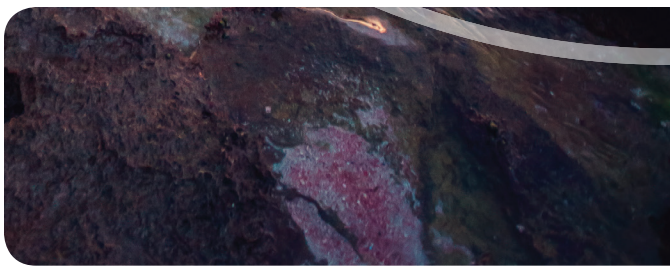
THIRD EDITION

ESSENTIALS of STRATEGIC PLANNING in HEALTHCARE

JEFFREY P. HARRISON



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PREFACE

Essentials of Strategic Planning in Healthcare is intended to be the primary textbook for introductory courses in healthcare strategic planning. The book opens with 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. This third edition incorporates discussion boards and other exercises that can be used in hybrid or online courses.

Healthcare research shows that the most successful organizations create a culture that fosters creativity, innovation, and transformational leadership. Effective strategic planning depends on leaders' commitment to creating an organizational culture that supports change. The first part of the book includes chapter 1, "Leadership, Mission, Vision, and Culture" and chapter 2, "The Shared Motivation of Transformational Leadership." These chapters show leadership's important role in strategic planning and in creating an organizational culture that fosters successful strategic planning. They also highlight the challenges and opportunities in executive leadership.

The second part of the book demonstrates essential strategic planning techniques for the healthcare field. It emphasizes the importance of positioning the healthcare organization in its community environment to achieve its objectives and to ensure its survival. Chapter 3, "Fundamentals of Strategic Planning," explains how strategic planning begins with an analysis of the external environment and organizational factors critical to the process. Chapter 4, "SWOT Analysis," focuses on the strengths, weaknesses, opportunities, and threats facing healthcare organizations and their importance in developing strategic plans.

It discusses the concept of downstream revenue to incorporate the growth of ambulatory care services, post-acute care, and palliative services. Chapter 5, "Healthcare Marketing," has been updated to include the six Ps of marketing. A sixth P, purpose, has been added to the traditional five-Ps approach, because a successful marketing plan must have a clear purpose if it is to become an integral part of the strategic plan. In addition, as health systems continue to grow, reflecting the consolidation in the industry, marketing is shifting from the local level to the regional or national level for some organizations. Chapter 5 also discusses trends in website enhancement, social media, and other digital media.

The third part of the book considers data, analytical tools, and other essential components of a strategic plan. Chapter 6, "Health Information Technology," identifies key data sources available to strategic planners in healthcare. It discusses artificial intelligence and recent enhancements in online data security. Chapter 7, "Designing an Effective Business Plan," discusses financial tools used to inform healthcare strategic planning. It examines the role of venture capital firms in the healthcare business planning model. Finally, chapter 8, "Communicating the Strategic Plan," emphasizes the importance of effectively sharing the strategic plan with multiple stakeholder groups and various outlets for sharing, including Facebook and Twitter.

The fourth part of the book focuses on strategic planning initiatives across the continuum of healthcare services. These initiatives include physician group management, long-term care, and other joint ventures. Chapter 9, "Accountable Care Organizations and Physician Alignment," discusses how hospitals can gain strategic advantage by linking with physicians. The chapter also describes the latest trends in physician group practice and incorporates the latest research on accountable care organizations. Chapter 10, "Post-Acute Care," discusses the growth in palliative care as a partnership across the continuum of care. The chapter has been updated to incorporate the growing need for dementia care through day care centers, memory care units, and inpatient facilities. Overall, it explores strategic planning opportunities in inpatient rehabilitation, skilled nursing, hospice, and other post-acute care services.

The fifth part of the book is written from a futurist perspective. It discusses the constant changes in regulatory and quality requirements and the evolving healthcare innovations that should be considered in strategic planning. Chapter 11, "Political, Business, and Ethical Decisions in Health Systems," discusses the growth of national and international health systems, the increasing rate of integration among healthcare organizations, and nontraditional partnerships with insurance companies and retail markets. Chapter 12, "Quality, Safety, Patient Experience, and Value," addresses the critical need to create value for both the organization and the consumer. The concept of value for today's consumer emphasizes high quality and low cost. The chapter examines the growing demand for quality-related data and transparency, as well as the ever-evolving pay-for-performance initiatives intended to enhance quality. Finally, chapter 13, "The Future of Healthcare," focuses on the need for innovation and disruption in current models for healthcare delivery. It looks at the

current trend of increased customization in healthcare, highlights upcoming value-based care initiatives, and considers proposals for Medicare for All.

Each chapter of the book includes definitions of key terms, review questions, exercises and questions related to the Coastal Medical Center case study, individual exercises and questions, and online exercises. Instructors may choose which activities fit best in their curriculum. The reference list at the end of each chapter can also serve as a list of recommended readings. Chapters 9 through 13 are modular, enabling the instructor to change their order or exclude one or more according to individual preference or classroom requirements.

The epilogue, "Ten Concepts for Effective Leadership," presents a real-life example of how to bring strategic planning forward in an organization. It describes ways to improve job satisfaction and organizational performance.

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

Instructor Resources

This book's Instructor Resources include a test bank, PowerPoint slides, answers to the end-of-chapter and case study questions, and a Health Administration Press (HAP) syllabus planner.

For the most up-to-date information about this book and its Instructor Resources, go to ache.org/HAP and search for the book's order code (24201).

This book's Instructor Resources are available to instructors who adopt this book for use in their course. For access information, please e-mail hapbooks@ache.org.

HAP course lesson plans are designed to promote an active classroom. They can be used to set up a new course or to adapt an existing syllabus to this edition of the textbook. Activities have been designed to enhance critical-thinking and problem-solving skills, as well as information retention and retrieval capacity. The course lesson plans are designed for either an online or an on-ground environment.

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I thank my coauthors, including Dr. Debra Harrison, who is the author of three chapters and who helped me throughout the preparation of this third edition. In addition, I thank Brian Hernke, MHA, a healthcare leader, for his contributions on healthcare quality and Liubov Harrison, MBA, for her work on health informatics. I also thank my mother, Gloria Harrison, who helped with previous editions and is a source of ongoing support and encouragement.

I also acknowledge the behind-the-scenes work necessary to publishing a book. In particular, I thank the staff at Health Administration Press. They were a pleasure to work with and were there every step of the way.

COASTAL MEDICAL CENTER COMPREHENSIVE CASE STUDY

Introduction

This comprehensive case study serves as a basis for the exercises included throughout the book. Although the case is fictional, it encompasses many of the challenges and situations that health administrators typically face in practice.

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 1.3 million, located in the Sunbelt. This tricounty area has had one of the fastest population growth rates in the country since 2015. According to the local health planning council, the area's population is projected to increase by 10 percent from 2020 to 2025. Appendix A, at the end of this case study, provides detailed population statistics for the city and tricounty area.

The growth rate of households (families) has been 1 to 2 percentage points higher than that of the overall population. The growth rate of the population younger than age 44 shows a young and growing community. Per capita (per person) income in the tricounty area is high and increasing. As the population of the area increases, the need for healthcare services is likely to increase. The region's economy is largely supported by manufacturing, though service companies and agriculture also play an important role. Unemployment, at 4 percent, is in line with national benchmarks. The overall poverty rate is 12.4 percent. A 2019 study revealed that 40,000 city residents live below 125 percent of the established federal poverty level.

Healthcare Costs

Healthcare costs in the region are higher than those in most other areas of the state. In response to what they have considered to be excessively high healthcare costs, county businesses formed a business coalition in 2018. They hired a full-time executive and publicly announced their intent to reduce healthcare costs. The local press has also expressed concern about the high cost of healthcare in the local community and consistently bashes the area's hospitals and physicians. The coalition has refused to allow the three major medical centers in the area to join, despite the fact that each is a major employer.

The Competition

CMC has two major competitors. Johnson Medical Center (JMC) is the larger of two hospitals in a for-profit healthcare system, and Lutheran Medical Center (LMC) is the largest of three hospitals in a faith-based, not-for-profit healthcare system.

JMC, located approximately two miles from CMC, is a 430-bed tertiary care facility. The medical center 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 tricounty 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.

full-time equivalent (FTE)
A unit of measurement equal to one employee working a full-time job during a specified period.

JMC has 1,920 **full-time equivalents (FTEs)**, which translates to 5.2 FTEs per **adjusted occupied bed**. In 2019, JMC hired a consultant to reduce its FTEs, flatten its structure, broaden its control, and improve its operations in general.

adjusted occupied bed
A unit of hospital bed occupancy that is adjusted (increased) to account for outpatient services, partial hospitalization, and home services.

JMC's occupancy rate has been averaging 74 percent. Outpatient revenues, 40 percent of total revenues, have grown by about 6 percent per year since 2017. The center's bottom line (i.e., net income) of $15 million in 2019 was higher than that in the two previous years ($11 million in 2017 and $14 million in 2018). **Profit margins** exceeded 5 percent from 2016 to 2019. In essence, JMC is a strong competitor of CMC's. The organization reportedly has a "war chest" of reserves exceeding $70 million.

profit margin
Difference between how much money the hospital brings in and how much it spends.

LMC is a 310-bed acute care hospital located outside the city limits but within the tricounty area. It does not offer tertiary, intensive services to the extent that CMC and JMC do, but the highly regarded general hospital enjoys an occupancy rate of 75 percent. Especially strong in obstetrics, pediatrics, general medicine, and ambulatory care, the hospital 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. In addition to serving its more affluent patients, LMC provides a great deal of indigent care. 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 several tertiary care services, except for 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 6.2 days, compared with a statewide average of 4.6 days at hospitals of similar size and services. This difference is probably attributable to the intensity of services CMC offers. The medical center's expenses per patient-day are also the highest in the state, outside of two large, university-affiliated teaching medical centers. Its FTEs per adjusted occupied bed (7.5), paid hours per adjusted patient-day (35.2), and paid hours per patient discharge (238.5) all greatly exceed those of its competitors and the norms of comparable facilities. CMC is currently authorized for 2,240 positions but employs 2,259 FTEs. Salary expenses per adjusted discharge are $2,769, and salary expenses per adjusted patient-day are $491.

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 market advantage in adult medical and surgical care. At a late 2019 administrative meeting, the following CMC utilization figures for the year were reviewed:

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

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

An 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 were grossly inaccurate.
- Insurers were not billed for services by certain hospital-based employed specialists ($7 million in the past year), because the hospital billing staff neglected to charge insurers.
- A total of $1.7 million in 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 through 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

HIGHLIGHT CASE.1
Hill-Burton Act

In the mid-1940s, many hospitals in the United States were becoming obsolete because they lacked money to invest in their facilities after the Great Depression and World War II. To combat this lack of capital and to 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 it 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, though it more clearly defines the requirements for the facilities. For example, facilities receiving grant money must prove they are providing a certain amount of uncompensated care to populations that meet particular eligibility requirements.

beds and now offers a full range of services. Credit for the major growth and past success of CMC has been given to Don Wilson, who served as CEO from 1994 until his retirement in 2016. Mr. Wilson was a visionary and successfully transformed the medical center to its present status as a tertiary care facility offering high-intensity care, including open-heart surgery and liver and kidney transplantation.

With an excellent revenue stream and a strong balance sheet, the medical center made $52.5 million in 2016 after Mr. Wilson's retirement. Consequently, his successor, Ron Henderson, was not pressed to make major changes. For three years, Mr. Henderson served largely as a caretaker, practicing a loose, informal style of management. He encouraged the board of trustees, the medical staff, and his administrative staff to submit new ideas for improving community healthcare services using CMC as the focal point for delivery. He received an avalanche of ideas during his first two years, and he moved quickly on them. He established himself as a person who made swift decisions on new ventures, kept things rolling, and simply let other executives "do their thing"—neither discouraging nor evaluating their work. His strategy was, apparently, rapid growth and diversity in new businesses. He made major fund commitments to new ideas but did little to evaluate the compatibility of those ideas with CMC's mission and strategic direction; furthermore, he seldom considered all the financial implications of these ventures. His approach was simply "Let's do it."

Before 2017, CMC was in excellent financial shape and faced few financial problems. By 2018, however, expenses began to skyrocket while utilization and revenues failed to keep pace. Notable among CMC's excessive costs were labor, material, and purchased services. The chief financial officer (CFO) was convinced that a major part of this problem was union activity, particularly among employees in support services and nursing services. Added to this cost burden was the more than $5 million being transferred to support other CMC subsidiaries. At the same time, 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.

During the second year of his tenure, Mr. Henderson began to receive criticism from the board of trustees. He 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 2019, the medical center suffered a net loss of $16 million (see appendix B). Surprised by this major loss, the board of trustees fired Mr. Henderson. The members contended that he should have kept them better informed about the center's problems and that a better strategic planning process should have been in place for the selection of projects on which millions of dollars had been spent. The board could not understand how overall corporate net income could drop to a loss of $16 million when the same calculation had been $7.3 million in profit in the previous year.

Board of Trustees

CMC's governing board has 27 members, all of which are prominent, influential, and generally wealthy members of the community. The board is self-perpetuating. Its members have continued their positions beyond the normal limits without any external intervention, and 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 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 the fact that racial minorities account for 25 percent of the service area population. Only 1 of the 27 members of the board is a woman. The average age of the trustees is 66.

Exhibit Case.2
Committees of the Coastal Medical Center Board

Committee	Number of Members	Meeting Frequency
Ambulatory care	11	Monthly
Audit	9	Quarterly
Budget	18	Quarterly
Construction	13	Monthly
Executive	16	Monthly
Executive compensation	9	Annually
Finance	13	Monthly
Joint conference	24	Monthly
Material and equipment	11	Monthly
Patient care	11	Monthly
Personnel	11	Monthly
Public relations	9	Monthly
Quality assurance	9	Monthly
Strategic planning	16	Monthly

Parent Corporation

Coastal Healthcare Incorporated, the parent corporation of CMC, created a parent board through corporate restructuring several years ago, but the board's role has never been clear. This board is made up of friends of the most powerful trustees of the CMC board. In essence, when corporate restructuring was the in thing to do, this holding company was formed. When the corporation leaders appointed a few CMC trustees to the parent board as well and appointed friends of present CMC trustees, the leaders believed that the two boards would function as one happy family. From the parent board's inception, however, there has been constant conflict over the relative powers and roles of the two boards.

The parent board has 19 members, all of whom are white and male. The prominent, mostly wealthy backgrounds of the parent board trustees mirror those of the CMC trustees. Membership includes bankers, attorneys, business executives, business owners, developers, and prominent retired people. The parent board has three committees (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 2017, the two boards hired separate consultants to develop a long-range strategic plan. Two plans were produced, but they were never integrated and never really implemented.
- Committees from the parent board often request information about functions of the medical center, underscoring the parent board's tendency to micromanage CMC's routine operations.
- Separate committees of both boards spent more than two years trying to revise CMC's mission statement.

Committee	Number of Members	Meeting Frequency
Executive	11	Monthly
Finance	11	Monthly
Strategic planning	11	Quarterly

Exhibit Case.3
Committees of the Coastal Healthcare Inc. (Parent) Board

Medical Staff

The medical staff at CMC has historically had difficulty cooperating with the CMC board and administration. Patient length of stay is too 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. Furthermore, medical staff members, especially the radiologists and neurologists, have set up their own diagnostic services, despite having been granted exclusive service contracts at CMC.

In recent years, the specialists, who represent the majority of the medical staff, have been increasingly dissatisfied. They complain that their referrals are decreasing or remaining 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, in the most recent survey, also rated various aspects of medical center operations as unsatisfactory. The subjects of their complaints ran the gamut and included the following:

- Nursing services, and especially the nurses' attitudes, are not satisfactory. Nurses have arranged themselves into shared governance councils and are taking issue with both physicians and the administration regarding their autonomy.
- Excessive delays exist in every aspect of operations. Surgical procedures start late, supplies and equipment are often lacking when needed, and admissions take too long.
- CMC's recent Hospital Consumer Assessment of Healthcare Providers and Systems scores, which represent patient satisfaction, confirmed the doctors' perception. Only 74 percent of patients reported satisfaction with nurses' communication (appendix C). The percentage of patients satisfied with physicians' communication was even lower, at 72 percent.
- Medical staff members think they should have more voice in both financial and operational matters, especially in capital budgeting. However, they are asking for compensation to participate on committees since they are losing practice income when they attend the meetings.

CMC also is facing some quality problems, as noted in appendix C and appendix G. Two physicians should probably have their privileges revoked, three apparently have

substance abuse problems, and several have not kept up with current practices and should be asked to retire. Persuading physicians to hold elected offices and accept committee responsibility has also been difficult. Payment of honoraria has helped, but few physicians are still willing to serve. More than $200,000 has already been paid out to entice doctors to serve on committees.

Subsidiary Companies

Including CMC, Coastal Healthcare Inc. comprises 25 subsidiary corporations:

- Medical Enterprises, a for-profit joint venture with physicians, 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.
- Three nursing homes are collectively 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 the residents of the two facilities losing the greatest amount are Medicaid patients; the facilities have only a few self-pay patients.
- CMC Management Services was formed to sell management and consulting services. The company lost $360,000 in 2019, its third year of operation.
- Regional Neuroimaging is a joint venture with physicians. The company lost $920,000 in its first year of operation. Capital invested by the hospital to date totals $9 million.
- American Ambulance is a local ambulance company. Financially, it just breaks even, but it does increase admissions to CMC, especially through trauma pickups.
- 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 CMC to generate referrals. None of the operating sites is making a profit, though the company is five years old.
- MRI Enterprises is a successful mobile magnetic resonance imaging joint venture with a physician group. It has a consistently positive bottom line.

debt service
Cash required over a given period for the repayment of interest and principal on a debt.