits acute care hospitals; the American Society of Clinical Pathology, which accredits laboratory systems on the basis

of the Clinical Laboratory Improvement Amendments passed by Congress in 1988; and the American College of Surgeons, which accredits trauma centers.

Efficiency

Increased efficiency leads to improved quality of care and greater patient satisfaction (Griffiths 1990; Pink, Murray, and McKillop 2003). A healthcare organization is considered efficient if it has achieved an optimal fit between its structural characteristics and its processes. Even when an optimal fit is achieved, however, the healthcare organization struggles to maintain that fit because the healthcare environment is dynamic and requires organizations to make changes on a continuous basis.

Strategic Planning for Healthcare Value

Patients, employers, and the government want high-quality, low-cost healthcare. The degree to which organizations successfully coordinate high quality with low cost reflects the value of the care they are delivering.

In planning for healthcare value, strategists must consider all of the topics presented in this book:

- Development of a mission, vision, and culture that support change
- A transformational approach to leadership
- Evaluation of strengths, weaknesses, opportunities, and threats through SWOT analysis
- The use of health information technology
- Examination of financial data
- Healthcare marketing
- Opportunities for joint venture, merger, and affiliation (with physicians and other organizations)
- Opportunities in long-term care
- Compliance with pay-for-performance initiatives

The list does not end there, but guided by these basic elements, strategic planners in healthcare have a solid foundation on which to build an organization that provides the high value sought in healthcare today.

Review Questions

1. From your own experience as a patient, provide an example of when you received high-value healthcare.

2. Discuss the three pillars of Donabedian's model for healthcare quality assurance. Does this model have practical applications today, given the current focus on healthcare value?

3. What is the role of the following groups in the healthcare value improvement process: board of directors, senior leaders, physicians, employees, and payers?

Coastal Medical Center Case: Exercise 13

The newly hired CEO has been actively investigating the declining performance of Coastal Medical Center and was given clear direction by the board of directors to get the organization back on track. How would benchmarking help Coastal Medical Center move forward on a new road to success?

Questions

1. What type of organizations should Coastal Medical Center use as benchmarks?

2. Who should be involved in developing the Center's benchmarking strategy, and at what point do you get them involved?

3. How will you know whether the Coastal Medical Center plan to increase healthcare value is a success?

4. What do you see as the future of benchmarking and value improvement at Coastal Medical Center?

EPILOGUE

TEN CONCEPTS FOR EFFECTIVE LEADERSHIP

R. Timothy Stack

Leadership plays an important role in promoting change in a rapidly evolving healthcare industry. The literature shows that outstanding leadership is associated with future organizational success. By incorporating the concepts shown in Exhibit E.1 into your leadership repertoire, you will position yourself and your organization for outstanding achievement.

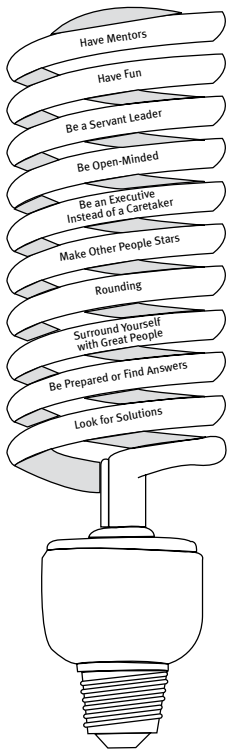


EXHIBIT E.1
Ten Concepts for Effective Leadership

HAVE MENTORS

Mentors are experienced leaders who can be consulted for advice on business and career planning issues. A mentoring situation is an opportunity for younger leaders to take advantage of the knowledge and experience of individuals who have "traveled the leadership road." Many organizations have a formal mentoring program that assigns senior executives as mentors to junior leaders. Informal mentors are equally important. Informal mentors are individuals outside the organization who can be consulted on a more personal level and serve as a sounding board for business issues, ethical dilemmas, or career planning purposes.

Have Fun

Individuals routinely spend eight hours per day at the workplace, so having fun at work is important. As you look at your future career, select work that is meaningful and inspiring to you. You can have fun by connecting with others on a personal level and offering positive feedback. Identify individuals with negative energy early on and take steps to insulate yourself from their temperament. When your job stops being fun, consider actions you can take to reinstate the fun or think about making a career change. Remember that everyone needs to maintain balance in their lives. For most people, the balance involves religion, family, and work. Establish priorities. Place work after religion and family. Healthcare leaders who place a high value on broader issues such as religion, family, and community relationships can make difficult decisions from a wider perspective. History has shown that many inappropriate and unethical decisions were made on the basis of one-dimensional thinking that considered only how the organization would be affected as a result of the decision.

Be a Servant Leader

A servant leader believes that each member of the organization makes a meaningful contribution toward meeting overall goals. As a servant leader, the issue is not how you can accomplish your work, but how you can assist your team in meeting the organization's goals. Servant leaders understand that their personal success and the organization's success are not driven by their individual efforts but by their team. This perspective can be liberating because it takes the pressure off the leader and puts it on the team. It also recognizes that the team's combined effort is more valuable than the contribution of any single individual.

Be Open-Minded

Older senior executives tend to think they have seen it all and have all the answers. In a complex, dynamic industry, leaders need to be open-minded and create an environment that fosters communication, innovation, and change. The best ideas will percolate up from within the organization.

Be an Executive Instead of a Caretaker

The authors have seen the impact that caretaker leaders, who believe their function is to safeguard resources, can have on an organization. In every case they observed, the organization stagnated, failed to take advantage of opportunities in the marketplace, and ultimately declined in profitability. Organizations whose leaders have the caretaker mentality fail to attract the best leadership and clinical talent. The best talent flocks to organizations that

support innovation and are successful in the marketplace. Be an executive who can make decisions, not just a caretaker.

Make Other People Stars

The authors have received many awards and have been humbled by the realization that, in many cases, another individual or team was responsible for the accomplishment. As a matter of personal ethics, make sure the recognition is placed where it is deserved. Rewards and recognition are part of a positive feedback loop that encourages recipients to continue their outstanding efforts.

Do Rounds

Research shows that a leadership concept called "management by walking around," also called *rounding*, is important to organizational success. Not only is it a way to get to know the individuals and facilities in the organization; it is also a convenient method of exercising. Walking around the organization helps the leader gain a greater perspective about each individual's critical, integral role in meeting the organization's mission. Rounding also helps the leader better understand the overall healthcare system and develop interpersonal relationships with staff. Finally, rounding lets staff know the organization values their contributions and that leaders are accessible.

Surround Yourself with Great People

Academic knowledge and practical experience are important to success, but in healthcare, no one individual could possibly develop the level of knowledge or skills necessary to succeed alone. Leaders should focus their efforts on identifying, hiring, training, and motivating the best individuals healthcare has to offer. This search begins by identifying individuals who have a track record of success. Once they have been identified and have demonstrated their knowledge and outstanding performance, they should be rewarded with appropriate financial compensation and other organizational recognition. Rewards are essential to retaining the great people who will lead the organization to future success.

Be Prepared or Find Answers

No single individual knows all the questions or has all the answers. Be willing to commit the time and effort to find them. If you do not know the answer to someone's question, be honest and say so, and then research the issue. Close the loop by getting back to the person with the answer in a timely manner. Giving half-baked answers

without supporting data may cause the organization to move forward in the decision-making process with invalid information.

Look for Solutions

The healthcare industry is dealing with manifold problems that require innovative solutions. Healthcare leaders need to proactively search for solutions that will support the organization and the community it serves; supporting the status quo is not acceptable. In short, if you are not part of the solution, you are part of the problem.

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