

## CHAPTER 3

# FUNDAMENTALS OF STRATEGIC PLANNING

*Experience is a hard teacher because it gives the test first, the lesson afterwards.*

—Vern Law

*Look before, or you'll find yourself behind.*

—Benjamin Franklin

### LEARNING OBJECTIVES

*After you have studied this chapter, you should be able to*

- demonstrate the ability to assess actual healthcare strategic-planning problems and, using the various knowledge disciplines, develop comprehensive and practical solutions;
- exercise business-planning techniques and demonstrate skills in professional writing and verbal communication;
- demonstrate a deeper understanding of the healthcare system and the management of costs, quality, and access and make sound business decisions and develop a strategy for change;
- successfully participate in teamwork; and
- use critical thinking skills and create an environment that supports innovation and entrepreneurial spirit.

## KEY TERMS AND CONCEPTS

- Ambulatory surgery center (ASC)
- Balanced score card
- Benchmarking
- Dashboard
- Efficiency frontier
- Fixed cost
- Gap analysis
- *Healthy People 2020*
- Medicare Payment Advisory Commission (MedPAC)
- Payer mix
- Safety-net providers
- Strategic planning
- Total cost
- Variable cost

## INTRODUCTION

Strategic planning brings leaders and stakeholders together to position their organization for success in an environment of uncertainty. A healthcare organization engages in strategic planning to reduce costs, improve quality and service, and ensure access to care. An innovative strategic-planning process also helps an organization allocate resources more effectively to enhance the value of its services and better meet the community's healthcare needs.

The US healthcare environment is changing substantially. By 2011 healthcare employed 15.7 percent of the US workforce and reached expenditures of \$2.7 trillion (Moses et al., 2013). Healthcare as a percentage of GDP has doubled since 1980 to 17.9 percent in 2011. During the same time period, government funding for healthcare has increased from 31 percent in 1980 to 43 percent. The rate of change in an organization's market factors or technological environment determines whether an organization structure should be hierarchical or participatory.

In a stable environment, a hierarchical structure with centralized decision making may improve overall efficiency, provided senior leaders and managers possess sufficient knowledge and information to make informed decisions. However, in unstable environments with white-water change, the knowledge and information required for innovation must be distributed throughout multiple levels in the organization. A greater flow of information combined with decentralized decision making fosters innovation. Such participatory organizational structures may be more appropriate in the current healthcare environment.

## DEFINITION

**Strategic planning** is the process by which an organization determines its future overall direction and defines the actions that will shape it. Planners gather information about the

### **Strategic planning**

The process by which an organization determines its future direction by defining the actions that will shape it and developing objectives and techniques for measuring ongoing performance.

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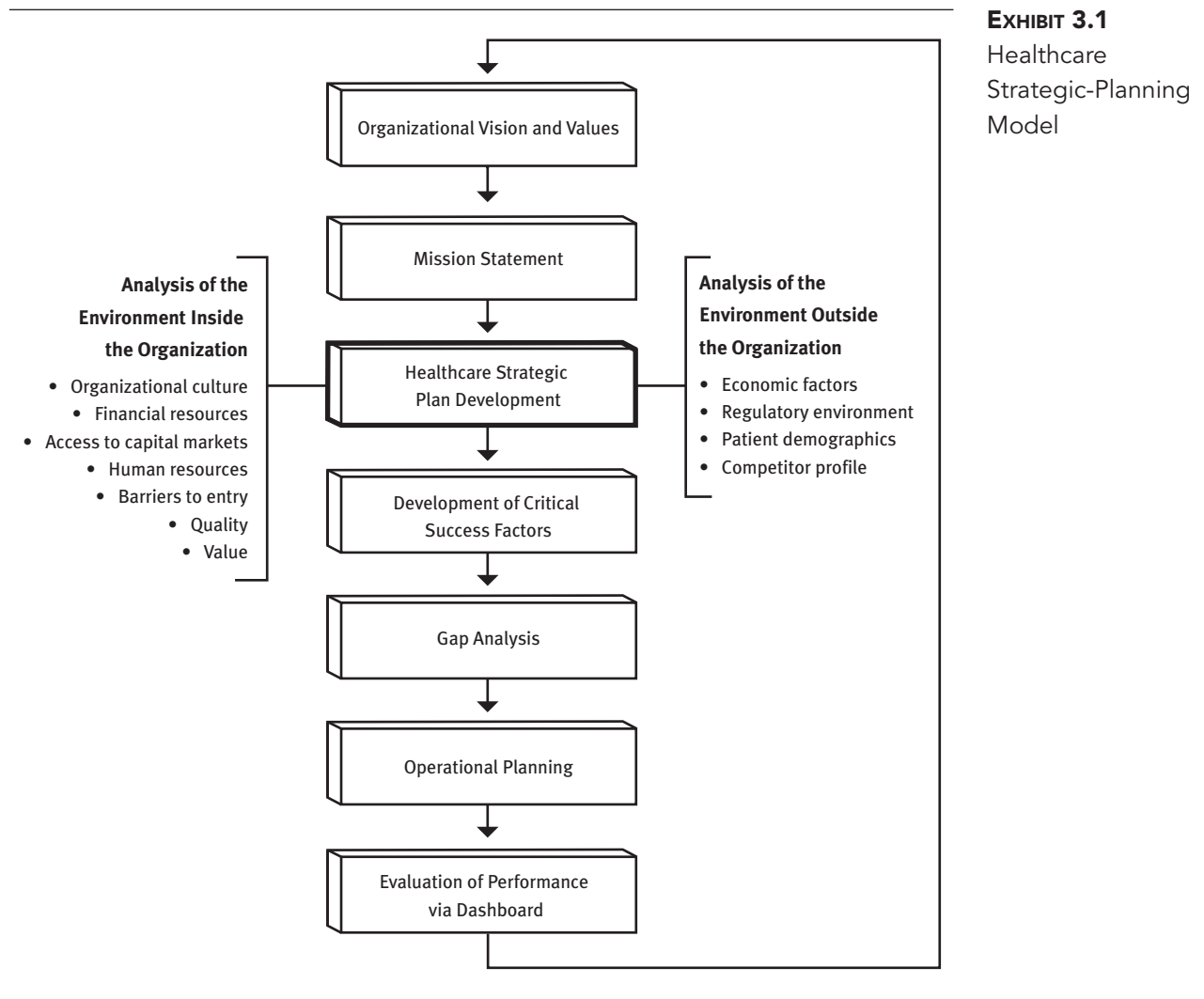
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internal and external environments and have in-depth discussions about the future of the organization. They also develop organizational objectives and techniques for measuring ongoing performance.

The critical components of the healthcare strategic-planning model are illustrated in Exhibit 3.1 and discussed in the sections that follow.

### ANALYSIS OF THE ENVIRONMENT INSIDE THE ORGANIZATION

Internal data focus on finances, personnel, key assets, and 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.



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**MISSION, VISION, AND VALUES**

Thomas Edison is reputed to have said that “vision without execution is hallucination.” An organization’s mission, vision, and values provide the foundation on which its strategic plan is built. Consistency among mission, vision, and values and clear links among all three enhance the strategic-planning process and increase the chance of performance improvement. The entire workforce must also buy into the mission, vision, and values, or execution will be difficult.

**CULTURE**

An organizational culture is the shared values and beliefs that guide behavior in each organization (Pellegrin and Currey 2011). An organization’s distinctive beliefs provide a framework for behavior. Social values in its surrounding communities shape this behavior. For example, many people believe that access to healthcare is a right, not a privilege, and patients want to be an organization’s first priority. Incorporating these social values in organizational culture is important to healthcare strategic planning.

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 allocate its resources carefully to be able to fund this costly priority. If the organization promotes life-long learning, it should not cut education and training budgets at the first sign of financial stress (Pellet 2013).

**CRITICAL SUCCESS FACTORS**

An organization’s strategic plan should address improvement in five core areas:

1. Healthcare quality
2. Patient access
3. Employee retention
4. Differentiation in the market
5. Alignment of resources

Successful strategic planning in healthcare should also include a clear connection between current projects and programs, those that are regulatory directed (such as preventive services and community wellness), the strategic objectives of the organization (such as evaluation of joint ventures or participation in a health system), and the measurements

being used to track success. Tracking success will reflect organizational competency and appropriate use of information technology. Implementation of the strategic plan will require collaboration between physicians and the hospital, employee training to upgrade skill levels in some instances, annual operating goals, and a plan to update every three years.

## **ANALYSIS OF THE 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 operations. In addition, as healthcare organizations focus more on illness prevention and community wellness, they will need to consider educational, behavioral, and social interventions that have not been a part of the traditional, episodic system of medical treatment. In short, healthcare organizations need to focus on the external environment and future changes to the field. By gathering information from external sources, healthcare organizations increase their likelihood of achieving success.

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

## **TRENDS IN THE EXTERNAL ENVIRONMENT**

Hospitals planning strategically need to be mindful of trends influencing the direction of the healthcare environment, including the advent of accountable care organizations (ACOs), expanded insurance coverage, increased hospital participation in healthcare systems, the impact of specialty hospitals, and the rise of ambulatory surgery centers.

### **The Advent of Accountable Care Organizations**

As a part of the Affordable Care Act (ACA), the Centers for Medicare & Medicaid Services (CMS) promoted the accountable care organization (ACO). Many ACOs create a partnership between a clinic, hospital, rehabilitation center, and nursing home. ACOs may also be a joint venture between a group of doctors or hospitals and other healthcare providers who collaborate on providing high-quality care at reduced cost. If the ACO is successful in reducing costs and improving quality at all the levels of care, the parties will share in the savings from Medicare (CMS 2015). ACOs are using strategies such as population health to manage a growing primary care base. Organizations need to consider the pros and cons of including participation in an ACO in their strategic plan. See Chapter 9 for more information about ACOs and population health.

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**Safety-net providers**

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

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**Expanded Insurance Coverage**

An estimated 10.3 million Americans became newly insured through provisions in the ACA. The greatest increase was observed among minorities and young adults. This shift will change organizational healthcare priorities to create more focus on preventative health and community well-being. Still, as of April 2014, 16.3 percent of the US population remains uninsured (Sommers et al. 2014). This uninsured segment 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 long waiting periods and may therefore choose to go without.

**Increased Participation in Healthcare Systems**

Faced with lower Medicare reimbursement rates and the responsibility to provide care for the uninsured, 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. 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. The literature is mixed on the benefits and downsides of specialty hospitals. The potential for conflict of interest exists, but most research suggests that specialty hospitals have had little impact on general hospitals (Babu, Rosenow, and Nahed 2011).

The number of specialty hospitals increased from 499 in 2000 to 956 in 2010—a 91 percent increase over the decade (Moses et al. 2013). In its 2006 report to Congress, the **Medicare Payment Advisory Commission (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. The commission also found that specialty hospitals admitted fewer severe cases and Medicaid patients than competitor community hospitals. Furthermore, the number of physician-owned specialty hospitals increased the most in states that have no certificate-of-need requirement (see Chapter 1, Highlight 1.13) and a growing demand for specialty services as a result of high population growth.

Other research has found that the number of people who undergo complex surgical procedures increases significantly when physician-owned specialty hospitals open. This trend 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.

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**Medicare Payment Advisory Commission (MedPAC)**

A government agency composed of 17 members and established by the Balanced Budget Act of 1997 to advise Congress on issues that affect the Medicare program

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## The Rise of Ambulatory Surgery Centers and Outpatient Surgery

In the twenty-first century, freestanding, outpatient **ambulatory surgery centers (ASCs)** were growing because they charged less than hospitals did. Most ASCs are for-profit and are located in large metropolitan areas. In 2013, 5,364 ASCs treated 3.4 million fee-for-service Medicare beneficiaries, and the Medicare program spent \$3.7 billion on ASC services.

Medicare bases its payment rates on average cost of care, acuity of patients, and other factors. In addition to procedure rates, ASCs often receive professional fees for the individual physician. A high percentage of ASCs are for-profit organizations, and some argue that CMS is supporting hospital-based outpatient programs in an effort to assure the survival of the hospitals. From 2008 through 2012, the number of Medicare-certified ASCs grew by an average annual rate of 1.7 percent, but in 2013, the number increased only by 1.1 percent. The government has shifted to higher Medicare payment rates in hospital outpatient departments (HOPDs), resulting in relatively slower growth of ASCs. In 2015, the Medicare rates were 82 percent higher for HOPDs than for ASCs. This payment difference may help explain why many hospitals have recently expanded their outpatient surgery capacity. In addition, physicians have increasingly sold their practices to hospitals, and these physicians are more likely to perform procedures at the hospitals that employ them than at freestanding ASCs (MedPAC 2015).

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### **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

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## GAP ANALYSIS

**Gap analysis** is a comparison of an organization's internal and external environments for purposes of revealing, as the name suggests, gaps. *Gaps* are differences between the organization's current standing and its target performance. These gaps become the focal points that shape the strategic plan.

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 in organizations today are in information technology and diversity. These elements are discussed in the following sections.

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### **Gap analysis**

A comparison of an organization's current standing and its target performance

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## HEALTH INFORMATION TECHNOLOGY AS A COMPETITIVE ADVANTAGE

Investments in healthcare information technology (HIT) steadily increased over the first decade of the twenty-first century, reaching \$33 billion in 2011 (Moses et al. 2013). This investment promises to increase efficiency in the healthcare system and improve quality of care through better coordination. Currently, 95 percent of US hospitals have electronic medical records and are spending an average of 3 percent of total expenditures on HIT.



Some large healthcare systems, such as the US Department of Veterans Affairs (VA) and Kaiser Permanente, are investing 4–5 percent of their revenue on HIT. Clinical information systems have the potential to improve both the inpatient and outpatient medical delivery systems. While some documentation of medical records in the United States is still paper based, electronic health records (EHRs) offer an opportunity for the seamless exchange of clinical information. Studies examining the use of EHRs have found in general that they have increased quality of care, reduced medication-related errors, improved follow-up on test results, and improved care coordination and communication within the care team (Nguyen, Bellucci, and Nguyen 2014).

EHRs allow the passage of real-time information to multiple users and timely feedback, both of which can foster more rapid quality improvement. Also, users can pull information from a centralized database to supplement evidence-based research on clinical treatments. EHRs ease administrative decision making and the allocation of healthcare resources. For example, an EHR provides detailed information on patient services and current **payer mix**. This information can be linked to billing software to project reimbursement levels and measure the profitability of new business initiatives. These improvements can provide competitive advantage.

To encourage the adoption of electronic information systems in the healthcare field, the Health Insurance Portability and Accountability Act (HIPAA) designated a standard electronic framework for electronic claims submission (see Highlight 3.1). Further, as part of the 2009 stimulus plan, President Obama called for a nationwide EHR system to be implemented by 2014. The program was managed through CMS and is called Meaningful Use. In 2013 the program reported that approximately 80 percent of eligible hospitals and more than 50 percent of eligible professionals have adopted EHRs and received incentive payments from Medicare or Medicaid (CMS 2013a).

As consolidation of healthcare organizations increases, more effective linkages are critical to the success of integrated delivery systems. From a risk management perspective, EHRs and supporting clinical information systems have the potential to reduce medical malpractice costs. Disjointed communication and incomplete records could become things of the past.

## DIVERSITY IN THE WORKPLACE AS COMPETITIVE ADVANTAGE

Healthcare is the fastest-growing sector of the US economy and currently employs 18 million workers, 80 percent of whom are women (CDC 2015). The US hospital workforce has had an annual growth rate of 2.1 percent since 2000, when it totaled 17 million (Moses et al. 2013).

Demographic evidence shows that the US population is becoming more diverse and multicultural. In 2002, the Institute of Medicine released a report entitled “Unequal

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### ***Payer mix***

Percentage of revenue coming from private insurance versus government insurance versus individuals.

The *mix* is important because Medicare and Medicaid pay hospitals less than what it costs to treat patients.

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**HIGHLIGHT 3.1** HIPAA and EHRs

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 standards. These 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 a list of administrative, physical, and technical safeguards and their required and addressable implementation specifications (CMS 2013b). 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 specialists 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.

Treatment: Confronting Racial and Ethnic Disparities in Healthcare.” Since that time, healthcare organizations have made efforts to improve their cultural competence. The goal of cultural competence is to create a healthcare system and workforce that are capable of delivering the highest quality of care to every patient, regardless of race, ethnicity, culture, or language proficiency. Such a system would be equitable, of high quality, and free of disparities based on individual patient characteristics (Armada and Hubbard 2010). The American College of Healthcare Executives (2015) believes that diversity in healthcare management is both an ethical and a business imperative. Thus, to improve profitability and have a positive impact on the health status of the community, healthcare organizations should diversify their workforces. By integrating diversity into the strategic-planning process, hospitals should be able to reduce health disparities in the communities they serve.

Improvement in cultural and gender diversity can be a competitive advantage for businesses. In a more diverse and inclusive workforce, individual discretionary effort improves by 12 percent, intent to stay improves by 20 percent, and team collaboration and commitment improve by about 50 percent (CEB 2012).

Greater diversity among healthcare providers can minimize language barriers and cultural differences. Improved communication between providers and patients leads to improved quality of healthcare. Under optimal conditions, the makeup of a hospital’s workforce mirrors the population it serves (HRET 2011).

## **PLANNING AREAS**

Strategic plans, at a minimum, need to address certain core areas in healthcare. These core areas include

- ◆ financial planning,
- ◆ efficiency,
- ◆ quality and value,
- ◆ management of healthcare personnel,
- ◆ current and long-term strategies,
- ◆ mix of products and services, 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

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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 resources. In addition, many hospitals are **benchmarking** against outstanding organizations—examining other organizations’ business practices and products for purposes of comparing and improving one’s own company—to improve internal operating procedures, enhance quality, maximize efficiency, and improve the value of healthcare services.

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, the organization should conduct a detailed study to determine whether the new service 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, operating expenses, and overall profitability. Poor forecasting of clinical workload can lead to the approval of unnecessary and unprofitable projects.

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 to invest in newer facilities. Not-for-profit hospitals have lower levels of debt because they often have difficulty borrowing money to fund facility improvements and technological advancements. Because they do a significant amount of charity care and earn lower profits, nonprofits have difficulty paying back debt.

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 correctly executed 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. In addition, 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 that they receive at least the maximum authorized reimbursement. Healthcare organizations should implement an audit program that reviews the accuracy of their billing and coding systems (Waugh 2014). Such a program ensures the accuracy of financial information used in the strategic-planning process.

Payments from the federal Medicare program as well as from the combined state and federal Medicaid program now provides 30 percent of total hospital revenue (Harrison, Spaulding, and Mouhalis 2015). This level of government reimbursement is significant because it is set by regulation rather than market factors. As a result, much of a hospital’s

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**Benchmarking**

Examining other organizations’ business practices and products for purposes of comparing and improving one’s own company

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**Fixed cost**

Costs incurred despite volume or use of a particular service. Examples of fixed-cost elements include buildings, equipment, and some salaried labor.

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**Variable cost**

Costs that change with volume or use and can be saved by the hospital if a service is not provided. Examples include medication, test reagents, and disposable supplies.

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**Total cost**

All hospital expenditures, including facility operating costs.

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**Efficiency frontier**

The best investment of resources for the best possible profits and outcomes of care.

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reimbursement for care does not adjust based on supply and demand factors. More important, in many states Medicaid payments do not meet the **variable cost** of care or the **total average cost** of care.

**EFFICIENCY**

As the population continues to age and more Americans become insured, the healthcare field is under growing pressure to improve efficiency as well as profitability. An efficient organization reduces its use of resources without worsening the outcomes of healthcare services (Harrison, Spaulding, and Mouhalis 2015). An efficiency evaluation compares organizations that share common characteristics in both clinical and administrative areas. For example, a comparison of two for-profit hospitals would be appropriate because they have similar missions. Individual hospital performance can be benchmarked against the **efficiency frontier** of “best-in-class” facilities, which model the maximal use of inputs (investment of resources) for the best possible outputs (profits and outcomes of care).

Efficiency increases with greater hospital size (Harrison, Spaulding, and Mouhalis 2015). As discussed in Chapter 1, during the last past years the number of not-for-profit hospitals with 400 or more beds has grown 15 percent and large for-profit hospitals have seen a 293 percent increase. Efficiency combined with improved quality represents greater value for healthcare services—an important consideration in the healthcare field as reimbursement for hospital services moves from a volume-based model to a value-based model as a result of the ACA.

**QUALITY AND VALUE**

Strategic planning in healthcare is often conducted by administrators focused on the business components and clinicians focused on patient care and quality. Striking a balance is important. Ongoing tension is often present in healthcare organizations between the value-driven approach and the volume-driven approach to service delivery. In times of economic strain, the temptation to decrease resources dedicated to quality is great; however, now, more than ever, quality and safety cannot be ignored in the strategic plan. The importance of publicly reported quality measures and patient experience scores will continue to increase and will be tied to reimbursement (Knight 2014).

The challenge in the planning process is finding a differentiating factor related to quality. Everyone is striving to be “the best,” but doing so will require more than developing a quality scorecard. Thoughtful exercises in brainstorming what clients need or want is a part of considering quality and value. Some areas for consideration are improving access and patient flow, using lean processes to improve efficiencies in care processes, leveraging technology, aligning with providers, managing population health and creating a positive patient experience (Knight 2014).

One definition of value is that for which the customer would willingly and knowingly pay. The consumer decides on the timeliness as well as the quality level of the product or service she is purchasing. The government even calls this value-based purchasing (see Chapter 12). Although consumers would prefer to purchase healthcare of the best quality, resource limitations tend to redirect their focus on cost. This is where the consumer starts to look hard at the best value for her time and money.

### **MANAGEMENT OF 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 those of local and state peers.

Hospitals require adequate numbers of well-trained and highly credentialed healthcare professionals. Research has shown there is a strong relationship between adequate nurse-to-patient ratios and safe patient outcomes (ANA 2014). Ensuring adequate staffing levels has been shown to reduce medical and medication errors, decrease patient complications, decrease mortality, and improve patient satisfaction. Yet 54 percent of nurses report excessive workload. One in three nurses report inadequate staffing levels. Two in five units are short-staffed (ANA 2015).

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 or more professional interactions that occur during an average hospital admission result in high-quality care (Nancarrow et al. 2013). Research has shown that healthcare organizations with well-coordinated teams report lower long-term illness and mortality. Patient satisfaction also improves when healthcare professionals communicate clearly, express empathy, and demonstrate 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.

### **CURRENT AND LONG-TERM STRATEGIES**

Excellent strategic planning is a key for healthcare organizations that have proved profitable in the long term. Strategic planning provides a framework for integrating marketing, efficiency, personnel management, and outstanding clinical quality while ensuring financial performance. The development of process-improvement teams is vital, and so is 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, leaders can develop sound strategic plans 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), the organization should evaluate them to ensure that they are fulfilling the objectives of the strategic plan. (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.

### **MIX OF PRODUCTS AND SERVICES**

Hospitals' reimbursement rates have been decreased as a result of federal government spending cuts and insurance payers are following government strategies. Patients are reconsidering healthcare spending because of the economic downturn and growing insurance deductibles. The impact on of these trends on a hospital's bottom line can be significant. One response is significant cost reductions, but cutting costs can often restrict a hospital's ability to increase revenue, creating a downward spiral for the facility. Healthcare leaders should find ways to redirect current resources to create more effective growth strategies. Growth is paramount in this very tumultuous time (Clark and Lindsey 2013).

Many hospitals located in growing communities are expanding their inpatient and outpatient capacities. While many services are profitable, these organizations need 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. Healthcare organizations should routinely monitor their medical staff network to maximize clinical services while ensuring a profitable mix. Such an assessment should take into consideration changing community demographics and needs and the product mixes that competitors offer. Healthcare organizations can gather information on changing community needs 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 in which 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 that 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.

## OPERATIONAL PLANNING

Operational 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. 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. 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, organizations must evaluate the results of strategic actions. To align behaviors, clear goals must be linked with the measurement of outcomes. Organizations that are able to create such an alignment are more likely to be successful, but they should monitor their performance on a routine basis. For example, performance data could be collected monthly and then evaluated over time.

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, an organizational 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, an organization'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 3.2.

Dashboard measures might include quality of care (nosocomial infection rates<sup>1</sup> and 30-day readmission rates<sup>2</sup>), patient satisfaction, market penetration, operating efficiency (by emergency wait times, average length of stay or cost per procedure), and financial performance (net operating income and cash on hand). The dashboard should include visual cues, such as green representing favorable performance, yellow representing areas of growing concern, and red representing areas of poor performance.

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 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 will still make a profit.

As shown in Exhibit 3.1, 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. An organization modifies its strategy as needed, reimplements it, and evaluates it again, and new strategies are developed in response to the changing environment.

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### **Dashboard**

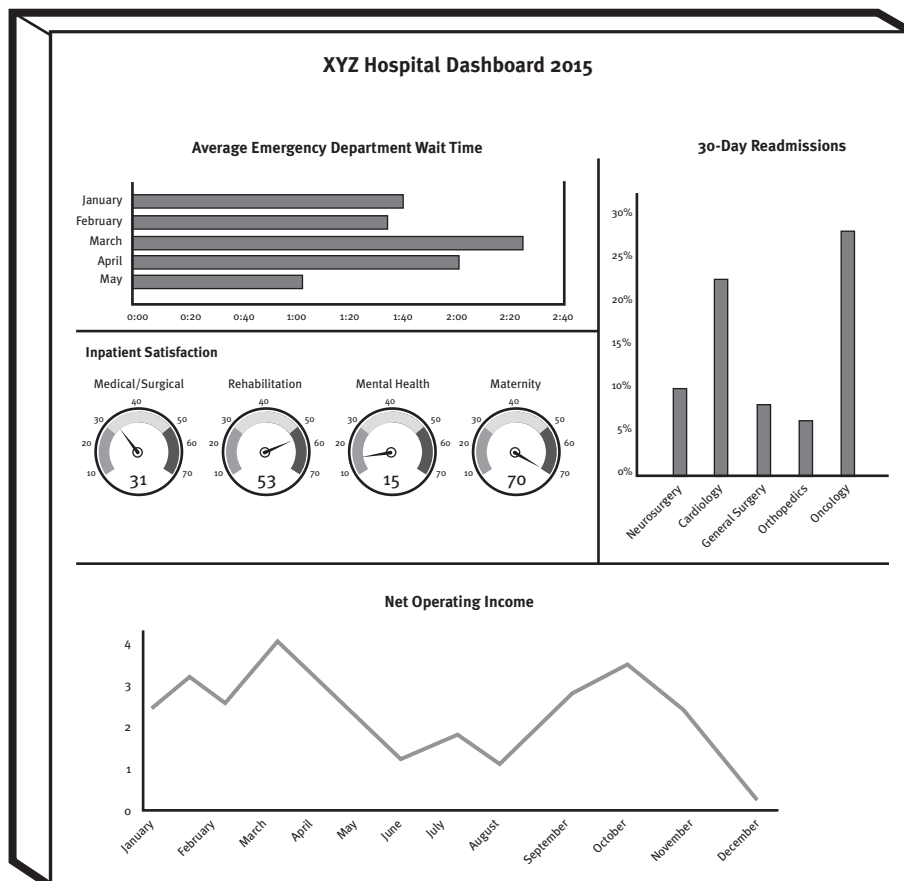
Tool that links strategic goals to operating performance

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**EXHIBIT 3.2**

Sample Hospital Dashboard (Type: update Ex. 4.2 in 1e as follows:

**Balanced scorecard**

A tool that allows organizations to assess their missions by evaluating specific objectives and metrics across multiple domains.

Another tool is the **balanced scorecard** (BSC), which allows a corporation to view its performance. The balanced scorecard (BSC) is a strategy and management system that focuses an organization on several areas of performance measurement. Prior to the introduction of the BSC, in most cases, performance was measured on the basis of financial achievements alone.

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, patient satisfaction, financial position, quality and safety outcomes, or employee professional development. For each area, the organization states objectives and identifies specific measurements that will demonstrate how it 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

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the turnover rate, cost per hire, length of employment, and so forth. The balanced scorecard allows everyone in the organization to see easily what the organization's priorities are and which areas need improvement.

Specific metrics should meet the following criteria: (1) importance to organization and staff, (2) measurability, (3) data validity, and (4) actionability. The BSC is balanced because it meets four goals. First, it provides a broad view of performance; second, it creates transparency and accountability; third, it communicates goals and engages staff; and last, it ensures the use of data in the strategic-planning process.

## **PLANNING AT THE LOCAL, REGIONAL, AND NATIONAL LEVELS**

Organizational planning at the local level is different from regional and national healthcare planning. As a result of the growth in health systems, many healthcare organizations are doing more regional and national planning.

### **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 healthcare 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.

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 effect of its communities' economic status on the availability of healthcare services in the area. Economic factors affect individuals' 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.

### **REGIONAL PLANNING**

As healthcare complexity increases in the United States, a case can 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.

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. Typically, academic medical centers generate the strongest presence on a regional level, followed by larger tertiary community hospitals. Some hospitals have differentiated themselves by affiliating with academic medical centers or health systems (Beckham 2014).

The ACA broadened Medicaid's role, making it the foundation of coverage for nearly all with incomes up to 138 percent of the federal poverty level. However, the 2012 Supreme Court ruling on *National Federation of Independent Businesses v. Sebelius* made the decision to implement the Medicaid expansion optional for states. For those that expand, the federal government will pay 100 percent of Medicaid costs of those newly eligible for Medicaid from 2014 to 2016. The federal share will phase down gradually to 90 percent in 2020, where it remains well above traditional federal medical-assistance percentage rates. As of March 2015, 29 states (including the District of Columbia) had adopted the Medicaid expansion, though debate continues in other states (Dorn et al. 2015). Consideration of the low-income population and their increased access to medical should be considered in the planning process depending on the state position on Medicaid.

## NATIONAL PLANNING

A framework for healthcare strategic planning at the national level is important. The passage of the ACA provided the foundation of a national strategic healthcare plan that integrates the priorities of key stakeholders, including patients, employers, plans, healthcare providers, and medical suppliers. The strategic plans was developed by the federal government and then implemented by governmental authorities at the local and regional levels.

The United States experienced significant improvement in the health status of its population –between 2005 and 2015. However, research demonstrates that minorities suffer disproportionately from many diseases. The federal and state governments are working to reduce these disparities through such projects as the *Healthy People 2020* report—a statement of healthcare objectives, around which local and regional planning can take place, produced by the US Department of Health and Human Services. Also the name of a ten-year effort to promote the goals it outlines, this comprehensive analysis of the US population's healthcare needs specifies healthcare improvement goals and measures by which progress toward those goals can be monitored.

*Healthy People 2020* contains 42 topic areas with more than 1,200 objectives. The *Healthy People 2020* objectives, called Leading Health Indicators, were selected to communicate high-priority health issues and actions that can be taken to address them. Great strides have been made over the past decade: Life expectancy at birth has increased; rates of death from coronary heart disease and stroke have decreased. Nonetheless, public health challenges remain, and significant health disparities persist.

### **Healthy People 2020**

A comprehensive analysis of the US population's healthcare needs and a statement of goals and measures by US Department of Health and Human Services, the s around which local and regional planning can take place Also the name of a ten-year effort to achieve the goals it outlines.

The *Healthy People 2020* leading health indicators place renewed emphasis on overcoming these challenges as we track progress up to the year 2020. The indicators will be used to assess the health of the nation, facilitate collaboration across sectors, and motivate action at the national, state, and community levels to improve the health of the US population (HHS 2015).

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.

## ENDNOTES

1. *Nosocomial infections* are infections that are not caused by a patient's condition but rather result from the treatment a patient receives in a hospital.
2. A *30-day readmission rate* is the percentage of patients who were 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.

## 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 achieving outstanding performance and then complete a gap analysis designed to identify where improvement is needed. At the operational level, developing programs and services that support the overall strategic plan and turn plan objectives into action is important for healthcare organizations.

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.

## EXERCISES

### REVIEW QUESTIONS

1. What roles do boards of directors, senior leaders, physicians, employees, and community organizations play in a healthcare organization's strategic-planning process?
2. Do you agree that healthcare organizations should monitor key business metrics throughout the year? Evaluate this idea and provide an example from the chapter that illustrates the monitoring of 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 EXERCISES

According to Chapter 4 and the case that appears at the beginning of the book, does CMC have the organizational capabilities for future success?

Richard Reynolds, the newly hired CEO, has been actively investigating the declining performance of CMC. During the hiring process, the board of directors assigned him the responsibility of getting the organization back on track. Help Mr. Reynolds develop a strategic-planning process that will place CMC on a new road to success by considering five new business initiatives, creating a dashboard, and evaluating CMC based on these metrics.

### COASTAL MEDICAL CENTER QUESTIONS

1. Many stakeholders described the original CEO of CMC, Don Wilson, as a visionary who helped the organization grow and prosper for more than 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 Mr. Henderson's performance was weak.
2. Of the five areas of new business initiatives to improve performance, which one should be the first priority?
3. How is CMC positioned relative to its competitors?
4. How should CMC create new and innovative approaches to community needs?
5. What do you see as the future of strategic planning at CMC?

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