Strategic Management of Health Care Organizations

SEVENTH EDITION

PETER M. GINTER • W. JACK DUNCAN • LINDA E. SWAYNE

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PREFACE

More than two decades ago, the three of us agreed that health care was experiencing evolutionary, and in some segments revolutionary, change. At that time, we wrote in the Preface of the first edition that clearly health care organizations have "had difficulty in dealing with a dynamic environment, holding down costs, diversifying wisely, and balancing capacity and demand." Our conclusion was that only a structured strategic management approach that recognized the value of emergent thinking could make sense of such a rapidly changing environment. Our only surprise has been that the rate of change in the health care environment has been even greater than we imagined.

Today, health care organizations have almost universally embraced strategic management as first developed in the business sector and now have developed strategic management processes that are uniquely their own. Health care leaders have found that strategic thinking, planning, and managing strategic momentum are essential for coping with the dynamics of the health care industry and strategic management has become the single clearest manifestation of effective leadership in health care organizations.

In the broadest terms, this text is about leadership; more narrowly, it concerns the essential strategic tasks of leading and managing health care organizations. As a result, the seventh edition continues to advocate the importance of strategic thinking and clearly differentiates strategic thinking, strategic planning, and managing strategic momentum. These concepts represent the central elements of a complete strategic management process that we believe reflects the realities of conceptualizing, developing, and managing strategies.

Specifically, our approach depicts strategic management as the processes of strategic thinking, consensus building and documentation of that thinking into a strategic plan, and managing strategic momentum. Through the management of the strategic plan, new insights and perspectives emerge and strategic thinking, planning, and managing are reinitiated. Therefore, strategic managers must become strategic thinkers with the ability to evaluate the changing environment, analyze data, question assumptions, and develop new ideas. Additionally, strategic managers must be able to develop and document a plan of action through strategic planning. Once a strategic plan is developed, managers maintain the strategic momentum of the organization. As strategic managers attempt to carry out the strategic plan, they evaluate its success, learn more about what works, and incorporate new strategic thinking.

It is our view that strategic control is integral to managing strategic momentum and cannot be thought of or taught as a separate process. Therefore, traditional strategic control concepts are integrated into the strategy development chapters under the heading of "Managing Strategic Momentum." We believe that

this approach better reflects how strategic control works in organizations – as a part of managing the strategy, not as an afterthought or add on.

Although we present a structured strategic management process, we believe that strategic management is highly subjective, often requiring significant intuition and even well-informed guesswork. However, intuition and the development of well-informed opinions are not easily learned (or taught). Therefore, a major task of the future strategic thinker is to first develop a thorough understanding of analytic strategic management processes and then – through experience – develop the intuition, perspective, and insight to consider previously uncharted strategic issues. Our map and compass metaphor provides a framework for blending rational, analytical planning with learning and responsiveness to new realities. We believe this text provides that foundation for effective strategic thinking, planning, and managing strategic momentum.

Features of the Text

Feedback from users of previous editions of *Strategic Management of Health Care Organizations* has reinforced our belief that these features aid in providing an informative, interesting, and pedagogically sound foundation for understanding and embracing strategic management of health care organizations.

- Each chapter begins with an *Introductory Incident* to provide a practical example of the concepts discussed in the chapter.
- *Learning Objectives* direct attention to the important points or skills introduced in the chapter.
- *Models, examples, and exhibits* are included to assist in learning chapter material.
- *The Map and Compass* provides a useful metaphor for conveying the view that strategic leaders must both plan as best they can but also learn, adjust, and establish new direction (develop a new plan) as they progress.
- *Perspectives* in each chapter are drawn from actual health care organizations' experiences or emphasize recurring themes and abiding truths and are useful to augment the content of each chapter. These sidebars are designed to enable the student to relate to particular concepts presented in the chapter.
- *Lessons for Health Care Managers* serve as chapter summaries and highlight the most important lessons to be taken away from each chapter.
- *Health Care Manager's Bookshelf* introduces classic and popular books that have particular relevance to the strategy topic discussed in the text. Books were selected on the basis of their importance to present and future health care managers and included because they either represent a "classic contribution" to the field or provide potentially trend-setting information for strategic health care managers.
- *Key Terms and Concepts* present the essential vocabulary and terminology relative to the chapter's material.

- *Questions for Class Discussion* aid the reader in reviewing the important material and thinking about the implications of the ideas presented.
- *Notes* contain the references used in development of the chapter materials.
- Three *Appendices* to assist readers – *Analyzing Strategic Health Care Cases*, *Health Care Organization Accounting, Finance, and Performance Analysis*, and *Health Care Acronyms*.
- A *Web-based Instructor's Support* site is available to verified course instructors using the text. The support material includes PowerPoint slides for each chapter, chapter lecture notes that include suggestions for effective teaching, and answers to the end-of-chapter questions. The *Instructor's Support* also contains a true/false, multiple choice, and discussion question test bank and can be found at www.wiley.com/go/ginter7e.

Through our own teaching, research, and consulting in the health care field, we have applied the process outlined in this text to physician practices, hospitals, local and state public health departments, long-term care facilities, social service organizations, and physical therapy practices. We have students who report back to us saying that they lead strategic planning in their organizations using the process with great success. The process works.

Organization of the Text

The text contains 10 chapters and three appendices addressing the philosophy and activities of strategic management. Chapter 1 introduces definitions for strategic management and its activities – strategic thinking, strategic planning, and managing strategic momentum. The chapter discusses the need and rationale for strategic management in today's turbulent health care environment and briefly traces its historical foundations. In addition, Chapter 1 presents a conceptual model or map that guides strategic thinking, focuses on important areas for strategic planning, and provides the constructs for managing strategic momentum.

Chapter 2 contains strategic thinking and planning maps for investigating the external environment – both the general environment and the health care industry environment. Chapter 3 narrows the external environmental focus by providing strategic thinking maps for conducting service area and competitor analysis for a specific health care organization. Assessment of the internal environment is accomplished through strategic thinking maps for a health care value chain and analysis of the organization's resources, capabilities, and competencies, as examined in Chapter 4.

The directional strategies – mission, vision, values, and strategic goals – are examined in Chapter 5. Developing a mission asks members of an organization to strategically think about its distinctiveness; developing a vision allows them to think about their hopes for the organization's future; and building awareness of organizational values makes members aware of the principles that should be cherished and not compromised as the mission and vision are pursued. Strategic goals establish clear targets and help focus activities. Chapters 2–5 collectively constitute situation analysis.

Strategy formulation is concerned with making strategic decisions using the information gathered during situational analysis. Chapter 6 provides the decision logic for strategy formulation and demonstrates that strategic decisions are connected in an "ends–means" chain. Each decision along the decision chain more explicitly defines the strategy and must be consistent with upstream and downstream decisions. Chapter 7 discusses how to evaluate the strategic alternatives within each strategy type in the decision chain. These evaluation methods do not make the strategy decision. Rather, they are constructs or maps for helping strategists to think about the organization and its relative situation, thus enabling them to understand the potential risks and rewards of their strategic choices.

Managing strategic momentum entails putting strategies to work (managerial actions that accomplish the strategy), incorporating strategy evaluation and control, and building strategic awareness. Implementation requires that strategic managers shape and coordinate the value chain components and ensure that the organization's action plans are directly tied to selected strategies. Chapter 8 addresses the development of implementation plans through either maintaining or changing the pre-service, point-of-service, and after-service strategies. Strategic managers should determine the essential characteristics of service delivery to ensure it best contributes to accomplishment of the strategy. Chapter 9 examines the role of organizational culture, organizational structure, and strategic resources in implementing strategy. These value chain components determine the organizational context and are vital in effective strategy implementation. Chapter 10 demonstrates how strategy may be translated into organizational unit objectives and action plans. It is the organizational units that must carry out strategy and strategic managers must review objectives and action plans to ensure that they are coordinated and make best use of human, physical, and financial resources. Each of these chapters points out the need to manage strategic momentum by thinking, planning, and doing, and then rethinking, new planning, and doing.

Finally there are three appendices as a reference for users of the text. Appendix A, Analyzing Strategic Health Care Cases, presents a methodology for case analysis for those using case studies to "practice" strategic thinking and planning; Appendix B, Health Care Organization Accounting, Finance, and Performance Analysis, as an accounting and finance refresher and reference; and finally, Appendix C, Health Care Acronyms, is a quick source for definitions of the "short-hand" language of health care.

The Author Team

In developing and writing this book, as with all our collaborative projects, we have created a team in its truest sense. Recognizing that each of us makes a unique contribution and provides leadership, we have changed the order in which the authors are listed every two editions. For the first and second editions, the authors were listed as Duncan, Ginter, and Swayne; for the third and fourth editions, the authors were listed as Ginter, Swayne, and Duncan. In the fifth and sixth editions, the order was Swayne, Duncan, and Ginter.

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A number of people have provided inspiration, ideas, and considerable effort to produce the seventh edition. We are indebted to many individuals for their assistance and encouragement. A special note of thanks to Sunil Erevelles, Chair of the Department of Marketing at the Belk College of Business at the University of North Carolina at Charlotte, and to Dean Max Michael, MD of the School of Public Health at the University of Alabama at Birmingham, who have continuously been supportive of our efforts. Also, a special thanks to Andrew C. Rucks for his Appendix B, Health Care Organization Accounting, Finance, and Performance Analysis and his invaluable contribution to the text's Web-based Instructor's Support. Thank you Rongbing (Bing) Xie, our teaching assistant at UAB, who tirelessly supported our in-class and on-line teaching.

We must also thank our many students (many of whom became strategic management course instructors), who have provided feedback, made contributions, used the book in their professional careers, and kept in contact to tell us of the value of the book that remains on their bookshelves.

Finally, but most importantly, we thank our families who have supported and encouraged us as we worked on still another writing project. Thank you all for your understanding.

1 The Nature of Strategic Management

"It is not the strongest of the species that survive, nor the most intelligent, but the one most responsive to change."

—CHARLES DARWIN

Introductory Incident

It Can Be Done: Premier Healthcare Alliance Accountable Care Collaboratives Are Saving Lives and Saving Costs

Statistics show that health care costs have been growing at an unsustainable rate, reaching an estimated 17.3 percent of gross domestic product (GDP) in 2009, according to the Centers for Medicare and Medicaid Services (CMS), representing the largest one-year increase in history when the nation itself was in the midst of the "great recession." Predictions are for health care costs to be 19.3 percent of GDP in 2019 (four times the 5.1 percent of GDP in 1960). Despite the high cost of health care, gaps and inequities persisted, leading to health care reform. The 2010 Patient Protection and Affordable Care Act (PPACA), or commonly Affordable Care Act (ACA) is attempting to change the US health care system from a volume-based to a value-based model.

Premier Healthcare Alliance believes that accountable care organizations (ACOs) are the way to better align the incentives and needs of all stakeholders. Premier's components to the ACO model include:

- People-centered health homes that deliver primary care and coordinate with other providers as needed.
- New approaches to primary, specialty, and hospital care that reward care coordination, efficiency, and productivity.
- Tightly integrated relationships with specialists, ancillary providers, and hospitals to provide focus and alignment on achieving high-value outcomes.
- Provider/payer partnerships and reimbursement models that reward improved outcomes (value over volume).
- Population health information infrastructure, including health information exchanges to enable care across a designated population.

The goal is to incentivize health and wellness, rather than paying for treating disease. ACOs actually began in 2005, when CMS began the Physician Group Practice demonstration. Its success in developing incentives based on the quality of care provided and the estimated savings generated for the Medicare population served, led to the formation of the Medicare Payment Advisory Commission (MedPAC) to begin looking for real ways to reduce costs, while improving quality of care and patient satisfaction. ACOs were incorporated into the Affordable Care Act legislated in March 2010.

Premier Healthcare Alliance has developed a proven model for ACOs based on the following key elements:

- Establish goals and mission – create a definition of areas to address and what the collaborative will do to fulfill its mission.
- Define consistent measures of success – common measures that will be used to improve defined outcomes.
- Data collection and normalization – use standardized data sets to meaningfully compare results across participants.
- Transparency – participants commit to open sharing of performance data across the collaborative to identify the top performers and learn from them.
- Driver analysis and collaborative execution – using transparent data, the collaborative can set performance targets, identify opportunities for improvement, and establish areas of focus.
- Share best practices – share across the collaborative to realize improvement gains.
- Performance improvement analysis – analyze data from the cohort and individuals to highlight trends/opportunities that will drive performance and achieve goals.

Premier established QUEST®: High-Performing Hospitals collaborative (200 not-for-profit hospitals in 31 states) for hospitals to learn from the top performers and develop and implement systemic improvements across their organizations. Three goals drove the process: save lives, safely reduce the cost of care, and deliver the most reliable and effective care. In three years, QUEST hospitals saved an estimated 22,164 lives and reduced health care spending by $2.13 billion (national translation would be more than 86,000 lives and $25 billion saved).

Source: Premier Healthcare Alliance, Inc.

Learning Objectives

After completing the chapter you will be able to:

1. Explain why strategic management has become crucial in today's dynamic health care environment.
2. Trace the evolution of strategic management and discuss its conceptual foundations.
3. Describe and explain the concept of strategic thinking maps.
4. Define and differentiate between strategic management, strategic thinking, strategic planning, and managing strategic momentum.
5. Understand the necessity for both the analytic and emergent models of strategic management.
6. Understand how an organization may realize a strategy that it never intended.
7. Understand the benefits of strategic management for health care organizations.
8. Understand the importance of systems approaches.
9. Explain the links between the different levels of strategy within an organization.
10. Describe the various leadership roles of strategic management.

Managing in a Dynamic Environment

The dramatic changes in the health care industry that began in the 1980s, marked by the implementation of Medicare's prospective payment system in 1983, continue today (see Perspective 1–1 for an overview of the Patient Protection and Affordable Care Act – the most significant change for health care since the passage of Medicare and Medicaid in the 1960s, and still changing as components are tested in courts and in its phased-in implementation). As a result, health care institutions continue to face a turbulent, confusing, and often threatening

environment. Significant change comes from many sources, including: legislative and policy initiatives; international as well as domestic economic and market forces; demographic shifts and lifestyle changes; technological advances; and fundamental health care delivery changes. Certainly, health care systems, as well as other domestic and international health care organizations, have had to continuously adapt to these and other changes. As suggested in the introductory quote, health care organizations will have to be responsive to and effectively manage change in this dynamic environment.

PERSPECTIVE 1–1

The Patient Protection and Affordable Care Act (PPACA)

The PPACA was enacted in March of 2010; most of its provisions go into effect in 2014. This complex law has many provisions; some of the more important ones are summarized here.

First, the law requires most US citizens and legal residents under age 65 to have health insurance; this is the "insurance mandate." The law provides financial penalties, if one does not obtain coverage, and it provides subsidies, if one has sufficiently low household income.

Second, the law requires large employers, those with 50 or more employees, to provide health insurance to their workers who work 30 or more hours per week. Failure to do so results in financial penalties on the employer. The most significant of these is a fine of $2,000 per uninsured worker. Firms with less than 50 workers are not required to offer coverage, but receive short-term (two-year) subsidies if they choose to do so.

Third, the law requires the establishment of "health insurance exchanges" in each state. The states have discretion in how these organizations operate, but if a state fails to establish an exchange, the federal government will operate one in the state. Exchanges are virtual marketplaces where individuals and small employers can compare coverage from different insurers, obtain subsidies if they are eligible, and buy insurance. The state exchange has to be self-sufficient, covering the administrative costs by taxes or fees.

Fourth, within the exchanges individuals and small firms may buy "platinum," "gold," "silver," and "bronze" coverage. Each of these tiers reflects coverage of the same "essential health benefits" at a different expenditure level. A silver plan, for example, must cover 70 percent of the costs of the benefit package, with the subscriber paying the other 30 percent out of pocket. Each insurer may offer several combinations of deductibles, copays, and coinsurance features to meet the spending level in each tier. The states, with strong guidance from the federal government, determine what constitutes "essential health benefits."

Fifth, the law required the states to expand the Medicaid programs to include citizens and legal residents between ages 19 and 64, inclusive, if their income was below 139 percent of the federal poverty line. The Supreme Court found the provision enforcing this expansion to be unconstitutional. As a result, the states now have the option to expand Medicaid. If they do so, the federal government will initially pay 100 percent of the costs of the expansion, declining to 90 percent by 2019.

This legislation poses a number of issues for states, for employers, and for health care providers. The challenges include:

- Should a state undertake the Medicaid expansion? The expansion provides coverage to many uninsured people in the state and is largely paid for with federal dollars. However, state Medicaid budgets are already strapped.
- Should the state create an insurance exchange tailored, to the extent possible, to the preferences of the state, or should it simply let the federal government do it? Exchanges are to be "self-sustaining;" how will the administrative functions be funded?
- Should a smaller employer who currently offers coverage, drop the coverage, raise wages, and encourage her employees to buy coverage through the exchange?
- Large employers are required to offer coverage or pay a fine. Should they drop coverage, forget the headaches of employer-sponsored coverage, and just pay the fine?
- How is a hospital affected by PPACA? There will be fewer uninsured, but patient copays and deductibles may be larger and government payments (i.e., Disproportionate Share payments) to care for the poor and uninsured will be reduced.

SUGGESTED READING

J. P. Newhouse, "Assessing Health Reform's Impact on Four Key Groups of Americans," *Health Affairs* 29, no. 9 (2010), pp. 1714–1724.

Sources: Michael A. Morrisey, PhD, Director, Lister Hill Center for Health Policy and Department of Health Care Organization and Policy, University of Alabama at Birmingham.

Coping with Change

How can health care leaders deal with change? Which issues are most important or most pressing? Furthermore, what new issues will emerge? It is likely that there will be new issues for health care organizations that have yet to be identified or fully assessed. Even more sobering, it seems certain that there will be more change in the health care industry in the next 10 years than there has been in the past 10 years.

Dealing with rapid, complex, and often discontinuous change requires leadership. Successful health care organizations have leaders who understand the nature and implications of external change, the ability to develop effective strategies that account for change, and the will as well as the ability to actively manage the momentum of the organization. These activities are collectively referred to as "strategic management." The clearest manifestation of leadership in organizations is the presence of *strategic management* and its activities. Strategic management is fundamental in leading organizations in dynamic environments. Strategic management provides direction and momentum for change.

Organizational change is a fundamental part of success. As health care leaders chart new courses into the future, in effect, they create new beginnings, new

chances for success, new challenges for employees, and new hopes for patients. Therefore, it is imperative that health care managers understand the changes taking place in their environment; they should not simply be responsive to them, they must create the future. Health care leaders must see into the future, create new visions for success, and be prepared to make significant improvements.

The Foundations of Strategic Management

In political and military contexts, the concept of strategy has a long history. For instance, the underlying principles of strategy were discussed by Sun Tzu, Homer, Euripides, and many other early strategists and writers. The English word strategy comes from the Greek *stratēgōs*, meaning "a general," which in turn comes from roots meaning "army" and "lead."[1] The Greek verb *stratēgēō* means "to plan the destruction of one's enemies through effective use of resources."[2] Similarly, many of the terms commonly used in relation to strategy – objectives, strategy, mission, strengths, weaknesses – were developed by the military.

Long-Range Planning to Strategic Planning

The development of strategic management began with much of the business sector adopting long-range planning. Long-range planning was developed in the 1950s in many organizations because operating budgets were difficult to prepare without some idea of future sales and the flow of funds. Post-WWII economies were growing and the demand for many products and services was accelerating. Long-range forecasts of demand enabled managers to develop detailed marketing and distribution, production, human resources, and financial plans for their growing organizations. The objective of long-range planning is to predict for some specified time in the future the size of demand for an organization's products and services and to determine where demand will occur. Many organizations have used long-range planning to determine facilities expansion, hiring forecasts, capital needs, and so on.

As industries became more volatile, long-range planning was replaced by strategic planning because the assumption underlying long-range planning is that the organization will continue to produce its present products and services – thus, matching production capacity to demand is the critical issue. However, the assumption underlying strategic planning is that there is so much economic, social, political, technological, and competitive change taking place that the leadership of the organization must periodically evaluate whether it should even be offering its present products and services, whether it should start offering different products and services, or whether it should be operating and marketing in a fundamentally different way.

Although strategies typically take considerable time to implement, and thus are generally long range in nature, the time span is not the principal focus of strategic planning. In fact, strategic planning, supported by the management of the strategy, compresses time. Competitive shifts that might take generations to evolve instead occur in a few short years.[3] In a survey of senior executives, 80 percent indicated that the productive lives of their strategies were getting shorter and 75 percent believed that their leading competitor would be different within

five years.[4] Therefore, it is preferable to use "long range" and "short range" to describe the time it will take to accomplish a strategy rather than to indicate a type of planning.

Strategic Planning to Strategic Management

The 1960s and 1970s were decades of major growth for strategic planning in business organizations. Leading companies such as General Electric were not only engaged in strategic planning but also actively promoted its merits in the business press. The process provided these firms with a more systematic approach to managing business units and extended the planning and budgeting horizon beyond the traditional 12-month operating period. In addition, business managers learned that financial planning alone was not an adequate framework.[5] In the 1980s the concept of strategic planning was broadened to strategic management. This evolution acknowledged not only the importance of the dynamics of the environment and that organizations may have to totally reinvent themselves, but also that continuously managing and evaluating the strategy are keys to success. Thus, strategic management was established as an approach or philosophy for managing complex enterprises and, as discussed in Perspective 1–2, should not be viewed as a passing fad.

Strategic Management in the Health Care Industry

Strategic management concepts have been employed within health care organizations only in the past 30 to 35 years. Prior to this time, individual health care organizations had few incentives to employ strategic management because typically they were independent, freestanding, not-for-profit institutions, and health services reimbursement was on a cost-plus basis. In many respects health care has become a complex business using many of the same processes and much of the same language as the most sophisticated business corporations. Certainly, in the late 1980s and 1990s many health care organizations had much to learn from strategically managed businesses. As a result, many of the management methods adopted by health care organizations, both public and private, initially were developed in the business sector.

PERSPECTIVE 1–2

Are the Following Management Approaches Fads?

Management fads? Management techniques? Management fads is usually the flippant answer. However, each of these management approaches was a genuine attempt to change and improve the organization – to focus efforts, to improve the quality of the products and services, to improve employee morale, to do more with less, to put meaning into work, and so on. Some of the approaches worked better than others; some stood the test of time and others did not. Yet, it would be too harsh to simply dismiss them as fads or techniques. The goals

1950s	• Theories X and Y • Management by Objectives • Quantitative Management • Diversification
1960s	• Managerial Grid • T-Groups • Matrix Management • Conglomeration • Centralization/ Decentralization
1970s	• Zero-Based Budgets • Participative Management • Portfolio Management • Quantitative MBAs
1980s	• Theory Z • One-Minute Managing • Organization Culture • Intrapreneuring • Downsizing • MBWA (Management by Wandering Around) • TQM/CQI
1990s	• Customer Focus • Quality Improvement • Reengineering • Benchmarking • Resource-Based View
2000s	• Six Sigma • Balanced Score Card • Transformational Leadership • Self-Managed Teams • Dynamic Capabilities • Virtual Organizations • Blue Oceans • The Learning Organization
2010s	• Knowledge Management • LEAN Six Sigma • Strategic Mapping • Black Swan • Disruptive Innovation • Predictable Surprises

for all of these management approaches were to manage and shape the organization – to make it better, to make it an excellent organization. One of the things that has distinguished all of these "fads" is the enthusiasm and commitment they have engendered among managers and workers. For many, these approaches have significantly increased the meaning of work – no small accomplishment in an era in which people are increasingly hungry for meaning. And certainly organizations need to create meaning.[1]

When management approaches such as these fail, it is usually because they become an end in themselves. Managers lose sight of the real purpose of the approach and the process becomes more important than the product. Managers start working for the approach rather than letting the approach work for them.

What will be the "management fads" of the next decade?[2] Will you be a part of these or past attempts to make the organization better or will you simply dismiss them as fads? Perhaps benchmarking, quality improvement, the learning organization, or LEAN Six Sigma will turn your organization around. One of these approaches may help to make your organization truly excellent or save it from decline.

Is strategic management just another fad? Will it stand the test of time? If strategic management becomes an end in itself, if its activities do not foster and facilitate thinking, it will not be useful. However, if strategic management helps managers to think about the future and guide their organizations through turbulent environments, strategic management will have succeeded.

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1. J. Daniel Beckham, "The Longest Wave," *Healthcare Forum Journal* 36, no. 6 (November/ December 1993), pp. 78, 80–82.
2. "Rethinking the Cause of Management Fads," *Strategic Direction* 21, no. 4 (2005), p. 28.

Although the values and practices of for-profit business enterprises in the private sector have been advocated as the appropriate model of managing health care organizations, a legitimate question arises concerning the appropriateness of the assumption that business practices may always be relevant to the health care industry. Certainly, not all the "big ideas" have delivered what was promised, even in business.[6] It has been pointed out that:

1. Some strategic alternatives available to non-health care organizations may not be realistic for many health care organizations.
2. Health care organizations have unique cultures that influence the style of and participation in strategic planning.
3. Health care has always been subject to considerable outside control.
4. Society and its values place special demands on health care organizations.[7]

However, strategic management, especially when customized to health care, does seem to provide the necessary processes for health care organizations to cope with the vast changes that have been occurring. Over time these business approaches increasingly have been modified to fit the unique aspects of health care organizations.

Strategic Management Versus Health Policy Planning

There has been and continues to be substantial health planning (policy) in the United States. Efforts at health planning are initiated by either state or local governments and the resulting health policies are implemented through legislation or private or non-governmental agencies. Many of these planning efforts are disease specific; that is, they are categorical approaches directed toward specific health problems (e.g., the work of the National Tuberculosis Association that stimulated the development of state and local government tuberculosis prevention and treatment programs).[8] As a result, a variety of state and federal health planning or policy initiatives have been designed to: (1) enhance quality of care and reduce medical errors; (2) provide or control access to care; and (3) contain costs.

These health-planning efforts are not strategic management. Health planning is the implementation of local, state, and federal health policy and affects a variety of health care organizations. As explained in Perspective 1–3, the intent of *health policy* is to provide the context for the development of the health care infrastructure as a whole. In contrast, strategic management is organization specific. Strategic management helps an individual organization to respond to state and federal policy and planning efforts, as well as to a variety of other external forces.

PERSPECTIVE 1–3

What is Health Policy?

Health policy determines the rules of the game that apply to all consumers and providers in the field. It is the development and maintenance of an infrastructure to efficiently enhance the health of the public.

An infrastructure need not imply a governmentally financed health care system nor the delivery of services by a governmental entity. What it does imply is a set of institutions that meet the preferences of most of the society. These institutions can take many forms, ranging from unfettered markets to the provision of services by governments.

The role of health policy is to determine the preferences of the society and to develop and fine tune institutions that can efficiently meet those preferences. Meeting preferences may mean defining the ground rules under which insurers and providers compete. It may mean defining those services that will be provided by only a single provider, and then deciding whether that provider will be a public or private organization. It will certainly mean revisiting these decisions as new ways of doing things and new problems emerge.

The Congress and the state legislatures set health policy. In addition, the administrative authority given to executive branches and their agencies sets policy. Therefore, the Center for Medicare and Medicaid Services determines much of the health policy for federal Medicare and Medicaid. The Centers for Disease Control and Prevention, the Food and Drug Administration, and the Occupational Health and Safety Administration set and enforce health and safety standards. State departments of health, insurance, and environmental quality set health policy within their own spheres of influence.

There are many analytic tools that come into play in helping to determine the rules that are adopted. These include economics, law, political science, epidemiology, medicine, and health services research. Health policy questions are sometimes very broad and at other times very specific. Some important questions include:

- Is health care a right or an individual responsibility?
- Can the human costs of poor health be quantified?
- Can higher taxes on saturated fats reduce the prevalence of obesity?
- Would a refundable tax credit encourage the uninsured to buy coverage?
- Would higher incomes or more health services do more to improve health status?
- Who pays if employers are required to provide health insurance?

Source: Michael A. Morrisey, PhD, Director, Lister Hill Center for Health Policy and Department of Health Care Organization and Policy, University of Alabama at Birmingham.

The Dimensions of Strategic Management

There are many ways to think about strategic management in organizations. In fact, Henry Mintzberg identified ten distinct schools of thought concerning organizational strategy.[9] Three of these approaches were prescriptive and analytical:

the design school, the planning school, and the positioning school. Six schools of thought were descriptive and emergent: the entrepreneurial school, the cognitive school, the learning school, the political school, the cultural school, and the environmental school. The final school of thought, the configurational school, specifies the stages and sequence of the process and attempts to place the findings of the other schools in context.[10]

Analytical Versus Emergent Approaches

Given the careful reasoning of the proponents of these various approaches to strategic management, it is safe to assume that there is no one best way to think or learn about strategy making in complex organizations. *Analytical* or *rational approaches* to strategic management rely on the development of a logical sequence of steps or processes (linear thinking). Emergent models, on the other hand, rely on intuitive thinking, leadership, and learning and are viewed as being a part of managing. Both approaches are valid and useful in explaining an organization's strategy. However, neither the analytical approach nor the emergent view, by itself, is enough. David K. Hurst explains:

> "The key question is not which of these approaches of action is right, or even which is better, but when and under what circumstances they are useful to understand what managers should do. Modern organizational life is characterized by oscillations between periods of calm, when prospective rationality seems to work, and periods of turmoil, when nothing seems to work. At some times, analysis is possible; at other times, only on-the-ground experiences will do."[11]

As a result, both approaches are required. It is difficult to initiate and sustain organizational action without some predetermined logical plan. Yet in a dynamic environment, such as health care, managers must expect to learn and establish new directions as they progress. The analytical approach is similar to a map, whereas the emergent model is similar to a compass. Both may be used to guide one to a destination. *Maps* are better in known worlds – worlds that have been charted before. *Compasses* are helpful when leaders are not sure where they are and have only a general sense of direction.[12]

Managers may use the analytical approach to develop a strategy (map) as best they can from their understanding of the external environment and by interpreting the capabilities of the organization. Once they begin pursuing the strategy, new understandings and strategies may emerge and old maps (plans) must be modified. Harvard Professor Rosabeth Moss Kanter concluded from her research that pacesetter organizations "did not wait to act until they had a perfectly conceived plan; instead, they create the plan by acting."[13] Therefore, managers must remain flexible and responsive to new realities – they must learn. However, the direction must not be random or haphazard. It must be guided by some form of strategic sense – an intuitive, entrepreneurial sensing of the "shape of the future" that transcends ordinary logic. The concept of the compass provides a unique blend of thinking, performance, analysis, and intuition.[14]

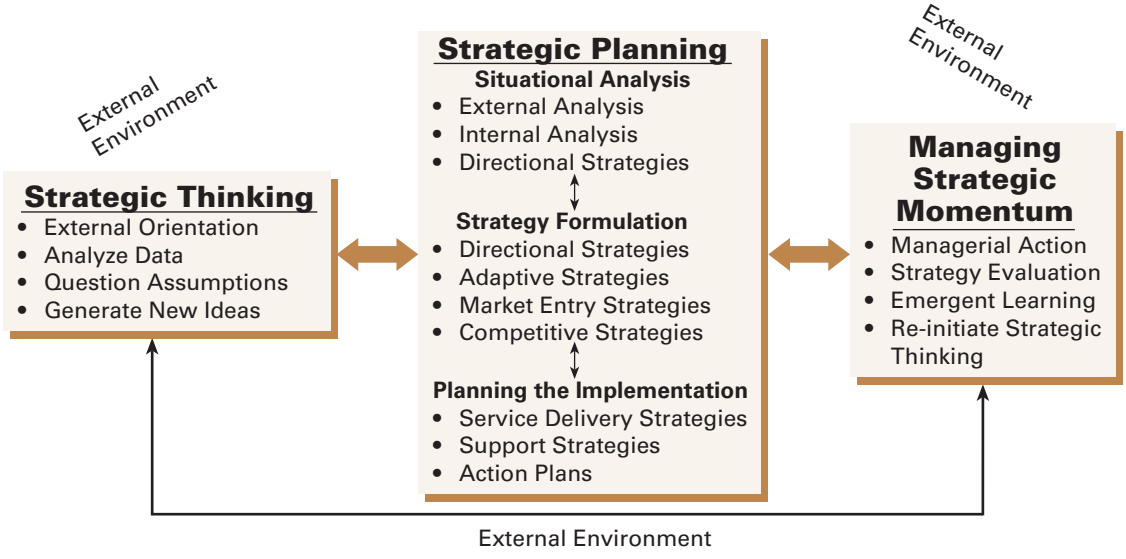
What is needed is some type of model that provides guidance or direction to strategic managers, yet incorporates learning and change. If strategy making can be approached in a disciplined way, then there will be an increased likelihood of its successful implementation. A model or map of how strategy may be developed will help organizations to view their strategies in a cohesive, integrated, and systematic way.[15] Without a model or map, managers run the risk of becoming totally incoherent, confused in perception, and muddled in practice.[16]

Combining the Analytical and Emergent Views

In this text, a series of "strategic thinking maps" are presented. These maps are designed to ignite strategic thinking as well as strategic planning and foster new thinking and planning when required. The strategic thinking maps will start the journey to develop a comprehensive strategy for the organization, yet the maps cannot anticipate every contingency. Managers will learn a great deal about their strategic plans as they manage them. Therefore, strategic managers will have to think, analyze, use intuition, and reinvent the strategy as they go. As the physicist David Bohm observed, the purpose of science is not the "accumulation of knowledge" but rather the creation of "mental maps" that guide and shape our perception and action.[17]

A model or map that accounts for both the analytical and the emergent views of strategic management is presented in Exhibit 1–1. This strategic thinking map serves as a general model for health care strategic managers, illustrates the interrelationships and organizes the major components, and provides the framework for much of the discussion in this book. As illustrated in Exhibit 1–1, strategic management has three elements – strategic thinking, strategic planning, and managing strategic momentum. These activities are interdependent; activities in each element affect, and are affected by, the others.

EXHIBIT 1–1 Strategic Thinking Map of Strategic Management



Strategic managers must become strategic thinkers with the ability to evaluate the changing environment, analyze data, question assumptions, and develop new ideas. Additionally, they must be able to develop and document a plan of action through strategic planning. Strategic planning is a decision-making and documentation process that creates the strategic plan. Once a strategic plan is developed, strategic managers must manage the strategic momentum of the organization. As strategic managers attempt to carry out the strategic plan they evaluate its success, learn more about what works, and incorporate new strategic thinking. As indicated by the double-headed arrows in Exhibit 1–1, any one element of the model may initiate a rethinking of another element. For example, planning the implementation may provide new information that necessitates taking another look at strategy formulation. Similarly, managing strategic momentum may provide new insights for implementation planning, strategy formulation, or the *situational analysis*.

The distinction among the terms strategic thinking, strategic planning, and managing strategic momentum is important and all three activities must occur in truly strategically managed organizations. Therefore, each stage of the model is explored in more depth.

Strategic Thinking

The first stage depicted in Exhibit 1–1 is strategic thinking and is the fundamental intellectual activity underlying strategic management. It has been observed that leaders, similar to great athletes, must simultaneously play the game and observe it as a whole.[18] Mired in a complex situation, the leader must rise above it to understand it. Preserving distance may be the only way to see the full picture.[19] This skill is similar to leaving the playing field and going to the press box to observe the game and see its broader context. Thus, strategic managers must be able to keep perspective and see the big picture – not get lost in the action. But to truly understand the big picture, one must not only go to the press box to observe the "game," but must also have a "quiet room" to periodically think about it, to understand it, and perhaps to change the strategy or players.

Strategic thinking is an individual intellectual process, a mindset, or method of intellectual analysis that asks people to position themselves as leaders and see the "big picture." Vision and a sense of the future are inherent parts of strategic thinking. Strategic thinkers are constantly reinventing the future – creating windows on the world of tomorrow. James Kouzes and Barry Posner in *The Leadership Challenge* have indicated: "All enterprises or projects, big or small, begin in the mind's eye; they begin with imagination and with the belief that what is merely an image can one day be made real."[20] Strategic thinkers draw upon the past, understand the present, and envision an even better future. Strategic thinking requires a mindset – a way of thinking or intellectual process that accepts change, analyzes the causes and outcomes of change, and attempts to direct an organization's future to capitalize on the changes. More specifically, strategic thinking:

- acknowledges the reality of change,
- questions current assumptions and activities,

- builds on an understanding of systems,
- envisions possible futures,
- generates new ideas, and
- considers the organizational fit with the external environment.

Strategic thinking generates ideas about the future of an organization and ways to make it more relevant – more in tune with the world. Strategic thinking assesses the changing needs of the organization's stakeholders and the changing technological, social and demographic, economic, legislative/political, and competitive demands of its world.

Strategic thinkers are always questioning: "What are we doing now that we should stop doing?" "What are we not doing now, but should start doing?" and "What are we doing now that we should continue to do but perhaps in a fundamentally different way?" For the strategic thinker, these questions are applicable to everything the organization does – its products and services, internal processes, policies and procedures, strategies, and so on. Successful strategies often require being what you haven't been, thinking as you haven't thought, and acting as you haven't acted.[21] Strategic thinkers examine assumptions, understand systems and their interrelationships, and develop alternative scenarios of the future. Strategic thinkers forecast external technological, social and demographic changes, as well as critical changes in the legislative and political arenas. Strategic thinking is very much a leadership activity and quite different from what subject matter experts do. For example, strategic thinkers specialize in relationships and context whereas expert thinkers specialize in well-defined disciplines and functions. Strategic thinkers act on intuition and "gut feel" when data is incomplete – focus on action and moving forward where as experts pay rigorous attention to knowledge, evidence, and data – focus on understanding.

Everyone a Strategic Thinker Strategic thinking provides the foundation for strategic management. However, strategic thinking is not just the task of the CEO, health officer, or top administrator of the organization. For strategic management to be successful, everyone must be encouraged to think strategically – think as a leader. *Leadership* is a performing art – a collection of practices and behaviors – not a position.[22] Everyone, even the lowest paid employees, should be encouraged to think strategically and consider how to reinvent what he or she does. For example, understanding that a nursing home's image is based on the customers' perception of cleanliness can motivate custodians to think strategically and reinvent the way the nursing home is cleaned. Strategic thinking is supported by the continuous management of the strategy and documented through the periodic process of strategic planning.

Strategic Planning

Strategic planning is the next activity in the general model of strategic management illustrated in Exhibit 1–1. *Strategic planning* is the periodic process of developing a set of steps for an organization to accomplish its mission and vision using strategic thinking. Therefore, periodically, strategic thinkers come together

to reach consensus on the desired future of the organization and develop decision rules for achieving that future. The result of the strategic planning process is a plan or strategy. More specifically, strategic planning:

- provides a sequential, step-by-step process for creating a strategy,
- involves periodic group strategic thinking (brainstorming) sessions,
- requires data/information, but incorporates consensus and judgment,
- establishes organizational focus,
- facilitates consistent decision making,
- reaches consensus on what is required to fit the organization with the external environment, and
- results in a documented strategic plan.

The process of strategic planning defines where the organization is going, sometimes where it is not going, and provides focus. The plan sets direction for the organization and – through a common understanding of the vision and broad strategic goals – provides a template for everyone in the organization to make consistent decisions that move the organization toward its envisioned future.

Strategic planning, in large part, is a decision-making activity. Although these decisions are often supported by a great deal of quantifiable data, strategic decisions are fundamental judgments. Because strategic decisions cannot always be quantified, managers must rely on "informed judgment" in making this type of decision. As in our own lives, generally the more important the decision, the less quantifiable it is and the more we will have to rely on the opinions of others and our own best judgment. For example, our most important personal decisions – where to attend college, whether or not to get married, where to live, and so on – are largely informed judgments. Similarly, the most important organizational decisions, such as entering a market, introducing a new service, or acquiring a competitor, although based on information and analysis, are essentially judgments.

Decision consistency is central to strategy; when an organization exhibits a consistent behavior it has a strategy. *Strategy* is the set of guidelines or plan an organization chooses to ensure decision consistency and move it from where it is today to a desired state some time in the future – it is the road map to that future. Developing the road map (strategic plan) requires situational analysis, strategy formulation, and planning the implementation of the strategy.

Analyzing and understanding the situation is accomplished by three separate strategic thinking activities: (1) external environmental analysis; (2) internal environmental analysis; and (3) the development or refinement of the organization's directional strategies. The interaction and results of these activities form the basis for the development of strategy. These three interrelated activities drive the strategy. Forces in the external environment suggest "what the organization *should* do." That is, success is a matter of being effective in the environment – doing the "right" thing. Strategy is additionally influenced by the internal resources, competencies, and capabilities of the organization and represents "what the organization *can* do." Finally, strategy is driven by a

common mission, common vision, and common set of organizational values and goals – the directional strategies.

The *directional strategies* are the result of considerable thought and analysis by top management and indicate "what the organization *wants* to do." Together, these forces are the essential input to strategy formulation. They are not completely distinct and separate; they overlap, interact with, and influence one another. Chapter 2 provides strategic thinking maps for examining the general and health care external environment and Chapter 3 addresses service area competitor analysis. Chapter 4 discusses the internal environment and provides strategic thinking maps for evaluating the organization's strengths and weaknesses and the creation of competitive advantage. The development of the directional strategies through strategic thinking maps is explored in more detail in Chapter 5.

Whereas situational analysis involves a great deal of strategic thinking – gathering, classifying, and understanding information – strategy formulation involves decision making that uses the information to create a plan. Hence, *strategy formulation* involves directional, adaptive, market entry, and competitive strategy decisions and, typically, these decisions are made in strategic planning sessions. Strategic maps for strategy formulation are presented in Chapters 6 and 7.

Once the strategy for the organization has been formulated (including directional, adaptive, market entry, and competitive), *implementation plans* that accomplish the organizational strategy are developed. These implementation plans are made up of strategies developed in the key areas that create value for an organization – service delivery and support activities – and are typically discussed as part of strategic planning. Strategies must be developed that best deliver the products or services to the customers through pre-service, point-of-service, and after-service activities. In addition to service delivery strategies, strategies must be developed for value-adding support areas such as the organization's culture, structure, and strategic resources. Strategy implementation is discussed further in Chapters 8 through 10.

A Group Process of Key Players The CEO can develop a strategy. A separate planning department can develop a strategy. However, such approaches run into trouble during implementation, as there is no common "ownership" of the plan or the tasks associated with it. Therefore, strategic planning for organizations is typically a group process. It involves a number of key participants working together to develop a strategy. Although strategic planning provides the structure for thinking about strategic issues, effective strategic planning also requires an exchange of ideas, sharing perspectives, developing new insights, critical analysis, as well as give-and-take discussion. Strategic planning efforts will be diminished without future-oriented highly provocative thinking and dialog.[23]

For most organizations, it is not possible for everyone to be a full participant in the strategic planning process. Decision making is protracted if everyone must have a say – and a consensus may never be reached. A few key players – senior staff, top management, or a leadership team – are needed to provide balanced and informed points of view. Often, representatives of important functional areas are included as well. An effective leader will incorporate a variety of individuals with different backgrounds and perspectives to provide input to the process. Some

participants may be mavericks and nudge the group in new ways. If everyone is pre-programmed to agree with the leader, participation is not required – but neither will an actionable plan be realized.

The key to successful strategic planning is to have a recurring group process. Having a periodic structured process initiates a reconsideration, discussion, and documentation of all the assumptions. Without a planned process, managers never quite get to it. Without a process, ideas are not discussed, conclusions are not reached, decisions are not made, strategies are not adopted, and strategic thinking is not documented. The nature of the group and the process are often the keys to success.

Managing Strategic Momentum

Sometimes a strategic plan is created but nothing really changes, strategic momentum is lost, and plans are never implemented. As the next year rolls around, it is once again time for the annual strategic planning retreat and the cycle repeats itself. This example is one of strategic planning without managing strategic momentum. Alan Weiss, in his irreverent book, *Our Emperors Have No Clothes*, explains that in these situations the problem is that, "Strategy is usually viewed as an annual exercise at best, an event that creates a 'product,' and not a process to be used to actually run the business."[24]

The third element of strategic management shown in Exhibit 1–1, *managing strategic momentum*, concerns the day-to-day activities of managing the strategy to achieve the strategic goals of the organization. Once plans are developed, they must be actively managed and implemented to maintain the momentum of the strategy. Strategic thinking and periodic planning should never stop; they become ingrained in the culture and philosophy of a strategically managed organization. Managing strategic momentum:

- is the actual work to accomplish specific objectives,
- concerns decision-making processes and their consequences,
- provides the style and culture,
- evaluates strategy performance,
- is a learning process, and
- relies on and initiates new strategic thinking and new periodic strategic planning.

For many organizations, strategic planning is the easiest part of strategic management and the planning process receives the greatest attention. However, plans must be implemented to create momentum and to realize strategic intent. Poor implementation or lack of implementation has rendered many strategic plans worthless. Whereas the strategic plan and its underlying strategic thinking must be viewed as important, they fall apart without implementation and the decision-making guidelines provided for managers at all levels in the organization. If the strategy is not actively managed, it will not happen.

At the same time, managers often need to react to unanticipated developments and new competitive pressures. Such environmental shifts may be subtle,

other times they can be discontinuous and extremely disruptive. When external changes occur, new opportunities emerge and new competencies are born, while others die or are rendered inconsequential. Inevitably, the basic rules of competing and survival will change.[25] Managing strategic momentum is how an organization constructively manages change, evaluates strategy, and reinvents or renews the organization. As Henry Mintzberg has indicated, ". . . a key to managing strategy is the ability to detect emerging patterns and help them take shape."[26]

Different environmental characteristics and different organizational forms require new and different ways of defining strategy.[27] Strategy may be an intuitive, entrepreneurial, political, culture-based, or learning process. In these cases, maps are of limited value. Managers must create and discover an unfolding future, using their ability to learn together in groups and interact politically in a spontaneous, self-organizing manner. However, learning is difficult in organizations. Learning requires engagement, mastering unfamiliar ideas, and adopting new behaviors. Engaged learning demands that executives share leadership, face harsh truths, and take learning personally. It requires them to fundamentally change the way they manage.[28] It requires managing strategic momentum.

Clearly, rational strategies do not always work out as planned (an *unrealized strategy*). In other cases, an organization may end up with a strategy that was quite unexpected as a result of having been "swept away by events" (an *emergent strategy*). Leadership, vision, and "feeling our way along" (learning) often provide a general direction without a real sense of specific objectives or long-term outcomes. It is quite possible that a strategy may be developed and subsequently realized. However, we must be realistic enough to understand that when we engage in strategic management the theoretical ideal (strategy developed, then realized) may not, and in all probability will not, be the case. A great deal may change. The possibilities include:

1. There is a reformulation of the strategy during implementation as the organization gains new information and feeds that information back to the formulation process, thus modifying intentions en route.
2. The external environment is in a period of flux and strategists are unable to accurately predict conditions; the organization may therefore find itself unable to respond appropriately to a powerful external momentum.[29]
3. Organizations in the external environment implementing their own strategies may block a strategic initiative, forcing the activation of a contingency strategy or a period of "groping."

Obviously, health care organizations formulate strategies and realize them to varying degrees. For instance, as a part of a deliberate strategy to broaden their market, improve service to the community, and retain referral patients, many community hospitals began offering cardiac services such as catheterization and open heart surgery. As a result, some of these hospitals have built market share and increased profitability. Other community hospitals have not fared as well. Their managers had unrealistic expectations concerning the profitability of cardiac services and the number of procedures required. A large volume is

crucial to cardiac services because it allows the hospital to order supplies in bulk and provides physician experience that produces better outcomes and shorter lengths of stay. In addition, some community hospital managers misjudged the level of reimbursement from Medicare, thereby further squeezing profitability. The strategies of those community hospitals that left the cardiac services market were not realized.

Still other community hospitals seemed to move into a full range of cardiac services without an explicit strategy to do so. In an effort to retain patients and enhance their images, these hospitals began by offering limited cardiac services but shortly found that they were not performing enough procedures to be "world class." They added services, equipment, and facilities to help create the required volume and, without really intending to at the outset, ended up with emergent strategies that resulted in significant market share in cardiac services.

Everyone Must Manage the Strategic Momentum As with strategic thinking, everyone plays a role in managing strategic momentum. Everyone in the organization should be working for the strategy and understand how their work contributes to the accomplishment of the strategic goals. As Max DePree has suggested, "Leaders are obligated to provide and maintain momentum."[30] The only legitimate work in an organization is work that contributes to the accomplishment of the strategic plan. Although organizations may accomplish superior results for a brief period of time, it takes the orchestration of management as well as leadership to perpetuate these capabilities far into the future.[31]

The Benefits of Strategic Management

The three stages of strategic management – strategic thinking, strategic planning, and managing strategic momentum – will provide many benefits to health care organizations. However, because strategic management is a philosophy or way of managing an organization, its benefits are not always quantifiable. Overall, strategic management:

- ties the organization together with a common sense of purpose and shared values;
- improves financial performance in many cases;[32]
- provides the organization with a clear self-concept, specific goals, and guidance as well as consistency in decision making;
- helps managers to understand the present, think about the future, and recognize the signals that suggest change;
- requires managers to communicate both vertically and horizontally;
- improves overall coordination within the organization; and
- encourages innovation and change within the organization to meet the needs of dynamic situations.

Strategic management is a unique perspective that requires everyone in the organization to cease thinking solely in terms of internal functions and operational responsibilities. It insists that everyone adopts what may be a fundamentally new attitude – an external orientation and a concern for the big picture. It is basically optimistic in that it integrates "what is" with "what can be." Perspective 1–4 illustrates an application of Jim Collins' book, *Good to Great*, to health care organizations.

PERSPECTIVE 1–4

Good to Great in Health Care

Several years ago Jim Collins' book, *Good to Great: Why Some Companies Make the Leap . . . and Others Don't*, made an impact on the business scene. Collins studied 1,435 good companies and then analyzed why 11 of the companies became great (see Health Care Manager's Bookshelf in Chapter 8). Chip Caldwell & Associates began a "good to great" project in health care and studied 44 health care organizations ranging in size from 15 to 854 beds. An additional project conducted by the group assessed 226 health-related organizations in Los Angeles County, California. For each organization they measured changes in cost per case mix adjusted discharge. Those organizations that finished in the 75th percentile or higher were labeled quantum improvers and those in the bottom quartile were labeled non-starters.

About 20 percent of the quantum improvers were already in a favorable cost position and about 20 percent of the non-starters were already in an unfavorable cost position. The researchers observed that this meant the quantum improvers were becoming better faster and the non-starters were becoming worse faster. In other words, the performance gap was growing and health care firms not applying quantum improver strategies risked being left behind by organizations that were raising the bar and redefining the playing field. Some important principles of the quantum improvers:

1. **Set non-negotiable goals.** Quantum improvers perform a gap analysis and determine areas where improvement is possible and necessary. They determine where the biggest differences are from established benchmarks and focus on the vital few areas that will make the biggest positive difference to the organization. Non-starters receive gap information, debate it for six months, seek more data, and agree to talk some more. Quantum improvers interpret the results as an immediate call for action. Strategic leaders step up at defining moments, keep the organization on path, and demonstrate that failure to act is not an option.
2. **Focus on key businesses.** Health care organizations cannot be all things to all people. Organizations have to develop a "stop doing" list to include those services that are least profitable and must be eliminated. Doing away with any service is very hard in health care because no one wants to eliminate a service that is helping people even if it is very expensive. Focusing on those services that support the core mission and separating financial issues from emotional issues may make the decision to eliminate a service easier and more objective.
3. **Use a tight–loose–tight approach.** Begin with a tight understanding of the

preferred direction for the organization, then delegate the understanding to a group of leaders who have flexibility in determining how they will achieve the direction, and finally, monitor with tight accountability to make sure that the selected approach is working.

Quantum improvers have a culture of accountability but not a punitive culture. They are not threat driven. Rather than punish those who do not achieve, assistance is provided by upper leadership until the desired results are accomplished. As Collins notes, great organizations do not have miracle moments of change; instead they emphasize committed, controlled, and practical leadership.

Source: Shannon K. Pieper, "Good to Great in Healthcare: How Some Organizations Are Elevating Their Performance," *Healthcare Executive* 19, no. 3 (2004), pp. 20–26.

Health care leaders require a comprehensive strategic management approach to guiding their organizations through societal and health care industry changes that will occur in the future. Strategic management concepts, activities, and methods presented in this text will prove to be valuable in coping with these changes. In addition, the internal, non-quantifiable benefits of strategic management will aid health care organizations in better integrating functional areas to strategically utilize limited resources and to satisfy the various publics served. Strategic management is the exciting future of effective health care leadership.

What Strategic Management is Not

Strategic management should not be regarded as a technique that will provide a "quick fix" for an organization that has fundamental problems. Quick fixes for organizations are rare; it often takes years to successfully integrate strategic management into the values and culture of an organization. If strategic management is regarded as a technique or gimmick, it is doomed to failure. Similarly, strategic management is not just strategic planning or a yearly retreat where the leadership of an organization meets to talk about key issues only to return to "business as usual." Although retreats can be effective in refocusing management and for generating new thinking, strategic management must be adopted as a philosophy of leading and managing the organization.

Strategic management is not a process of completing paperwork. If strategic management has reached a point where it has become simply a process of filling in endless forms, meeting deadlines, drawing milestone charts, or changing the dates of last year's goals and plans, it is not strategic management. Effective strategic management requires little paperwork. It is an attitude, not a series of documents. Similarly, strategic management should not be initiated merely to satisfy a regulatory body's or an accrediting agency's requirement for a "plan." In these situations, no commitment is made on the part of key leadership, no participation is expected from those in the organization, and the plan may or may not be implemented.[33]

Strategic management is not a process of simply extending the organization's current activities into the future. It is not based solely on a forecast of present trends. Strategic management attempts to identify the issues that will be important in the future. Health care strategic managers should not simply ask the question, "How will we provide this service in the future?" Rather, they should be asking questions such as, "Should we provide this service in the future?" "What new services will be needed?" "What services are we providing now that are no longer needed?"

A Systems Perspective

The problems facing organizations are so complex that they defy simple solutions. Understanding the nature of the health care environment, the relationship of the organization to that environment, and the often-conflicting interests of internal functional departments requires a broad conceptual paradigm. Yet, it is difficult to comprehend so many complex and important relationships. Strategic managers have found general systems theory or a systems approach to be a useful perspective for organizing strategic thinking.

A *system* may be defined as "a perceived whole whose elements 'hang together' because they continually affect each other over time and operate toward a common purpose."[34] More simply, a system is a set of interrelated elements. Each element connects to every other element, directly or indirectly, and no subset of elements is unrelated to any other subset. Further, a system must have a unity of purpose in the accomplishment of its goals, functions, or desired outputs.[35] Understanding the complex whole through a systems approach:

- aids in identifying and understanding the "big picture";
- facilitates the identification of major components;
- helps to identify important relationships and provides proper perspective;
- avoids excessive attention to a single part;
- allows for a broad scope solution;
- fosters integration; and
- provides a basis for redesign.

The use of the *systems approach* requires strategic managers to define the organization in broad terms and to identify the important variables and interrelationships that will affect decisions. By defining systems, strategic managers are able to see the "big picture" in proper perspective and avoid devoting excessive attention to relatively minor aspects of the total system.[36] A systems approach permits strategic managers to concentrate on those aspects of the problem that most deserve attention and allows a more focused attempt at resolution. As Peter Senge has indicated, systems approaches help us to see the total system and how to change the pieces within the system more effectively and intelligently.[37] Perspective 1–5 provides additional insight into the use of systems approaches to see the big picture.

PERSPECTIVE 1–5

To Manage is to Control – To Control is to Manage

To control means to regulate, guide, or direct. To manage means to control, handle, or direct. Therefore, management is control and control is management. The very act of managing suggests controlling the behavior or outcome of some process, program, or plan. Vision, mission, values, and strategies are types of controls. Similarly, policies, procedures, rules, and performance evaluations are clearly organizational controls. All of these are attempts to focus organizational efforts toward a defined end. Yet, if these tools are improperly used, employees may perceive control to be dominating, overpowering, dictatorial, or manipulative.

When processes are poorly managed, control runs afoul as well. It is interpreted as domination when management enforces too much control and manages too closely by controlling subprocesses or too many details. Management requires the right touch. If control is too great, we create hopeless bureaucracy. If control is too weak, we have a lack of direction causing difficulty in accomplishing organizational goals. When there is too much management (control), then innovation, creativity, and individual initiative will be stifled; when there is too little, chaos ensues. Management should focus efforts but not be dictatorial or manipulative.

Given how easy it is to overdo management (control), a general rule of thumb is that "less is best." Setting direction and empowering people to make their own decisions on how best to achieve the vision seems to work. Effective management (control) is essential if organizations are to renew themselves; however, overmanaging (overcontrolling) can destroy initiative and be viewed as meddling, often reducing motivation as well.

Recognizing the importance of a systems framework, health care managers commonly refer to "the health care system" or "the health care delivery system" and strive to develop logical internal organizational systems to deal with the environment. In a similar manner, health care strategic managers must use systems to aid in strategic thinking about the external environment. The community and region may be thought of as an integrated system with each part of the system (subsystem) providing a unique interdependent contribution.

The Level and Orientation of the Strategy

A systems perspective will be required to specify the level of the strategy and the relationship of the strategy to the other strategic management activities. Therefore, the organizational level and orientation should be carefully considered and specified before strategic planning begins. For example, strategies may be developed for large, complex organizations or small, well-focused units. The range of the strategic decisions that are considered in these two organizations is quite different, but both can benefit from strategic management.

A clear specification of the "level" of thinking will determine the type and range of decision to be made in strategic planning. For example, a large integrated health care system may develop strategy for a number of levels – a corporate level, a divisional level, an organizational level, and a unit level. As illustrated in Exhibit 1–2, when considered together these strategic perspectives create a hierarchy of strategies that must be consistent and support one another. Each strategy provides the "means" for accomplishing the "ends" of the next higher level. Thus, the unit level provides the means for accomplishing the ends of the organizational level. The organizational level, in turn, provides the means for accomplishing the ends of the divisional level. Finally, the divisional level is the means to the ends established at the corporate level. As illustrated in Exhibit 1–2, part of the context for lower-order strategy is provided by the strategic planning of higher-order strategies.

EXHIBIT 1–2 The Link between Levels of Strategic Management

Trinity Health is the tenth largest health system and fourth largest Catholic health system in the United States and is an example of a health care organization that should develop strategy for all four organizational levels. As of the beginning of 2013, Trinity had over $11.3 billion in assets, $9 billion in revenues, and was comprised of 49 acute-care hospitals, 432 outpatient facilities, 33 long-term care facilities, and numerous home health offices and hospice programs located in ten US states. Clearly, strategies should be developed for the corporate level – Trinity Health, for each major division such as Saint Joseph Mercy Health System, for each distinct organization within the division such as Saint Joseph Mercy Saline Hospital, and within the various units (clinical operations).

Corporate-Level Strategy *Corporate-level strategies* address the question, "What business(es) should we be in?" Such strategies consider multiple, sometimes unrelated, markets and typically are based on return on investment, market share or potential market share, and system integration. For Trinity Health, clearly the corporate perspective is an important one. The question of "What businesses should we be in?" has resulted in several semi-autonomous "businesses" operating in a number of different markets, including hospitals, outpatient facilities, long-term care, home health, and hospices. Key strategic questions might include, "What other types of businesses should Trinity consider?" For example, would wellness or mental health centers be an appropriate strategic move?

Divisional-Level Strategy *Divisional-level strategies* are more focused and provide direction for a single business type. Divisional strategies are most often concerned with positioning the division to compete. These semi-autonomous organizations are often referred to as SBUs (*strategic business units*) or SSUs (*strategic service units*). Therefore, strategic managers for these units are most concerned with a specified set of competitors and well-defined markets (service areas).

For Trinity Health, strategies must be developed for the hospital division, outpatient facilities division, long-term care division, and so on. For the hospital division key strategic questions may include, "How many hospitals are optimal?" or "Which markets should Trinity enter with a new hospital?" This perspective concerns a single business type and its markets. Therefore, it is quite different from the corporate perspective of what businesses Trinity should be in.

Organizational-Level Strategy Within a division, individual organizational units may develop strategies as well. These *organizational-level strategies* typically concern one organization competing within a specific well-defined service area. For example, each hospital in Trinity's hospital division may develop a strategic plan to address its own particular market conditions. Key strategic questions for this level of strategy may include, "What combination of hospital services is most appropriate for this market?" and "What strategies are the competitors using to increase market share?"

Unit-Level Strategy *Unit-level strategies* support organizational strategies through accomplishing specific objectives. Unit operational strategies may be

developed within departments of an organization such as clinical operations, marketing, finance, information systems, human resources, and so on. Unit strategies address two issues. First, they are intended to integrate the various subfunctional activities. Second, they are designed to relate the various functional area policies with any changes in the functional area environment.[38] In addition, linkage strategies are directed toward integrating the functions themselves and creating internal capabilities across functions (for example, quality programs or changing the organization's culture).

Strategy Hierarchy Strategic management may be employed independently at any organizational level. However, it is much more effective if there is top-down support and strategies are integrated from one level to the next. For some organizations, of course, there is no corporate or divisional level, such as with a free-standing community hospital or independent long-term care organization. For these organizations the question of scope and perspective and integration of the strategy is much more straightforward.

The Importance of Leadership

Ultimately, strategic decision making for health care organizations is the responsibility of top management. The CEO is a strategic manager with the pre-eminent responsibility for positioning the organization for the future. The leader must be able to inspire, organize, and implement effective pursuit of a vision and maintain it even when sacrifices are required.[39] As a result, the leader must have an ability to identify what needs to be done today and what can wait. They prioritize constantly; aware that wars are lost by fighting on too many fronts. They know the key messages to communicate from day to day, from audience to audience.[40] If the CEO does not fully understand or faithfully support strategic management, it will not happen.

Leadership Roles throughout the Organization

In the past, strategy development was primarily a staff activity. The planning staff would create the strategy and submit it for approval to top management. This process resulted in plans that were often unrealistic, did not fully consider the realities and resources of the divisions or departments, and separated planning from leadership.

Over the past two decades, many large formal planning staffs have been dissolved as organizations learned that strategy development cannot take place in relative isolation. Therefore, the development of the strategy has become the responsibility of key managers. The coordination and facilitation of strategic planning typically may be designated as the responsibility of a single key manager (often the CEO), but the entire leadership team is responsible for strategy development and its management. The rationale underlying this approach is that no one is more in touch with the external environment (regulations, technology, competition, social change, and so on) than the managers who must deal with it every day and lead change. The leadership team must

coordinate the organization's overall strategy and facilitate strategic thinking throughout the organization. As a result, the organization's key top managers act as an extension of the CEO to ensure that an organized and used planning process ensues.[41]

Lessons for Health Care Managers

Strategic management is an often complex and difficult task. A model of strategic management provides a useful framework or intellectual map for conceptualizing and developing strategies for an organization. Strategic management includes strategic thinking, strategic planning, and managing strategic momentum. In reality, these elements are blended together as the strategy is formed and reformed through leadership, intuition, and organizational learning. Indeed, implementing the strategy may actually create an entirely new, unintended strategy.

The concept of strategic management has been successfully used by business organizations, the military, and in government agencies; health care managers are finding it essential for their organizations as well. The strategic management model presented and discussed in this chapter may be applied to a variety of types of health care organizations operating in dramatically different environments, is useful for both large and small organizations, and facilitates strategic thinking at all levels of the organization.

The strategic planning portion of the model incorporates situational analysis, strategy formulation, and strategy implementation. The strategic thinking activities within situational analysis combine to influence strategy formulation.

Strategy formulation in turn affects planning the implementation. Finally, the strategy must be managed, evaluated, and modified as needed. Managing strategic momentum is an iterative process that may incorporate new understandings of the situation, change the fundamental strategy, or modify strategy implementation. Managing strategic momentum essentially continues strategic thinking and strategic planning.

The strategic thinking map presented in this text is designed to provide the essential logic of the activities involved in strategic management and therefore is based on both analytical (rational) as well as emergent (learning) approaches for understanding strategy making in organizations. The analytical model provides an excellent starting point for understanding the concept of strategy and a foundation for comparing and contrasting strategies. However, the strategic thinking map does not perfectly represent reality and must not be applied blindly or with the belief that "life always works that way." Strategic management is not always a structured, well-thought-out exercise. In reality, thought does not always precede action, perfect information concerning the environment and organization never exists, and rationality and logic are not always superior to intuition and luck. Sometimes organizations "do" before they "know." For instance, the intended strategies are often not the realized strategies. Sometimes managers are able to just "muddle through." Or, managers may have a broad master plan or logic underlying strategic decisions, but, because of the complexity of the external

and internal environments, incremental adjustments or guided evolution is the best they can do.[45]

Managers must realize that, once introduced, strategies are subject to a variety of forces, both within and outside the organization. Sometimes we learn by doing. Yet, without a plan (a map) it is difficult to start the journey, difficult to create any type of momentum for the organization, and difficult to have consistent decision making. Thus, strategic managers begin with the most rational plan that can be developed and continue to engage in strategic thinking. Effective strategic managers become adept at "freezing" and "unfreezing" their thinking and strategic plans as the situation changes.

Health Care Manager's Bookshelf

H. Igor Ansoff, *Corporate Strategy: An Analytical Approach to Business Policy for Growth and Expansion* (New York: McGraw-Hill, 1965)

Henry Mintzberg declared that the publication of *Corporate Strategy: An Analytical Approach to Business Policy for Growth and Expansion* by H. Igor Ansoff was a major event in the world of management. The book "represented a kind of crescendo in the development of strategic planning theory, offering a degree of elaboration seldom attempted since."[1]

Corporate Strategy is considered by many to be the first book devoted exclusively to business strategy.[2] Ansoff uses the term *strategic* to mean "pertaining to the relationship between the firm [organization] and its environment."[3] Hussey noted that with the publication of *Corporate Strategy* "managers were offered, for the first time, a book which took them through all the steps of a formal approach to strategic decision making" and provided a number of analytical tools for aiding strategic thinking.[4]

Ansoff introduced the concept of *synergy* or the familiar business rule of 2 + 2 = 5. Gilmore and Brandenburg acknowledge their debt to Ansoff for introducing this important concept, which Ansoff developed while employed at Lockheed Aircraft Corporation and continues to be an essential part of much strategy formulation.[5] Synergy is a critical concept as strategists evaluate the financial wisdom of entering into strategies such as vertical integration and differentiation.

Ansoff argued that an organization cannot define itself as simply being in the health care, transportation, or energy business. These definitions are too broad to define the *common thread*. The common thread is the relationship between present and future services, products, and markets which "enable outsiders to perceive where the organization is heading, and inside management to give it guidance" (p. 105). It was with regard to this common thread that Ansoff developed and introduced the *product–market matrix*. This matrix became so popular that even 30 years later Ansoff received a request to reprint the matrix every three or four months.[6]

Ansoff's *Corporate Strategy* is an important milestone in the evolution of strategic

management. Strategic managers will appreciate the care with which Ansoff related his innovative concepts to leading organizations. Melvin Anshen emphasizes the value the book has to managers and scholars because it "identifies and precisely orders the discrete, sequential building blocks of logical analysis as applied to the design of planning for strategy growth."[7] Walter Schaffir underscored the importance of *Corporate Strategy* stating that it is "one of the first attempts to offer a professional, technical, and comprehensive approach to the problem of selecting long-range direction" for an organization.[8]

Perhaps the best summary of Ansoff's contributions is given by one who knew him well. Gen-Ichi Nakamura stated that Ansoff's construction of a coherent and dynamic conceptual framework for strategic management could be described as "Ansoff's mountains." He suggests that people "try to climb the Ansoff mountains. At the outset, you may find it difficult and tiresome. After some trial, however, you will find your effort most enjoyable, enriching, and rewarding."[9]

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KEY TERMS AND CONCEPTS IN STRATEGIC MANAGEMENT

Analytical/Rational Approach
Corporate-Level Strategy
Directional Strategies
Divisional-Level Strategy
Emergent Strategy
Health Policy
Implementation Plans
Managing Strategic Momentum
Map/Compass
Organizational-Level Strategy
Rational Approach
Situational Analysis
Strategic Business Unit (SBU)
Strategic Management
Strategic Planning
Strategic Service Unit (SSU)
Strategic Thinking
Strategic Thinking Map
Strategy
Strategy Formulation
Systems Approach
Unit-Level Strategies
Unrealized Strategies

Questions for Class Discussion

1. Explain why strategic management has become crucial in today's dynamic health care environment.
2. What is the rationale for health care organizations' adoption of strategic management?
3. Trace the evolution of strategic management. Have the objectives of strategic management changed dramatically over its development?
4. How is strategic management different from health policy?
5. Compare and contrast the analytical view of strategic management with the emergent, learning approach. Which is most appropriate for health care managers?
6. Why are conceptual models of management processes useful for practicing managers?
7. What is a strategic thinking map? How are strategic thinking maps useful? What are their limitations?
8. What are the major activities of strategic management? How are they linked together?
9. Differentiate among the terms strategic management, strategic thinking, strategic planning, and managing strategic momentum.
10. Who should be doing strategic thinking? Strategic planning? Managing strategic momentum?
11. Is strategic thinking enough? Why do we engage in strategic planning? What are the elements of strategic planning?
12. What is meant by realized strategies? How can strategies be realized if they were never intended?
13. What can change well-thought-out strategies that were developed using all the steps in strategic planning?
14. Explain and illustrate the possible benefits of strategic management. What types of health care institutions may benefit most from strategic management?
15. Why is a "systems approach" helpful to strategic managers?
16. At what organizational level(s) may a strategy be developed? If at more than one level, how are these levels linked by the planning process?
17. How has the role of the strategic planner changed over the past several decades? What new skills will be essential for the strategic planner?

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2 Understanding and Analyzing the General Environment and the Health Care Environment

"Whether you think you can or whether you think you can't, you're right!"

—HENRY FORD

Introductory Incident

Not-for-profit Status for Hospitals: Is Community Benefit Equal to Lost Tax Revenue?

Because of the Great Recession, local and state governments have cut school budgets, personnel, and infrastructure – items noticed by taxpayers/voters. Cash-strapped states are looking for ways to "find" funds. One area that has been increasingly targeted is the tax-exempt status of not-for-profit hospitals that often are taking in huge amounts of revenue and not paying any kind of taxes. Prior to 1969, hospitals were exempt from taxes because they "serve the public good by caring for patients in the community who cannot afford the medical care they need."

As communities watch hospitals build new buildings, pay CEOs high salaries, and purchase the latest technologies, the question arises: "What percent of the hospital's revenues goes toward uncompensated medical care?" For some hospitals, it is less than 1 percent; nevertheless, the hospital pays no property tax (local), income tax (state and federal), sales tax (local, county, state), or capital gains/earnings tax on investments. For example, BJC Hospital in St. Louis made $372 million in investments this past year (not taxed), plus issued tax-free bonds (an additional tax loss).

The Illinois Department of Revenue revoked the not-for-profit status of Provena Covenant Medical Center in 2004 because it did not provide sufficient charity care ($800,000 on $113 million in revenue). Appeals were denied as the court found that the Urbana hospital failed to justify its exemption by providing charity care to less than one-half of 1 percent of the patients it served in 2002. Three additional Illinois hospitals, Northwestern Memorial Hospital's Prentice Women's Hospital in Chicago (1.85 percent charity care), Edward Hospital in Naperville (1.04 percent charity care), and Decatur Memorial Hospital in Decatur (0.99 percent charity care), were denied renewal of not-for-profit status in 2011 and 15 others were under investigation when the Governor asked for new legislation that would define criteria for hospitals to qualify for tax-exempt status. In a press release dated January 11, 2012, the Illinois Hospital Association (IHA) announced that non-profit hospitals in the state contributed $4.6 billion in community benefits ($561 million for free or discounted care at cost) in the 2009–10 fiscal year – a 124 percent increase over 2005. IHA proposed that the new legislation expand the definition of charity in the tax code to include not only free medical care to the indigent but also programs and losses that hospitals incur under Medicaid, with reimbursement rates are well below market rates (an issue of hospitals wanting to look at "charges" versus "costs" in determining charity care). The Illinois State Supreme Court ruled in 2010 that discounts given to the state's Medicaid program could not be considered charity care.

Since 1969, the IRS has not specifically required hospitals to provide charity care in order to be exempt from federal taxation and have access to tax-exempt bond financing and charitable donations, as long as the hospital provides benefits to the community in other ways (an IRS ruling brought about this change in response to the mandate that emergency rooms had to be open to all members of the community without regard for ability to pay). The 1969 ruling identified other factors that might support a hospital's tax-exempt status, such as having a governance board composed of community members and using surplus revenue to improve facilities, patient care, medical training, education, and research.

Perhaps Boston Children's Hospital has the right approach. To demonstrate the value that Boston Children's provides to the community, it hired Ernst & Young to calculate what it would owe in local, state, and federal taxes if it were a for-profit hospital. According to the accounting firm's calculation, in FY 2010, Boston Children's would owe $43.8 million in taxes as a for-profit hospital (and Ernst & Young included every possible tax). Children's then

calculated the community benefits it has delivered as defined by the new IRS guidelines, using a conservative projection: $244.6 million in benefits to taxpayers in exchange for its tax-exempt status.

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Learning Objectives

After completing the chapter you will be able to:

1. Appreciate the significance of the external environment's impact on health care organizations.
2. Understand and discuss the specific goals of external environmental analysis.
3. Point out some limitations of external environmental analysis.
4. Describe the various types of organizations in the general and health care environments and how they create issues that are of importance to other organizations.
5. Identify major general and industry environmental trends affecting health care organizations.
6. Identify key sources of environmental information.
7. Discuss important techniques used in analyzing the general and health care environments.
8. Conduct an analysis of the general and industry external environments for a health care organization.
9. Suggest several questions to initiate strategic thinking concerning the general and industry environments as a part of managing strategic momentum.

The Importance of Environmental Influences

Fifty years ago the delivery of health care was a relatively uncomplicated relationship of facilities, physicians, and patients working together. Government and business stood weakly on the fringes, having little significant influence. Today, a multitude of interests are directly or indirectly involved in the delivery of health care. For instance, the for-profit provider segment has grown dramatically; private-sector businesses are largely responsible for the development and delivery of drugs, medical supplies, and many technical innovations; and government agencies regulate much of the actual delivery of health care services. As a result, in their quest for competitive advantage, organizations are investing increasingly more time and money in collecting and organizing information about the world in which they operate.[1]

Ultimately, strategic thinking is directed toward positioning the organization most effectively within its changing external environment. Peter Drucker writes, "The most important task of an organization's leader is to anticipate crisis. Perhaps not to avert it, but to anticipate it. To wait until the crisis hits is already abdication. One has to make the organization capable of anticipating the storm, weathering it, and in fact, being ahead of it."[2] Therefore, to be successful, health care organization leaders must have an understanding of the external environment in which they operate; they must anticipate and respond to the significant shifts taking place within that environment. Strategic thinking, and the incorporation of that thinking into the strategic plans for the organization, is now more important than ever. Futurist Joel Barker has suggested that "in times of turbulence the ability to anticipate dramatically enhances your chances of success. Good anticipation is the result of good strategic exploration."[3] Organizations that fail to anticipate change, ignore external forces, or resist change will find themselves out of touch with the needs of the market, especially because of antiquated technologies, ineffective delivery systems, and outmoded management. Institutions that anticipate and recognize significant external forces and modify their strategies and operations accordingly will prosper.

Evolving External Issues

One of the greatest challenges for health care organizations is identifying the changes that are most likely to occur and then planning for that future. Interviews with health care professionals and a review of the health care literature suggest that health care organizations will have to cope with change in some or all of the following areas: legislative/political, economic, social/demographic, technological, and competitive.[4]

Legislative/Political Changes

- Passage of the Affordable Care Act (ACA) in 2010: major reform legislation is in place and in 2012 was generally supported by the Supreme Court (only the mandate/penalty for Medicaid was disallowed, resulting in the right of states to opt out of that requirement). Different parts of the legislation are being phased in, a few began immediately (for example, coverage

of children to age 26), others begin in as late as 2014 (use of electronic health records by any provider that interacts with the US government, although in 2012 many players in the health care system were asking for an extension). The results of the 2012 presidential election suggest that the PPACA will remain in tact and further revisions are likely.

- Increased accountability for corporate governance (e.g., Sarbanes–Oxley).
- Employer-based insurance may diminish as the penalties to be paid under ACA for not providing insurance for employees are less than the cost of health insurance; more employees will likely shift to government accounts.

Economic Changes

- Health care by most measures is the US's largest industry and biggest private employer.[6]
- Procedure costs may be falling while total spending is rising.[7]
- Employers will become more unwilling to shoulder the entire burden of increasing costs for health care insurance and health care for their employees and retirees.
- Over 49.9 million Americans are without health insurance in 2011 – a number that has been predicted to increase, but with ACA the number is unpredictable. Those previously uncovered may become insured through government programs, but the number of people already insured by employers may decrease, causing the total number of uninsured to increase. Or, if all the uninsured roll-over to government programs, will the cost be lowered or increased?

Social/Demographic Changes

- Without a truly radical adjustment in health care spending, which there is no reason to expect, demographics alone will drive health care's share of GDP (gross domestic product) from the current 16 percent to as high as 25 percent.[8]
- An aging population and increased average life span will place capacity burdens on some health care organizations while a lessening of demand threatens the survival of others. By 2020, the US population over the age of 65 is expected to reach 53.7 million.
- The Hispanic population, many of whom do not speak English or speak it poorly, will continue to grow. Hispanics have become the largest minority population. By 2050, one out of four Americans will be Hispanic.
- A more ethnically diverse population will continue to develop.
- An increase in income disparity is expected – a critical factor in determining health care delivery.
- "Tiered" access to health care is anticipated, with the division between the tiers becoming more extreme.
- There are predictions of critical shortages of non-physician health care professionals and primary care physicians, yet a surplus of physicians within some specialties and in some geographic regions.

Technological Changes

- The high costs of purchasing new, sophisticated, largely computer-based technologies to meet the demand for high-quality health care will continue to rise.
- The ACA requirement for an electronic health record will supply copious amounts of data and many will struggle to turn it into information that will improve the quality of care, which will be used to determine payments for hospitals and physicians (see Perspective 2–1).
- Significant advances in medical information technology are anticipated, such as automation of basic business processes, clinical information interfaces, data analysis, and telehealth.
- New technologies will emerge in the areas of drug design, imaging, minimally invasive surgery, genetic mapping and testing, gene therapy, vaccines, artificial blood, and xenotransplantation (transplantation of tissues and organs from animals into humans).

Competitive Changes

- Further consolidation will be seen within the health care industry because of cost pressures and intensified competition.
- The disintegration of some health care networks can be expected.
- Health care corporations will continue to expand into segments that have less regulation and into businesses outside the traditional health care industry.
- The importance of market niche strategies and services marketing will increase.
- Outpatient care and the development of innovative alternative health care delivery systems will continue to grow.
- The decreasing viability of many of the nation's small, rural, and public hospitals means that there will be a reconfiguration of the rural health care delivery system.
- Increasing numbers of physician executives will have leadership roles in health care organizations.
- More emphasis will be on preventive care through wellness programs and healthy behaviors.
- An increased emphasis will be placed on cost containment and measurement of outcomes of care (cost/benefit).
- A changing role for public health is expected, moving back to “core” activities (prevention, surveillance, disease control, assurance) and away from the delivery of primary care.
- A shortage of 800,000 nurses will occur by 2020. The Southern Regional Education Board, for example, estimates that in its 16-state region and the District of Columbia there will be 40,000 job openings for Registered Nurses every year until 2014. This, in spite of the fact that 26,000 qualified applicants were denied admission to nursing programs in the region due to shortages of the faculty and facilities necessary to train them.
- Pressure to reduce the costs of administration of health care will increase.

PERSPECTIVE 2–1

Physicians as Data Analysts?

In the past physicians kept a few statistics, especially if they operated in a group practice. Patient deaths and, if the MD were an obstetrician, number of births, were the main activities they counted. That is about to change – and rather significantly – as data sharing with the government is becoming essential and will impact how physicians are paid, receive bonuses, or are penalized as our health care system moves from a fee-for-service world to one that is value based.

Medicare is required to phase a "value-based modifier" into physicians' groups of 25 or more in 2015. The value-based modifier payments would apply to all physicians in 2017. The Affordable Care Act has authorized CMS to penalize physicians who do not participate; up to 2 percent of allowable Medicare charges, with the same amount as incentive payments.

The American Medical Association (AMA) and more than 60 other organizations (academies, such as the American Academy of Orthopedic Surgeons; colleges, such as the College of Pathologists; societies, such as the Medical Society of the State of New York; associations, such as the Renal Association; and others) pledged to help physicians better improve use of the data, which includes insurer information, to "enhance the quality and value of patient care."

Failure by physicians to embrace data sharing will be counterproductive. Eventually, "every physician will be evaluated by quality resources based on their information that would result in bonuses or not," according to Niall Berman, director of the CMS Office of Information Products and Analysis. "We're harnessing raw data into actionable information at the point of care." CMS hasn't much choice, Brennan said. The organization can't say a physician is "good or bad" without data.

A specific area of concern for physicians is the complexities of the reporting and the methods CMS will use to evaluate quality to determine pay scales when there are so many differences in an individual service line with many subspecialties. For example, an orthopedics practice reflects many areas where there may *seem* to be quality differences, but because of variations in patient conditions not how the work is performed. A sports-medicine physician may have lower costs because he/she sees "sports-minded people" as opposed to a foot and ankle surgeon who sees "patients who have uncontrolled diabetes" that may cost more, but it is not because of patient treatment but rather due to the uncontrolled diabetes. Thus, the physician quality reports may differ dramatically without a true reflection of the quality of the doctor's work.

CMS officials acknowledge that they are still sorting out the role of subspecialties, but they believe a "tiered" structure would be implemented to take into account such quality differences among patient conditions.

Source: Joe Cantlupe, "Data Changes the Doctors' Game," *HealthLeaders Media*, August 23, 2012, online.

The External Nature of Strategic Management

Strategic thinking, strategic planning, and managing strategic momentum should be directed toward positioning the organization most effectively within its changing environment. Environmental analysis is a part of the situational analysis section of the strategic thinking map presented in Exhibit 1–1. The conclusions reached in environmental analysis will affect the directional strategies and internal analysis. *Environmental analysis* is largely strategic thinking and strategic planning, and consists of understanding the issues in the external environment to determine the implications of those issues for the organization.

Environmental analysis requires externally oriented strategic managers who search for ways to radically alter the status quo, create something totally new, or revolutionize processes. They search for opportunities to do what has never been done previously or to do known things in a new way. Therefore, the fundamental nature of strategic management requires the awareness and understanding of outside forces. Strategic managers encourage adoption of new ideas in the system, maintain receptivity to new ways of doing things, and expose themselves to broad views. Environmental analysis can remove the protective covering in which organizations often seal themselves.[9] Effective environmental analysis occurs through strategic thinking. This chapter concerns methods to assess the general environment and the health care environment, and Chapter 3 focuses on analysis methods to evaluate the service area and competitors within it.

Determining the Need for Environmental Analysis

Based on extensive experience in the business sector, A. H. Mesch developed a series of questions to determine if an organization needs environmental analysis.[10] The questions are equally relevant to health care organizations and include:

1. Does the external environment influence capital allocation and decision-making processes?
2. Have previous strategic plans been scrapped because of unexpected changes in the environment?
3. Has there been an unpleasant surprise in the external environment?
4. Is competition growing in the industry?
5. Is the organization or industry becoming more marketing oriented?
6. Do more and different kinds of external forces seem to be influencing decisions, and does there seem to be more interplay between them?
7. Is management unhappy with past forecasting and planning efforts?

These questions concern the general and health care industry environments as well as the service area. Answering "yes" to any of the questions suggests that management should consider some form of environmental analysis. Answering "yes" to five or more of the questions indicates that environmental analysis is imperative. In today's dynamic environment, most health care managers would probably answer "yes" to more than one of these questions and should therefore be performing environmental analysis – assessing trends, events, and issues in the general environment, the health care industry environment, and the service area.

External environmental analysis attempts to identify, aggregate, and interpret environmental issues as well as provide information for the analysis of the internal environment and the development of the directional strategies. Therefore, environmental analysis seeks to eliminate many of the surprises in the external environment. Organizations cannot afford to be surprised. As one writer has pointed out, "to the blind all things are sudden." The elimination of surprises is an appropriate goal because even in periods of dynamic, rapid transformation, there are vastly more elements that do not change than new things that emerge.[11]

Strategic managers who practice environmental analysis are so "close" to the environment that by the time change becomes apparent to others, they have already detected the signals of change and have explored the significance of the changes. These managers are often called visionaries; however, vision is often the result of their *strategic awareness* – thoughtful detection and interpretation of subtle signals of change. Such strategic managers are able to eliminate "predictable surprises" for the organization – surprises that shouldn't have been. These managers are able to avoid disasters by recognizing the issue, making it a priority in the organization, and mobilizing the resources required to address it.[12]

The lack of forecasting and planning success is sometimes the result of directing processes internally toward efficiency rather than externally toward effectiveness. Such planning systems have not considered the growing number and diversity of environmental influences. Early identification of external changes through environmental analysis will greatly enhance the planning efforts in health care organizations. For example, according to the *Nashville Business Journal* (September 14, 2012), HCA Holdings, Community Health Systems, and LifePoint Hospitals are attempting to anticipate whether or not Tennessee will participate in the Medicaid expansion allowed under the Patient Protection and Affordable Care Act (PPACA). If Tennessee opts out, Nashville's for-profit hospitals could miss out on $22.7 billion in Medicaid reimbursements in 2014 alone. The problem is more complex. In addition, Nashville companies operate 51 hospitals in Texas. If Texas opts out, Nashville health care organizations could miss out on their share of the $9.3 billion that would go to Texas during the first year. As discussed in Perspective 2–2, another shift in the external environment to which health care organizations must successfully respond is emergency and disaster preparedness.

PERSPECTIVE 2–2

Preparedness: An Evolving External Issue for Health Care Organizations in the 21st Century

> Public health threats are always present. Whether caused by natural, accidental, or intentional means, these threats can lead to the onset of public health incidents. Being prepared to prevent, respond to, and rapidly recover from public health threats is critical for protecting and securing our nation's public health.[1]

Following September 11, 2001, a significant increased emphasis was directed by the US government to improve the capability and capacity of health care organizations to deal with large-scale disasters of all types. Although it is widely accepted that all responses are local, the strategy for preparing for and planning local responses has been influenced by national mandates from both the Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC). Both agencies provide funding and technical assistance to state, local, and territorial public health departments through the Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Cooperative Agreements. These agreements provide resources that facilitate preparing hospitals, health care systems, and their community partners to prevent, respond to, and rapidly recover from mass casualty incidents (MCIs) and medical surges to the nation's hospital and health care system.[2] Legislative resource commitments are provided through the Pandemic and All-Hazards Preparedness Act (PAHPA).

The primary role of the federal government is the coordination of interagency response to a disaster incident. The National Response Framework organizes interagency response into 15 essential support functions (ESFs), which are groupings of functions most frequently used to provide federal support to states. The ESF focusing on public health and the one of primary interest to health care organizations is ESF#8 – Public Health and Medical Services. The scope of ESF#8 is broad, with responsibility for providing supplemental assistance in the following core functions:

- Assessment of public health/medical needs.
- Health surveillance.
- Medical care personnel.
- Health/medical/veterinary equipment and supplies.
- Patient evacuation.
- Patient care.
- Safety and security of drugs, biologics, and medical devices.
- Blood and blood products.
- Food safety and security.
- Agriculture safety and security.
- All-hazard public health and medical consultation, technical assistance, and support.
- Behavioral health care.
- Public health and medical information.
- Vector control.
- Potable water/wastewater and solid waste disposal.
- Mass fatality management, victim identification, and decontaminating remains.
- Veterinary medical support.

The PHEP and HPP cooperative agreements translate into new demands and interactions

for health care organizations. For example, health care organizations may be required or requested to participate in the development of health care coalitions with other ESF#8 partners. Some states may require that in order to be licensed, hospitals must participate in the state's hospital preparedness program while in other states, participation is voluntary. Participation in preparedness activities may involve financial, human, and facilities resources. It is important for health care organizations to understand the requirements and expectations of state and local authorities concerning preparedness and to incorporate these expectations into the environmental assessment.

In addition, health care organizations must consider stakeholders such as the Joint Commission, the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Officials (NACCHO), the American Hospital Association (AHA), the American Academy of Pediatrics (AAP), the Federal Emergency Management Agency (FEMA), and state and local emergency management agencies and health departments. These stakeholders collaborate to define and operationalize public health preparedness capabilities.[3]

Natural and human-initiated disaster preparedness will continue to influence health care organization strategy. Planning and preparing for hurricanes, earthquakes, tornados, human-initiated incidents, and other types of disaster is now a part of health care organization strategy. In addition, as new preparedness approaches, directives, and laws are created, health care organizations will have to respond accordingly.

Source: Andrew C. Rucks and Lisa C. McCormick, Department of Health Care Organization and Policy, University of Alabama at Birmingham.

[1]US Department of Health and Human Services, Centers for Disease Control and Prevention (2011) Public Health Preparedness Capabilities: National Standards for State and Local Planning. Available at: http://www.ndhealth.gov/epr/php/PHEP%20Capabilities%202011.pdf

[2]US Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response (2012) Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness. Available at: http://www.phe.gov/preparedness/planning/hpp/reports/documents/capabilities.pdf

[3]FEMA (2008). Emergency Support Function Annexes: Introduction. Available at: http://www.fema.gov/pdf/emergency/nrf/nrf-esf-all.pdf

The Goals of Environmental Analysis

Although the overall intent of environmental analysis is to position the organization within its environment, more specific goals may be identified. The specific goals of environmental analysis are:

- to identify and analyze current important issues and changes that will affect the organization;
- to detect and analyze early or weak signals of emerging issues and changes that will affect the organization;
- to speculate on the likely future issues and changes that will have significant impact on the organization;
- to classify and order issues and changes generated by outside organizations;

- to provide organized information for the development of the organization's internal analysis, mission, vision, values, goals, and strategy; and
- to foster further strategic thinking throughout the organization.

In addition to the identification of current issues, environmental analysis attempts to detect early or weak signals within the external environment that may portend a future issue. Sometimes based on little hard data, managers attempt to identify patterns that suggest emerging issues that will be significant for the organization. Such issues, if they continue or actually do occur, may represent significant challenges. Early identification aids in developing strategy.

Strategic managers must go beyond what is known and speculate on the nature of the industry, as well as the organization, in the future. This process often stimulates creative thinking concerning the organization's present and future products and services. Such speculation is valuable in the formulation of a guiding vision and the development of mission and strategy. The bulleted list of evolving external issues at the beginning of this chapter provides some of the emerging and speculative forces that strategic managers will begin to incorporate into their thinking today.

There is an abundance of data in the external environment. For it to be meaningful, managers must identify the sources as well as aggregate and classify the data into information. Once classified, important issues that will affect the organization may be identified and evaluated. This process encourages managers to view environmental changes as external issues that may affect the organization.

When strategic managers – top managers, middle managers, and front-line supervisors – throughout the organization are considering the relationship of the organization to its environment, innovation and a high level of service are likely. Strategic thinking within an organization fosters adaptability, and those organizations that adapt best will ultimately displace the rest.

The Limitations of Environmental Analysis

Environmental analysis is important for understanding the external environment, but it provides no guarantees for success. The process has some practical limitations that the organization must recognize. These limitations include:

- Environmental analysis cannot foretell the future.
- Managers cannot see everything.
- Sometimes pertinent and timely information is difficult or impossible to obtain.
- There may be delays between the occurrence of external events and management's ability to interpret them.
- Sometimes there is a general inability on the part of the organization to respond quickly enough to take advantage of the issue detected.
- Managers' strongly held beliefs sometimes inhibit them from detecting issues or interpreting them rationally.[13]

Even the most comprehensive and well-organized environmental analysis processes will not detect all the changes taking place. Sometimes events occur that are significant to the organization but were preceded by few, if any, signals. Or the signals may be too weak to be discerned.

Perhaps the greatest limiting factor in external environmental analysis is the preconceived beliefs of management. In many cases, what leaders already believe about the industry, important competitive factors, or social issues inhibits their ability to perceive or accept signals for change. Because of managers' beliefs, signals that do not conform to what they believe may be ignored. What an individual actually perceives is dramatically determined by paradigms (ways of thinking and beliefs). And any data that exist in the real world which do not fit the paradigm will have a difficult time permeating the individual's filters – he or she will simply not see it.[14] As creativity expert Edward De Bono explains, "We are unable to make full use of the information and experience that is already available to us and is locked up in old structures, old patterns, old concepts, and old perceptions."[15] Despite long and loud signals for change, in some cases organizations do not change until it is too late.

The External Environment

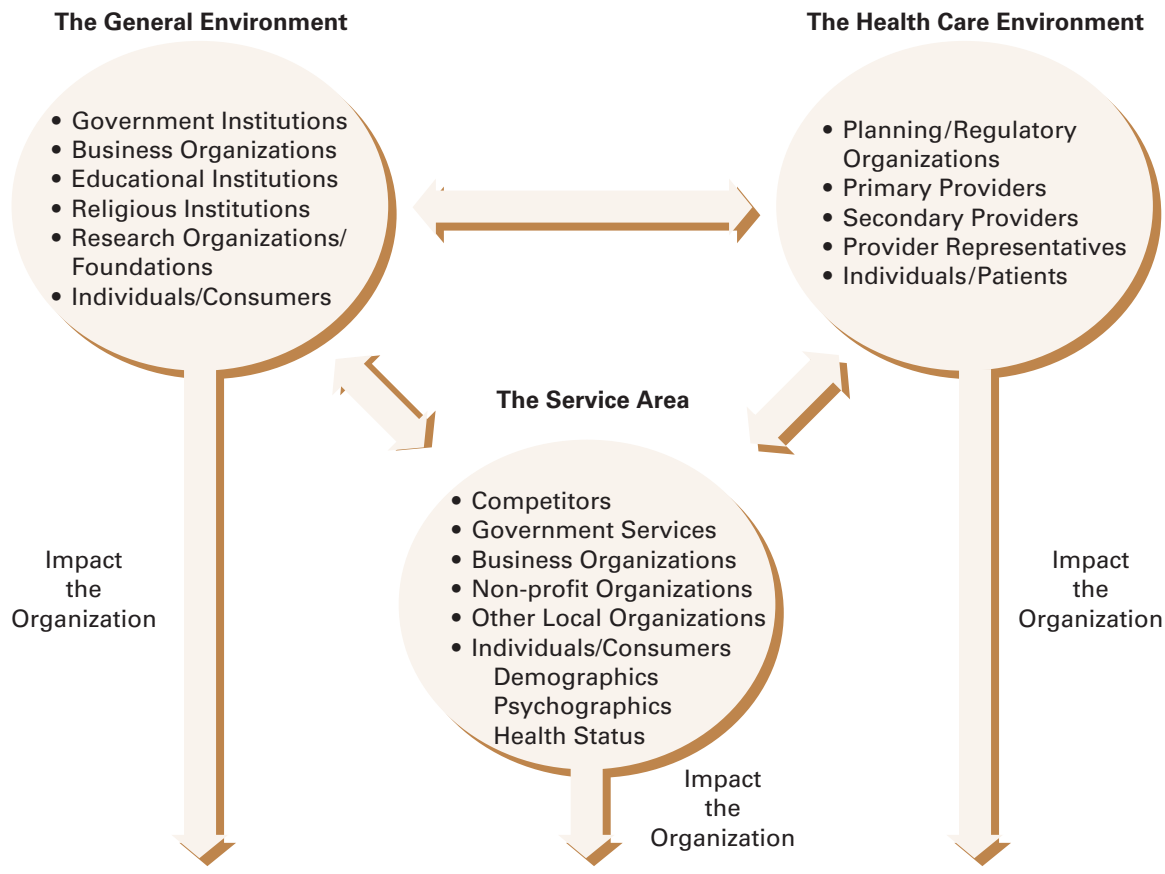
Organizations and individuals create change. Therefore, if health care managers are to become aware of the changes taking place outside their own organization, they must have an understanding of the types of organizations that are creating change and the nature of the change. Exhibit 2–1 illustrates the concept of the external environment for health care organizations. In this chapter we will explore the types of change initiated in the general environment and the health care industry environment.

Components of the General Environment

All types of organizations and independent individuals generate important issues – and subsequently change – within the general environment. For example, a research firm that is developing imaging equipment may introduce a new technology that could be used by a variety of other organizations in very diverse industries such as hospitals (magnetic resonance imaging) and manufacturing (robotics). The members of the *general environment* may be broadly classified in a variety of ways depending on the strategic management needs of the organization analyzing the environment. These groups of organizations and individuals make up the broad context of the general environment:

- government institutions,
- business organizations,
- educational institutions,
- religious institutions,
- research organizations and foundations, and
- individuals and consumers.

EXHIBIT 2–1 The External Environment of a Health Care Organization



Organizations and individuals in the general environment, acting alone or in concert with others, initiate and foster the "macroenvironmental" changes within society. These organizations and individuals generate legislative/political, economic, social/demographic, technological, and competitive change that will, in the long run, affect many different industries (including health care) and may even directly affect individual organizations. Therefore, external organizations engaged in their own processes and pursuing their own missions and strategic goals will affect other industries, organizations, and individuals.

In the general environment, changes usually affect a number of different sectors of the economy (industry environments). For example, passage of the prescription drug bill during the George W. Bush presidency affected a variety of organizations as well as individuals including insurance companies, organizations representing the elderly, and retirees. Similarly, the early health care reform initiatives of the Obama administration resulted in the passage of ACA, however, its implementation was spread over a number of years and affected virtually all institutions in the general environment, not just health care organizations.

The organization itself may be affected directly by the legislative/political, economic, social/demographic, technological, and competitive change initiated and fostered by organizations in the general environment. In the aggregate, these alterations represent the general direction of societal change that may affect the success or failure of any organization. Therefore, an organization engaging in strategic management must try to sort out the fundamental changes being generated in the external environment and detect the major shifts taking place. A shift in consumer attitudes and expectations about health care is an example of a societal change that may affect the success or failure of health care organizations. Demographic changes are somewhat more predictable and the growing number of seniors in the US population will impact every aspect of the environment as well as the health care environment. However, sometimes the demographics of the general environment can provide leading health care trends, as illustrated in Perspective 2–3.

Typically, as information is accumulated and evaluated by the organization, it will be summarized as environmental issues affecting the industry or organization. The identification and evaluation of the issues in the general environment are important because the issues will accelerate or retard changes taking place within the industry yet may affect the organization directly as well.

Components of the Health Care Environment

Organizations and individuals within the *health care environment* develop and employ new technologies, deal with changing social and demographic issues, address legislative and political change, compete with other health care organizations, and participate in the health care economy. Therefore, strategic managers should view the health care environment with the intent of understanding the nature of all these issues and changes. Focusing attention on major change areas facilitates the early identification and analysis of industry-specific environmental issues and trends that will affect the organization. However, in today's environment a more focused service area competitor analysis is typically required as well (see Chapter 3).

PERSPECTIVE 2–3

The Largest Minority Impacting Health Care Delivery

As of mid-year 2009, Hispanics became the largest and fastest-growing ethnic or race minority in the United States, with more than 48.4 million people. Hispanics constitute 16 percent of the nation's total population, with a median age of 27.4 years (compared with 36.8 years for the US population as a whole). Factors that contribute to poor health outcomes among Hispanics include language (unwillingness to try to speak with a health care provider and confusion over medical information provided), cultural barriers, lack of access to preventive care, and lack of health insurance (especially illegal immigrants).

Access to care is uneven for many Hispanics. In one study comparing a group of Hispanics living in Minnesota where they were a small percentage of the population to a group living in Texas where they were the largest minority population, found those living in Minnesota had access and good quality care whereas those living in Texas felt they had limited access and inferior quality care to that they could receive in Mexico. Many (who were in the US legally and could do so) travelled to Mexico for care and especially for medications that were much less expensive. In Minnesota the burden is not great (lowest uninsured population in the USA at 8.42 percent and lowest uninsured Latinos at 18 percent) compared with Texas (highest uninsured population in the USA at 24.2 percent and highest uninsured Latinos at 60 percent).

One way that the health care needs of Hispanics are being met is in-store medical clinics that offer affordable health care targeted at Hispanic customers. This growing trend of retail-based medical clinics could be particularly beneficial to retailers catering for Hispanics. For example, Minyard Food Stores operates its Carnival-banner as a Hispanic format, incorporating in-store medical centers called MedBasics. Started in Texas locations, the in-store clinics are staffed by nurse practitioners and physician assistants and charge about $49 for most non-urgent services.

The clinics range from about 400 to 600 square feet. Although Carnival loses that footprint as retail space, it benefits from additional store traffic – 98 percent of MedBasics patients use the Carnival pharmacy to fill their prescriptions and while there customers often buy other health-related items, such as over-the-counter medications and Band-Aids. MedBasics centers reach out to Hispanics with a range of services including bilingual staff and paperwork, signage, and brochures in Spanish. In addition, MedBasics partnered with several insurance companies so that insured patients are typically charged just a copay.

A similar concept has been effective at Bashas's Food City-banner stores in Phoenix, Arizona. Its MediMin health care clinics employ a bilingual staff and all communications are in Spanish. The basic office visit is $50 (or the patient's insurance copay). MediMin centers are located at the front of the store, near the pharmacy, in approximately 450 square feet of space. A small patient waiting area, two exam rooms, a small lab, and a bathroom provide the look and feel of a doctor's office, but it's better because the clinics are staffed seven days a week with a nurse practitioner or physician's assistant plus an administrator who is fluent in Spanish. Bashas's research revealed that all socioeconomic groups – from blue-color workers to high-end households – are using the clinics. The hospital ERs like the concept as well.

Source: www.cdc.gov/nchs/fastats/hispanic_health.htm and www.census.gov/hhes/www/hlthins/data/incpovhlth/2010/tables.html.

Carolyn Garcia, José A. Pagán, and Rachel Hardeman, "Context Matters: Where Would You be the Least Worse Off in the US if You Were Uninsured?" *Journal of Health Policy* 94, no. 1 (2010), pp. 76–83.

The wide variety of health care organizations makes categorization difficult. However, the health care system may generally be grouped into five segments:

- Organizations that regulate primary and secondary providers.
- Organizations that provide health services (*primary providers*).
- Organizations that provide resources for the health care system (*secondary providers*).

- Organizations that represent the primary and secondary providers.
- Individuals involved in health care and patients (consumers of health care services).[16]

Exhibit 2–2 lists the types of organizations and individuals within each segment and provides examples. The categories of health care organizations listed under each of the health care segments are not meant to be all-inclusive, but

EXHIBIT 2–2 Organizations in the Health Care Environment

Organizations that Regulate Primary and Secondary Providers

- Federal regulating agencies:
  Department of Health and Human Services (DHHS)
  Center for Medicare and Medicaid Services (CMS)
- State regulating agencies:
  Public Health Department
  State Health Planning Agency (e.g., certificate of need [CON, see Perspective 3–3])
- Voluntary regulating groups:
  Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- Other accrediting agencies:
  Council on Education for Public Health (CEPH)

Primary Providers (Organizations that Provide Health Services)

- Hospitals:
  Voluntary (e.g., Barnes/Jewish/Hospital)
  Governmental (e.g., Veteran's Administration Hospitals)
  Investor-owned (e.g., HCA – The Healthcare Company, Tenet)
- State public health departments
- Long-term care facilities
- Skilled nursing facilities (e.g., HCR ManorCare)
- Intermediate care facilities
- HMOs and IPAs (e.g., United Healthcare)
- Ambulatory care institutions (e.g., Ambulatory Care Centers)
- Hospices (e.g., Hospice Care & Palliative Care, Inc.)
- Physicians' offices
- Home health care institutions (e.g., CareGivers Home Health)

Secondary Providers (Organizations that Provide Resources)

- Educational institutions:
  Medical schools (e.g., Johns Hopkins, University of Alabama at Birmingham [UAB])
  Schools of public health (e.g., The University of North Carolina at Chapel Hill, Harvard)
  Schools of nursing (Presbyterian School of Nursing)
  Health administration programs (University of Washington, The Ohio State University)

(*Continued*)

EXHIBIT 2–2 *(Continued)*

- Organizations that pay for care (third-party payers):
  Government (e.g., Medicaid, Medicare)
  Insurance companies (e.g., Prudential, Metropolitan)
  Businesses (e.g., Microsoft, Ford Motor Company)
  Social organizations (e.g., Shriners, Rotary Clubs)
- Pharmaceutical and medical supply companies:
  Drug distributors (e.g., McKesson)
  Drug and research companies (e.g., Bristol Myers Squibb)
  Medical products companies (e.g., Johnson & Johnson)

Organizations that Represent Primary and Secondary Providers

- American Medical Association (AMA)
- American Hospital Association (AHA)
- State associations (e.g., Illinois Hospital Association, New York Medical Society)
- Professional associations (e.g., Pharmaceutical Manufacturers Association [PMA], American College of Healthcare Executives [ACHE], American College of Physician Executives [ACPE], Medical Group Management Association [MGMA])

Individuals and Patients (Consumers)

- Independent physicians
- Nurses
- Non-physician professionals
- Non-professionals
- Patients and consumer groups

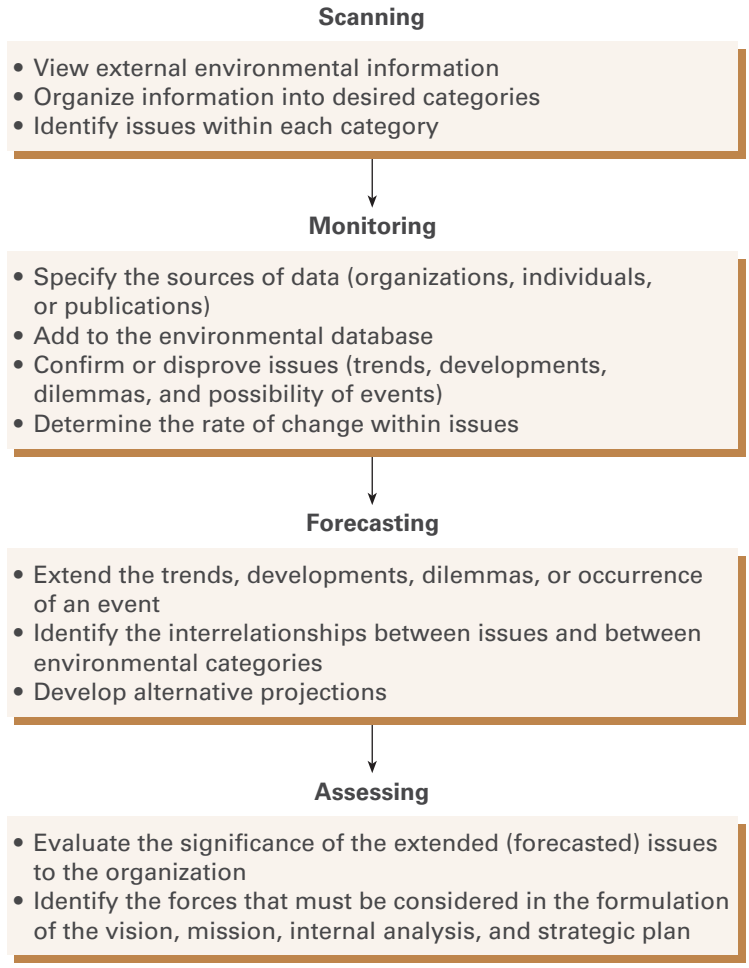
Source: Adapted from Beaufort B. Longest Jr., *Management Practices for the Health Professional*, 4th edn (Norwalk, CT: Appleton & Lange, 1990).

rather to provide a starting point for understanding the wide diversity and complexity of the industry.

The Process of Environmental Analysis

There are a variety of approaches to conducting an environmental analysis. Regardless of the approach, four fundamental processes are common to environmental analysis efforts (see Exhibit 2–3): (1) scanning to identify signals of environmental change, (2) monitoring identified issues, (3) forecasting the future direction of the issues, and (4) assessing the organizational implications of the issues.[17]

EXHIBIT 2–3 **Strategic Thinking Map of the Environmental Analysis Process**



Scanning the External Environment

As suggested earlier in this chapter, the external environment is composed of a number of organizations and individuals in the general and health care environments. Some of the organizations and individuals in the external environment have little direct involvement with the health care industry while others are directly involved. The distinction is not always clear. These organizations and individuals, through their normal operations and activities, are generating changes that may be important to the future of other organizations. Changes in the general environment are always "breaking through" to the health care environment. For example, health care often advances hand in hand with technology, as is the case with the convergence of imaging technology and biotechnology – enabled by advanced health care information technology – which promises to radically change diagnosis and treatment for many chronic diseases.[18]

The environmental scanning process acts as a "window" to these organizations. These organizations and individuals are generating strategic issues that may shape the entire health care industry or have a direct impact on any one health care organization. Managers engaged in environmental scanning carry out three functions. They:

- view external environmental data;
- organize external information into several desired categories; and
- identify issues within each category.

Strategic issues are trends, developments, dilemmas, and possible events that affect an organization and its position within its environment. Strategic issues are often ill-structured and ambiguous and require an interpretation effort (forecasting and assessment).[19] Often, in attempting to identify important external issues, general labels such as opportunities or threats are used to classify issues. However, the use of these labels leads strategists to think in terms of potential strategies to address the issue rather than the impact of the issue. Therefore, at this stage in strategic planning, it is beneficial to avoid using the terms opportunities/threats, positive/negative, gain/loss, or controllable/uncontrollable and instead consider the consequences of the issue itself. Strategies can be worked out later, after leaders have a better understanding of external issues as well as internal resources, competencies, and capabilities.

The *scanning* function serves as the organization's "window" or "lens" on the external world. The scanning function is a process of viewing a number of external organizations either in the general or health care environment in search of current and emerging trends or issues. In the scanning process, planners focus on data generated by external organizations and individuals, and compile and organize it into meaningful categories. As a result, issues found in the external environment are organized through the scanning process. Prior to this interpretation process, issues are diverse, unorganized, sporadic, mixed, and undefined. The scanning process categorizes, organizes, accumulates, and, to some extent, evaluates issues.

Information Categories To effectively monitor and further analyze issues, they should be organized into logical categories. Categories not only aid in tracking but also facilitate the subsequent assessment of the issues. The categories most used to classify issues are legislative/political, economic, social/demographic, technological, and competitive. Issues, of course, are not inherently technological, social, and so on. However, using this approach helps managers to understand the nature of the issues and aggregate information and organize it. Through the aggregation and organization process, patterns may be identified and evidence accumulated on an issue.

Information Sources There are a variety of sources for environmental information. Although organizations create change, they are often difficult to monitor directly. However, various secondary sources (published information) are readily available. Essentially, people and publications both outside and inside the organization serve as the lens to the external world. Typically, within the

organization, there are a variety of experts who are familiar with external issues and who may be the best sources of such information. In addition, many organizations collect patient and consumer information and subscribe to and archive industry, technical reports, and databases. Outside the health care organization, patients, physicians, nurses, suppliers, third-party payers, pharmaceutical representatives, and managed care companies may be considered important direct sources. Indirect sources are mostly newspapers and journals, the Internet, television, libraries, and public and private databases.

Environmental scanning is perhaps the most important part of environmental analysis because it forms the basis for the other processes. In the scanning activity, issues and changes are specified and sources identified. It is from this beginning that a database for decision making will be built. It is crucial that managers understand the thinking that led to the development and selection of strategic and tactical issues from among those identified in the scanning process. It is therefore advantageous if as many managers as possible take part in scanning. An important aspect of environmental scanning is that it focuses leaders' attention on what lies outside the organization and enables them to create an organization that can adapt to and learn from that environment.

Monitoring the External Environment

The *monitoring* function is the tracking of issues identified in the scanning process. Monitoring accomplishes four important functions:

1. It researches and identifies additional sources of information for specific issues delineated in the scanning process that were determined to be important or potentially important to the organization.
2. It adds to the environmental database.
3. It attempts to confirm or disprove issues (trends, developments, dilemmas, and the possibility of events).
4. It attempts to determine the rate of change within issues.

The monitoring process investigates the sources of the information obtained in the scanning process and attempts to identify the organization or organizations creating change and the sources reporting change. Once the organizations creating change and the publications or other information sources reporting change have been identified, special attention should be given to these sources.

The monitoring function has a much narrower focus than scanning; the objective is to accumulate a database around an identified issue. The database will be used to confirm or disconfirm the trend, development, dilemma, or possibility of an event and to determine the rate of change taking place within the environment.

The intensity of monitoring is reflected in management's understanding of the issue. When managers believe they understand the issue well, less monitoring will be done. However, when environmental issues appear ill-structured, vague, or complex, the issues will require a larger amount of data to arrive at an interpretation.[20]

Forecasting Environmental Change

Forecasting environmental change is a process of extending the trends, developments, dilemmas, and events that the organization is monitoring. Further, forecasting looks at how hidden currents in the present signal possible changes in direction for organizations and societies. Thus, the primary goal of forecasting is to identify the full range of possibilities.[21] Therefore, the forecasting function attempts to answer the question, "If these trends continue, or if issues accelerate beyond their present rate, or if this event occurs, what will the issues and trends 'look like' in the future?"

Three processes are involved in the forecasting function:

1. Extending the issues (trends, developments, dilemmas, or occurrences of an event).
2. Identifying the interrelationships between the issues and environmental categories.
3. Developing alternative projections.

Assessing Environmental Change

Information concerning the environment, though abundant, is seldom obvious in its implications. Strategic managers must interpret the data they receive. After all, facts do not speak for themselves; one has to make sense of the facts, not just get them straight.[22] *Assessing* environmental change is a process that is largely non-quantifiable and therefore judgmental. The assessment process includes evaluation of the significance of the extended (forecasted) issue on the organization; identification of the issues that must be considered in the internal analysis; development of the vision and mission; and formulation of the strategic plan. However, even when exposed to identical issues, different managers may interpret their meaning quite differently. Interpretations are a result of a variety of factors, including perceptions, values, past experiences, and context.

Strategic decisions are made in the context of changing financial, social, political, technical, and environmental forces – understanding the context in which an organization operates is, therefore, fundamental. Understanding context is called "*sensemaking*," a term coined by organizational psychologist Karl Weick.[23] Strategic leaders who have a sense of context know how to quickly capture the complexities of their environment and explain them to others in simple terms. This explanation helps to ensure that everyone is working from the same map, which makes it far easier to discuss and plan for the journey.[24]

Sensemaking is a dynamic challenge, however, as Perspective 2–4 illustrates. PricewaterhouseCooper's annual *Medical Cost Trend: Behind the Numbers 2013* provides data that individual health care organizations will have to make "sense" of for their individual situation.

PERSPECTIVE 2–4

A New Normal for Medical Costs?

Health care spending in the United States has slowed over the past three years. Despite expectations that costs would resume previous high growth rates in 2012, they did not. PricewaterhouseCooper (PwC) Health Research Institute's *Medical Cost Trend: Behind the Numbers 2013* report projected medical costs to grow at a historically low rate of 7.5 percent in 2013. Previous history carried forward would indicate that the slowdown is simply a dip reflecting the current economic situation and that medical cost growth will return to "normal" – a much higher inflation rate than that of GDP as the economy recovers.

There may be more to the slower growth rate of medical costs than the economy; however, behaviors are beginning to change: employers are pushing wellness programs and trying to keep their health insurance expenses down with higher out-of-pocket costs for employees; health care providers and drug manufacturers are embracing "value"; and patients are becoming more cost conscious and beginning to "shop" for medical care.

The focus on medical cost containment is continuing, aided by the sluggish economy, reforms in the health care industry, and efforts by employers to keep costs down. Four factors will deflate the medical cost trend. (1) Market pressures on medical supply and equipment costs will reduce prices. Supplies can amount to 40 percent of the cost of some procedures; "physician preferences" will be less of an influencer as practices become part of group purchasing plans where negotiated lower prices lead to fewer choices. (2) New methods of delivering primary care are becoming more accepted. Alternatives to the traditional office visit include workplace and retail health clinics, telemedicine, and mobile health tools. (3) Comparative cost information is becoming more widely available. Purchasers – including employers and consumers – are shopping for lower cost alternatives. (4) Cost-saving generics are on the rise. Consumers have greater awareness and preference for generics driven by cost savings. Both 2011 and 2012 set records for the number of drugs going off patent; therefore, 2012 and 2013 set records for the number of generics – now up to 80 percent of all prescriptions in the United States.

Two factors will inflate medical costs: (1) As more jobs are added in the economy, those newly hired workers will likely tap into their new health care benefits, plus an uptick will occur in utilization by those who have postponed medical treatment while the economy has been in recession. (2) New technologies such as robotic surgery and positron emission tomography (PET) services have grown; although more comfortable for patients, they are more expensive. During 2010, 36 percent of hospitals performed robotic surgery.

The *Medical Cost Trend: Behind the Numbers 2013* report incorporated a survey that found:

- More than half (57 percent) of employers are considering increasing employee contributions to health plans.
- Half of employers are considering increasing cost sharing through plan design, such as higher deductibles. The average emergency room copay is now $125 or more.

- More than half of employers are considering raising employee prescription drug plan costs.
- Average enrollment in high deductible plans coupled with a Health Reimbursement Account have increased to 43.2 percent in 2012 from 34.2 percent in 2010.
- Nearly three-quarters (72 percent) of employers offer wellness programs, and half say they are considering expanding those programs next year.

Forced to do more with less, health care providers and consumers have begun to embrace new strategies and habits that have the potential to be long lasting. Hospitals are adopting use of information technology (IT) to have greater access to information and using analytics to make more cost-effective decisions with the information gathered. In addition, they are developing new relationships with physicians to pressure suppliers for lower prices and because more physicians are "managed" by hospitals, restricting supply choice allows for better contracted prices for those supplies. Employers and insurers are encouraging comparison shopping by patients, coordinated care that pays for better outcomes, and promotion of healthier lifestyles. As consumers are beginning to understand the high costs (they have seen copays and deductibles increase), they are open to alternatives; we seem to be entering a "new normal" for health care.

Source: Health Research Institute, *Medical Cost Trend: Behind the Numbers 2013*, report by PricewaterhouseCoopers (May, 2012), pp. 1–22.

The assessment process is not an exact science, and sound human judgment and creativity may be bottom-line techniques for sensemaking – a process without much structure. The fundamental challenge is to make sense out of vague, ambiguous, and unconnected data. Strategic leaders have to infuse meaning into data; they have to make the connections among discordant data such that signals of future events are created. Sensemaking involves acts of perception and intuition. It requires the capacity to suspend beliefs, preconceptions, and judgments that may inhibit connections being made among ambiguous and disconnected data.[25]

Environmental Analysis Tools and Techniques

Several different strategic thinking frameworks and techniques may be used to examine the general and health care environments. These frameworks, which are informal and generally not overly sophisticated, have been variously described as "judgmental," "speculative," or "conjectural."[26] Indeed, environmental analysis is largely an individual effort and is directed to person-specific interests. Further, environmental analysis usually is not limited to just one of the environmental analysis tools and techniques. The remainder of this chapter will discuss environmental analysis frameworks that identify issues in the general and health care

environments. An approach and techniques for more specific market segmentation and competitive analysis will be discussed in Chapter 3.

Simple Issue Identification and Extrapolation

Issue identification and extrapolation is a matter of identifying issues and then, from the existing data, anticipating the importance of the issue and likelihood that it will remain an issue. Perhaps because of its relative simplicity, issue identification and extrapolation is a widely practiced analysis method. Unfortunately, environmental issues are rarely presented as a neat set of quantifiable data; rather, environmental issues are ill-structured and conjectural. Thus, in many cases, issue identification and extrapolation in environmental analysis is a matter of reaching consensus on the existence of an issue and speculating on the likelihood of its continuance.

As illustrated in Exhibit 2–4, the issue identification and extrapolation process for a nursing home includes the identification of issues by environmental category and the determination of its probable impact on the organization. Additionally, managers may assess the likelihood that the trend, development, or dilemma will continue or that the event will occur, and then identify the sources for additional information.

These issues may then be plotted on the chart shown in Exhibit 2–5. The assumption is that the issues to the right of the curved line in the exhibit have a significant impact (high impact) on the organization and are likely to continue or occur (high probability) and should be addressed in the strategic plan.

The formats illustrated in Exhibits 2–4 and 2–5 are useful for organizing environmental data and providing a starting point for speculating on the direction and rate of change for identified trends. However, trend extrapolation of environmental issues requires extensive familiarity with the external environment (the issues) and a great deal of sound judgment.

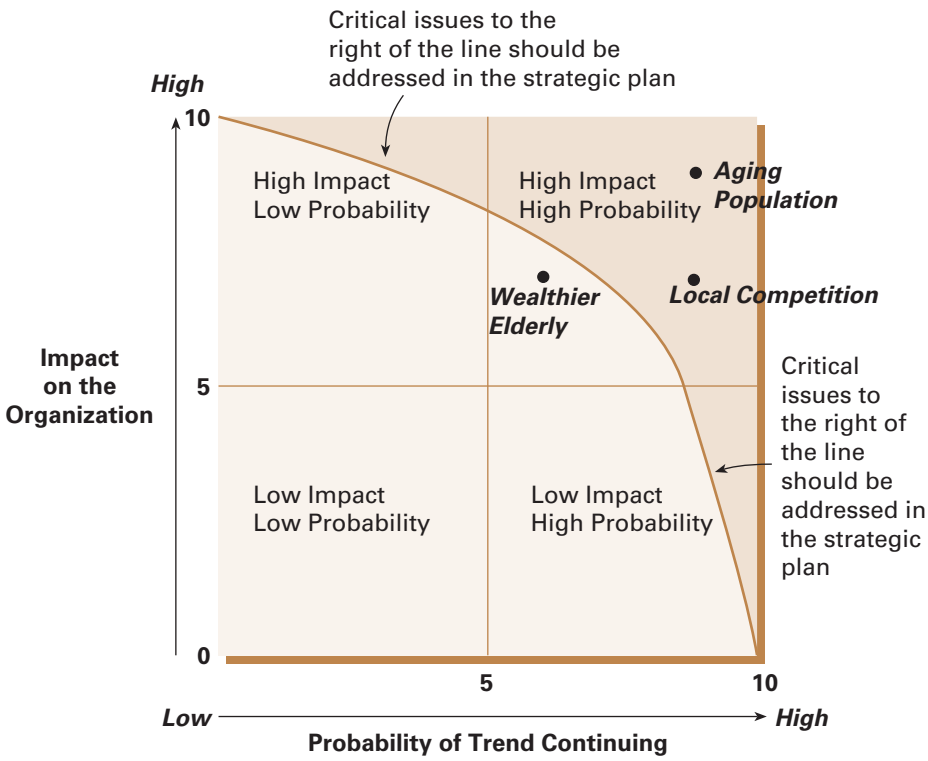
EXHIBIT 2–4 Issue Identification and Evaluation by a Nursing Home

Trend/Issue	Evidence	Impact on Our Organization (1–10)	Probability of Trend Continuing (1–10)
Aging population	1 in 5 Americans will be at least 65 by 2030	9	9
Wealthier elderly	Income of those 60+ has increased 10 percent faster than any other group	7	6
Local competition	Over past 5 years, number of nursing homes in the service area has increased from 5 to 7	7	9

10 = High impact or probability

1 = Low impact or probability

EXHIBIT 2–5 Environmental Trends/Issues Plot



Solicitation of Expert Opinion

Expert opinion is often used to identify, monitor, forecast, and assess environmental trends. Experts play a key role in shaping and extending the thinking of leaders. Health care leaders can use these opinions to stimulate their strategic thinking and begin developing human resources strategies. To further focus leaders' thinking and generate additional perspectives concerning the issues in the external environment, there are a number of more formal expert-based environmental analysis techniques. These strategic thinking frameworks help to solicit and synthesize the opinions and best judgments of experts within various fields.

The Delphi Method The *Delphi method* is a popular, practical, and useful approach for analyzing environmental data. The Delphi method may be used to identify and study current and emerging trends within each environmental category (technological, social/demographic, economic, and so on). More specifically, the Delphi method is the development, evaluation, and synthesis of individual points of view through the systematic solicitation and collation of individual judgments on a particular topic. In the first round, individuals are asked their opinions on the selected topic. Opinions are summarized and then sent back to the

participating individuals for the development of new judgments concerning the topic. After several rounds of solicitation and summary, a synthesis of opinion is formulated.[27]

The traditional Delphi method has undergone a great deal of change in the context of environmental analysis. The salient features of the revised Delphi method are to:

- identify recognized experts in the field of interest;
- seek their cooperation and send them a summary paper (based on a literature search); and
- conduct personal interviews with each expert based on a structured questionnaire.[28]

In contrast to traditional Delphi methods, there is no further feedback or repeated rounds of questioning. The major advantage is that it is easier to recruit recognized experts because they do not need to commit as much of their time.

The Delphi method is particularly helpful when health care managers want to understand a specific environmental issue. For example, a Delphi study was designed to define the role and responsibilities of sports medicine specialists in the United Kingdom. A mail questionnaire was sent to a random sample of 300 members of the British Association of Sport and Exercise Medicine. The original questionnaire contained 300 attributes and allowed participants to modify their responses based on feedback from other participants. The study was recognized as the first systematic attempt to define the role and responsibilities of the sports medicine specialist and concluded that sports medicine was an evolving specialty in the United Kingdom.[29] More recently, methods and experts from other disciplines have been applied to health care issues such as the forecasting of infectious diseases.

Nominal Group Technique, Brainstorming, and Focus Groups The nominal group technique (NGT), brainstorming, and focus groups are interactive group problem identification and solving techniques. In the *nominal group technique*, a group is convened to address an issue, such as the impact of consolidation within the health care industry or the impact of an aging population on hospital facilities. Each individual independently generates a written list of ideas surrounding the issue. Following the idea-generation period, group members take turns reporting one idea at a time to the group. Typically, each new idea is recorded on a large flip chart for everyone to consider. Members are encouraged to build on the ideas of others in the group. After all the ideas have been listed, the group discusses the ideas. After the discussion, members privately vote or rank the ideas. After voting, further discussion and group generation of ideas continue. Typically, additional voting continues until a reasonable consensus is reached.[30]

A *brainstorming* group is convened for the purpose of understanding an issue, assessing the impact of an issue on the organization, or generating strategic alternatives. In this process, members present ideas and are allowed to clarify them with brief explanations. Each idea is recorded, but evaluation is generally

not allowed. The intent of brainstorming is to generate fresh ideas or new ways of thinking. Members are encouraged to present any ideas that occur to them, even apparently risky or impossible ideas. Such a process often stimulates creativity and sparks new approaches that are not as risky, crazy, or impossible as first thought.[31]

NGT and brainstorming could be used to understand and respond to the increasing competition for ambulatory surgery. The outpatient surgery center is a rapidly growing trend and hospitals are very concerned about the impact this growth could have on their bottom line. In 1980, for example, only 15 percent of all surgeries were performed on an ambulatory basis. Today, more than 75 percent are outpatient. Inpatient surgeries requiring a one-day or longer length of stay now constitute only about 18 to 20 percent of hospital surgery profits and the percentage is dropping each year. The most popular outpatient areas are gastroenterology, orthopedics, gynecology, ophthalmology, as well as podiatry, ENT, and general surgery. However, increasingly there are signs that angioplasty, peripheral vascular surgery, and low-risk coronary interventions such as pacemakers and cardiac defibrillators may be next.

These changes and the prospect of even greater changes offer an opportunity for hospital managers to employ brainstorming groups to plan for the future. Some of the major uncertainties that could be addressed by the groups include the PPACA. Brainstorming groups could provide serious insights into how willing physicians are to continue performing their procedures in hospitals and turn away from investments in outpatient facilities that could provide a 25 percent return on invested capital. Moreover, outpatient surgeries are easier for physicians to schedule without the aggravation of sharing operating rooms with inpatient and emergency services. Brainstorming groups might also be used to project the future direction of hospital reimbursement. Although both of these factors represent major uncertainties, informed groups could be very useful in preparing for the increasingly competitive health care environment.[32]

Similar to the process of brainstorming, *focus groups* bring together 10 to 15 key individuals to develop, evaluate, and reach conclusions regarding environmental issues. Focus groups provide an opportunity for management to discuss particularly important organizational issues with qualified individuals. Hospitals and large group practices have used focus groups of patients to better understand the perceived strengths and weaknesses of the organization from the patient's view. For example, Johns Hopkins was considering the establishment of an integrated delivery system under one umbrella name. Focus groups of physicians, present and past patients, non-patients, and others convinced them to change plans. Focus groups can provide new insights for understanding issues and suggest fresh alternatives for their resolution.

Dialectic Inquiry

Dialectic inquiry is a "point and counterpoint" process of argumentation. The 19th-century German philosopher Hegel suggested that the surest path to truth was the use of a dialectic process – an intellectual exchange in which a thesis is pitted against an antithesis. According to this principle, truth emerges from the search for synthesis of apparently contradictory views.[33]

More specifically, in environmental analysis, dialectic inquiry is the development, evaluation, and synthesis of conflicting points of view (environmental issues) through separate formulation and refinement of each point of view.[34] For instance, one group may argue that health care costs will be declining between 2014 and 2020 (thesis) because of the Patient Protection and the Accountable Care Act. Another group may present a case that the trend toward rising health care costs will continue (antithesis) because of hospital failures, the high cost of new technology, shortage of primary care providers, and so on. Debating this issue will unearth the major factors influencing health care costs and the implications for the future.

Any health care provider can utilize this technique by assigning groups to debate specific external issues. The groups make presentations and debate conflicting points of view concerning the environment. After the debate, the groups attempt to form a synthesis of ideas concerning the likely future.[35]

Stakeholder Analysis

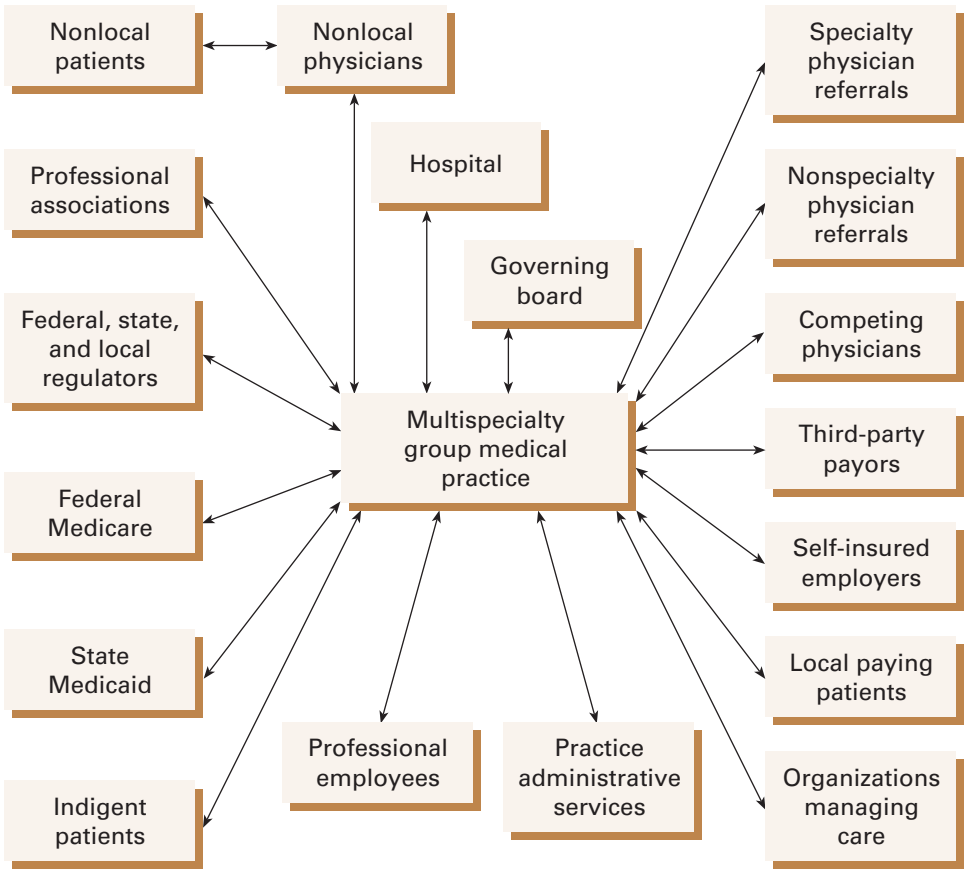
Stakeholder analysis is based on the belief that there is a reciprocal relationship between an organization and certain other organizations, groups, and individuals. They are referred to as stakeholders: that is, organizations, groups, and individuals that have an interest or "stake" in the success of the organization. Examples of possible health care stakeholders, shown as a "stakeholder map," are presented in Exhibit 2–6.

Stakeholders may be categorized as internal, interface, and external. Internal stakeholders are those who operate primarily within the bounds of the organization, such as managers and other employees. Interface stakeholders are those who function both internally and externally, such as the medical staff and the corporate officers of the parent company. External stakeholders operate outside the organization and include such entities as suppliers, third-party payers, competitors, regulatory agencies, the media, the local community, and so on.[36] Such stakeholders have been referred to as the "organization ecosystem"– organizations that affect and are affected by the creation and delivery of the organization's product or service. Part of stakeholder analysis is to systematically identify the organizations with which their future is most closely intertwined and determine the dependencies that are most critical.[37]

Some of these stakeholders are almost always powerful or influential; others are influential regarding only certain issues; still others have little influence or power. If the stakeholders can be identified and evaluated, then the "forces" affecting the organization may be specified. The needs and wants of these constituencies may dramatically affect the strategy of an organization.[38]

Typically, managers tend to focus attention on known, salient, or powerful stakeholders to help protect existing competitive advantages. However, there is growing evidence that "fringe" stakeholders are important as well – particularly for developing new ways of thinking. Stuart Hart and Sanjay Sharma suggest that "the knowledge needed to generate competitive imagination and to manage disruptive change increasingly lies outside the organization, at the periphery" of the organization's established stakeholder network.[39] Therefore, strategic

EXHIBIT 2–6 **A Stakeholder Map for a Large Multispecialty Group Practice**



thinkers must be open to fringe ideas and non-traditional thinking developed by fringe players. At first, these stakeholders may appear to be poor, weak, isolated, non-legitimate, or radical.[40] In reality, they may be strong purveyors of change.

Scenario Writing and Future Studies

Many businesses regularly use scenarios. The popularity of scenario analysis is due in large part to the inability of other, more quantitative forecasting methods to predict and incorporate major shifts in the environment and provide a context for strategic thinking. Scenarios avoid the need for single-point forecasts by allowing users to explore several alternative futures.[41] Scenario analysis is an alternative to conventional forecasting that is better suited to an environment with numerous uncertainties or imponderables – where there is no map.

A *scenario* is a coherent story about the future, using the world of today as a starting point. Based on data accumulated in the scanning and monitoring processes, a scenario or narrative that describes an assumed future is developed. The objective of scenarios and future studies is to describe a point of time in the future as a sequence of time-frames or periods of time. Scenario writing often requires generous assumptions. Few guidelines indicate what to include in the scenario. In most cases several plausible scenarios should be written. It is an all-too-common mistake to envision only one scenario as the "true picture of the future."[42] Most authorities advocate the development of multiple scenarios. However, to avoid decision makers focusing only on the "most likely" or "most probable" scenario, each scenario should be given a distinctive theme name, such that they appear equally likely.

Multiple scenarios allow the future to be represented by different cause–effect relationships, different key events and their consequences, different variables, and different assumptions. The key question is: "If this environmental event happens (or does not happen), what will be the effect on the organization?" The use of multiple scenarios was particularly helpful as organizations considered the probable impact of health care reform legislation (PPACA) on their organizations. Perspective 2–5 presents a brief summary of four scenarios or alternative futures for primary health care between now and 2025. The scenarios were developed by the Institute for the Future to provide a description of critical factors that will influence health and health care in the 21st century.

PERSPECTIVE 2–5

Primary Care 2025: A Scenario Exploration

With significant uncertainty facing health care in 2012, the Institute for Alternative Futures (IAF) used its "aspirational futures" technique to develop four primary care scenarios. The technique develops scenarios in three zones: a zone of conventional expectation (the expected future by extrapolating known trends), a zone of growing desperation (a challenging future based on plausible issues to be faced), and a zone of high aspiration (visionary strategies pursued by a critical mass of stakeholders that achieve surprising success). An advisory committee of seven experienced health care leaders from provider organizations, health professionals, policy makers, and academics was recruited to inform the development of the scenarios. Next a workshop was held with 26 knowledgeable participants. Then 56 leading experts in the health care field were interviewed, followed by ten focus groups held around the country. The collaboration of all these innovative thinkers led to the development of the following scenarios for Primary Care 2025.

SCENARIO 1: MANY NEEDS, MANY MODELS

Primary care improves as the payment system changes to the patient-centered medical home (PCMH) model and the use of electronic medical

records (EMRs) improves the quality of care. Reductions in payment rates for health care providers force providers to reduce costs, accomplished in part by focusing on prevention, shifting/sharing tasks with non-physician providers, and increasing patient contact by phone or online. Based on the Patient Protection and Affordable Care Act (ACA) of 2010, many employers quit providing health insurance benefits and employees move to health insurance exchanges mandated by ACA, although the access and affordability vary widely from state to state. A significant portion of Americans purchase the mandated individual coverage consisting of high-deductible, catastrophic care plans requiring them to pay for primary care out-of-pocket. The primary care physician shortage increases the use of teams including nurse practitioners, social workers, community health workers, and pharmacists who increasingly use phones and email to interact with patients; patients use support technologies similar to IBM's "Dr. Watson" as digital health agents to guide their own healthy behaviors in a social, fun way. Payment is through integrated systems including HMOs and ACOs (40 percent), semi-integrated systems such as community health centers and others using the PCMH model (30 percent), and fee-for-service – from "concierge services" at one end to minute clinics at the other (30 percent). Primary care improves in the aggregate; however, disparities continue among some poor, minority, and rural populations. Health care accounts for 19 percent of GDP in 2025.

SCENARIO 2: LOST DECADE, LOST HEALTH

Recurring economic challenges prompt significant cuts in federal health care spending. The global debt crisis pushes the world into an enduring recession; health care is especially hard hit. When payments on the national debt increased to the point of being the same as Medicare costs, international creditors raised interest rates and the federal government instituted a 10 percent across the board spending cut. Health insurance exchanges were successful in only a few states; they were either underfunded or unable to provide affordable, high quality care. Moreover, businesses opted out of providing insurance for employees. Because of the unaffordability of care for many, Congress enacted a series of postponements that eventually acted as a de facto repeal of the ACA.

Estimates of medical shortages did not take into consideration the number of baby boomer physicians who would retire early because of deep cuts in reimbursements for Medicare and Medicaid. The aging boomer cohort stressed the system, resulting in many health care providers operating beyond the scope of their licenses, leading to a black market for care.

In 2025 most primary care is provided in one of three settings. (1) Premium fee-for-service (15 percent): "concierge" services offering more sophisticated services. (2) Low-cost fee-for-service (35 percent): high-deductible catastrophic care health plans requiring individuals and families to pay out-of-pocket for most primary care – retail clinics in pharmacies and big box stores grow to fill the gap. (3) Integrated (30 percent) and semi-integrated systems (20 percent): care takes place in integrated systems using single payments to cover all care (Kaiser Permanente-type) with higher costs but better quality care or in semi-integrated settings that have a mix of fee-for-service and pay-for-performance as offered in many group practices and community health centers.

SCENARIO 3: PRIMARY CARE THAT WORKS FOR ALL

US policy makers actively pursue the "triple aim" in health care initiatives: enhancing patient care, reducing per capita health care costs, and improving health of the population. Provider teams receive a single capitated payment based on population data that considers relative health care risks of the patient, causing the provider to optimize health outcomes while reducing costs. With the development of health insurance exchanges, employers no longer provide health insurance as an employee benefit but do offer support systems and rewards for healthy behaviors that reduce medical care demands. Community care health homes (CCHHs) provide primary care for 85 percent of the population; fee-for-service/concierge service for 10 percent; and 5 percent of the population remains uninsured and seeks care at emergency rooms and community health centers.

CCHHs deliver primary care and work at creating the social and economic foundations for a healthier community by improving the primary care delivered and the use of electronic medical records that collect health and lifestyle data to provide a patient's health status and prospects. The team interacts via phone, email, and virtual reality as well as health advocate avatars (digital health coaches). Providers delivering better outcomes at lower costs keep the savings, an approach that proves to reorient primary care toward value and moving upstream to affect the social determinants of health.

SCENARIO 4: I AM MY OWN MEDICAL HOME

Advanced medical technologies allow individuals using self-care to take over many functions of primary care. New smartphone "apps" monitor diet, physical activity, sleep, and collect the data in personal health records. New monitoring devices record blood pressure, blood chemistry, blood flow, and alert the individual to changes in health; new technology provides lab tests at home or sends data to a lab. Consumers have much information available to them, including advice tailored to their health care needs.

A significant segment of the population (40 percent) relies on consumer-directed health plans and uses advanced self-care tools. Data is collected, aggregated, and used for tracking population health and producing rapid comparative effectiveness and safety studies. A second significant segment (40 percent) wants more traditional providers and personal relationships as in integrated health care systems or ACOs. They can afford more costly insurance premiums; however, their buying decisions are based on transparency of available cost and quality data on nearly every provider. Concierge practices (10 percent) provide high-value services such as physiome models and simulations for predicting health. These physicians have to be charismatic, high energy, and well recognized as excellent to maintain the patients in the "panel" that they serve. The remaining 10 percent of the population are near poor individuals removed from Medicaid or individuals who choose to avoid insurance and have the income to pay for care (which they choose wisely). Because of the self-care tools as well as the health care avatars and coaches, much less in-person interaction with providers occurs and the demand for primary care physicians diminishes.

Source: *Primary Care 2025: A Scenario Exploration* (Alexandria, VA: Institute for Alternative Futures, January, 2012, 43 pages).

Selecting the Strategic Thinking Framework

The purpose of analyzing the general and health care environments is to identify and understand the significant shifts taking place in the external environment. Exhibit 2–7 summarizes the primary focus, advantages, and disadvantages of each strategic thinking framework.

The approach selected for evaluating the general and health care environments will depend on such factors as the size of the organization, the diversity of the products and services, and the complexity and size of the markets (service areas). Organizations that are relatively small, do not have a great deal of diversity, and have well-defined service areas may opt for a simple strategic thinking framework that may be carried out in-house, such as trend identification and extrapolation, in-house nominal group technique or brainstorming, or stakeholder analysis. Such organizations may include independent hospitals, HMOs, rural and community hospitals, large group practices, long-term care facilities, hospices, and county public health departments.

EXHIBIT 2–7 **Primary Focus, Advantages, and Disadvantages of Environmental Techniques**

Technique	Primary Focus	Advantage	Disadvantage
Simple Trend Identification and Extrapolation	Scanning Monitoring Forecasting Assessing	• Simple • Logical • Easy to communicate	• Need a good deal of data in order to extend trend • Limited to existing trends • May not foster creative thinking
Delphi Method	Scanning Monitoring Forecasting Assessing	• Use of field experts • Avoids intimidation problems • Eliminates management's biases	• Members are physically dispersed • No direct interaction of participants • May take a long time to complete
Nominal Group Technique	Scanning Monitoring Forecasting Assessing	• Everyone has equal status and power • Wide participation • Ensures representation • Eliminates management's biases	• Structure may limit creativity • Time consuming
Brainstorming	Forecasting Assessing	• Fosters creativity • Develops many ideas, alternatives • Encourages communication	• No process for making decisions • Sometimes gets off track
Focus Groups	Forecasting Assessing	• Uses experts • Management/expert interaction • New viewpoints	• Finding experts • No specific structure for reaching conclusions

EXHIBIT 2–7 *(Continued)*

Technique	Primary Focus	Advantage	Disadvantage
Dialectic Inquiry	Forecasting Assessing	• Surfaces many subissues and factors • Conclusions are reached on issues • Based on analysis	• Does not provide a set of procedures for deciding what is important • Considers only a single issue at a time • Time consuming
Stakeholder Analysis	Scanning Monitoring	• Considers major independent groups and individuals • Ensures major needs and wants of outside organizations are taken into account	• Emerging issues generated by other organizations may not be considered • Does not consider the broader issues of the general environment
Scenario Writing	Forecasting Assessing	• Portrays alternative futures • Considers interrelated external variables • Gives a complete picture of the future	• Requires generous assumptions • Always a question as to what to include • Difficult to write

Health care organizations that are large, have diverse products and services, and have ill-defined or extensive service areas may want to use a strategic thinking framework that draws on the knowledge of a wide range of experts. As a result, these organizations are more likely to set up Delphi panels and outside nominal groups or brainstorming sessions. In addition, these organizations may have the resources to conduct dialectics concerning environmental issues and engage in scenario writing. Such approaches are usually more time consuming, fairly expensive, and require extensive coordination. Organizations using these approaches may include national and regional for-profit health care chains, regional health care systems, large federations and alliances, and state public health departments. Ultimately, the strategic thinking framework selected for environmental analysis may depend primarily on the style and preferences of management. If used properly, any of the frameworks can be a powerful tool for identifying, monitoring, forecasting, and assessing issues in the general and health care environments.

Managing Strategic Momentum – Validating the Strategic Assumptions

The strategic plan is based in part on an analysis of the external environment. Initially this analysis provides the basic beliefs or assumptions that

management holds concerning various issues in the external environment. Once strategic management is adopted as the operating philosophy of managing, strategic thinking, strategic planning, and managing the strategic momentum require frequent validation of the strategic assumptions to determine whether issues in the external environment have changed and to what extent. Continued strategic thinking is vital to maintaining strategic momentum.

The strategic thinking map presented in Exhibit 2–8 provides a series of questions designed to detect signals of new perspectives regarding these assumptions. The questions examine management's understanding of the external environment and the effectiveness of the strategy. The board of directors, strategic managers, or others may use these questions as a beginning point to confirm the assumptions underlying the strategy. Such strategic thinking questions may indicate the emergence of new external opportunities or threats that will affect the organization and may suggest areas where additional information will be required in future planning efforts. Current, accurate information may mean survival for many health care organizations. Questions concerning the external environment may reveal that a group practice knows far too little about the views of its major constituents (stakeholders) or the existence of new technologies or social trends. A validation (or invalidation) of the strategic assumptions reinvigorates strategic thinking and provides a basis for investigating whether to change the strategy.

EXHIBIT 2–8 **Strategic Thinking Questions for Validation of the Strategic Assumptions**

1. Has the organization's performance been adversely affected by unexpected or new trends or issues in the general environment?
2. Has the organization's performance been adversely affected by unexpected or new trends or issues in the health care environment?
3. Have new opportunities emerged as a result of new trends, issues, or events in the external environment?
4. Is the strategy acceptable to the major stakeholders?
5. Are there new technological developments that will affect the organization?
6. Have there been social or demographic changes that affect the market or strategy? Changes in ethnic mix? Language barriers? Family structure?
7. Has the legislative/political environment changed?
8. Are there new local, state, or federal regulations or laws being introduced, debated, or passed that will affect operations or performance?
9. Are there new economic issues?
10. Have new competitors outside the industry considered entering or actually entered into health-related areas?
11. Is the strategy subject to government response?
12. Is the strategy in conformance with the society's moral and ethical codes of conduct?

Lessons for Health Care Managers

Health care managers must be able to understand and analyze the general and health care industry environments. To be successful, organizations must be effectively positioned within their environment. Organizations involved in making capital allocations, experiencing unexpected environmental changes or surprises from different kinds of external forces, facing increasing competition, becoming more marketing oriented, or experiencing dissatisfaction with their present planning results should engage in environmental analysis.

The goal of environmental analysis is to classify and organize the general and health care industry issues and changes generated outside the organization. In the process, the organization attempts to detect and analyze current, emerging, and likely future issues. The gathered information is used for internal analysis; development of the vision and mission; and formulation of the strategy for the organization. In addition, the process should foster strategic thinking throughout the organization.

Although the benefits of environmental analysis are clear, there are several limitations. Environmental analysis cannot foretell the future; nor can managers hope to detect every change. Moreover, the information needed may be impossible to obtain or difficult to interpret, or the organization may not be able to respond quickly enough. The most significant limitation may be managers' preconceived beliefs about the environment.

The external environment includes organizations and individuals in the general environment (government institutions and agencies, business firms, educational institutions, research organizations and foundations, and individuals and consumers), and organizations and individuals in the health care environment (organizations that regulate, primary providers, secondary providers, organizations that represent providers, and individuals and patients).

Organizations and individuals in both the general and health care environments generate changes that may be important to health care organizations. Typically, such change is classified as legislative/political, economic, social/demographic, technological, or competitive. Such a classification system aids in aggregating information concerning the issues and in determining their impact. Sources for environmental issues are found both inside and outside the organization and are direct as well as indirect.

The steps in environmental analysis include scanning to identify signals of environmental change, monitoring identified issues, forecasting the future direction of issues, and assessing organizational implications. Scanning is the process of viewing and organizing external information in an attempt to detect relevant issues that will affect the organization. Monitoring is the process of searching for additional information to confirm or disprove the issue (trend, development, dilemma, or likelihood of the occurrence of an event). Forecasting is the process of extending issues, identifying their interrelationships, and developing alternative projections. Finally, assessing is the process of evaluating the significance of the issues. The information garnered from external environmental analysis influences internal analysis, the development of the vision and mission, and formulation of the strategy for the organization.

There are several strategic thinking frameworks to conduct the scanning, monitoring, forecasting, and assessing processes. These methods include simple issue identification and extension, solicitation of expert opinion, dialectic inquiry, stakeholder analysis, and scenario writing. Finally, as part of managing the strategic momentum, evaluation of the strategic assumptions (external issues) should periodically take place. The next chapter focuses on service area competitive analysis.

Health Care Manager's Bookshelf

Peter Schwartz, *The Art of the Long View: Planning for the Future in An Uncertain World* (New York: Currency Doubleday, 1991)

Peter Schwartz was working as a futurist at the Stanford Research Institute in 1975 when he met Pierre Wack of Royal/Dutch Shell. Later, in 1982, he replaced Wack as head of Shell Group Planning. This position provided a unique opportunity to perfect the scenario-building skills he had practiced for years. In his book, *The Art of the Long View: Planning for the Future in An Uncertain World*, Schwartz presents the fundamental nature of scenarios, how to build them, and how to use them.[1]

One way to avoid becoming a victim of surprise is to create different stories of equally likely futures. These stories are called *scenarios,* an important objective of which is to aid strategists in "creating a fit" between their organization and its environment.[2] Scenarios are not about predicting the future but are about perceiving futures in the present (p. 36). They are "vehicles for helping people learn."[3] In a sense, scenario planning is about "freeing the mind" of the health care strategist to admit that tomorrow may not be like today.[4]

Schwartz extended his work in *The Art of the Long View* and introduced the concept of *inevitable surprises*. Even though we do not like surprises, they are inevitable because they have already started taking place through *predetermined events* – forces we can anticipate with certainty.[5] If we can identify these events, why will there be surprises? The answer is simple – while the events are predetermined, the timing, results, and consequences are not (p. 6).

The Art of the Long View provides planners with a uniform process for developing scenarios. Schwartz suggests an eight-step process: step 1 – identify a focal decision; step 2 – list key factors influencing the success or failure of the decision; step 3 – list the driving forces in the environment that influence the key factors; step 4 – rank the key factors and driving forces in terms of their importance and the uncertainty associated with each; step 5 – select the scenario logic, involving determining the dimensions along which the eventual scenarios will differ; step 6 – flesh out the scenarios; step 7 – return to the focal decision and rehearse implications for the

future; and step 8 – select leading indicators and signposts and determine the indicators necessary to monitor each scenario in an ongoing manner.

One writer stated that *The Art of the Long View* is "destined" to become a milestone in long-range planning and strategic thinking. Understanding the lessons in this book should provide decision makers with the "ability to act confidently" because of the knowledge they have of where the uncertainties of the future in health care will lie.[6] Surprises will never be eliminated. However, futurists such as Schwartz have provided strategic thinkers with the tools to at least minimize the ill effects of those surprises that are predictable, even if they are inevitable.

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KEY TERMS AND CONCEPTS IN STRATEGIC MANAGEMENT

Assessing
Brainstorming
Delphi Method
Dialectic Inquiry
Expert Opinion
External Environmental Analysis
Focus Groups
Forecasting
General Environment
Health Care Environment
Issue Identification and Extrapolation
Monitoring
Nominal Group Technique (NGT)
Primary Provider
Scanning
Scenarios
Secondary Provider
Sensemaking
Stakeholder Analysis
Strategic Issues

Questions for Class Discussion

1. What types of changes are likely to occur in the health care environment in the next several years?
2. Why is environmental analysis important for an organization?
3. Describe the "setting" for health care management. Is the setting too complex or changing too rapidly to accurately predict future conditions?

4. Most health care managers would answer "yes" to many of A. H. Mesch's questions to determine whether an organization needs environmental analysis. Are there other questions that seem to indicate that health care organizations should be performing environmental analysis?
5. What are the specific goals of environmental analysis?
6. What are the limitations of environmental analysis? Given these limitations, is environmental analysis worth the effort required? Why?
7. What four processes are involved in environmental analysis? What are their subprocesses?
8. How does the scanning process create a "window" to the external environment? How does the window concept help in understanding organizations and the types of information they produce?
9. Why is the process of environmental analysis as important as the product?
10. Which of the environmental analysis strategic thinking frameworks are most useful? Why?
11. Using Exhibit 2–6 as an example, develop a "stakeholder map" for a health care organization in your metropolitan area or state. On this map show the important health care organizations and indicate what impact they may have on the industry.
12. Which of the scenarios in Perspective 2–5 do you think is most likely? Why? Based on today's issues, develop your own scenario of health care in 2025.
13. What are an organization's strategic assumptions? How may the strategic assumptions be evaluated as part of managing strategic momentum?

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3 Service Area Competitor Analysis

"Natural competition is evolutionary.
Strategic competition is revolutionary.
Natural competition is wildly expedient in its moment-to-moment interaction, but is inherently extremely conservative in its change.
Strategic competition is deliberate, carefully considered, and tightly reasoned in its commitments but the consequences may be radical change in a relatively short time."

—BRUCE D. HENDERSON

Introductory Incident

Medical Tourism Complicates Service Area Analysis

Nearly a half-million people were medical tourists in 2012, according to Patients without Borders, a consumer advisory service that expects the number to grow about 25 to 35 percent next year.[1] Medical tourism is "the practice of travelling to another country with the purpose of obtaining

health care (elective surgery, dental treatment, reproductive treatment, organ transplantation, medical check-ups, and so on). Medical tourism is estimated to be 2 percent of world tourism and about 4 percent of hospital admissions in the world.[2] The term "medical tourism" is evolving based on increasing specialization and heterogeneity in services, thereby leading to the use of more specific terms such as reproductive tourism, organ transplant tourism, abortion tourism, and so on. It excludes health or wellness tourism which generally refers to all the non-invasive (external) treatments including visits to spas, homeopathy treatments, or traditional therapies that improve the health or the mind of the patient.[3]

Health care consumers today are concerned with the cost of medical treatment because of high copays, percentage of cost to be paid by an employee, and in some cases, loss of insurance through unemployment. Bumrungrad International Hospital (Bangkok), one of the largest facilities, attracts more than 400,000 international patients per year, primarily because many of its 900 doctors completed US fellowships or residencies, around 200 are US board-certified, and nearly all speak English. At Bumrungrad a laminectomy (spinal surgery to relieve the pressure on a nerve) costs $4,700 (including a 5-day stay in a private room) versus a US quote of $70,000 and higher. A coronary valve replacement and bypass surgery in Taiwan is $18,000 compared with the US cost of $85,000. India is a top destination for orthopedic and heart surgeries (16 hospitals have already received International Joint Commission accreditation and the Indian government has introduced the "M" visa for those engaged in medical tourism). In Singapore English is widely spoken, many medical professionals are US- or UK-trained, and a number of hospitals are accredited by US agencies. Singapore is known for cancer diagnosis and treatment. Israel is emerging as a popular destination for in vitro fertilization and Latin America (already the cosmetic surgery destination of choice) is becoming known for its dentistry.[4]

The primary factors driving the cost differential in many medical tourism destinations are lower labor costs, no malpractice insurance costs, and lower pharmaceutical costs. Of course, each of these factors suggests additional risks such as quality of care, counterfeit medications, and security and purity of blood supplies. The main risk is quality of care (being alleviated increasingly by the number of global hospitals, centers, and clinics being accredited by the Joint Commission International, JCI). Although hospitals may be accredited by the JCI, other critical activities such as clinical analysis laboratories, radiology centers/departments, medical imaging and interpretation, plus the differences in malpractice laws and lack of follow-up care (including handling complications at home) may cause problems.

In the past, wealthy individuals from developing nations have tended to seek care in North American or Western European nations, but that is changing to preferences for other developing countries that have increasingly sophisticated medical technology and training but lower comparable costs. How rapidly medical tourism grows for US citizens will depend on whether insurers, employers, and the US government encourage treatment abroad. Blue Cross & Blue Shield of South Carolina was one of the first insurers to launch an initiative to allow overseas medical coverage for enrollees.[5] It has alliances with Bumrungrad International Hospital Parkway Group Healthcare (owner of three hospitals in Singapore), as well as other hospitals in Turkey, Ireland, and Costa Rica. The International Medical Travel Association (www.intlmta.org) president identified

three areas of concern that limit greater adoption of medical tourism: quality (do these hospitals offer the same quality I would receive in the USA?), liability (what happens if something goes wrong?), and continuity of care (who will be responsible for care once I return home?).[6]

What are the implications for service area competitor analysis in the case of medical tourism? The most obvious strategic impact of medical tourism is the complications it presents in determining service area boundaries. Clearly the boundaries for categories such as gall bladder surgery, orthopedic surgery – such as full hip replacement surgery, and numerous other procedures extends well beyond the boundaries of the United States to Thailand, India, Mexico, Hungary, and Singapore.

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Learning Objectives

After completing the chapter you will be able to:

1. Understand the importance of service area competitor analysis as well as its purpose.
2. Understand the relationship between general and health care environmental issue identification and analysis and service area competitor analysis.
3. Define and analyze the service area for a health care organization or specific health service.
4. Conduct a service area structure analysis for a health care organization.
5. Understand strategic groups and be able to map competitors' strategies along important service and market dimensions.
6. Understand the elements of service area competitor analysis and assess likely competitor strategies.
7. Aggregate general environmental and health care industry issues with service area and competitor issues and synthesize specific strategy implications.
8. Suggest several questions to initiate strategic thinking concerning the service area and competitors as a part of managing the strategic momentum.

Further Focus within External Environmental Analysis

Environmental analysis involves strategic thinking and strategic planning, focusing on increasingly more specific issues. Chapter 2 provided the fundamental approach and strategic thinking frameworks for scanning, monitoring, forecasting, and assessing trends and issues in the general and health care environments. However, once these trends and issues have been identified and assessed, a more focused analysis is required. As shown in Exhibit 2–1, service area competitor analysis is the third part of a comprehensive environmental analysis. *Service area competitor analysis* attempts to further define and understand an organization's environment through identifying specific service area and service category issues, identifying competitors, determining the strengths and weaknesses of these rivals, and anticipating their strategic moves. It involves collecting data concerning the service area and competitors as a part of strategic thinking and strategic planning.

Strategic Significance of Service Area Competitor Analysis

Within the health care community there is an understanding that health care organizations must be positioned effectively *vis-à-vis* their competitors. Competitor information is essential for selecting viable strategies that position the organization strongly within the market. Many health care managers agree that an organized competitor intelligence system is necessary for survival. The system acts like a radar grid constantly monitoring consumer and competitor activity, filtering the raw information picked up by external and internal sources, processing it for strategic significance, and efficiently communicating actionable intelligence to those who need it.[1]

The Focus of Service Area Competitor Analysis

An organization engages in *service area competitor analysis* to determine the service area (geographically), gain an understanding of the competitors in that service area, identify any vulnerabilities of the competitors, assess the impact of its own strategic actions against specific competitors, and identify potential moves that a competitor might make that would endanger the organization's position in the market. Analyzing competitors assists organizations in identifying the context for creating *competitive advantage* – a basis on which they are willing to compete with anyone. Competitive advantage is the means by which the organization seeks to develop cost advantage or to differentiate itself from other organizations. Organizations constantly take offensive and defensive actions in their quests for competitive advantage *vis-à-vis* competitors.[2] Competitive advantage might be centered on image, high-quality services, an excellent and widely recognized staff, or efficiency and low cost, among others. Competitor information is important for an organization to:

- avoid surprises in the marketplace;
- provide a forum for leaders to discuss and evaluate their assumptions about the organization's capabilities, market position, and competition;

- make everyone aware of significant and formidable competitors to whom the organization must respond;
- help the organization to learn from rivals through benchmarking (specific measures comparing the organization with its competitors on a set of key variables);
- build consensus among executives concerning the organization's goals and capabilities, thus increasing their commitment to the chosen strategy;
- foster strategic thinking throughout the organization;
- identify market niches and discontinuities;
- select a viable strategy;
- contribute to the successful implementation of the strategy;
- anticipate competitors' moves; and
- shorten the time required to respond (countermoves) to a competitor's moves.

Depending on the intent of the competitor analysis, an organization might engage in service area competitor analysis for all of these reasons or just one or two. For example, in the early stages of competitor analysis, the organization may seek only to provide a forum for discussion or to make everyone aware of a formidable competitor. As an organization plans to enter new markets, offensive information may be the primary focus of the competitor analysis and an identification of market niches might be the goal. In the face of strategic moves by a powerful competitor, anticipating the competitor's moves and shortening the time required to respond may take precedence. In large, complex markets, all of these information categories are appropriate and essential for positioning the organization.

Obstacles to Effective Service Area Competitor Analysis

Monitoring the actions and understanding the intentions of competitors is often difficult. Health care executives agree that it is necessary and growing in importance, yet many are still not engaged in effective competitor analysis. Six common obstacles have been identified that slow an organization's response to its competitors' moves or even cause the selection of the wrong competitive approach. Flawed competitor analysis, resulting from these blind spots, weakens an organization's capacity to seize opportunities or interact effectively with its rivals, ultimately leading to erosion in the organization's market position and profitability.[3] Obstacles to effective competitor analysis include:

- misjudging industry and service area boundaries,
- poor identification of the competitors,
- overemphasis on competitors' visible competencies,
- overemphasis on where, rather than how, to compete,
- faulty assumptions about the competition, and
- paralysis by analysis.[4]

A major contribution of competitor analysis is the development of a clear definition of the industry, industry segment, or *service area*. Traditionally, health care managers have focused their analysis on locally served markets. Patients were treated by the local doctor, in a local hospital (or the closest one available). There was little travel for medical or health care. Thus, doctors and hospitals were insulated from other health care organizations outside their geographic service area; however, that is no longer the case. Market entry by competitors from outside the metropolitan area, the region, the state, and as illustrated in the Introductory Incident, from around the world, is now quite common. To avoid a focus that is too narrow, the industry, industry segment, and service area must be defined in the broadest terms that are useful. In addition, in today's health care environment, competition may come from non-traditional competitors (outside the health care industry). As competition increases from non-traditional competitors, social activities, décor, meals, and housekeeping may become more important competitive factors.

In the past, only cursory attention has been given to other segments of the health care industry. For example, hospitals traditionally focused on acute care. Management was not concerned with intermediate care or home care or hospice care as a competing segment. Today, all of those segments are commonly incorporated into the continuum of care. With length-of-stay issues, and the increasing emphasis on unnecessary readmissions, hospitals want to control the patients (integrated delivery systems) and assure the care is appropriate (continuum of care) to increase revenues and provide seamless care. As a result there are fewer but more direct competitors in many market areas. Clearly, misjudging how the industry, industry segments, or service area is defined will lead to poor competitor analysis.

Another possible flaw of competitor analysis is the improper or poor identification of precisely which organizations are the competitors. In many cases, health care executives focus on a single established major competitor and ignore emerging or lesser-known potential competitors. Such myopia is especially true when the perceived strengths of competitor organizations do not fit traditional measures or there is an inflexible commitment to historical critical success factors (traditional inpatient services instead of outpatient approaches). Academic medical centers (AMCs), with their focus on research, have traditionally viewed only other academic medical centers as competitors; however, with lowered reimbursements and increased numbers of charity care from the loss of jobs during the "great recession" beginning in 2008, AMCs are struggling to increase revenues and have had to realize changes in their business model. For example, the Louisiana State University (LSU) hospitals and its medical clinics are the state's predominant provider of health care for the poor and uninsured. Because of reduced financial allocations, LSU is seeking public–private partnerships to deliver care. The discussions with community hospitals in several areas are coming down to dollars and cents and how to preserve uninsured care. The talks are just the beginning of LSU's exploration of potential cooperative endeavor agreements, leases, or the possible sale of some facilities in the system of ten public hospitals.[5]

Another problem in performing competitor analysis is the tendency to be concerned only with the visible activities of competitors. Less visible attributes

and capabilities such as organizational structure, culture, human resources, service features, intellectual capital, management acumen, and strategy may cause misinterpretation of a competitor's strengths or strategic intent. Certainly the Mayo Clinic's strong culture of excellence has played an important role in shaping its strategic decisions. Operating from only one location for 135 years, Mayo expanded carefully first to Scottsdale/Phoenix, Arizona (1998) and then to Jacksonville, Florida (2008) to make sure the Mayo culture could be maintained in dispersed locations. Similarly, in an environment of rapid change, intellectual capital represents a primary value-creation asset for the organization.[6] In addition, effective competitor analysis requires predicting how competitors plan to position themselves. Although difficult, determining competitors' strategic intent is at the heart of competitor analysis. An effective competitor analysis should focus on what rivals can do with their resources, capabilities, and competencies – an extension of what competitors are currently doing – and include possible radical departures from existing strategies.[7]

Accurate and timely information concerning competitors is extremely important in competitor analysis. Misjudging or underestimating competitors' resources, capabilities, or competencies is a serious misstep. Faulty assumptions can suggest inappropriate strategies for an organization. Poor environmental scanning perpetuates faulty assumptions.

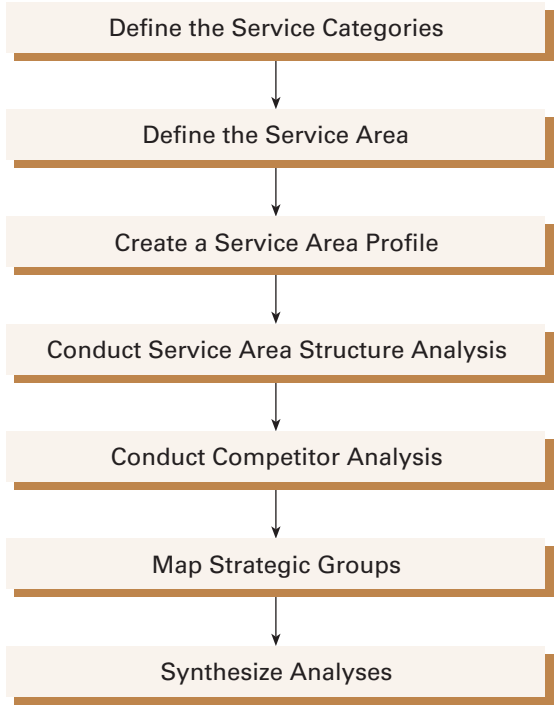
Because of the sheer volume of data that can be collected concerning the external environment and competition, paralysis by analysis can occur. In environments undergoing profound change, huge quantities of data are generated and access to it becomes easier. Under such conditions, information overload is possible and separating the essential from the non-essential is often difficult. As a result, it should be emphasized that the intent of competitor analysis is to support strategic decision making; over-analysis or "endless" analysis should be avoided. Competitor information must be focused and contribute to strategy formulation.

A Process for Service Area Competitor Analysis

Service area competitor analysis is a process of understanding the market and identifying and evaluating competitors. Together with general and health care trends and issues, service area competitor analysis must be synthesized into the strategic issues facing the organization. The synthesis is an explicit input into the formulation of the organization's strategy.

As illustrated in the strategic thinking map in Exhibit 3–1, service area competitor analysis begins with an understanding of specific services or service categories the organization provides to its customers. Next, the service area must be specified for the various service categories. Then the service area structure or competitive dynamics should be assessed. Competitors providing services in the same category in the service area must be analyzed for positioning against the important dimensions of the market and assessed as to their likely strategic moves. Finally, the results of the analysis must be synthesized and implications drawn. These conclusions will provide important information for strategy formulation.

EXHIBIT 3–1 Service Area Competitor Analysis



With the use of an actual service category (plastic surgery) and services area (Charlotte, North Carolina), each step of the service area competitor analysis process will be illustrated. Plastic surgery represents a highly competitive and low market share industry, especially for cosmetic procedures that are rarely covered by health insurance. Reconstructive plastic surgery (required because of accidents and disfigurements, birth defects, ravages of disease, and so on) is often covered by insurance; however, reimbursement rates have been declining. Typically there are a number of board-certified plastic surgeons in any given service area. These physicians compete not only among themselves but also against emergent niche providers – physicians in ophthalmology (eye), dermatology (skin), EENT (eye, ear, nose, and throat), dental (teeth and jaw), and OB/GYN (women's reproductive system), as well as laser centers and medi-spas. The competition seeks to capture the lucrative and expanding, less invasive sectors of the cosmetic plastic surgery market such as Botox®, injectables, laser peels, cool sculpting, and so on.

If a plastic surgeon were to consider establishing a practice in Charlotte, North Carolina, the completion of a service area competitor analysis would be essential to evaluate whether the area represents a potentially profitable location. Cosmetic plastic surgery requires a reputation for excellent work that takes some time to establish; selecting the wrong service area could force relocation, causing the surgeon to have to begin anew in establishing a reputation. Similarly, already established competitors in an existing service area should re-evaluate the competition as a part of developing an effective strategy. Perspective 3–1 provides an overview of the nature of plastic surgery and serves as background for a service area competitor analysis.

PERSPECTIVE 3–1

Plastic Surgery

Plastic surgery is a medical specialty that entails two major subspecialties: cosmetic plastic surgery and reconstructive plastic surgery. A simple definition of cosmetic plastic surgery is that it entails procedures to *improve on* a person's natural appearance. Reconstructive plastic surgery is *to return* someone to a natural appearance when an accident, disease, or congenital defect has occurred. Although cosmetic procedures are not covered by insurance; most reconstructive procedures are covered by insurance. In many states, legislation exists to require insurance companies to provide coverage for reconstructive plastic surgery for congenital (birth) defects and breast reconstruction after mastectomies for women who are dealing with cancer.

To become a plastic surgeon, one must be awarded an MD (Medical Doctor) degree from an accredited medical school or college, of which there are 126 in the United States. Slightly more than 17,300 students graduated with an MD degree in June 2012. At graduation, 0.9 percent planned to become board-certified in plastic surgery (156 students); however, 450 applied for plastic surgery residencies. The 2011 National Residency Match Program reported that there were 70 positions for first-year postgraduates and all 70 were filled and there were 35 positions for second-year postgraduates and all of them were filled as well.

Most plastic surgeons have residency and fellowships before board certification. Members of the American Society of Plastic Surgeons (ASPS) are certified by the American Board of Plastic Surgery or the Royal College of Physicians and Surgeons of Canada. An ASPS Member Surgeon has at least six years of training and experience in surgery, with three years specifically in plastic surgery; is certified by the American Board of Plastic Surgery; operates only in accredited medical facilities; adheres to a strict code of ethics; fulfills continuing education requirements, including patient safety techniques; and works as a partner, to achieve the patient's goals.

The American Society for Aesthetic Plastic Surgery (ASAPS) is the leading referral source of board-certified plastic surgeons specializing in cosmetic procedures of the face and body. Active Membership in the American Society for Aesthetic Plastic Surgery is reserved for American Board of Plastic Surgery certified physicians (or in Canada, physicians certified in plastic surgery by the Royal College of Physicians and Surgeons of Canada), with wide experience in cosmetic surgery and demonstrated commitment to aesthetic surgery continuing education.

Plastic surgeons often establish solo practices. Nationally, 47 percent of plastic surgeons are in solo practices with another 6 percent in solo practices that share facilities. Small group practices (2–5 physicians) represent 14 percent of plastic surgery practices; medium multispecialty group practices (6–20 physicians) represent 1 percent; and large multispecialty group practices (more than 20 physicians) represent 4 percent. Other practices are military and academic (with and without private practice). In Charlotte, solo practitioners (16 in number) represent 67 percent of those who are board certified and all of the other board-certified plastic surgeons are in small group practices having no more than five physicians (8 practices or 33 percent). The current environment may make individual practices more challenging because the cost to purchase health care IT plus the amount of time to learn how to use it will be significant.

Nearly three-quarters (74 percent) of plastic surgeons who participated in a recent survey reported that they did not offer "spa" services (e.g., wraps, facials, massages) in conjunction with their medical practices. Further, 86 percent of the doctors said they did not work in conjunction with medical spas where non-surgical procedures, such as injections and laser procedures, were performed. Many plastic surgeons consider medical spas to be less professional and potentially dangerous if someone other than the surgeon is performing procedures where harm can come to the patient.

The top five reconstructive procedures are tumor removal, laceration repair, maxillofacial surgery, scar revision, and hand surgery. The top five cosmetic plastic surgical procedures are breast augmentation, lipoplasty (liposuction), blepharoplasty (cosmetic eyelid surgery), abdominoplasty (tummy tuck), and breast reduction. The top five cosmetic minimally invasive procedures are Botulinum Toxin Type A (Botox®), soft tissue fillers, chemical peels, laser hair removal, and microdermabrasion.

Sources: ASPS and ASAPS websites; National Match Registry website; Association for American Medical Colleges website. Accessed August 2012.

Defining the Service Categories

The first step in service area competitor analysis is to specify the *service category* to be analyzed. Many health care organizations have several service categories or products, and each may have different geographic and demographic service areas. For a multihospital chain deciding to enter a new market, the service category may be defined as acute hospital care, but for a rehabilitation hospital, the service category might be defined as physical therapy or occupational therapy or orthopedic surgery. In addition, because many health care services can be broken down into more specific subservices, the level of service category specificity should be agreed on before analysis begins. For example, pediatric care may be broken down into well-baby care, infectious diseases, developmental pediatrics, pediatric hematology–oncology, and so on. Certainly pediatric hematology–oncology as a service category would have a far larger service area than well-baby care. A parent with a child who has cancer would travel farther for care from a specialist than a parent who sought well-baby care available from nurse practitioners.

Similar to cosmetic plastic surgery, cosmetic dentistry is a dental specialty that can be defined as a service category; however, many general dentists do not consider it a separate specialty. Improvements in dental hygiene along with the fluoridation of community water supplies has dramatically enhanced the general dental health of Americans, resulting in fewer general dentistry procedures. A shift in practice focus and the accompanying expansion of dental specialties such as public health, pediatric dentistry, endodontics, oral/maxillofacial pathology, oral/maxillofacial radiology, oral/maxillofacial surgery, peridontics, orthodontics, prosthodontics, plus an emerging area of cosmetic dentistry has occurred as dentists attempt to make up for lost revenue.

Cosmetic dentistry is not a traditional dental specialty. Its closest specialty, prosthodontics, focuses on the treatment, rehabilitation, and maintenance of the teeth with respect to function, comfort, and appearance when associated with a

clinical condition. Cosmetic dentistry, on the other hand, has no such limiting parameters and its practitioners typically engage in its delivery entrepreneurially, at the request of their patients, or from external market pressures. The business of cosmetic teeth bleaching/whitening is not restricted to the dental practice, as seen by its extension into the retail market (teeth whitening in the mall and over-the-counter whitening products for do-it-yourselfers to use at home). To focus on those dentists who identify themselves as specializing in cosmetic dentistry is likely to substantially underestimate the number of competitors in the service category.[8] Thus, an important determination for a service area competitor analysis is how customers perceive the service category.

Service Category – Plastic Surgery A national obsession with exterior beauty and appearance, extensive media attention, and the availability of information from the Internet have contributed to the emergence of the service category of plastic surgery. Once only available to Hollywood stars who could afford it and needed to always look great for the camera, or those with serious deformities/injuries whose surgery was paid for by insurance, plastic surgery today is increasingly popular among business executives, twenty- and thirty-somethings, and baby boomers to look good and feel younger and more confident about their personal appearance.

Plastic surgery can be defined as a service category as it is recognized as a board-certified specialty within medicine; however, there are additional service categories that need to be explored to determine direct and indirect competitors for a given practice. For instance, plastic surgeons may offer a full range of services including reconstructive surgery or they may specialize on the face, dealing with congenital deformities and injuries due to trauma or they may focus on cosmetic procedures for the face, breast, or other body parts for purely aesthetic reasons. Eye, ear, nose, and throat physicians as well as oral surgeons are performing some of the same procedures. Furthermore, plastic surgeons may specialize on the basis of procedures they use, such as laser or liposuction. As they often deal with skin, dermatologists may become competitors, especially in terms of some of the less invasive procedures, such as Botox® injections that may be administered by any physician, not necessarily a plastic surgeon, and in many instances by nurses (RNs) with physician supervision. Thus, the service category is important to identify and understand because it affects the service area as well.

Determining Service Area Boundaries

The service area is considered to be the geographic area surrounding the health care provider from which it pulls the majority of its customers/patients. It is usually limited by sometimes ill-defined geographic borders. Beyond these borders, services may be difficult to render because of distance, cost, time, and so on. However, as illustrated in the Introductory Incident, in some circumstances the service area might be worldwide. Nevertheless, a health care organization must not only define its service area, but also analyze in detail all relevant and important aspects of the service area, including geography, economic, demographic, psychographic (lifestyle), disease pattern characteristics, and technology.

The service area is defined by customers' preferences and the health care providers that are available. Certainly, the consumer has become empowered

by the amount of information available concerning disease conditions and providers (see Perspective 3–2). Exhibit 3–2 shows the determinants of a service area including the consumer variables and the market (provider) variables. For the consumer, the services needed could include health care that is preventive, diagnostic, alternative, routine, episodic, acute, chronic, or cosmetic. Usage rates would be related to a variety of economic, demographic, psychographic, and disease pattern variables.

Brand predisposition indicates the consumer has a preference for some health care providers over others. For example, if there is only one hospital in town, and the consumer does not like its "looks," location, or perceived quality of care, he or she may prefer to drive to the nearest larger city. For routine medical care, some consumers prefer to go to specialists; others prefer a primary care doctor; still others prefer clinics that have primary care physicians and specialists; and, finally, some consumers prefer physician assistants or nurse practitioners. These different consumer preferences will be determinants in defining the service area.

Another group of consumer determinants will be related to personal factors such as personal and social values, epistemic (knowledge) values, past experiences, and the individual's personal state of health. In concert, these variables develop the individual's preferences for health care providers. However, if providers are not available in that there are limited or no options in the immediate area, the consumer will travel greater distances to gain the desired care. For example, Mayo Clinic treats more than 1 million patients each year, from more than 135 countries.[9]

PERSPECTIVE 3–2

The Empowered Patient Wants Shared Decision Making

The empowered patient has become a significant presence in the health care environment and a challenge for health care organizations. When patients participate in medical decisions along with their physicians they feel more comfortable with their decisions, more satisfied with their treatment, and more engaged in their care. That engagement increases adherence, improves health outcomes, and may even save lives, according to a study team's published research in the *Journal of General Internal Medicine*.

The study did not look at whether physicians actually covered the topics of preference for different procedures to resolve the medical issue or the pros and cons of particular procedures in their discussions with patients, but what patients remembered about the discussion. Only 1 in 10 reported that they were presented with serious options for stenting for coronary artery disease. Although 77 percent reported their doctors talked about the reasons to undergo the procedure, only 19 remembered talking about the cons. Only 16 percent said they were asked about their preferences for treatment.

Shared decision making is viewed favorably by physicians and patients, but actual communication about the decision does not seem to be occurring. The American Medical Association defines shared decision making as "a formal process or tool that helps physicians and patients work together to choose the treatment option that best reflects medical evidence

and the individual patient's priorities and goals for his or her care."

We have known for some time that boomers resist the paternalistic "doctor knows best" approach that worked well with their parents. Shared decision making has gained increased attention for several reasons: boomers want to be involved in their care, they are getting older and require more medical attention, and medical technology has provided more – but not always better – treatment options. With more than one medical treatment as a reasonable option for a patient's given circumstances, the person whose preference matters most is the patient's.

Shared decision making is associated with better decision quality and more efficient care, improved patient knowledge, and increased patient feelings of comfort with their decision. Shared decision making becomes even more important in the management of chronic conditions, such as diabetes and heart disease. The more patients understand about their condition and their treatment choices, the more likely they are to follow the treatment plan. Enhanced patient compliance leads to improved outcomes.

Shared decision making relates to patient safety, as a procedure that a patient would not want if he or she understood the treatment options can never be done safely enough. The lack of shared decision making may account for the variations in medical practice in different regions of the country. Clinical preferences rather than patient desires could explain why there are more mastectomies versus lumpectomies depending on where a woman lives.

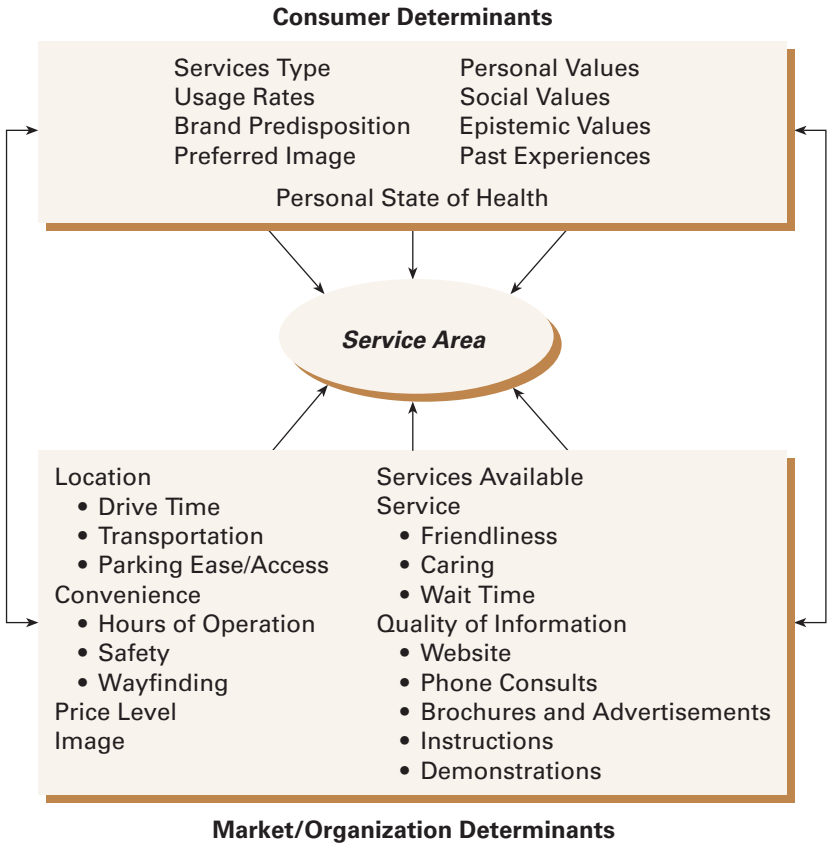
Some evidence exists that when presented with all the information about clinical alternatives, some patients will choose the more conservative, less expensive alternative. Patients then feel that they are receiving care that incorporates their values and personal preferences, leading to greater satisfaction with care (and possibly avoidance of malpractice issues as patients have more realistic expectations for outcomes). Shared decision making is really perfected informed consent.

Medical providers are supportive of shared decision making but are concerned about the time it takes as the current reimbursement system has codes only for procedures. Decision aids have been created that can assist with the patient's involvement in the selection of a treatment program. A number of states have incorporated shared decision making into legislation and the Affordable Care Act includes provisions to encourage shared decision making. A number of medical associations, such as the American Board of Internal Medicine Foundation, have joined the effort to enhance patients' abilities to provide informed consent.

A patient decision aid is a tool designed to help patients understand their medical conditions, available screening and procedure options, and the possible outcomes of the options. Information is presented in an unbiased manner that emphasizes the patient's preferences as well as clinical evidence involved in making a decision. Technology, such as a tablet computer, can be used to provide step-by-step explanations though voice, animation, charts and graphs, and question/answer between doctor and patient. The study found that, with the decision aid, the clinician generally did not have to take more time than he or she normally would with a patient. The entire process can be recorded and shared with other family members, providing them with more and better information, and relieving the physician of that burden. In addition, the recording, including the completed informed consent form, becomes part of the medical record documenting the entire process.

Source: F. J. Fowler, P. M. Gallagher, P. B. Bynum, M. J. Barry, L. L. Lucas, and J. S. Skinner, "Decision Making Process Reported by Medicare Patients Who Have Had Coronary Artery Stenting or Surgery for Prostate Cancer," *Journal of General Internal Medicine* (February 28, 2012), pp. 911–916.

EXHIBIT 3–2 Service Area Determinants



Options or choices are controlled by the health care structure. The market and organizations within it determine what will be offered or made available to the consumer. The "market" contains health care providers in a variety of locations that bear on convenience and image. Location includes drive time from home (or, increasingly, work), availability of transportation, as well as access and parking ease. Convenience may be hours of operation, safety, availability of food, signs to assist in finding the way, and so on. Image for the market entails positioning among the various providers. The health care provider might have the image of being more caring, friendlier, or more high-tech; or it may be perceived as attracting desirable or undesirable demographic, socioeconomic, or ethnic groups. The organization itself has an image of the services (health care provided) as well as the service and the quality of information provided. Location, convenience, and image are all in relationship to the other providers in the area, including those within driving distance and those that are remote but perceived as providing better quality, further services, or other desirable characteristics. Health care providers make these decisions, in part, based on their understanding of consumers' needs and wants.

Managed care interrupts the normal decision making by consumers. An employed individual today usually has some choice in health care insurance. The employer may offer one or more different health plans. However, once the consumer has

selected a managed care plan, the ability to choose providers – both hospitals and physicians – becomes more restrictive. And, in fact, the more the HMO attempts to control health care costs by further structuring health care delivery, the more restricted the choice becomes for consumers. Restricted choice is not favored by most Americans and they have been quite vocal about it with their employers. The result is that many employers are only willing to commit to a health plan that offers choice (and thereby removes the quantity discounts previously offered) and, hence, organizations have seen health care cost increases in double digits.

Multiple Service Areas Understanding the geographic boundaries is important in defining the service area, but is often difficult because of the variety of services offered. In an acute care hospital, the service area for cardiac services may be the entire state or region, whereas the service area for the emergency room might be only a few blocks. Thus, for a health care organization that offers several service categories, it may be necessary to conduct several service area analyses. For example, the Des Moines, Iowa market has two geographic components: the metropolitan area of the city as well as the suburbs of Polk County (population approximately 437,000) and the 43 primarily rural counties of central Iowa that surround the capital (population of over 1 million). The issues for each of these multiple service areas may be quite different; therefore, considerable effort is directed toward understanding and analyzing the nature of the health care organization's various service areas. At the same time, for some organizations, defining only one service category may suffice (such as in the case of a long-term care facility in a major metropolitan area).

Service areas will be different for different organizations. A national for-profit hospital chain may define its service area quite generally, but even then there may be different strategies in place. As illustrated in the Introductory Incident, hospital strategy often defines the service area. Similarly, HCA Holdings Inc. (HCA) is a holding company that owns and operates hospitals and related health care entities. As of December 2011 it operated 157 general, acute care hospitals, five psychiatric hospitals, and one rehabilitation hospital. HCA's strategy is to become a major health care presence in highly concentrated markets in the nation. On the other hand, Health Management Associates owns 70 hospitals in non-urban areas of 15 states. Its strategy is to only enter local markets to partner with mid-sized communities and local hospital leaders, primarily in non-urban markets in the Southeast and Southwest.

An individual hospital, home health care organization, or HMO may define its service area much more specifically. In general, health services are provided and received within a well-defined service area, where the competition is clearly identified and critical forces for the survival of the organization originate. For instance, hospitals in rural areas have well-defined service areas for their particular services. These hospitals must be familiar with the needs of the population and with other organizations providing competing services. Similarly, the service areas for public health departments vary within a state, depending on whether they are metropolitan or rural, and may suggest quite different opportunities and threats.

Determining the geographic boundaries of the service area may be highly subjective and is usually based on patient histories, the reputation of the organization, available technology, physician recognition, and so on. In addition, geographic impediments such as a river, mountains, and limited access highways

can influence how the service area is defined. The definition of communities (see Perspective 3–3) is often helpful in determining a service area.

Service Area – Charlotte, North Carolina The general service area for plastic surgery example has been determined to be Charlotte, North Carolina. Charlotte is the largest city within North Carolina and resides on the border with South Carolina. Charlotte (also known as the Queen City as it was named after King George III's wife who was born in Mecklenburg, Germany) has grown to be a top-25 major city and hosted the Democratic National Convention in 2012. Charlotte's population is younger, upwardly mobile, educated, and relatively affluent – and increasing in number. There are approximately 28 active, board-certified plastic surgeons in the Charlotte metropolitan area; there is little need to travel outside the city for medical or health care services. The city is sufficiently large at 730,000 that the people in the 7-county, nearly 2 million metropolitan statistical area are pulled to Charlotte for medical and health care.

PERSPECTIVE 3–3

What Is a Community?

Community is a very important concept in public health as well as health care policy, planning, and management. In general parlance, a community refers to a group of people living together in a defined place; the place could be a neighborhood, a rural village, an urban area, or an entire country. In addition, community implies a collective group of individuals who share some feature in common, be it a profession (the scientific community), a religion (the Jewish community), or some other characteristic (the gay community, the Hispanic community).

The public health community (a group of professionals who share a common purpose) spends considerable effort monitoring the health of communities (groups of people living together in geographic areas within states and nations) because of its interest in promoting and preserving the health of entire populations. Issues relating to the larger community within which health care organizations do business must be critically examined and either accommodated or exploited to promote successful health care outcomes.

In this context, the community represents the competitive environment within which health care organizations function, while also representing a set of community factors – values, needs, resources, and constraints – that may suggest modifications to a typical health care structure or a usual set of services offered and delivered. The *competitive environment* as community would include such factors as availability of and access to care, available financing strategies, the ways in which resources are allocated, and systems of accountability.

Examples of *community factors* that can affect health care organizations include:

1. The level and scope (federal, state, regional, local) of governmental entities that regulate the health system and the extent of regulation directed at health care organizations.
2. The nature and scope of professional organizations that set standards, accredit, or otherwise engage in accountability functions for health care organizations.

3. The nature and scope of health care financing agencies, including purchasers and private and public insurers, that participate in the health care marketplace in the community.
4. The availability of health care providers, facilities, supplies, and ancillary services across the community.
5. The characteristics of the populations ultimately paying for and receiving health care services. These characteristics could include socioeconomic status (education, occupation and income), race and ethnicity, family structure, health status, health risk, and health-seeking behaviors.

A community, then, in this context, can refer to the health care community, the community of individuals served by a health care system, the physical community within which the individuals reside and the health system functions, and the competitive environment within which any given health care organization operates. Identifying and considering the community of interest (service area) facilitates strategic planning and strategic management of health care organizations.

Source: Donna J. Petersen, MHS, ScD, Dean, College of Public Health, University of South Florida.

Service Area Profile

Once the geographic boundaries of the service area have been defined, a general service area profile should be developed. Capturing the dimensions of a service area requires gathering and synthesizing information from various sources:

- both quantitative and qualitative data for framing and understanding a service area;
- population-based health status data (specifics of the various health dimensions of an entire population and its subgroups); and
- health services utilization data (specifics on the patterns and frequency of health service use for various health conditions by different groups of individuals in the population).[10]

The *service area profile* includes key competitively relevant economic, demographic, psychographic (lifestyle), and community health status indicators. Relevant economic indicators may include income distribution, major industries and employers, types of businesses and institutions, economic growth rate, seasonality of businesses, unemployment statistics, and so on. Demographic indicators most commonly used in describing the service area include age, gender, race, marital status, education level, mobility, religious affiliation, and occupation.

Psychographic indicators are often better predictors of consumer behavior than demographic indicators and include values, attitudes, lifestyle, social class, or personality. For example, consumers in the service area might be classified as medically conservative or medically innovative. Medical conservatives are only interested in traditional health care – drugs, therapies, and diagnostics they are familiar with – whereas medically innovative individuals are willing (often eager) to try new alternative drugs, therapies, or diagnostics. Although

medically independent individuals are high in self-esteem and assertiveness, often questioning one physician's diagnosis and seeking a second opinion, medically dependent individuals follow what the doctor prescribes exactly and would never think of questioning "doctor's orders."

Health status of the service area is also important in considering its viability, as disease may be related to age, occupation, environment, or economics. Health status includes all types of data normally considered to represent the physical and mental well-being of a population. Demographic, psychographic, and health status information should be included in the analysis only if it is competitively relevant. Possible variables in developing a service area profile are summarized in Exhibit 3–3.[11] Bear in mind that not every one of these possible variables will be competitively relevant. For example, cosmetic dentistry (teeth-whitening) service area competitor analysis would be improved by analyzing most economic factors (price vs. substitutes), some geographic factors (distance to travel for a short procedure), at least one psychographic factor (youthfulness), and very few of the health status factors (diseases requiring drugs that affect coloration of the teeth). The specific, selected variables are analyzed to identify issues that must be integrated and considered in conjunction with the general and health care environmental issues.

EXHIBIT 3–3 Examples of Possible Service Area Profile Variables

Economic

- Income Distribution
- Foundation of the Economy
- Major Employers
- Types of Business
- Growth Rate
- Seasonality
- Unemployment

Demographic

- Age Profile
- Gender Distribution
- Average Income
- Race Distribution
- Marital Status
- Education Level
- Religious Affiliation
- Population Mobility
- Stage in Family Life Cycle
- Occupational Mix
- Residence Locations

Psychographic

- Medical Conservatives
- Medical Innovators

EXHIBIT 3–3 ***(Continued)***

- Medical Dependents
- Personal Health Controllers
- Youthfulness
- Sociability

Health Status Indicators

- Mortality
- Deaths from all causes per 100,000 population
- Motor vehicle crash deaths per 100,000 population
- Suicides per 100,000 population
- Female breast cancer deaths per 100,000 population
- Stroke deaths per 100,000 population
- Cardiovascular deaths per 100,000 population
- Work-related injury/deaths per 100,000 population
- Lung cancer deaths per 100,000 population
- Heart disease deaths per 100,000 population
- Homicides per 100,000 population
- Infant deaths per 1,000 live births

Notifiable Disease Incidence

- AIDS incidence per 100,000 population
- Tuberculosis incidence per 100,000 population
- Measles incidence per 100,000 population
- STD incidence per 100,000 population

Risk Indicators

- Percentage of live-born infants weighing under 2,500 g at birth
- Births to adolescents as a percentage of live births
- Percentage of mothers delivering infants who received no prenatal care in first trimester of pregnancy
- Percentage of children under 15 years of age living in families at or below the poverty level
- Percentage of children under 15 years of age without all childhood inoculations
- Percentage of women over 50 without a mammogram
- Percentage of population more than 50 pounds overweight
- Percentage of persons living in areas exceeding the US EPA air quality standards
- Percentage of persons who do not wear seatbelts

Service Area Profile – Charlotte, North Carolina For the service category plastic surgery example in the Charlotte, North Carolina service area, a service area profile will be helpful in understanding the unique characteristics of the service area likely to affect competition and provider strategies. A profile of the Charlotte service area is presented in Exhibit 3–4. The "comments" column is used to indicate the relevancy of each selected issue.

EXHIBIT 3–4 Analysis of the Charlotte, North Carolina, Plastic Surgery Service Area

Service category	Plastic surgery
Service area	Charlotte, Mecklenburg County, North Carolina

Service Area – General

Competitively Relevant Issues	Comments
The largest city in either of the Carolinas (19th largest in the USA, 7.3 million people living within a 100-mile radius), located on the border of North Carolina and South Carolina. The nearest city, Winston-Salem, is more than 90 miles away. As a result, Charlotte has emerged as a financial, distribution, and transportation center for the entire urban region.	Not much need for residents to travel outside Charlotte for health care; many in the greater Charlotte MSA travel to Charlotte for health care.
Charlotte is renowned for its vibrant banking sector. Bank of America, the nation's largest bank, is headquartered here. In total, 26 banks with more than 226 local branches, as well as a Federal Reserve Branch, are located in Charlotte.	Banking has taken the biggest "hit" in the Great Recession; Wachovia Bank was purchased by Wells Fargo and one of Charlotte's banking headquarters companies no longer exists.
Insurance typically covers reconstructive surgery for injuries from accidents, correcting birth defects, and ravages from disease but rarely covers aesthetic/cosmetic surgery.	Coverage for reconstructive breast surgery and reconstructive congenital defects surgery is legislated. The North Carolina General Statute citation closely mirrors the federal legislation that requires coverage.
Charlotte/Mecklenburg has nearly 15,800 automobile accidents annually, with more than 36 percent of them having injuries (5,824); Charlotte/Mecklenburg has 9.2 deaths/100,000 population from auto accidents (NC has 16.7 deaths/100,000 population); 90 percent of residents in Charlotte/Mecklenburg report they always use seatbelts (88 percent in NC).	Some injuries require plastic surgery; Charlotte drivers and their passengers wear seatbelts and are safer.
FDI Magazine (2011) ranked Charlotte #1 large city in the Americas to attract foreign investment; 950 foreign firms operate in the Charlotte area.	Plastic surgery is less available in a number of countries in the world.
Charlotte is a major transportation center; from the city it is possible to reach 50 percent of the US population in 2 hours by air, 24 hours by truck. Charlotte's airport received the IATA Best Airport award in 2011, 7th most active air transportation center in the world.	It is quite easy to travel direct from Charlotte to most any place in the USA and many foreign destinations, including those with known successes with plastic surgery at very reasonable costs.

Service Area – Economic

Competitively Relevant Issues	Comments
Median household income in Charlotte is $55,666.	Charlotte has a population that can afford cosmetic procedures.

EXHIBIT 3–4 *(Continued)*

Service Area – Economic

Competitively Relevant Issues	Comments
Cost-of-living index for the top 40 largest cities ranks Charlotte as 8th at 93.3 (Houston is the lowest at 89.3 and New York City is the highest at 218.5).	A low cost-of-living allows for greater discretionary spending.
Percentage below poverty at 13.6 percent in Charlotte/Mecklenburg is less than the national percentage of 14.2 percent; the state has a higher rate of 16.3 percent below the poverty level.	People with a higher standard of living are interested in and can more likely afford the out-of-pocket cost of cosmetic plastic surgery.
Retail sales per capita $15,084 (NC: $12,641 and US: $12,990).	People in Charlotte spend more at retail than the averages for the state and the nation.
Economy improving and number of jobs increasing – however, unemployment is still considerably higher than pre-2008 beginning of the Great Recession – at 7.9 percent for Charlotte (NC: 9.6 percent, US: 7.9 percent).	Unemployed postpone the purchase of plastic surgery because it is an out-of-pocket expense (not covered by insurance); those who are employed have been conservative in their spending because they fear they may lose their job (especially if they work in banking).
Identified as one of the top cities for entrepreneurs.	Entrepreneurs are often innovators and early adopters.
Over 58 percent of Charlotte's workforce is white collar.	White collar workers are most likely to be concerned with appearance.
Nearly 60 percent of Charlotte's employed residents work in businesses of less than 100 employees.	Sometimes lower wages, fewer co-workers, less pressure to look younger.

Service Area – Demographic

Competitively Relevant Issues	Comments
In 2010, more than 730,000 people lived within Charlotte's city limits (an increase of 35 percent over 2000); 920,000 in Mecklenburg County (an increase of 32 percent over 2000); 1.8 million in the Charlotte MSA.	Generally, one plastic surgeon is needed for every 50,000–75,000 in population (compared with a national average of 88 primary care doctors per 100,000).[a]
Charlotte, Mecklenburg County, and surrounding areas have continuing population growth: about 50,000 move to the area each year (3 percent growth rate).	A growing population may mean there's more room for a new provider of plastic surgery; increasing population growth typically equates to more accidents.
Population over 65 at 8.0 percent is lower than the state and nation (NC: 12.2 percent and US: 18.6 percent); median age in Charlotte is 35.3 years (NC: 37.3 years and US: 37.2); the largest population cohort in Charlotte is residents aged 25–44 (33 percent), followed by residents aged 45–64 (23.1 percent); the largest population cohort in NC is aged 25–44 (27.2 percent) with those aged 45–64 close (25.4 percent).	A younger population is more likely to adopt the new surgery; Charlotte has younger residents and greater numbers in those ages most likely to purchase plastic surgery.
Population over 25 with college degree in Charlotte: 39.9 percent (NC: 26.0 percent and US: 24.4 percent); 11.6 percent in Charlotte have advanced degrees; Charlotte/Mecklenburg School System was named top urban school district in 2011; 35 colleges and universities in the area.	Better educated consumers are more likely to have the income to pay for cosmetic plastic surgery.

(*Continued*)

EXHIBIT 3–4 *(Continued)*

Service Area – Demographic

Competitively Relevant Issues	Comments
Ethnic mix is 58.3 percent white (NC: 68.5 percent and US: 72.4 percent), black 32.7 percent (NC: 21.5 percent and US: 12.6 percent), Native American 0.3 percent (NC: 1.3 percent and US 0.9 percent), Asian 3.4 percent (NC: 2.2 percent and US 4.8 percent), Hispanic 8.4 percent (NC 8.4 percent and US 16.3 percent); Hispanic growth has been 1,572 percent between 1990 and 2010.	The black population has been slower to adopt plastic surgery; only one of the plastic surgery physicians in Charlotte is black; two Hispanic plastic surgeons are in the area and multiple practices offer Spanish-speaking providers (physicians, nurses, administrative staff).

Service Area – Psychographic

Competitively Relevant Issues	Comments
Younger, upwardly mobile population, youthful orientation; ranked 5th among US large cities attracting this segment.	Plastic surgery is often for lifestyle (confidence) and cosmetic reasons.
Business-oriented community: 2nd largest banking center (behind New York City); 6th largest in wholesaling; 6th in number of Fortune 500 company headquarters (9 in the area); 274 Fortune 500 companies have facilities.	City is business dominated; big business tends to require the corporate "look" that includes youthful appearance and a strong chin.
Bible belt – 73 percent church or synagogue members.	Religious question: "Is surgery for cosmetic reasons the right thing to do?"
Outdoor activities year round at the beach or mountains; both within easy driving distance.	Summer outdoor activities often require less clothing.

Service Area – Health Status

Competitively Relevant Issues	Comments
Generally healthy population.	Healthy candidates required for this elective procedure.
New cancer cases: 7,390 for 2011 in NC.[b]	Breast cancer, skin cancer, and so on may require reconstructive plastic surgery.
NC Health Statistics report 210 orofacial birth defects (cleft palate with/without cleft lip) for North Carolina in 2007 (190 in 2006 and 167 in 2005); in Mecklenburg County, 8 babies were born with orofacial defects in 2007 (10 in 2006 and 11 in 2005).[c]	The number of birth defects are increasing for the state, but decreasing in the Charlotte/Mecklenburg area.

Information in this exhibit is based on secondary data from the US Census (2010), the Charlotte Chamber, and websites in addition to personal interviews with Charlotte area plastic surgeons unless otherwise noted. Opinions and conclusions presented are those of the authors and intended to be used as a basis for class discussion rather than to illustrate effective or ineffective business practices.

[a]Ashley Halsey III, "Primary-Care Doctor Shortage May Undermine Health Reform Efforts," *The Washington Post*, June 20, 2009, p. 1.

[b]*Cancer Facts & Figures 2011*, American Cancer Society.

[c]*Birth Defects Monitoring Program*, North Carolina: State Center for Health Statistics.

Service Area Structural Analysis

Harvard's Michael E. Porter developed a five forces framework for analyzing the external environment through an examination of the competitive nature of the industry. *Service area structural analysis* provides considerable insight into the attractiveness of an industry and provides a framework for understanding the competitive dynamics (the future viability of an industry). Porter's five forces framework has been applied to industry analysis for many industries – however, because of the nature of competition in health care, it is more appropriate to apply the framework to the service category/service area. Use of Porter's five forces in health care can be referred to as service area structural analysis.

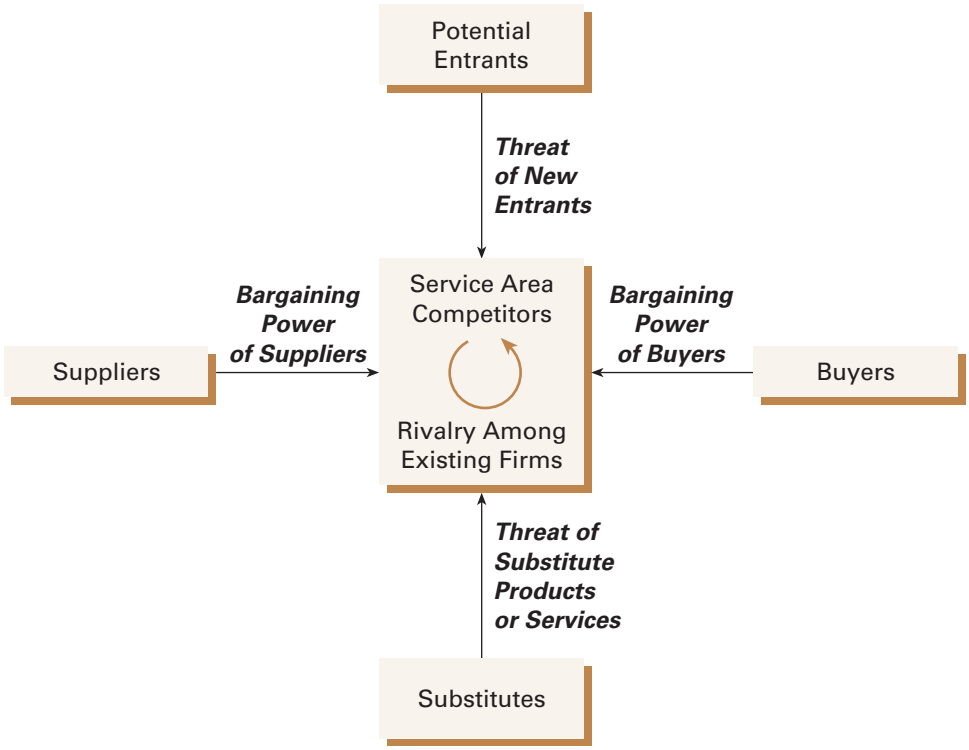
Porter suggested that the level of competitive intensity within the industry is the most critical factor in an organization's environment. In Porter's model, intensity is a function of the threat of new entrants to the market, the level of rivalry among existing organizations, the threat of substitute products and services, the bargaining power of buyers (customers), and the bargaining power of suppliers.[12] The strength and impact of these five forces must be carefully monitored and assessed to determine the viability of the service category today and may be used to assess the changes likely to occur in the future. As illustrated in Exhibit 3–5, Porter's industry structural analysis may be adapted to service areas to understand the competitive forces for health care organizations.

Threat of New Entrants New entrants into a market are typically a threat to existing organizations because they increase the intensity of competition. New entrants may have substantial resources and often attempt to rapidly gain market share. Such actions may force prices and profits down. The threat of a new competitor entering into a market depends on the industry or service area barriers. If the barriers are substantial, the threat of entry is low. Porter identified several barriers to entry that may protect organizations already serving a market:

- Existing organizations' economies of scale.
- Existing product or service differentiation.
- Capital requirements needed to compete.
- Switching costs – the one-time costs for buyers to switch from one provider to another.
- Access to distribution channels.
- Cost advantages (independent of scale) of established competitors.
- Government and legal constraints.

These barriers may be assessed to determine the current or expected level of competition within an industry or service area. In health care markets, the barriers to entry for new "players" may be substantial. Consolidation (creation of large health care systems) and system integration (control of physicians and insurers) may make entry into a particular service area difficult because of economies and cost advantages. In an effort to create cost efficiencies, managed care has had

EXHIBIT 3–5 **Service Area Structural Analysis: Forces Driving Service Area Competition**



Source: Michael E. Porter, *Competitive Strategy: Techniques for Analyzing Industries and Competitors*. Copyright © 1980 by the Free Press. All rights Reserved. Adapted with the permission of the Free Press, a division of Simon & Schuster Adult Publishing Group.

the effect of limiting the ease of market entry. Where managed care penetration is high, market entry by new competitors will be more difficult because switching costs for some populations are high. However, the difficulty of adding new service categories for existing organizations in a managed care market may be lessened. Service categories may be added to better serve a captured (managed care) market.

Certificate of Need (CON) laws and regulations can present significant barriers to entry in those states that have them (see Perspective 3–4). For example, CON laws are the reason some specialty hospitals in cardiology and orthopedics were built in states in the southwestern USA and the Midwest, where there were no CON barriers or the CON laws were much less restrictive than other areas of the nation.

Intensity of Rivalry Among Existing Organizations Organizations within an industry are mutually dependent because the strategy of one organization affects the others. Rivalry occurs because competitors attempt to improve their

PERSPECTIVE 3–4

CON: Definite Need or a Dinosaur?

As of June 2012, 36 states retain some type of certificate of need (CON) program, law, or agency. CON programs originated to regulate the number of beds in hospitals and nursing homes, and to prevent overbuying of expensive equipment. In 1964, New York became the first state to enact a statute granting the state government power to determine whether there was a need for a new hospital or nursing home before it was approved for construction. In 1972, an amendment to the Public Health Service Act included withholding of Medicare and Medicaid funds for facilities and projects (which in effect became the first CON legislation, although a version of a CON process was incorporated into the Hill-Burton Act in 1946 that provided federal funds for new hospital construction completed through state planning and evaluation). The National Health Planning and Resources Development Act in 1974 strengthened certificate-of-need regulations by requiring all 50 states to implement such regulations to receive funds through the Public Health Service Act; however, sanctions from this law were not imposed.

Statutory criteria were often created to help planning agencies determine what was necessary for a given location (number of new beds, new technologies, etc.). By reviewing the activities and resources of hospitals, the agencies made judgments about what needed to be improved. Once need was established, the applicant (corporation, not-for-profit, partnership, or public entity) was granted permission to begin a project. These approvals are generally known as "Certificates of Need." Many states implemented CON programs in part because of the incentive of receiving federal funds.

In 1986, Congress repealed the mandate for states to have CON programs, along with federal funding. In the decade that followed, Arizona, California, Colorado, Idaho, Indiana, Kansas, New Mexico, North Dakota, Pennsylvania, South Dakota, Texas, Utah, Wisconsin, and Wyoming (14 states) no longer have CON requirements; other states maintain CONs for various types of facilities and dollar amounts for technology. Although the CON process across states that still have it is similar, no two states are exactly alike, with the scope of regulation varying a great deal by state. Some states require providers to document the community need for all regulated services regardless of cost, while others do not require CON approval for any project under certain cost thresholds; however, the capital expenditure thresholds vary widely in amounts from hundreds of thousands to millions of dollars ($1 million in Georgia, $6.5 million in Illinois). More than 25 states have CONs for acute care hospital beds (28), ambulatory surgical centers (27), cardiac catheterization (26), long-term acute care (28), nursing home beds (36), open-heart surgery (25), psychiatric services (26), and rehabilitation (25).

Some CON regulations attempt to protect access to safety net hospitals in urban areas and access to care in rural areas, either by requiring the provision of a specified amount of charity care or by having applicants address the potential impact of the CON on charity care. Enforcement is challenging because penalties for not meeting the standard are frequently not included; however, in a few states an organization's failure to meet its charity care commitment requires it to make up the shortfall by paying the difference to the state.

CONs have been plagued in recent years by providers attempting to game the process, a deterioration of state health planning over time because of inadequate funding, reduction of public interest, and a broader move toward deregulation. When the federal mandate for CON programs was repealed in 1986, funding for state health planning dropped substantially. State agencies responsible for issuing CONs cite insufficient staffing and training and an often overwhelming workload. An enduring challenge for CON review boards is meaningful competition while maintaining access to care without allowing excess capacity.

CONs have been used as a way to claim territory. For example, in Fort Mill, SC, three provider groups submitted competing CON applications to secure the right to build a hospital in the same suburban bedroom community outside Charlotte, NC (one from Rock Hill, SC and two from Charlotte, NC; the largest health care system from Charlotte was awarded the CON; appeals are in process). Such situations are typically contentious and require a significant amount of time to resolve and finalize. Applications can be challenged at various stages, and decisions can be overturned by hearing officers, courts, or sometimes state legislatures. CON boards generally include appointed state officials, physicians, hospital representatives, and other stakeholders. This scrutiny, coupled with a lack of enforcement power to uphold decisions, has made the role of CON boards increasingly challenging.

Hospitals use the process to protect existing market share – either geographic or by service line – and block competitors. Certificate-of-need approval from the hospital perspective is usually viewed as a license to claim ownership of a service line or geographic area. In addition, hospitals track CON applications as a way to "keep tabs" on current competitors and block new entrants. Smaller community hospitals often lack the financial resources to go through an extended CON process. Large hospitals, which often have ample financial resources and political clout, have kept smaller hospitals out of a market by simply tying them up in CON litigation for years.

CON has been used by hospitals to block new physician-owned facilities. Physicians interested in establishing for-profit facilities (especially surgery centers) view CON programs as overly restrictive and support repeal of the regulations. Reflecting physician views, medical societies tend to support repeal of CONs as well. Physicians view CONs as barriers to innovation, since the process may take up to 18 months, delaying facilities from offering the most-advanced equipment to patients and limiting providers' ability in some states to recruit top-tier specialist physicians who are attracted to work in facilities with the newest technologies.

Originally, the rationale for CON in the 1970s was policymakers' beliefs that market forces could not be trusted to discourage overinvestment in health care facilities. Cost-plus reimbursement did encourage constant additions to hospitals, nursing homes, etc.; however, the introduction of the prospective payment system (PPS) in the 1980s removed the major reason for the overinvestment that brought about CON. Payment reforms have probably had more impact on containing health care costs than CON laws. CONs may be less necessary as Medicare and other payers move away from fee-for-service payments that rewarded volume. The 2010 Patient Protection and Affordable Care Act incorporates two provisions that may impact CON programs:

- An increase in the insured population who will in turn increase demand for services (may increase the need for provider capacity).

- Payment reforms that focus on increasing efficiency may encourage providers to determine that they have adequate capacity and can absorb increased demand without difficulty.

According to Clark Havighurst, "Resources too easily gained may easily be wasted in inefficient operations and spent on things not clearly worthy of public support. A number of major US hospitals are 'largely unaccountable' for the amounts of money they raise and the ways they spend it."

SUGGESTED READING

Grant Bosse, "CON: A Failed Health Care Diet," *Business NH Magazine* 29, no. 5 (2012), p. 19.

Joe Carlson, "Trump Card? Appeals Court Ruling Could Affect CON Laws," *Modern Healthcare* 41, no. 35 (2011), pp. 12–13.

Clark C. Havighurst, "Monopoly Is Not the Answer," *Health Affairs* (August 5 2005), pp. 373–375.

National Conference of State Legislatures (January 2011; material added March 2012). Website: www.ncsl.org/issues-research/health/con-certificate-of-need-state-laws.aspx Section: Certificate of Need State Health Laws and Programs.

Tracy Yee, Lucy B. Stark, Amelia M. Bond, and Emily Carrier, "Health Care Certificate-of-Need Laws: Policy or Politics?" National Institute for Health Care Reform Research Brief Number 4 (May 2011).

position. Typically, actions by one competitor foster reactions by others. Intense rivalry is the result of the following factors:

- Numerous or equally balanced competitors.
- Slow industry (service area) growth.
- High fixed or storage costs.
- A lack of differentiation or switching costs.
- Capacity augmented in large increments.
- Diverse competitors – diverse objectives, personalities, strategies, and so on.
- High strategic stakes – competitors place great importance on achieving success within the industry.
- High exit barriers.

Often, consolidation has created several balanced large health care systems in a service area. For example, in the Cleveland market, consolidation has resulted in two large integrated systems with high fixed costs and extremely high strategic stakes. For some markets, consolidation has resulted in competition between large for-profit and not-for-profit systems. Additionally, because of managed care, switching costs for consumers are high. Because many markets have supported too many providers in the past, the strategic stakes are extremely high.

Most experts agree that further consolidations are likely, rivalry will intensify, and still more providers will not survive.

Threat of Substitute Products and Services For many products and services there are various substitutes that perform the same function as the established products. Substitute products limit returns to an industry because at some price point consumers will switch to alternative products and services. Usually, the more diverse the industry, the more likely there will be substitute products and services. A major substitution taking place in health care has been the switch from inpatient care to outpatient alternatives. In addition, alternative therapies such as chiropractic, massage therapy, acupuncture, biofeedback, and so on are increasingly substituted for traditional health care (see Perspective 3–5).

PERSPECTIVE 3–5

Complementary + Alternative Medicine = Integrative Medicine: Are We There Yet?

Americans are frustrated with the inability of traditional medicine to meet their expectations and needs. In addition, US society has a growing interest in generally better health and wellness. Further, individuals have access to more health care information than ever before through the Internet. Discontent and the search for "more" have led many Americans to explore complementary and alternative medicine (CAM). CAM is a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine (that practiced by medical doctors). CAM includes acupuncture, herbal medicine, homeopathy, message, osteopathy, biofeedback, chiropractic, hypnotherapy, meditation, and naturopathy. CAM systems are characterized by a holistic and highly individualized approach to patient care with an emphasis on using the body's inherent healing ability and involving patients as active participants in their own care. A 2007 study of CAM use by the general population reported that 38.3 percent of US adults used some form of CAM within the past year, up from 36 percent in 2002.

Integrative medicine incorporates elements of CAM with traditional western (allopathic) medicine. The model of integration has resulted in some CAM therapies becoming mainstream. Integrative medicine is an attempt to provide a new paradigm that incorporates core CAM values in contemporary medicine; however, the extent to which integration occurs will depend on attitudes of physicians. A 2011 study of medical students found that 84 percent agreed to some extent that CAM contains beliefs, ideas, and therapies from which conventional medicine could benefit; 74 percent agreed that a system of medicine that integrates benefits of both conventional medicine and CAM would be more effective than either one provided independently; and 98 percent agreed that a patient's treatment should take into consideration all aspects of his/her physical, mental, or spiritual health. Study respondents reported that they had used CAM

to treat themselves (49 percent), used another CAM provider (acupuncturist, chiropractor, and so on) for themselves (38 percent), and used CAM to treat someone else (14 percent). The authors concluded that although medical students as future physicians are willing to use complementary, alternative, and integrated medicine (CAIM) themselves, many are not yet willing to recommend or use CAIM in their practices.

A national survey of hospitals that offer complementary services found a number of significant barriers for CAIM therapies: lack of evidence-based research (39 percent), physician resistance (44 percent), and budgetary constraints (65 percent). In addition, hospitals that are considering use of integrative medicine have a number of legal/liability hurdles to overcome. A hospital's basic duty is to ensure that those who treat patients within its facilities are qualified and competent to do so. Reasonable steps must be taken to control and supervise practitioners by appropriate credentialing (licensure, passing examinations, and so on). In addition, the hospital has a duty to create a safe environment for patients that should include going to reasonable lengths to allow CAIM – at least those therapies that current evidence indicates could improve patients' health or help manage their symptoms.

In 1998, cognizant of society's changing perspectives on health care and well-being, Congress expanded the Office of Alternative Medicine (started in 1993) by creating the National Center for Complementary and Alternative Medicine (NCCAM). NCCAM is the federal government's lead agency for scientific research on complementary and alternative medicine and is one of the 27 institutes and centers that make up the National Institutes of Health (NIH). On February 4, 2011, NCCAM released its third strategic plan, *Exploring the Science of Complementary and Alternative Medicine: Third Strategic Plan 2011–2015*. With a budget of $127.7 million in 2011, NCCAM's mission is: "… to define, through rigorous scientific investigation, the usefulness and safety of complementary and alternative medicine interventions and their roles in improving health and health care." Its vision states: "Scientific evidence informs decision making by the public, by health care professionals, and by health policymakers regarding use and integration of complementary and alternative medicine."

The 2011–2015 strategic plan presents a series of goals and objectives to guide NCCAM in determining priorities for future research in complementary and alternative medicine:

1. Advance research on mind and body interventions, practices, and disciplines.
2. Advance research on CAM natural products.
3. Increase understanding of "real-world" patterns and outcomes of CAM use and its integration into health care and health promotion.
4. Improve the capacity of the field to carry out rigorous research.
5. Develop and disseminate objective, evidence-based information on CAM interventions.

As predicted by the first Director of NCCAM:

> "As CAM interventions are incorporated into conventional medical education and practice, the exclusionary terms 'complementary and alternative medicine,' will be superseded by the more inclusive, 'integrative medicine.' Integrative medicine will be seen as providing novel insights and tools for human health, practiced by health care providers skilled and knowledgeable in the multiple traditions and disciplines that contribute to the healing arts."

CAM is expected to increase substantially in the future. It is estimated that this sector will grow at a rate of 38 percent over the next 5 years; Americans spend between $36 and $50 billion annually on alternative medicine. About $20 billion of this amount was paid out-of-pocket to massage therapists, chiropractors, and acupuncturists. More than 60 percent of adults state that they have tried some form of integrative medicine. Involvement in integrative medicine has become so widespread that the Food and Drug Administration is preparing new guidelines that threaten new, costly regulation of complementary and alternative medicine.

SUGGESTED READING

R. B. Abbott, K.-K. Hui, R. D. Hays, J. Mandel, M. Goldstein, B. Winegarden, D. Glaser, and L. Brunton, "Medical Student Attitudes toward Complementary, Alternative and Integrative Medicine," *Evidence-Based Complementary and Alternative Medicine* (2011), pp. 1–14.

"FDA Seeks to Regulate Complementary and Alternative Medicine: Products Such As Vegetable Juice Could Be Restricted for Medical Use," *PR Newswire* (September 5, 2007), pp. 3–4.

J. Gilmour, C. Harrison, L. Asadi, M.H. Cohen, and S. Vohra, "Hospitals and Complementary and Alternative Medicine: Managing Responsibilities, Risk, and Potential Liability," *Pediatrics* 128, no. 4 (November 2011), pp. S193–199.

National Center for Complementary and Alternative Medicine website (http://nccam.nih.gov/) and its strategic plan, *Exploring the Science of Complementary and Alternative Medicine: Third Strategic Plan 2011–2015.*

Bargaining Power of Customers Buyers of products and services attempt to obtain the lowest price possible while demanding high quality and better service. If buyers are powerful, then the competitive rivalry will be high. A buyer group is powerful if it:

- purchases large volumes;
- concentrates purchases in an industry (service area);
- purchases products that are standard or undifferentiated;
- has low switching costs;
- earns low profits (low profits force lower purchasing costs);
- poses a threat of backward integration;
- has low quality requirements (the quality of the products purchased by the buyer is unimportant to the final product's quality); and
- has enough information to gain bargaining leverage.

Perhaps the greatest change in the nature of the health care industry in the past decade has been the growing power of the buyers. Managed care organizations purchase services in large volume and control provider choices.

The increasing power of the buyers has fueled system integration as well as blurring of providers and insurers. Large employers as buyers have power over managed care organizations, because they determine whether the MCO will be on the list that employees have to choose from for their health care.

Bargaining Power of Suppliers Much like the power of buyers, suppliers can affect the intensity of competition through their ability to control prices and the quality of materials they supply. Through these mechanisms, suppliers can exert considerable pressure on an industry. Factors that make suppliers powerful tend to mirror those making buyers powerful. Suppliers tend to be powerful if:

- there are few suppliers;
- there are few substitutes;
- the suppliers' products are differentiated;
- the product or service supplied is important to the buyer's business;
- the buyer's industry is not considered an important customer; and
- the suppliers pose a threat of forward integration (entering the industry).

Traditionally, physicians and other health care professionals have been important and powerful "suppliers" to the industry because of their importance to health care institutions. The physician or the insurance plan remains the "gatekeeper" to the system and plays a crucial role in controlling consumer choice. This supplier power has added pressure to purchase primary care individual and group practices by hospital systems. Other suppliers, such as those who supply general medical needs (e.g., bandages, suture materials, thermometers, and so on), have tended not to exercise a great deal of control over the industry. Still others who supply equipment with new, patented technology (e.g., software, new type scanner, and so on) could have moderate to high supplier power, especially in the short run.

Service Area Structural Analysis – Plastic Surgery Michael Porter's five forces analysis is used to evaluate the viability of cosmetic plastic surgery within the Charlotte service area. Competitive intensity and ultimately the profitability of the service category in the service area is determined by a number of favorable factors. As described in Exhibit 3–6, the five forces model suggests that it would be somewhat challenging to enter this market of 24 board-certified plastic surgery practices when these existing competitors face increased competitive pressure. The cosmetic plastic surgery segment will remain competitive because there are barriers to entry for new competitors; however, one barrier to entry is higher: participants generally have some form of medical or dental degree and most of the physicians practicing plastic surgery in Charlotte are board-certified plastic surgeons. However, there are 21 plastic surgery practices listed with the North Carolina Medical Board where

EXHIBIT 3–6 Service Area Structural Analysis – Plastic Surgery, Charlotte, NC

Five Forces	Forces Driving Service Area Competition	Conclusion
Intensity of Rivalry	• Approximately 45 practices (24 with board-certified plastic surgeons) actively advertise that they have physicians who perform procedures or provide products for plastic surgery in the Charlotte, NC area. • Diverse competitors – mostly solo and a few small group practices employing distinctly different strategies (also diverse personalities). • All strategic competitors are plastic surgeons and members of one of the professional plastic surgery associations: the American Plastic Surgery Association (APSA), the American Cosmetic Plastic Surgery Association, or the American Board of Plastic Surgery; however, not all patients know to look for board-certified surgeons. • Other competitors are in different specialties: ophthalmology (eye), dermatology (skin), dentistry (oral-maxillofacial surgery), etc. and are willing to perform "plastic surgery" on patients. • Still others like to state they are "board eligible," meaning they have training or experience in plastic surgery but have not passed the boards or have not bothered to attempt board certification.	***High*** Rivalry is likely to remain intense in this market as the competitors are more numerous relative to the "need" for plastic surgeons, strategic stakes are high, and it is moderately difficult to exit the market (hard to find and establish a practice in a new, better market; establishing referral relationships and credentialing at new hospital(s); some investment in equipment).
Threat of New Entrants	• Existing providers have established reputations and been in practice in the Charlotte area for a number of years. Experience, artistic ability, "good hands," and great personality to easily and confidently interact with patients are important in maintaining a successful cosmetic plastic surgery practice. • Board certification is a major hurdle; however, many consumers do not understand that when an MD states on his/her website that they are "board certified" it does not necessarily mean that it is in the plastic surgery specialty.	***Medium*** Threat of new entrants (new plastic surgeons) into the Charlotte market is presently medium–low, primarily because of the poor economy (consumers abandon elective procedures when they are uncertain about employment), and the existing service area already has numerous competitors. To obtain board certification in plastic surgery is a major hurdle to accomplish by the physician; however, consumers' lack of awareness of the meaning of certification in plastic surgery dilutes it as a hurdle. In Charlotte, 24 practices (38 physicians) are board certified; 21 practices identify "plastic surgery" as their medical specialty using non-certified plastic surgeons.

EXHIBIT 3–6 *(Continued)*

Five Forces	Forces Driving Service Area Competition	Conclusion
	• Capital requirements are not high. For example, the cost of equipment that may be used in the office is less than $50,000 new; however, used equipment is readily available to purchase or lease. Equipment is generally upgraded before it becomes obsolete to maintain cutting-edge technology. • Most single practices operate on a 3+1 office: one doctor and three staff (operating room nurse, office administrator, office nurse). • Many of the procedures are performed in a hospital or surgery center setting that can be used by physicians who are credentialed by that hospital or surgery center (costs are passed on to the patient). • Existing service differentiation – perceived differentiation (high image) for high-end providers through referral from "stars" who freely discuss the procedures they have had. • Market leaders have a strong market position given their experience and consistency in providing great outcomes.	Financial barriers for setting up an office are low.
Threat of Substitutes	• Cosmetics that can enhance appearance at a fraction of the cost. • Injectables, face peels, etc. by any MD – internist, general practitioner, primary care physician, or other non-certified plastic surgeons. • New, strong chins by oral-maxillofacial surgeons. • Patients do not need to have cosmetic plastic surgery and it is quite expensive.	***High*** Currently there are a number of low-cost, non-surgical substitutes provided over-the-counter (OTC). Less invasive procedures are considerably less expensive, less painful, less time (to no time) for recovery, and less intimidating.
Bargaining Power of Customers	• The elective procedure of cosmetic plastic surgery is rarely covered by insurance, rather it is a cash business (some credit is offered – using MasterCard, VISA, or a medical procedure credit card, CareCredit®). • Consumers can easily defer purchase to a later time – or never – after numerous sessions with a number of surgeons. • Patients/consumers have the ability to negotiate the price, but many of them are embarrassed to do so; most physicians are uncomfortable with a negotiation.	***High*** Consumers have high bargaining power because of the elective nature of the procedure and its out-of-pocket cost. Consumers can opt for a much less expensive substitute, shop price, wait for prices to decline, or forego the procedure.

(*Continued*)

EXHIBIT 3–6 *(Continued)*

Five Forces	Forces Driving Service Area Competition	Conclusion
	• Patients/consumers may prefer to travel away from Charlotte to keep the procedures confidential; others may travel to exotic destinations where the costs for cosmetic surgery are considerably lower and a vacation "recovery" period is enjoyable. • Word-of-mouth referral is very powerful.	Brazil has an international reputation for excellent outcomes with plastic surgery and offers a more affordable price (including air fare and top-tier hotels for recovery).
Bargaining Power of Suppliers	• Quite a number of suppliers of laser, liposuction, etc. equipment compete in the market space. • Rent-to-own, purchase, or lease – equipment is essential to the business. Many procedures can be performed in the office or in surgery centers.	***Low*** Currently there are multiple major suppliers of professional-grade equipment for cellulite reduction and more than ten suppliers of laser equipment.

the physician is either board certified in a specialty other than plastic surgery or not board certified (all but one are solo practices). Many of these doctors have performed plastic surgery for many years and tout their experience, expertise, and great outcomes over "paper credentials." For the less invasive plastic surgery procedures, such as Botox® and other injectables, face peels, etc., barriers to entry are not very high as they are often administered by RNs "under physician supervision."

Competitive rivalry is high as more board-certified plastic surgeons than would be expected are located in Charlotte and are already established in practice in the service area. Given the rule-of-thumb of one plastic surgeon for every 50,000–75,000 in population, Charlotte exceeds the number of plastic surgeons needed (and is considerably over the number when both board-certified and non-board-certified physicians with practices in this medical specialty are considered). In addition, most of the board-certified physicians have been in the area and have practices that are long established (average: 15 years, only five physicians have been in the area for 5 years or less).

Consumers (buyers) wield a great deal of choice power because aesthetic plastic surgery in particular is a cash business (no insurance company to dictate choices, little to no integration of these services in a health care system) and a number of substitutes exist – the most important of which is to choose not to elect any of the procedures. Suppliers of medical devices, such as lasers and cellulite reduction (liposuction) machines, are relatively stable with few new entrants and quite a number of manufacturers. Laser manufacturers include: Cutera, Lumenis, Cynosure, Syneron, Focus Medical, Aesthera, Alderm, and Alma Lasers. Cellulite reduction machine manufacturers include: Bausch Instruments, WellsJohnson, Syneron, Alma Lasers, Cynosure/Deka, Argon, DRE, Derma Sense, Alderm, Erchonia, Sharp & Botanica, Pollogen, and LPG Systems). The power of these suppliers has decreased somewhat because of lack of exclusivity in choice of product lines from the market leaders by plastic surgeons. Thus, for cosmetic

plastic surgery in the Charlotte service area, only one of Porter's five forces is favorable (power of suppliers) and four are unfavorable, resulting in thin profit margins and intense competition.

In the future, the five forces for this service category, in this service area, are not likely to change dramatically. Barriers to entry for new competitors will remain consistent, rivalry will remain high, the consumer will be able to shop on price and defer purchase, and substitutes will likely increase. At the same time, the reconstructive plastic surgery market overall remains stable and not greatly affected by swings in the economy; however, the cosmetic plastic surgery market is subject to swings in the economy as the consumer pays out-of-pocket for nearly all procedures.

Conducting Competitor Analysis and Mapping Strategic Groups

The next step in service area competitor analysis (refer to Exhibit 3–1) is to evaluate the strengths and weaknesses of competitors, characterize their strategies, group competitors by the types of strategies they have exhibited, and predict competitive future moves or likely responses to strategic issues and initiatives by other organizations.

Competitor Strengths and Weaknesses In assessing the rivalry of the service area, the competitors are identified. Next, the strengths and weaknesses of each competitor should be specified and evaluated. Organizations have a unique resource endowment and a comparison with a given competitor will help to illuminate the relationship between them and to predict how they compete with (or respond to) each other in the market.[13] Evaluation of competitors' strengths and weaknesses provides clues as to their future strategies and to areas where competitive advantage might be achieved.

Both quantitative and qualitative information may be used to identify strengths and weaknesses. Competitor information is not always easy to obtain, and it is often necessary to draw conclusions from sketchy information. A list of possible competitor strengths and weaknesses is presented in Exhibit 3–7.

Such information may be obtained through local newspapers, trade journals, websites, focus groups with customers and stakeholders, consultants who specialize in the industry, securities analysts, outside health care professionals, and so on. Identification of competitor strengths and weaknesses will aid in speculating on competitor strategic moves. The range of possible competitive actions available to organizations varies from tactical moves, such as price cuts, promotions, and service improvements that require few resources, to strategic moves, such as service category/area changes, facilities expansions, strategic alliances, and new product or service introductions that require more substantial commitments of resources and are more difficult to reverse. Such competitive actions represent clear, offensive challenges that invite competitor responses.[14]

Competitor Strengths and Weaknesses – Plastic Surgery The strengths and weaknesses may be assessed for providers of plastic surgery procedures. For this analysis, a few representative plastic surgery providers

EXHIBIT 3–7 Potential Competitor Strengths and Weaknesses

Potential Strengths	Potential Weaknesses
• Distinctive competence	• Lack of clear strategic direction
• Financial resources	• Deteriorating competitive position
• Good competitive skills	• Obsolete facilities
• Positive image	• Subpar profitability
• Acknowledged market leader	• Lack of managerial depth and talent
• Well-conceived functional area strategies	• Missing key skills or competencies
• Achievement of economies of scale	• Poor track record in implementing strategies
• Insulated from strong competitive pressures	• Plagued with internal operating problems
• Proprietary technology	• Vulnerable to competitive pressures
• Cost advantages	• Falling behind in R&D
• Competitive advantages	• Too narrow a product/service line
• Product/service innovation abilities	• Weak market image
• Proven management	• Below-average marketing skills
• Ahead on experience curve	• Unable to finance needed changes in strategy
	• Higher overall costs relative to key competitors

are profiled in Exhibit 3–8. Assessing strengths and weaknesses of competitors is often difficult for outsiders and, as suggested in the exhibit, weaknesses (in particular those not manifest in the market) are often difficult to identify and assess. However, careful observation, data gathering through websites and media, and a local resource can make this somewhat speculative process fairly accurate. In addition, over time the understanding of competitors' strengths and weaknesses can be refined and improved, and used to update the competitive analysis.

Service Category Critical Success Factor Analysis *Critical success factor analysis* involves the identification of a limited number of activities for a service category within a service area for which the organization must achieve a high level of performance if it is to be successful. The rationale behind critical success factor analysis is that there are five or six areas in which the organization must perform well and that it is possible to identify them through careful analysis of the environment. In addition, critical success factor analysis may be used to examine new market opportunities by matching an organization's strengths with critical success factors.

Typically, once the service category critical success factors have been identified, several goals may be developed for each success factor. At that point, a strategy may be developed around the goals. Important in critical success factor analysis is the establishment of linkages among the environment, the critical success factors, the goals, and the strategy. In addition, it is important

EXHIBIT 3–8 Competitor Strengths and Weaknesses**

Competitor*	Strengths	Weaknesses
Abner Center for Plastic Surgery	• Only female African-American board-certified plastic surgeon in the service area. • Practicing for 14+ years.	• Website has a great opening page but the tabs for photos have no content. • Limited to fewer types of reconstructive and cosmetic surgeries than others. • Cash basis, except reconstructive.
Criswell & Criswell	• Husband/wife team allowing choice of male or female surgeon. • 15 percent off skin care products and sunscreens during July. • Opening second office in upscale area of the city. • Website suggests artistry; they state talented, passionate, artistic, and experienced physicians. Both doctors have art backgrounds (undergraduate major/minor). • Speak Spanish. • Committed to both cosmetic and reconstructive surgery. Many research papers and lectures on reconstructive surgery. • Both are children of physician parents.	• New to Charlotte relative to nearly all other practices (established in 2009). • Consultation fee is applied to surgical procedures. • Use CareCredit®.
Matthews Plastic Surgery	• In practice for over 20 years. • Cosmetic and significant reconstructive surgery. • Serves on the local hospital ethics board. • Performs medical mission trips every year to Third World countries to perform reconstructive surgery; donates supplies as well. • Board certified in cosmetic and reconstructive plastic surgery. • Informative website.	• Initial consultation fee will be credited to patient's bill if procedure is performed within 6 months. • Cosmetic is cash basis; however, major credit cards accepted, financing provided by CareCredit®, a subsidiary of GE Capital which has a reputation for aggressive collections; reconstructive is private or public insurance.
Premier Plastic Surgery Center	• Discount pricing specials ($500 off Mommy Makeover or $400 off Tummy Tuck). • Informative website. • SurgeryMorph® – an online tool using a user-supplied photo to preview what certain plastic surgery procedures would look like for the individual (breast, body, face, or skin can be selected with variations for each). • Free consultation.	• Dense website; somewhat difficult to navigate. Uses CareCredit® for financing. Many (too many?) marketing efforts (advertising, coupons, promotions, etc.).

(*Continued*)

EXHIBIT 3–8 *(Continued)*

Competitor*	Strengths	Weaknesses
Lifestyle Lift Center	• Dedicated to facial cosmetic plastic surgery. • Uses social media and has impressive website. • Uses EPIC: every patient interaction counts. • Included on www.realself.com. • Official physician trainer for Lumenis Corporation, manufacturer of cosmetic laser equipment. • Fluent in Spanish.	• National organization, Lifestyle Lift Centers, does the marketing. • Additional surgeon is not in the Charlotte area. • Practices in North Florida and Mississippi Gulf Coast in addition to Charlotte. • Has two websites – confusing.
Voci Center	• Upscale spa services – aromatherapy, soothing organic candles, calming essential oils, fine lip balms, facial moisturizers, and massage. Also supply an assortment of herbal teas, juices, and purified water. • Private office operating room suites, accredited for general anesthesia by the AAAASF (American Association of Accredited Ambulatory Surgical Facilities) with a board-certified anesthesiologist. • Private overnight rooms for patients after surgery are staffed all night by an RN with ACLS training. • More than 27 years of experience.	• Website is text dense and has no pictures of the spa or operating room. • Consultation fee of $50; however, four open houses per year.

*All physicians are board-certified plastic surgeons.

**The Charlotte, North Carolina plastic surgery service area competitor analysis is based on secondary sources and interviews with plastic surgery practices in the Charlotte area. Opinions and conclusions presented are those of the authors and are intended to be used as a basis for class discussion rather than to illustrate effective or ineffective business practices.

to evaluate competitors on these critical success factors. Indeed, excellence in any (or several) of these factors may be the basis of competitive advantage. Further, these factors form the fundamental dimensions of strategy.

Organizational strategies may differ in a wide variety of ways. Michael Porter identified several strategic dimensions that capture the possible differences among an organization's strategic options in a given service area.

- *Specialization*: the degree to which the organization focuses its efforts in terms of the number of product categories, the target market, and size of its service area.
- *Reputation*: the degree to which it seeks name recognition rather than competition based on other variables.

- *Service/product quality*: the level of emphasis on the quality of its offering to the marketplace.
- *Technological leadership*: the degree to which it seeks superiority in diagnostic and therapeutic equipment and procedures.
- *Vertical integration*: the extent of value added as reflected in the level of forward and backward integration.
- *Cost position*: the extent to which it seeks the low-cost position through efficiency programs and cost-minimizing facilities and equipment.
- *Service*: the degree to which it provides ancillary services in addition to its main services.
- *Price policy*: its relative price position in the market (although price positioning will usually be related to other variables such as cost position and product quality, price is a distinct strategic variable that must be treated separately).
- *Relationship with the parent company*: requirements concerning the behavior of the unit based on the relationship between a unit and its parent company. (The nature of the relationship with the parent will influence the objectives by which the organization is managed, the resources available to it, and perhaps determine some operations or functions that it shares with other units.)[15]

The organization can determine the strategic dimension or dimensions that it will use to compete – however, these decisions cannot be made in a vacuum. Consideration must be given to which of the dimensions competitors have selected and how well they are meeting the needs of customers.

Critical Success Factors – Plastic Surgery From the service areas competitor analysis conducted thus far, the critical success factors may be inferred. The critical success factors for plastic surgery in Charlotte include the following:

1. Surgical and aesthetic expertise in procedures performed.
   - Expertise in initial consultation to set expectations and build a good relationship with the consumer (personality, time investment in a potential patient, "bedside manner").
   - Good hands to perform intricate surgeries with minimal scarring.
   - Medical service – pre-screening, pre-op, post-op.
2. Competitive pricing (secondary to #1) for cosmetic plastic surgery procedures. Free consultation is expected by consumers but this is very time consuming and often not productive. Some doctors require an upfront consultation fee and then apply it to the cost of the procedure(s) if the consumer chooses his/her practice.
3. Managing and meeting consumers' expectations with no complications, whether from surgery or less invasive techniques.
   - Patient's satisfaction with the new look.
   - No complications (infections, scarring that calls for further procedures, and so on).

4. Positive word-of-mouth (estimates are that a satisfied patient refers an average of five others, limited for cosmetic plastic surgery by some patients wanting to keep procedures secret).
   - Satisfaction of the clients.
   - Latest procedures and products, newest technologies.
5. Non-surgical products for surgical after care/appearance.
6. Use of less invasive cosmetic plastic surgery as a gateway to more intense surgical procedures.
   - Botox® and other injectables.
   - Medical spa.
7. Knowledge and profile development of desired specific target market (whether female/male, young/older, single/multiple procedures, cosmetic/reconstructive, etc.).
8. Office environment.
   - Aesthetically attractive physical space; appropriate look and feel for the target market identified.
   - Adoption of new office technologies: computers, practice management software, cameras with ability to "create the new look" based on the individual's own photograph.
   - Three-person staff (minimum) for solo practitioner.

Strategic Groups Service area analysis concentrates on the characteristics of the specific geographic market, whereas strategic group analysis concentrates on the characteristics of the strategies of the organizations competing within a given service area. Strategic groups have been studied in many different industries and there are often several strategic groups within a service area. A *strategic group* is a number of organizations within the same service category making similar strategic decisions. Members of a strategic group have similar "recipes" for success or core strategies.[16] Therefore, members of a strategic group primarily compete with each other and do not compete with organizations outside their strategic group – even though there are other competitors outside the group that may offer similar products or services.

External stakeholders have an image of the strategic group and develop an idea of the group's reputation. The reputation of each strategic group differs because the identity and strategy of each group differ.[17] Organizations within a strategic group use similar resources to serve similar markets. However, leadership in an individual organization must find ways (sometimes subtle) to have its organization stand out from the group (differentiation) to develop competitive advantage over other group members.[18]

Reputation has been defined as an organization's true character and the emotions toward the organization held by its stakeholders. Strategic group reputation may be a mobility barrier leading to increased performance. If reputation does lead to increased performance, individual organizations within the strategic group may need to consider the impact of their actions on the collective

reputation of the group.[19] Thus, if several nursing home organizations in a service area are in the same strategic group, the actions of one influence the reputation of them all. The grouping of organizations according to strategic similarities and differences among competitors can aid in understanding the nature of competition and facilitate strategic decision making. There are four major implications for the strategic group concept:

1. Organizations pursue different strategies within service categories and service areas. Creating competitive advantage is often a matter of selecting an appropriate basis on which to compete.
2. Organizations within a strategic group are each other's primary or direct competitors. As Bruce Henderson, founder of Boston Consulting Group, has noted, "Organizations most like yours are the most dangerous."
3. Strategic group analysis can indicate other formulas for success for a service category. Such insight may broaden a manager's view of important market needs.
4. Strategic group analysis may indicate important market dimensions or niches that are not being capitalized on by the existing competitors. Lack of attention to critical success factors by other competitive organizations offering the same or a similar service may provide an opportunity for management to differentiate its services.

Organizations within a group follow the same or similar strategy along the strategic dimensions. Group membership defines the essential characteristics of an organization's strategy. Within a service category or service area there may be only one strategic group (if all the organizations follow the same strategy) or there may be many different groups. Usually, however, there are a small number of strategic groups that capture the essential strategic differences among organizations in the service area.[20]

The analysis of competitors along key strategic dimensions can provide considerable insight into the nature of competition within the service area. Such an analysis complements Porter's structural analysis but provides some additional insights. As a means of gaining a broad picture of the types of organization within a service area and the kinds of strategy that have proven viable, strategic group analysis can contribute to understanding the structure, competitive dynamics, and evolution of a service area as well as the issues of strategic management within it.[21] More specifically, the usefulness of strategic group analysis is that it:

- can be used to preserve information characterizing individual competitors that may be lost in studies using averaged and aggregated data;
- allows for the investigation of multiple competitors concurrently;
- allows assessment of the effectiveness of competitors' strategies over a wider range of variation than a single organization's experience affords; and
- captures the intuitive notion that "within-group" rivalry and "between-group" rivalry differ.[22]

When analyzing strategic groups, care must be taken to ensure that they are engaging in market-based competition. Many organizations may not be direct or primary competitors because of a different market focus. Organizations will have little motivation to engage each other competitively if they have limited markets in common. It is not unusual for organizations that serve completely different markets yet have similar strategic postures to be grouped together and assumed by analysts to be direct competitors when in fact they are not.[23] For example, a pediatric group practice affiliated with a children's hospital and a community health clinic emphasizing preventive and well care may serve the same population but not be direct competitors because of a different market focus.

Strategic Groups – Plastic Surgery All plastic surgery practices within the Charlotte service area are not the same – products/services offered, emphasis, and patient focus differ greatly. For example, there are numerous single practice surgeons who have built their practices on word-of-mouth referrals and reputation focusing on certain segments of the service category (noses, breasts, eyelids, and so on). These practices may offer other services to their primary patients but undertake little new patient promotion. In contrast, there are also practices within the service area that offer specialty cosmetic treatments, patient pampering, and luxurious surroundings in full-scale medical spas and focus on recruiting new patients seeking a beautiful nose, face, or body. These two types of practices are generally not competing for the same patients.

A number of characteristics differentiate plastic surgeons in the Charlotte service area – practice size, number of ancillary procedures offered, medical spa incorporated with the practice, and focus purely on reconstructive or cosmetic plastic surgery. In addition, plastic surgery credentialing (board certification) identifies surgeons who have specific, additional training in the field. However, many consumers are not aware of the meaning of board certification and will allow eye, ear, nose and throat (EENT) physicians, dermatologists, dentists, and so on to perform the desired plastic surgery. It may be the comfort level they have with a specific doctor ("I love my EENT doctor and he/she takes great care of me . . .") or it may be price that causes them to use a non-board-certified surgeon.

There are nearly 30 physicians in 21 practices in Charlotte who promote plastic surgery as their area of specialization who are not board certified in plastic (cosmetic or reconstructive) surgery. Some of them are board certified in other specialties such as dermatology, general surgery, obstetrics/gynecology, or EENT, and some of them have had residencies or fellowships in plastic surgery, but they are not board certified. This analysis only considers the board-certified plastic surgeons in the service area.

Four major strategic groups make up the competitive landscape in plastic surgery in the Charlotte service area. Considering practice size, costs, number and types of procedures, extent of marketing procedures, and other provider information, the strategic groups are:

- **Strategic Group One – Single practitioners who focus on cosmetic plastic surgery.** This strategic group comprises providers that only offer

cosmetic procedures and are paid out-of-pocket (they do not accept medical insurance). These practices provide traditional cosmetic plastic surgery procedures, many within their own office but also in hospitals or surgery centers. If they advertise, it is primarily through the Internet and the Yellow Pages. Word-of-mouth communication – patients recommending a surgeon based on the great experience and outcome they had – is most common.

- **Strategic Group Two – Single practitioners who perform both reconstructive and cosmetic plastic surgery.** Members of this strategic group provide cosmetic procedures as well as reconstructive procedures. Members of this strategic group are typically reimbursed from insurance for the reconstructive portion of their practice and often accept Medicare and Medicaid patients as a result. Reimbursement rates have declined significantly over the past few years; yet, for some of the physicians their cosmetic surgeries (cash business) have declined even more as the "great recession" drags on. These practices often work "call" and are provided emergency cases or patients are referred by other physicians. A number of the physicians in this group are dedicated to maintaining reconstructive surgery in their practice despite the low reimbursement. For the cosmetic portion of their practice, they rely on some advertising, a web page, and word-of-mouth. The cosmetic portion of the practice is similar to group one; however, these surgeons do not have to rely solely on a cash business.
- **Strategic Group Three – Cosmetic Medical Spas.** Members of this strategic group provide full-service cosmetic plastic surgery as well as medical spas with luxurious surroundings and a wide variety of procedure and product options, ancillary services to support patient convenience, high prices, and word-of-mouth referral as well as sophisticated marketing campaigns that include advertising in newspapers and other paid media as well as excellent web pages. More attention is paid to the details of product and procedure offerings, as well as office aesthetics and holistic care. Prices of the procedures and products for members of this strategic group are higher than those in the other strategic groups, but pampering is desired by this target market. In addition, these practices may offer specials such as $500 off a "Mommy Makeover," $400 off a "Tummy Tuck," complementary fat grafting, $75 off Botox®, or 25 percent off Latisse®. Competitive rivalry is most intense within this group and members compete primarily on reputation, hours of operation, website information, and a great deal of advertising.
- **Strategic Group Four – Multispecialty Practices.** Only three practices have more than two plastic surgeons in the Charlotte area. They offer full-service plastic surgery – both reconstructive and cosmetic using a variety of technologies. One of them is associated with a teaching hospital.

There is little movement of providers from strategic group one or two to strategic group three; however, occasionally there is movement of a practice from group one to group two. Although multispecialty group practices or even single-focus,

multiphysician group practices are not common in plastic surgery that may change because of the pressures to have IT systems and electronic health care records. This new technology is costly and physicians may need to share the expenses.

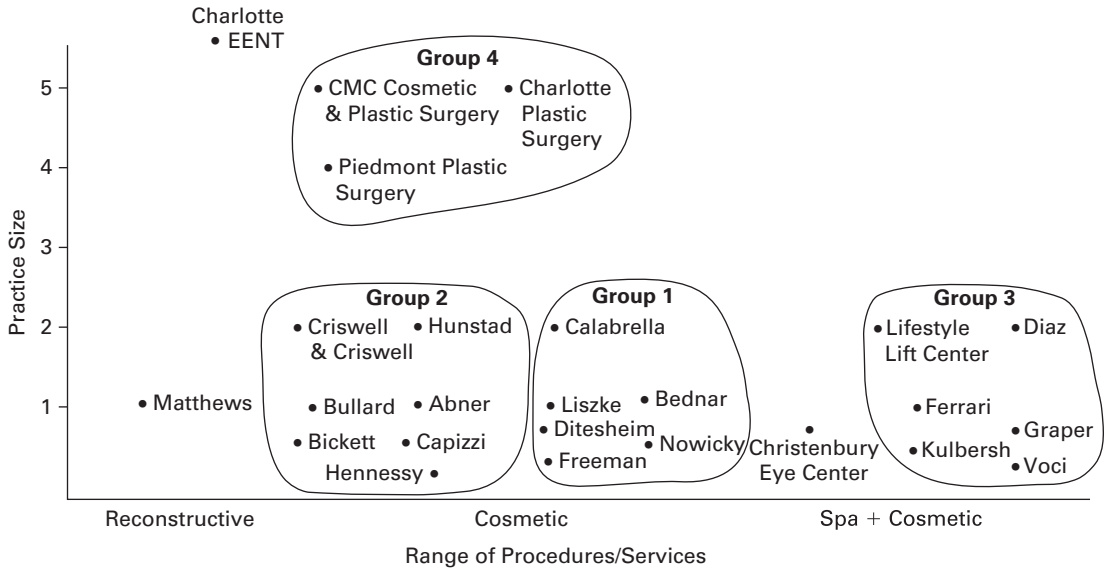
Outliers to this strategic map are one plastic surgeon who devotes his practice to reconstructive surgery; two physicians who are board certified in both otolaryngology and plastic surgery and work at Charlotte Eye, Ear, Nose, and Throat; and one physician who is board certified in both ophthalmology and plastic surgery and markets his practice continuously.

Mapping Competitors *Mapping competitors* for any service category (broadly or narrowly defined) within a service area may be based on the critical success factors or important strategy dimensions. The mapping of competitors helps to identify competitors that are most similar and therefore most dangerous to each other. Competitors in the same strategic group are competing directly with each other and only indirectly with members of other strategic groups.

The best approach to mapping competitors is to select two critical factors for success and evaluate each competitor as to whether it is high or low on these dimensions. Competitors may then be plotted on the basis of these two dimensions (see Exhibit 3–9). Competitors that are similar on these dimensions will cluster together (strategic groups) and are thus competing directly against each other. Several strategic maps may be constructed demonstrating different strategic views of the service area. In addition, a single dimension may be so important as a critical factor for success that it may appear on several strategic maps.

Mapping Competitors – Plastic Surgery Exhibit 3–9 shows a map of the strategic groups with 24 practices in the Charlotte plastic surgery market.

EXHIBIT 3–9 **Competitor Analysis – Mapping Competitors**



The market has split into four distinctive groups that, for the most part, do not engage in between-group competition. Strategic group one and two have some overlap, but the commitment to perform reconstructive plastic surgery is such that a number of the physicians in group two participate in medical missionary trips to Third World countries to perform surgery on cleft palates and other congenital deformities as well as ravages of diseases such as cancer. They tackle some of the most challenging plastic surgery work.

Considerable within-group competition occurs in all the groups but particularly within strategic group three where a number of non-surgical procedures are offered in luxurious surroundings with a great deal of personal attention to attract consumers to the practice along with extensive marketing and advertising to build awareness of the procedures offered at the medical spas. The practices without board-certified plastic surgeons are in different strategic groups (not shown on this map) and tend to engage in significantly more marketing.

Likely Competitor Actions or Responses

Strategy formulation is future oriented, requiring that management anticipate the next strategic moves of competitors. These moves may be projected through an evaluation of competitor strengths and weaknesses, membership in strategic groups, and the characterization of past strategies. In many cases competitor strategic goals are not difficult to project, given past behaviors of the organization. Strategic thinking is a matter of anticipating what is next in a stream of consistent decisions. Strategic behavior is the result of consistency in decision making, and decision consistency is central to strategy. Therefore, in determining competitors' future strategies, strategic managers must look for the behavioral patterns that emerge from a stream of consistent decisions concerning the positioning of the organization in the past.

A thorough analysis of the key strategic decisions of competitors may reveal their strategic intent. A strategic decision timeline can be helpful in showing the stream of decisions. *Strategic response* includes the likely strategic objectives and next strategic moves of competitors. These may be anticipated because of their perceived strengths and weaknesses, past strategies, or strategic group membership. If an organization is planning an offensive move within a service area, an evaluation of competitor strengths and weaknesses, past strategies, strategic group membership, and assumed strategic objectives can anticipate the likely strategic response. For example, HCA's analysis of the strategic response of competitors for a new market it is considering is an important variable in its expansion strategy.

Likely Response – Plastic Surgery A new competitor or any of the existing competitors must realize the following:

- Price decreases will likely be matched by competitors, particularly within strategic groups. Consumers do some "shopping" for a cosmetic plastic surgeon.
- Competition within strategic group one is likely to remain based on cosmetic plastic surgery. If the "great recession" continues, the trend will

move this group to offer more spa-like products and services, putting them into greater competition with strategic group three.

- Competition within strategic group three is likely to remain intense. The practices within this group will continue to invest resources in better and more upscale facilities to try to maintain differentiation from strategic group one.
- Members of strategic group two will continue to be the early adopters of new products and procedures and will compete on the basis of cutting-edge procedures and products with an increasing emphasis on reconstructive surgery. Members of this strategic group will likely match competitors' upgrades in procedures and products very quickly so as to maintain focus on doing good.
- Strategic group four will continue its intergroup competition and its members will focus on maintaining parity within the group. Practice size is not likely to change very much, despite the national data that verifies a number of larger, multispecialty practices.
- The wild card in trying to forecast likely response to a new competitor in the service area is the potential retirement of a number of currently practicing plastic surgeons. As in other specialties and subspecialties, physicians may decide to retire rather than adopt more aggressive activities to have enough patients to remain profitable, opening the door to additional young physicians. Skill in plastic surgery comes with practice; however, most consumers do not want to be the patient who provides the practice! Providers have to gain enough experience to avoid complications and generate positive word-of-mouth.

Synthesizing the Analyses

To be useful for strategy formulation, general and health care external environmental analysis (see Chapter 2) and service area competitor analysis (as covered in this chapter) must be synthesized and then conclusions drawn. It is easy for strategic decision makers to become overwhelmed by information. To avoid paralysis by analysis, external environmental analysis should be summarized into key issues and trends, including their likely impact, and then service area competitor analysis summarized.

Synthesizing the Analyses – Plastic Surgery Although once the domain of the rich and famous, plastic surgery today is more accessible to the public. A website, appropriately named "realself.com," provides feedback from ordinary people (who personally feel they have benefitted from plastic surgery) concerning various physicians by specialty and by city. The out-of-pocket costs for plastic surgery are high and a deterrent to many; however, financing by CareCredit®, a subsidiary of GE Capital, has enabled many middle-class Charlotteans to find their real self through cosmetic plastic surgery. CareCredit® works as a healthcare credit card enabling patients to pay off the cost of plastic surgery over time.

The Charlotte plastic surgery service area is saturated with a number of providers offering a wide range of procedures, products, and prices. The number of plastic surgeons needed is generally estimated to be 1 to 50,000–75,000 in

population. Given the Charlotte region's population, about 20 plastic surgeons are needed; 28 board-certified plastic surgeons have offices in the area plus there are another 30 practitioners who present themselves as plastic surgeons. Thus, significant competition exists for patients.

There are four distinct strategic groups, all of which achieved the hurdle of board certification in plastic surgery to enter the market, high competitive rivalry, high customer power, and some substitutes. Therefore, competition in all four strategic groups is intense and providing excellent service and maintaining the latest technology is always an issue.

There is limited competition across strategic groups and members of one strategic group do not view members of other strategic groups as serious competitors. The surgical practices of each group tend to be distinct to the group, with strategic group one increasing its focus on a more upscale, well-appointed office; strategic group two maintaining more traditional practices and office environments; and strategic group three focusing on elite surroundings with an extremely upscale spa environment that exudes personal attention. Strategic group four represents more traditional medical practices today with multiple physicians: office space is more limited and a budget set by the group is followed.

Market share is dominated by strategic groups one and three that more aggressively market their cosmetic surgery services. The basis for competition for strategic groups one and three is cosmetic plastic surgery services whereas groups two and four incorporate reconstructive surgery into their product mix. Members of strategic group four focus on offering any type of plastic or reconstructive surgery needed by having specialists on various body parts. If a hand specialist is needed, one is available down the hall in the office. If a hand and face specialist is needed, the practice covers those subspecialties, also.

The market is covered and any new entrant is very likely to have a challenging time carving out much market share; most new entrants will probably do so as junior members of someone else's practice. A new provider would have to have some experience with the various plastic surgery procedures, be willing to invest heavily in advertising to develop awareness, use the latest technology (which is typically the most expensive), and be willing (and able) to have low volume for some time. Given the risks, high barriers to entry, competitive rivalry, and so on, it appears that Charlotte would not be a new plastic surgeon's first choice to set up a practice. On the other hand, the Charlotte market is growing, its population is younger than average, and it possesses higher discretionary spending ability.

Managing Strategic Momentum – Validating the Strategic Assumptions

As with the general and health care environments, the initial analysis of the service area provides the basic beliefs or assumptions underlying the strategy. Once the strategic plan has been developed, managers will attempt to carry it out; however, as implementation proceeds, new insights will emerge and new understanding of the competitive services will become apparent. Changes within (and perhaps outside) the service area or from new competitor strategies will directly affect

EXHIBIT 3–10 Strategic Thinking Questions Validating the Strategic Assumptions

1. Is the strategy consonant with the competitive environment?
2. Do we have an honest and accurate appraisal of the competition?
3. Have we underestimated the competition?
4. Has the rivalry in the service category/service area changed?
5. Have the barriers to entering the service category/service area changed?
6. Does the strategy leave us vulnerable to the power of a few major customers?
7. Has there been any change in the number or attractiveness of substitute products or services?
8. Is the strategy vulnerable to a successful strategic counterattack by competitors?
9. Does the strategy follow that of a strong competitor?
10. Does the strategy pit us against a powerful competitor?
11. Is our market share sufficient to be competitive and generate an acceptable profit?

performance of the organization and therefore must be monitored and understood. Competitive awareness and analysis are ongoing activities. The strategic thinking map presented in Exhibit 3–10 provides a series of questions designed to surface signals of new perspectives regarding the service area assumptions.

The Use of General Environmental and Competitor Analysis

In health care organizations today there is a real understanding that not every organization will survive; that no one health care organization can be "everything to everybody." Understanding the external environment – including the general, health care, and service area/competitor environments – is fundamental to strategic management and survival. A comprehensive general and health care environmental analysis and service area competitor analysis, combined with an assessment of competitive advantages and disadvantages (Chapter 4), and establishment of the directional strategies (Chapter 5) provide the basis for strategy formulation.

Lessons for Health Care Managers

Service area competitor analysis is the third element of environmental analysis and increases the focus. Service area competitor analysis is an increasingly important aspect of environmental analysis because of the changes that have taken place in the health care industry throughout the past decade. Specifically, service area competitor analysis is the process of assessing service category/service area issues, identifying competitors, determining the strengths and weaknesses of rivals, and anticipating their moves. It provides a foundation for determining competitive advantage and subsequent strategy formulation.

Health care organizations engage in service area competitor analysis to obtain competitor information and for offensive and defensive reasons. However, analysts must be careful not to misjudge the service area boundaries, do a poor job of competitor identification, overemphasize visible competence, overemphasize where rather than how to compete, create faulty assumptions, or be paralyzed by analysis.

The process of service area competitor analysis includes an identification of the service category for analysis, assessment of the service area conditions, service area structure analysis, competitor analysis, and a synthesis of the information collected and analyzed. Identification of the service category provides the basis for the analysis. Service categories may be defined very broadly or quite specifically and will vary with the intent of the analysis. An identification of the service area will include establishing geographic boundaries and developing a service area profile that might include economic, demographic, psychographic, and disease pattern information.

Service area structural analysis may be accomplished through a Porter five forces analysis: evaluating the threat of new entrants into the market, the service area rivalry, the power of the buyers, the power of the suppliers, and the threat of substitute products or services. Next, competitor analysis should be undertaken. Comprehensive competitor analysis would include an identification and evaluation of competitor strengths and weaknesses, competitor strategy, strategic groups, critical success factors, and likely competitor actions and responses. Finally, service area and competitor information should be synthesized and strategic conclusions drawn to allow recommendations to be made.

Chapter 4 explores how an organization examines its own strengths and weaknesses to understand competitive advantages and disadvantages as a basis for strategy formulation.

Health Care Manager's Bookshelf

W. Chan Kim and Renée Mauborgne, *Blue Ocean Strategy: How to Create Uncontested Market Space and Make the Competition Irrelevant* (Boston, MA: Harvard Business School Press, 2005)

"The only way to beat the competition is to stop trying to beat the competition."[1] Red oceans are all the industries in existence today. The market space is known, the industry boundaries are defined, and the competitive rules are understood. "Products become commodities and cutthroat competition turns the red oceans bloody" (p. 4). Blue oceans, on the other hand, are defined by untapped market space and the opportunity for high growth and profits.

Organizations in red oceans try to beat the competition by building a defensible position in an existing industry. Creators of blue oceans engage in value innovation which is the cornerstone of blue oceans.[2] These firms do not try to beat the competition but focus on creating leaps in value thereby opening up new and uncontested market spaces (p. 12).

There are three characteristics of a sound blue ocean strategy – focus, divergence, and compelling tagline. First, strategies have focus and concentrate on a relatively few things that are done very well. Curves, a women's fitness company, entered the red ocean of fitness companies by focusing on the most desirable aspects of traditional health clubs and home exercise programs. Next, competitors in red oceans react to rivals and lose their uniqueness. Curves differentiated its services by getting rid of special machines, juice bars, and saunas and arranged a limited number of simple-to-operate hydraulic machines in a circle to facilitate interactions among members, making the exercise experience fun. In blue oceans, organizations differentiate themselves from the average industry profile. Finally, a compelling and truthful tagline effectively communicates the value innovation of blue ocean firms.[3] Curves' tagline could be "for the price of a cup of coffee a day you can obtain the gift of health through proper exercise" (p. 58).

There is an interesting paradox in blue ocean strategies. The more successful a firm is in value innovation, the more likely other firms are to imitate it.[4] The easier it is to imitate the blue ocean strategy, the less likely the strategy can be sustained. The blue ocean turns red. Blue ocean creators then become conventional competitors in a bloody sea or must innovate again. Look, for example, at Pfizer's success with Viagra. Pfizer successfully reconstructed the market boundaries by shifting the focus from medical treatment to lifestyle enhancement. Pfizer was incredibly successful and today there is a long list of FDA-approved erectile dysfunction products including Alprostadil, Caverject, CIALIS, Endex, LEVITRA, Muse, Sildenafil, Tadalafil, and Vardenafil.

The authors conclude the book with the recognition that blue and red oceans have always coexisted and successful organizations learn to navigate both types of sea. The penchant to imitate, however, makes it necessary for organizations to understand competition in red oceans and how to create and sustain blue oceans. Much is known about how to navigate red oceans. This book is dedicated to building a "balance by outlining how successful organizations formulate and execute blue ocean strategies" (p. 190). One reviewer indicated that adding this balance was a major stride in a central void in the field of strategy.[5]

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KEY TERMS AND CONCEPTS IN STRATEGIC MANAGEMENT

Competitive Advantage
Competitor Analysis
Critical Success Factor Analysis
Mapping Competitors
Service Area
Service Area Competitor Analysis
Service Area Profile
Service Area Structural Analysis
Service Category
Strategic Group
Strategic Response

Questions for Class Discussion

1. What is entailed in service area competitor analysis? Why should health care organizations engage in competitor analysis? Should not-for-profit organizations perform competitor analysis?
2. What is the relationship between general and health care environmental analysis versus service area competitor analysis?
3. What competitor information categories are useful in competitor analysis? Are these categories appropriate for health care organizations? How can these information categories provide a focus for information gathering and strategic decision making?
4. What are some obstacles to effective competitor analysis? How may these obstacles be overcome?
5. Explain the steps or logic of service area competitor analysis.
6. Why must the service categories be defined first in service area competitor analysis for health care organizations?
7. Why is it important to clearly define the service area? How does managed care penetration affect service area definition?
8. How does the use of Porter's five forces framework help to identify the major competitive forces in the service area?
9. Why is an identification and evaluation of competitor strengths and weaknesses and the determination of strategy essential in service area competitor analysis?
10. What are the benefits of strategic group analysis and strategic mapping?
11. Why should a health care organization attempt to determine competitors' strategies and likely strategic responses?
12. What is the purpose of the synthesis stage of service area competitor analysis?

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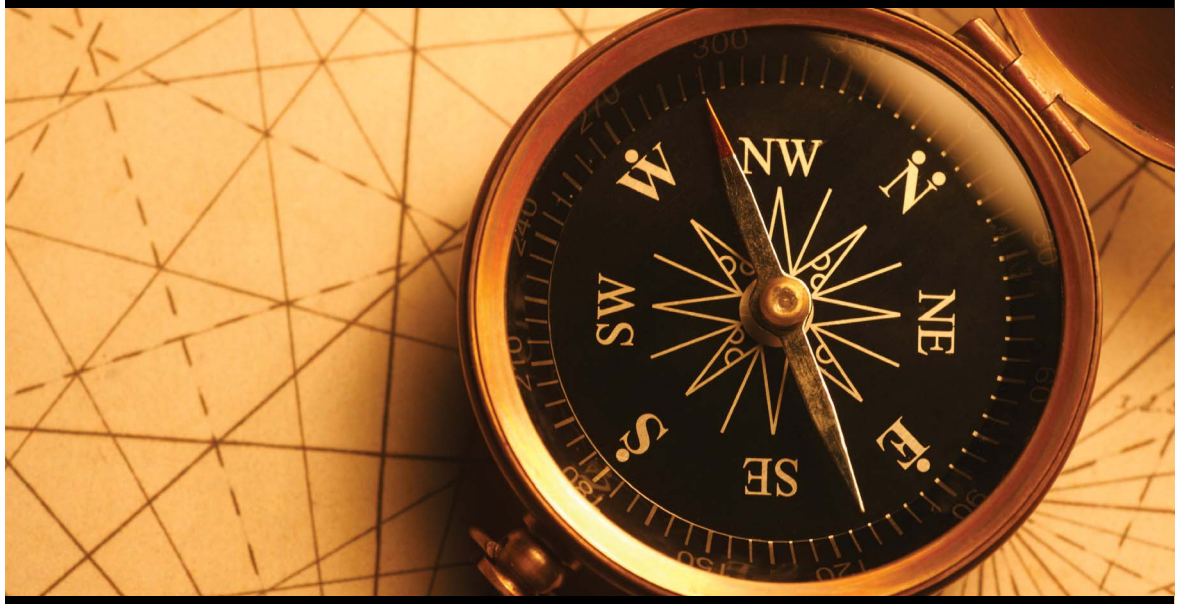
4 Internal Environmental Analysis and Competitive Advantage



"The biggest problem with health care isn't with insurance or politics. It's that we're measuring the wrong things the wrong way."

—ROBERT S. KAPLAN AND MICHAEL PORTER

Introductory Incident

Two-Way Communication and Competitive Advantage

Health care organizations are notorious for one-way communication. When communicating with patients and communities, health care organizations typically employ traditional techniques such as broadcast advertising, distribution of educational materials prepared for a variety of audiences, and similar methods.

A few organizations, however, have recognized the possibilities created by social media and understand that health is extremely personal and materials prepared for mass audiences rarely address the unique concerns of individual patients. Moreover, when patients must access the

health care system they are unprepared for the experience, lost in the confusion of the high-technology environment of health care, and grasping for information. Social media has done much to change this situation. Patients can easily communicate with people across the globe, share common experiences and fears, discover the personal experiences faced by others, and access all types of medical information.

Unfortunately, many health care organizations choose to use social media as just another means of one-way communication. In some cases most of the organization's posts are designed to promote the hospital or medical practice rather than address patient issues and concerns. A few organizations, recognizing this temptation, develop policies that "no more than a certain percentage" of posts can be used for promotion purposes. At Inova Health System an effort is made to ensure that 80–90 percent of its posts address patient health rather than promoting the System.

Inova has made serious attempts to use social media effectively. It has created Facebook communities in specific areas such as wellness, pediatric care, bariatric surgery, and so on. Attempts are made to encourage users to trust Inova as a supplier of valuable health information. Information can be shared about the System but only after trust is built and the interests of the organization are consistent with the interests of the communities.

It is essential to remember why social media is important. The goal is to connect with friends and build communities around common interests and to share information better and faster. Furthermore, communicating poorly is almost as bad as not communicating. The quality of posts is more important than the quantity. Because real-time communication is so exciting we frequently confuse social media overuse with proper use. Designing social media that is honest and transparent is the important determinant of how likely individuals are to follow and participate in an organization's communication efforts.

Some general recommendations for health care organizations to make the most of social media:

1. Be helpful. Patients usually turn to social media because they are afraid and need support or are confused because they cannot get what they need from the organization's website or other informational efforts.
2. Give patients the opportunity to weigh in on their experiences. If patients complain, listen and try to address the complaint directly and quickly. Intercede in a compassionate and helpful way rather than as a "know it all expert."
3. Refrain from traditional communication techniques (e.g., advertising, etc.). Avoid confusing "clinical speak."
4. Listen to your instincts. Social media sites grow and thrive organically. You will likely know when they are working and when they are not. Do not be afraid to fail. Friends do not expect perfection, the cost of entry into social media is low, and the financial risks of failure are small.

Source: Chris Boyer, "Social Media for Healthcare Makes Sense," *Frontiers of Health Services Administration* 28, no. 2 (2011), pp. 35–41.

Learning Objectives

After completing the chapter you will be able to:

1. Understand the role of internal environmental analysis in identifying the basis for sustained competitive advantage.
2. Describe the organizational value chain, including the components of the service delivery and support activities.
3. Understand the ways in which value can be created at various places in the organization with the aid of the value chain.
4. Use the value chain to identify organizational strengths and weaknesses.
5. Determine the competitive relevance of each strength and weakness with the aid of a series of carefully formulated questions.
6. Describe how competitively relevant strengths and weaknesses can be used to suggest appropriate strategic actions.

Identifying Competitive Advantage

To this point, situational analysis has concentrated on factors in the external environment of the health care organization in an attempt to answer the first of three strategic questions concerning situational analysis – "What *should* the organization do?" After assessing the external issues including competitors, the emphasis of situational analysis shifts to the organization and the ways in which competitive advantage may be established. As described in the Introductory Incident, even actions as simple as how we communicate with relevant stakeholders can create value and distinguish the organization, at least in the short run. The creation of some type of competitive advantage is essential. Experts writing on competitive advantage have concluded that successful organizations "focus relentlessly on competitive advantage . . . [they] strive to widen the performance gap between themselves and competitors. They are not satisfied with today's competitive advantage – they want tomorrow's."[1] As discussed in Perspective 4–1, an increasing number of hospitals are attempting to obtain a competitive edge by making public their quality data.

The task of establishing competitive advantage is sometimes perplexing, and not always successful. Developing a better product, charging a lower price, or delivering a better service does not guarantee success. Competitive advantage requires an organization to develop a distinctiveness that competitors do not have and cannot easily imitate. Identifying this distinctiveness requires a shift in focus to the internal environment and an introspective view that allows the organization to answer the second strategically relevant question of situational analysis – "What *can* the organization do?"

PERSPECTIVE 4–1

Reporting Quality Data on Hospital Websites

Public reporting of hospital quality data is intended to address two strategic goals:

1. Empower patients, referring doctors, and other purchasers of health care with information needed to make informed choices regarding their health care.
2. Encourage hospitals and doctors to participate in continuous performance improvement by creating a healthy and competitive environment for better patient outcomes.

Although the process is often seen as overly burdensome, there are some potential advantages for making hospital quality data public. Some of the more important are: better control of the messaging/interpretation of complex clinical data, opportunity to communicate best practices, and quality data used as a marketing tool.

The value of public reporting of hospital quality data is still evolving. To date, comprehensive case studies have not demonstrated that posting of quality data has increased effectiveness, safety, or patient-centered care. Some of the likely reasons for this failure are: (1) metrics for processes of care and clinical outcomes continue to mature; (2) quality of care data are difficult to access and the data are often outdated; (3) much of the data are aggregated or averaged, making it more difficult for patients to distinguish among providers; and (4) quality data are presented using complex medical terminology making it a challenge for consumers to understand and use the data.

Some experts think that in addition to quality data, information on topics such as out-of-pocket costs, days to first appointment, and physician qualifications would be especially useful in aiding consumer choice. After all, a consumer's concept of quality care may differ significantly from the quality data presented by the hospital.

Most consumers support the idea of public disclosure of quality data. However, medical malpractice concerns and the fear of unfair judgments about the quality of clinical practice make many hospitals hesitant to make their data public. Health care providers are skeptical about unintended consequences of public disclosure. Some providers, for example, might attempt to "game the system" by not accepting high-risk patients so as to not adversely affect their outcomes.

It has been suggested that any initiative to publically report quality data should accomplish the following:

- Enhance quality and cost effectiveness through a physician-driven, consumer-oriented approach to public reporting.
- Incorporate measurement tools that drive overall strategy and vision and aid in alignment of the interests of all parties – physicians, consumers, insurance companies, and so on.
- Present the data in an easy-to-understand format and avoid technical terminology.
- Include supplemental data (e.g., out-of-pocket costs, time to first appointment) in addition to standard quality metrics.
- Achieve physician support by providing financial and reputational incentives.
- Partner with insurance plans to integrate databases for better reporting.
- Use accurate, fair, and reliable data that have undergone rigorous scientific validation.

- Use risk-adjusted performance data that allow for severity of illness.
- Cultivate metrics that are actionable and can be used to improve performance, patient safety, and quality of care.
- Ensure reasonable protections against medical malpractice litigation and unfair retribution.

Source: Robert A. Cherry and Gregory M. Caputo, "Reporting Quality Data on Your Hospital Website: What? Why? And How?" *Physician Executive* 37, no. 3 (2011), pp. 24–28.

Analyzing the Internal Environment

Internal environmental analysis is sometimes accomplished by evaluating functional areas such as clinical operations, information systems, marketing, clinical support, human resources, financial administration, and so on. With such an approach, each function or organizational subsystem is carefully analyzed and a list of strengths and weaknesses is developed and evaluated. Although this approach has been successful in some instances, by itself it does not adequately address strategic issues. A better approach is to evaluate the various ways that organizations create value for present and prospective customers (patients) and other stakeholders. The organizational *value chain* is a useful tool for identifying and assessing how health care organizations create value.

Value Creation in Health Care Organizations

Organizations are successful when they create value for their customers. Similarly, health care organizations are successful to the extent that they create value for the patients, physicians, and other stakeholders that rely on their services. *Value* is defined as the amount of satisfaction received relative to the price and the expected outcome or results.[2] For example, a patient may go to a cosmetic surgeon and pay an extremely high price. Despite the high price, the perception of social acceptance, increased feeling of self-esteem, and improved self-confidence may provide so much satisfaction that the patient perceives a very high value. By contrast, patients may go to a free family practice clinic where services are provided in a rude and disrespectful manner and perceive that they have received little or no value. Value is the perceived relationship between satisfaction and price, it is not based solely on price.[3]

Organizational Value Chain

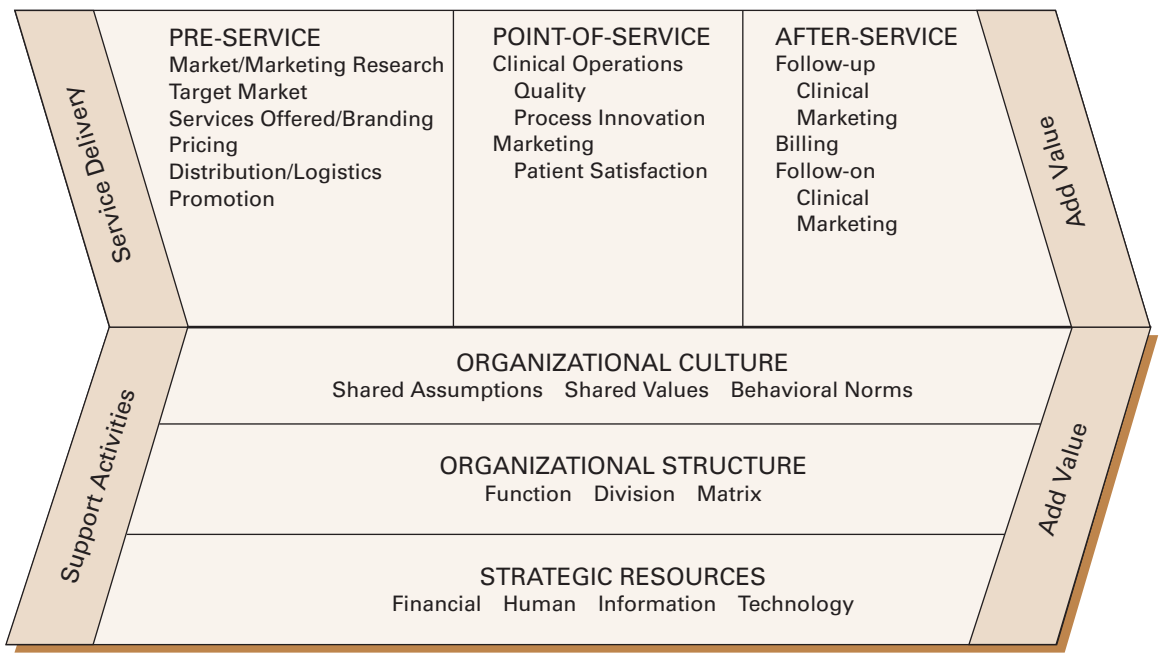
Health care organizations have numerous opportunities to create value for patients and other stakeholders.[4] For example, efficient appointment systems, courteous doctors and nurses, "patient-friendly" billing systems, easy-to-navigate

physical facilities, and the absence of bureaucratic red tape can greatly increase satisfaction.[5] The organizational value chain is an effective means of illustrating how and where value may be created.[6]

The value chain illustrated in Exhibit 4–1 has been adapted from the value chain used in business organizations to more closely reflect the value-adding components for health care organizations. The value chain utilizes a systems approach; value may be created in the service delivery subsystem (upper portion of the value chain) and by effective use of the support subsystem (lower portion). *Service delivery* activities (pre-service, point-of-service, and after-service) are placed above the support activities as they are the fundamental value creation activities; however, they are buttressed by, or "supported" by, activities that facilitate and improve service delivery. The three elements of service delivery – pre-service, point-of-service, and after-service – incorporate the production or creation of the service (product) of health care and include primarily operational processes and marketing activities. Organizational culture, organizational structure, and strategic resources are the subsystems that support service delivery by ensuring an inviting and supportive atmosphere, an effective organization, and sufficient resources such as finances, highly qualified staff, information systems, and appropriate facilities and equipment. Although not always apparent, such support systems and the value they add are critical for an effective and efficient organization.

The value chain as a strategic thinking map provides the health care strategist with a framework for assessing the internal environment of the organization (see Exhibit 4–2). Additionally, the value chain as a framework for developing implementation strategies will be discussed in Chapters 8 through 10.

EXHIBIT 4–1 The Value Chain



Source: Adapted from Michael E. Porter, *Competitive Advantage: Creating and Sustaining Superior Performance* (New York: Free Press, 1985), p. 37.

Service Delivery Activities Health care organizations can create value and significant advantages over competitors in all three of the service delivery subsystems. For example, in late summer and early fall, public health officials begin to remind citizens that it is time for immunization against influenza. There are numerous ways for a provider to create value even before the patients arrive

EXHIBIT 4–2 Description of Value Chain Components

Value Chain Component	Description
Service Delivery	Creation of value that is directly involved in ensuring access to, provision of, and follow-up of health care services.
Pre-Service Activities	Creation of value prior to the actual delivery of health care.
• Market/Marketing Research	Identification of recognizable groups (segments) that make up the market; information gathering to improve quality.
• Target Market	Determination of the appropriate segment to satisfy with health care services.
• Services Offered/ Branding	Dissemination of information to prospective patients and other stakeholders regarding the prices, range of products, and location of available services by an identified health care organization.
• Pricing	Determination of the charge schedule for available services.
• Distribution/Logistics	Actions that aid patient/customer entry into the health care delivery system, including appointments, registration, and parking.
• Promotion	Communication of information to customers concerning the health care offering; includes advertising, events, social media, and so on.
Point-of-Service Activities	Creation of value at the point where health care is actually delivered to the patient.
• Clinical Operations	Actions related to the actual delivery of health care to patients.
◦ Quality	Improvements in the efficiency and effectiveness of health care services.
◦ Process Innovation	Improvements in existing or new operational processes.
• Marketing	Determination of new products, prices; identification of new customers, provision of information to customers.
◦ Patient Satisfaction	Enhancement of the patient/customer health care experience.
After-Service Activities	Creation of value after the patient/customer has received the initial health care.
• Follow-up	Determination of additional services needed to supplement the initial health care.
◦ Clinical	Additional procedures, appointments, tracking.
◦ Marketing	Actions that provide information, assessment of patient/customer satisfaction, and continuation of quality of care.
• Billing	Implementation of clear, easy to understand billing procedures and documents.
• Follow-on	Facilitation of patient/customer entry into another health care setting.
◦ Clinical	Referrals to the proper clinical settings.
◦ Marketing	Provision of information concerning follow-on clinical settings for further (extended) care, tracking of outcomes of care.

(*Continued*)

EXHIBIT 4–2 ***(Continued)***

Value Chain Component	Description
Support Activities	The activities in the value chain that are designed to aid in the efficient and effective delivery of health services.
Organizational Culture	The overarching environment within which the health services organization operates.
● Shared Assumptions	The assumptions employees and others share in the organization regarding all aspects of service delivery (e.g., needs of patients, goals of the organization).
● Shared Values	The guiding principles of the organization and its employees. The understandings people in the organization have regarding excellence, risk taking, etc.
● Behavioral Norms	Understandings about behavior in the organization that can create value for patients.
Organizational Structure	Those aspects of organization structure that are capable of creating value for customers/patients.
● Function	Structure based on process or activities used by employees (e.g., surgery, finance, human resources).
● Division	Major units operate relatively autonomously subject to overarching policy guidelines (e.g., hospital division; outpatient division; northwest division).
● Matrix	Two-dimensional structure where more than a single authority structure operates simultaneously (e.g., interdisciplinary team with representatives from medicine, nursing, administration).
Strategic Resources	Value-creating financial, human, information resources, and technology necessary for the delivery of health services.
● *Financial*	Financial resources required to provide the facilities, equipment, and specialized competencies demanded by the delivery of health services.
● *Human*	Individuals with the specialized skills and commitment to deliver health services.
● *Information*	Hardware, software, and information-processing systems needed to support the delivery of health services.
● *Technology*	The facilities and equipment required to provide health services.

for their flu shot – *pre-service* activities. A provider that views administering flu shots as an effective way to build a caring, quality image might do considerable research to determine which patients need flu shots (or would benefit from having flu shots); where those patients live or work and where they might find it convenient to go for the immunization; how much they might be willing to pay; and how they might best find out about the benefits, convenience, and affordability (promotion). The provider's research discovered that

consumers want to get flu shots, but making an appointment, waiting, and so on, is too inconvenient. Thus, the provider rented space at the mall to enable consumers to receive shots conveniently and easily. Additional information is provided on the price of the shot at the mall compared with other providers (promotion/pricing). In this manner the clinic developed a distinctive market orientation that is not common in public health and many private health care organizations.[7]

Once the patient arrives, *point-of-service* activities occur; multiple ways are available to create value for the customer. The environment is clean and attractive. There is no waiting time. The nurse is courteous, and provides information about possible side-effects of the services to be provided. Numerous public and private organizations have attempted to improve point-of-service by ensuring the delivery of higher-quality services. However, there continues to be considerable controversy as to how effective service improvements alone can lead to a sustainable competitive advantage.[8] At the same time, when patient services are enhanced through innovation that results in an improvement in perceived outcomes, a competitive advantage may result – at least in the short run.[9]

Finally, value can be created through effective *after-service* activities, such as providing assistance in filing the necessary insurance papers or ensuring that credit cards are accepted as a payment alternative in addition to cash or personal checks. Finally, a friendly call (follow-up) from someone the next day to check that there were no adverse side-effects of the treatment is a thoughtful gesture and can create considerable satisfaction for the consumer. Patient satisfaction studies at a later date can serve to remind the consumer of the outstanding care received or, if the consumer was not delighted with the care, the study can identify areas that need improvement.

Support Activities Value creation in service delivery can be greatly enhanced by *support activities*. If the organizational culture is service oriented, patients feel it when they walk through the door.[10] The organizational structure increases patient satisfaction by effectively and efficiently facilitating the service delivery. The structure should have enough standardization to ensure consistent quality and enough flexibility to allow for responding to special needs. Strategic resources are important to the overall perception of value received at the health care organization. Employees with the proper skills, an up-to-date information system, an accessible parking lot, well-maintained buildings and grounds, and up-to-date diagnostic and treatment equipment will have a positive impact on a patient's satisfaction with the visit. It is also important to have modern responsive administrative and financial management systems.[11] Financial systems that are too complex for patients to understand and lost patient records may imply to some that the entire clinic is disorganized and its technology is out of date.

There are a number of opportunities for health care organizations to create value when patients come for a service as simple as immunizations. It is important to recognize that opportunities for value creation may be lost or destroyed within each subsystem just as it can be created.[12] Therefore, the goals, values, and behaviors of all employees must be integrated toward the common objective of patient satisfaction and service.

Identifying Current and Potential Competitive Advantage

Assessing an organization's current and potential competitively relevant strengths and weaknesses is the goal of internal environmental analysis. Competitively relevant strengths are the pathways to sustained competitive advantage.[13] *Competitive advantage* is created within the organization in the form of strengths that are important in the external environment. As illustrated in Perspective 4–2, there are a variety of ways competitively relevant strengths can affect an organization's ability to build and sustain a competitive advantage.

Identifying Strengths and Weaknesses

Identifying an organization's internal strengths and internal weaknesses is a challenging yet essential task of health care strategists as they assess the internal environment. However, organizational characteristics that appear to represent key strengths to strategists may have little importance to patients and other stakeholders or may be strengths of competitors.

In the past, a stable environment allowed static strategies based on one or two strengths to be successful for years, particularly for large, dominant organizations. Competitive advantage for many health care organizations was primarily a matter of "position" where the physician's office, hospital, or sales office occupied a well-defined competitive niche.[14] In today's environment, strengths can quickly become weaknesses as successful strategies are challenged by competitors. A critical component of strategic momentum is continuous evaluation of the organization's strengths and weaknesses relative to the environment.

Some strengths that health care organizations possess are clear and easily recognizable. For example, a particular location may be a strategic strength because it prohibits other organizations from occupying that specific location. Weaknesses may be easy to recognize as well. When an organization assumes excessive debt financing for its facilities, it may not be able to finance emerging technology. Other strengths are subjective in that they represent the opinions of the people who are doing the evaluating. For example, employees stating that the long-term care facility offers a caring environment would be a subjective strength. Employees may believe they provide a caring environment, but do the patients?

Still other strengths and weaknesses are not so obvious and can only be determined in relationship to the strengths and weaknesses of primary competitors (relative strength or weakness). For example, a world-renowned academic health center may lose a famous surgeon to a local hospital that is attempting to build more strength in the clinical area of the surgeon's specialty. The health center may remain very strong in terms of the services it provides but have a relative weakness with regard to the facility where the surgeon is now located.

Competitive advantages of an organization may be based on having rare or abundant resources, special competencies or skills, or management or logistical capabilities. Similarly, competitive disadvantages may result from a lack of resources, competencies, or capabilities. Therefore, strengths and weaknesses

PERSPECTIVE 4–2

Alternative Views of Competitive Advantage

Achieving and maintaining a competitive advantage is the goal of strategy. Organizations attempt different strategies for achieving advantage over competitors depending on what they perceive to be their competitively relevant strengths and weaknesses.

Although, competitive advantage is often discussed at three levels – global, industry, and firm, for health care strategists, the firm level is the most important as health care is delivered locally. Firm-level competitive advantage is the ability of an organization to design, produce, and market products/services that are superior to those offered by competitors, considering price and non-price qualities. Sources of competitive advantage are those tangible and intangible assets (resources and competencies) and processes (capabilities) in the organization that provide an advantage over competitors in the mind of customers.

Traditionally in health care, factors such as location and facilities have been thought of as the primary sources of competitive advantage. Competitiveness has been associated with an organization's resource base which is an important factor in firm-level competitiveness. Unfortunately, focusing on resources alone may overlook other important factors such as patient orientation and positioning in the marketplace. In the dynamic environment of health care, capabilities such as flexibility, agility, speed, and adaptability may be even more important than resources in achieving and maintaining competitive advantage.

Perhaps the most promising views of competitiveness integrate the importance of resources and capabilities in achieving competitive advantage. These approaches are sometimes referred to as APP (asset–process–performance) models. These models help managers to consider how tangible and intangible assets of the organization are combined to achieve desired outcomes (performance) and have the potential for assisting health care leaders in thinking about competitive advantage. Such models discourage functional-centric silo thinking and encourage strategists to think in terms of the entire organizational system, often generating advantages that do not reside within a single organizational subsystem. These models are particularly valuable for health care organizations that have often relied on a single area (for example, clinical excellence) to achieve competitive advantage only to discover that excellence in a single area of the value chain is not sufficient to overcome weaknesses in other areas such as lack of accessibility, stubbornness of bureaucracy, and reluctance to change.

Source: Ajitabh Ambastha and K. Momaya, "Competitiveness of Firms: Review of Theory, Frameworks, and Models," *Singapore Management Review* 26, no. 1 (2004), pp. 45–56.

are easier to identify if one thinks in terms of organizational resources, competencies, and capabilities.[15]

Resources The *resource-based view* of strategy argues that valuable, expensive, or difficult-to-copy resources provide a key to sustainable competitive advantage.[16] Even though the resource-based view has been an integral part of strategic thinking for more than two decades, it has consistently evolved and

matured into a comprehensive theory in recent years.[17] The basic assumption is that "resource bundles" used by health care organizations to create and distribute services are unevenly developed and distributed, explaining – at least to some extent – the ability of each organization to compete effectively. Organizations with marginal resources may break even; those with inferior resources might disappear; and those with superior resources typically generate profits.[18]

Basing strategy on the resource differences between organizations should be automatic rather than noteworthy.[19] However, the argument is far from evident, especially in light of the overwhelming attention given to the external environment in strategy formulation. In addition, there are many different types of resources. More recently the issue of resource orchestration has emerged and focuses not only the amount of resources an organization possesses but the effectiveness of health care managers in structuring, bundling, and leveraging resources.[20]

Resources are the stocks of non-human factors that are available for use in producing goods and services. Resources may be tangible, as in the case of land, labor, and capital, or they may be intangible, as in the case of intellectual property, reputation, and goodwill.[21] The importance of intangible resources should not be underestimated. Robert Kaplan and David Norton point out that unlike financial and physical resources, intangible resources are hard for competitors to imitate, making them a powerful source of sustainable competitive advantage.[22] Furthermore, according to a Harris Interactive Health Care Poll, a good reputation and a trusted physician's recommendation are two of the most important indicators of the quality of medical care. These factors ranked above more tangible indicators of resources, including location, appearance, and condition of physical plant.[23]

Competencies *Competency* is knowledge and skill based and, therefore, inherently human and may be a powerful source of sustained competitive advantage. For a growing number of health care organizations, competitive advantage lies in the ability to create an economy driven not by cost efficiencies but by ideas and intellectual know-how.[24] For example, for many years organizations within the pharmaceutical industry have relied on intellectual know-how and the industry is more innovative today than during its rapid post-World War II growth period.[25]

In many cases, competencies are socially complex and require large numbers of people engaged in coordinated activities.[26] For example, to enter a particular market or offer specific services the organization must possess *threshold competencies* – the minimally required knowledge and skills necessary to compete in a particular area. To offer cardiac services, an acute care hospital must have a minimum number of clinical personnel with specific knowledge and skill in cardiac care. Although all organizations offering cardiac services presumably possess threshold competencies, only one or two will develop the knowledge and skills to the point that it becomes a distinctive competency. This type of competency is a highly developed strength that can be critical in developing a sustained competitive advantage.

Capabilities A health care organization's ability to deploy resources and competencies, usually in combination, to produce desired services is known as its *capability*. The purposeful coordination of resources and competencies is another potential source of sustained competitive advantage.[27] The ability to effectively and

efficiently coordinate resources and competencies to achieve integrative synergies through leadership and management represents *strategic capability*.[28] For example, some assets almost never create value by themselves, they need to be combined with other assets – investments in IT (a resource) have little value unless complemented with effective HR training (competencies). Conversely, many HR training programs have little value unless complemented with modern technology and managerial tools. Another example involves the effective management of the health care organization's supply chain.[29] Individuals who are capable of building and maintaining relationships with suppliers can develop significant advantages over competitors.[30] As discussed in Perspective 4–3, one managerial tool to better utilize resources and competencies to reduce errors in health care is LEAN Six Sigma.

Capabilities fall into one of the two following categories:

1. The ability to make dynamic improvements to the organization's activities through learning, renewal, and change over time.
2. The ability to develop strategic insights and recognize and arrange resources and competencies to develop novel strategies before or better than competitors.[31]

Capabilities are architectural[32] or bonding mechanisms whereby leaders make use of resources and competencies and integrate them in new and flexible ways to develop new resources and competencies as they learn, change, and continually renew themselves and their organizations.[33] Capabilities, therefore, are integrating and coordinating abilities of managers and leaders to bring together resources and competencies in ways that may be superior to those of competitors.[34]

The stock of resources, knowledge, and integrative skills contained in a health care organization may not be sufficient to ensure a sustained competitive advantage. It is likely that two or more organizations competing in the same health care market could have essentially the same resources and similar competencies. When this is the case, the competitive advantage is likely to be the result of different capabilities – a unique culture, strategic leadership, or a set of processes strategically understood.[35] In other words, capabilities are best thought of as processes or ways of bringing together and organizing competencies and resources so as to obtain competitive advantage. Capabilities represent an ability to muster resources, skills, and knowledge in unique ways, coordinate diverse operational skills, and integrate multiple streams of technologies.[36]

Health care organizations that do not have superior resources or unique competencies may still develop sustainable competitive advantages if they are extraordinarily competent at converting ordinary resources and skills into genuine strategic assets.[37] For example, effective management of technology is more important than new computers and software. Effective IT management results in services that respond uniquely to customer needs and, thereby, provide a competitive advantage. The development of this type of capability is based on four interrelated principles:

1. The building blocks of strategy may be processes as well as people, products, services, and markets.
2. Competitive success depends on transforming an organization's key processes into services that consistently provide superior value to customers.

PERSPECTIVE 4–3

LEAN Six Sigma

The possibility of errors lurks in all facets of organizations and many organizations have turned to the techniques of Six Sigma to find them. Developed in the 1980s by Motorola to define, identify, and control defects, Six Sigma has since been used with great success by manufacturing companies such as General Electric, Microsoft, and 3M as well as a number of health care organizations. Although it took health care organizations two decades to pick up on the trend, an increasing number are adopting Six Sigma and its extension LEAN Six Sigma.

Sigma is a notation employed by statisticians to represent one standard deviation from the mean (a measure of variation). A key goal of Six Sigma is to eliminate variation or defects. Although most companies are estimated to be operating at the four-sigma level – tolerating 6,210 defects per million units – the goal of Six sigma is to reduce defects to only 3.4 defects per million units. This aggressive, but attainable, goal is accomplished through a five-phase approach: defining goals, measuring current performance, determining root causes of defects, improving processes to eliminate defects, and controlling ongoing performance. More recently, Six Sigma has been combined with a concept called LEAN organization. The primary focus of LEAN is to eliminate waste and streamline processes based on the following principles:

- Value – create value by examining what is important to the end-user.
- Value stream – understand and determine which steps in the process add value and which ones do not.
- Flow – maintain momentum throughout the process and eliminate waste and delays.
- Pull – avoid surplus and allow customer demand to pull the product or service to determine the supply.
- Strive for perfection – determine the optimum level of performance – the level of perfected services that requires the continuous pursuit of improvements.

One example of the goal of LEAN Six Sigma in health care is the Ottawa Ankle Rules used in the diagnosis of ankle sprain. Twenty years ago every patient presenting with an ankle sprain received an X-ray. Today only a moderate percentage of patients receive an X-ray because evidence-based medicine demonstrated that in many cases an X-ray was not necessary. In this manner an expensive, time-consuming element was eliminated from the treatment of ankle sprains and it has been done without the introduction of new technologies. Instead, the application of the Ottawa Ankle Rules by all physicians in the emergency department by means of clinical practice guidelines illustrates the importance of standardization of clinical practices and is at the heart of LEAN Six Sigma.

As this example illustrates, LEAN Six Sigma incorporates processes heavily focused on data – not opinions or anecdotal evidence – that aims to improve both financial performance and customer satisfaction. A basic premise of LEAN Six Sigma is that even the most complex processes can be broken down into a relatively small number of key factors that are responsible for the majority of defects. LEAN Six Sigma is being used increasingly in health care.

Sources: Adapted from Paul Murphree, Richard Robert Vath, and Larry Daigle, "Sustaining Lean Six Sigma Projects in Health Care," *Physician Executive* 37, no. 1 (2011), pp. 44–49; J. D. Polk, "Lean Six Sigma, Innovation, and the Change Acceleration Process Can Work Together," *Physician Executive* 37, no. 1 (2011), pp. 38–43; Greg Brue, *Six Sigma for Managers* (New York: McGraw-Hill, 2002), pp. 1–20; Clyde M. Creveling, *Six Sigma for Technical Processes* (Upper Saddle River, NJ: Prentice Hall, 2006).

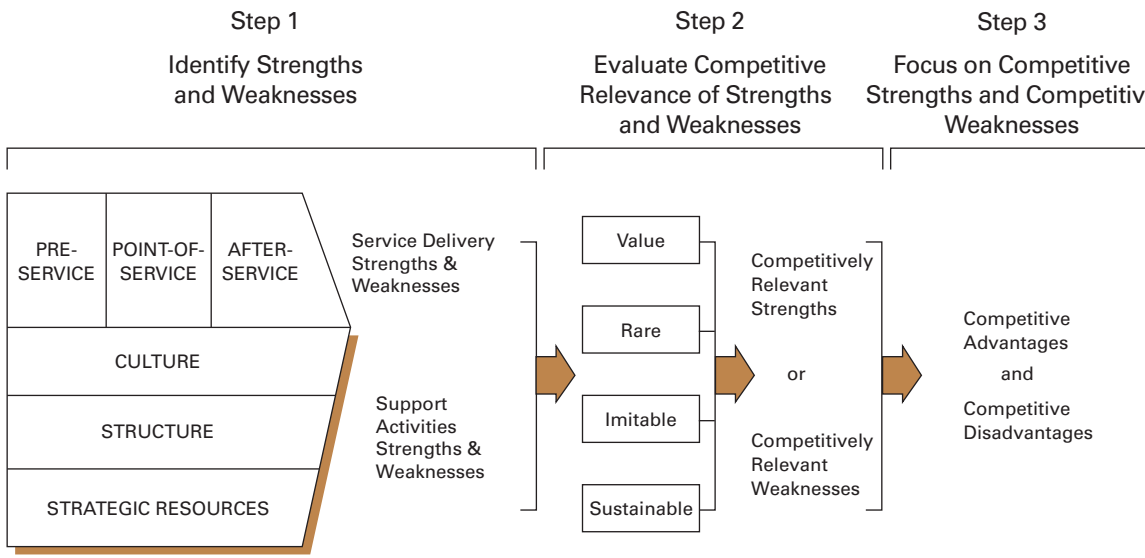
3. Organizations create these capabilities by making strategic investments in a support infrastructure that link together and transcend traditional functions and any single component of the value chain.
4. Because capabilities necessarily cross functions and value chain components, the champion of capabilities-based strategy must be the chief executive.[38]

The Importance of Context

In today's competitive and dynamic environment, the ability to develop a sustained competitive advantage is increasingly difficult. A health care organization enjoys a sustained competitive advantage only so long as the services it delivers have attributes that correspond to the key "buying criteria" of a substantial number of customers in the target market. *Sustained competitive advantage* is the result of an enduring value differential between the services of one organization and that of its competitors in the minds of patients, physicians, and so on.[39] This differential makes an understanding of internal factors extremely important. Health care organizations must consider how their resources, competencies, and capabilities – strengths and weaknesses – relate to those of competitors.

The strategic thinking map shown in Exhibit 4–3 illustrates the process for determining an organization's sources of competitive advantage. With the use of an actual organization, Medtronic, Inc., each step in the process of determining competitive advantage will be illustrated. The first step is to carefully assess the activities that Medtronic does well and the activities it does not do as well within each component of the value chain. After the organization's strengths

EXHIBIT 4–3 **Strategic Thinking Map for Discovering Competitive Advantages and Disadvantages**



and weaknesses have been identified, each is assessed to determine whether it is – or could become – a competitive advantage or competitive disadvantage. Perspective 4–4 provides an overview of Medtronic, Inc.[40]

PERSPECTIVE 4–4

Medtronic, Inc.

Medtronic, Inc., founded in 1949 as a partnership by Earl Bakken and his brother-in-law Palmer Hermundslie, had a modest beginning. The two men came up with an idea for a business while talking about Earl's part-time work at Northwestern Hospital in Minneapolis, Minnesota. The staff learned that Earl was a graduate electrical engineering student and began asking him to repair medical equipment. The partners recognized the opportunity, formed their partnership, and named it Medtronic.

The new company had a slow start; in its first month in business, Medtronic grossed exactly $8 for the repair of a centrifuge. During the second year, Earl and Palmer began representing several medical equipment manufacturers in the Midwest and Medtronic began to grow. The service business increased as doctors and nurses asked the partners to modify equipment, and to design and produce new devices needed for specialized tests. Although Medtronic built nearly 100 different custom devices during the 1950s, only 10 were actually part of the product line. These included two external defibrillators, forceps, an animal respirator, a cardiac rate monitor, and a physiologic stimulator.

Medtronic trades on the New York Stock Exchange under the ticker symbol MDT. Today, Medtronic is the world's leading medical technology company with operations primarily focused on providing therapeutic, diagnostic, and monitoring systems for cardiovascular, neurological, diabetes, spinal, and ear, nose, and throat markets. Since developing the first wearable external cardiac pacemaker in 1957 and manufacturing the first reliable long-term implantable pacing system in 1960, Medtronic has been the world's leading producer of pacing technology.

Medtronic has six operating segments organized under two major groups that manufacture and sell the company's products and medical technologies. These segments and their respective percentages of sales are:

Cardiac and vascular group	
● Cardiac rhythm disease management (CRDM)	31 percent
● Cardiovascular	20 percent
Physio-control restorative therapies group	
● Spinal & biologics	21 percent
● Neuromodulation	10 percent
● Diabetes	8 percent
● Surgical technologies	7 percent
Other	3 percent

The cardiac and vascular group's revenues were the same in 2010 and 2011 where as the restorative therapies group increased its revenue by 2 percent during the same period. The company recorded revenue of almost $16 billion in 2011, a 1 percent increase over the previous year. Non-US sales accounted for approximately 43 percent of total sales.

Research and development continued to be a major priority of Medtronic with more than 350 R&D projects underway in 2011 using the talents of more than 9,000 scientists and engineers. More than 2,000 new patents were awarded and 60 new products were introduced during 2011. Medtronic continued to spend large amounts on R&D (approximately 9.5 percent of sales). Medtronic employs approximately 45,000 people who serve physicians, clinicians, and patients in more than 120 countries worldwide.

Sources: Medtronic, Inc. Form 10-K filed with the Securities and Exchange Commission for fiscal year 2011. Medtronic, Inc. Form 10-Q filed with the Securities and Exchange Commission for fiscal year ended 2011. Medtronic, Inc. *Annual Report,* 2011. Medtronic website: www.Medtronic.com.

Service Delivery Activities

Medtronic, Inc. possesses important value-creating strengths and value-reducing weaknesses in service delivery. Many of Medtronic's strengths are built around the company's reputation for innovativeness as a biomedical engineering company. Medtronic made history when it developed the first wearable external cardiac pacemaker in 1957 and manufactured the first long-term implantable pacing system in 1960. In 1984, the National Society for Professional Engineers selected the wearable pacemaker as one of the 10 outstanding engineering accomplishments of the previous half-century. Since that time Medtronic has accomplished a long list of "firsts" in the area of biomedical engineering.

Another service delivery strength of Medtronic is its worldwide market presence, with 45,000 employees. The company is a market leader in its integrated product line that focuses device-based medical therapies in the areas of cardiac rhythm disease management, spinal and navigation, neurological, vascular, cardiac surgery, and diabetes. Company products have relevance to both the treatment of acute conditions and chronic diseases. In this sense, it is well positioned for the future.

Medtronic deals with products that require high reliability and constant monitoring. As a result it has developed effective systems for early warning of possible quality problems. An example was the speed with which the company notified clinicians when there were suspected shorting problems with the batteries in implantable cardiac defibrillators.

In addition to the service activity strengths, Medtronic has some apparent weaknesses. The worldwide presence makes the company subject to diverse cultural mores and governmental regulations. In addition, its global presence creates additional challenges to quality control and delivery interruptions. Moreover, the nature of the company's product lines, many of which require invasive medical

procedures, are particularly at risk for product liability and intellectual property suits. Even in the United States, the company is faced with difficulty bringing new technologies to market in light of the FDA approval process. Distribution of biomedically engineered products is complex and costly. The decision to self-insure and grow through acquisitions as well as internal development presents a variety of financial risks. Self-insurance might not be adequate for large product liability claims. As with all knowledge-based firms, Medtronic is frequently challenged relative to the use of intellectual properties.

Support Activities

One of Medtronic's greatest strengths lies in the entrepreneurial culture that led to its establishment and has been sustained throughout its history. This culture requires employees who are motivated and creative. In an effort to retain committed professionals, employees have available a variety of benefits including a defined benefit retirement plan, ability to participate in a defined contribution savings plan, and post-retirement medical insurance.

The company is pioneering efforts to combine multiple technologies into its products. Sometimes the technologies are developed by Medtronic and sometimes they are acquired from outside. Increasingly, Medtronic products are incorporating computational, sensing, and communication technologies.

Medtronic has routinely devoted 9 to 10 percent of its net sales to research and development. In addition to internal development, Medtronic has aggressively sought attractive acquisitions. Recently Medtronic acquired ATS Medical with its expertise in the area of cardiac surgery; Ardian, Inc. with its high-technology therapies for high blood pressure; and Osteotech, a company with expertise in the area of biologic products for regenerative medicine. Strong intellectual capital underlies most of Medtronic's key products.

The company has some weaknesses in its support activities. Acquisitions, although potentially valuable, present significant risks of culture clash. With more than 40 percent of the company's sales coming from global operations, many complications and some dangers in dealing with different cultural mores and government regulations arise.

Although Medtronic has a strong market presence in most of its markets, it is facing competition from powerful companies such as Boston Scientific, Johnson & Johnson, Roche Ltd, Stryker, and others. Finally, the company faces increased pricing pressure as more customers form purchasing groups to contain their costs.

After carefully searching through the value chain of an organization and reflecting on its resources, competencies, and capabilities in developing value, Step 2 may be undertaken to and evaluate the competitive relevance of the strengths and weaknesses discovered in Step 1 (see Exhibit 4–3). Exhibit 4–4 summarizes some important value-creating strengths and value-reducing weaknesses of Medtronic, Inc.

Evaluating Competitive Relevance at Medtronic

Identification of the strengths and weaknesses in the various components of the value chain in an organization such as Medtronic inevitably results in a lengthy list of things "we do pretty well" and "things we do not do so well." However,

EXHIBIT 4–4 Value Creating Strengths and Value Reducing Weaknesses for Medtronic, Inc.

Value Chain Component	Value-Creating Strength	Value-Reducing Weakness
Service Delivery, Pre-Service	• Reputation as leading biomedical engineering company. • Presence in the market. Founded in 1949. • Leader in selected market segments (e.g., implantable cardiac rhythm devices). • Operations in more than 120 countries worldwide.	• Vulnerability to diverse cultural mores and regulatory constraints. • Subject to high risk of litigation over patents, trademarks, and product liability claims.
Service Delivery, Point-of-Service	• Integrated product line focused on device-based medical therapies. • State-of-the-art facilities with convenient access to customers.	• Quality control and delivery challenges because of worldwide operations. • Challenges in bringing new technologies to market in a timely manner because of FDA approval process. • Distribution of biomedically engineered products costly.
Service Delivery, After-Service	• System for notification of possible service/quality issues. • After-sale service system with convenient access.	• Ongoing legal claims pose continuous threat to financial viability. • Self-insurance involves significant financial risk.
Support Activities, Culture	• Entrepreneurial culture. • Commitment to community through Medtronic Foundation. • Defined benefit, defined contribution, and post-retirement insurance encourages employees to remain with company. • Aggressive growth strategy based on internal development and acquisitions.	• Acquisitions present risk of culture clash with acquired companies. • Global operations has grown to about 43 percent of sales.
Support Activities Structure	None	None
Support Activities, Strategic Resources	• Numerous patents, trademarks, and trade names. • Strong intellectual capital underlying key products. • Healthy level of working capital and liquidity. • Experienced management team and directors. • R&D expenditures consistently 9–10 percent of net sales.	• Powerful competitors/trademarks in most product lines. • Some growth fueled by risky acquisitions. • Pricing pressures from increasing number of purchasing groups. • Significant increase in short-term borrowing.

not all of the strengths will necessarily be sources of competitive advantage for the organization. For example, executives often believe that "our reputation is our greatest asset." However, in the medical device industry there are numerous firms with excellent reputations (e.g., Boston Scientific and General Electric), so it is unlikely that reputation alone would constitute a significant competitive advantage. Similarly, an identified weakness may not necessarily be a competitive disadvantage if it is not competitively relevant or all competitors have the same weakness (such as a shortage of nurses).

Organizational Strengths *Strengths* must have value, be rare, be difficult to imitate, and be sustainable in order to create competitive advantage.[41] Strengths that are merely present do not represent competitive advantages in themselves. To be competitively significant, the specialized resources and competencies must be marshaled in a way that allows them to become genuine strategic assets, resulting in the accumulation of economic returns greater than could be achieved in any alternative use.[42]

Competitive relevance is determined by critically considering four important questions:

1. *Question of value*. Is the resource, competency, or capability of value to customers?
2. *Question of rareness*. Is this organization the only one that possesses the resource, competency, or capability or do many or all of its competitors possess it?
3. *Question of imitability*. Is it easy or difficult to duplicate the resource, competency, or capability?
4. *Question of sustainability*. Can the resource, competency, or capability be maintained over time?[43]

A judgment must be made as to whether the strength is of high (H) or low (L) value in the marketplace. Value is a critically important question because if a strength does not have high value in the marketplace there is no reason to ask the other three questions. A strength that does not have value is simply not relevant in a competitive sense.

The second question requires that a judgment be made as to whether the strength is rare or commonly found among competitors. If the strength is rare, an answer of "yes" (Y) is appropriate. If it is possessed by many or all competitors, the answer is "no" (N). Combined with value, the relative rareness of a strength is key to competitive advantage. Even critically valuable strengths that are not rare among competitors do not create a competitive advantage.

Question 3 attempts to determine whether it would be difficult (D) or easy (E) for competitors to obtain or imitate the strength. The rareness of a strength becomes even more important the more difficult the strength is to imitate. If a valuable and rare strength is easy to imitate, it may be the basis for a competitive advantage in the short run but is not a good bet for long-term strategy formulation. Competitors will likely imitate any resource, competency, or capability that is valuable, rare, and easy to imitate as soon as possible.

Finally, the fourth question involves a judgment as to whether the organization can sustain the resource, competency, or capability. A "yes" (Y) or "no" (N) answer is required to this question. If the strength cannot be sustained it will provide, at best, only a short-term advantage over competitors. Strengths are competitively relevant if they are valuable to customers and rare in the marketplace. The difficulty or ease with which competitors can imitate the strengths and the organization's ability to sustain them determines the extent of its long-term or short-term advantage. Exhibit 4–5 provides a strategic thinking map for

EXHIBIT 4–5 Strategic Thinking Map of Competitive Advantages Relative to Strengths in General

Is the *Value* of the Strength High or Low? (H/L)	Is the Strength *Rare*? (Y/N)	Is the Strength Easy or Difficult to *Imitate*? (E/D)	Can the Strength be *Sustained*? (Y/N)	Implications
H	N	E	Y	No competitive advantage. Most competitors have the strength and those that do not can develop it easily and sustain it. Because the strength is widely possessed and can be sustained, it is likely that it already has become a minimum condition for long-term success.
H	N	E	N	No competitive advantage. Most competitors have the strength and it is easy to develop. However, the strength generally is not sustainable. If the organization is the only organization in the service area that cannot sustain the strength, it will become a short-term competitive disadvantage.
H	N	D	Y	No competitive advantage. Many competitors possess the strength but it is difficult to develop, so care should be taken to maintain this strength. Because the strength is widely possessed and can be sustained, it is likely that it already has become a minimum condition for long-term success.
H	N	D	N	No competitive advantage. Many competitors possess the strength yet it is difficult to develop, and those who do possess it will not be able to sustain the strength. If the organization is the only organization that cannot sustain the strength, it will become a long-term competitive disadvantage.
H	Y	E	Y	Short-term competitive advantage. Because the strength is valuable and rare, competitors will do what is necessary to develop this easy-to-imitate strength. The organization should exploit this short-term advantage but should not base long-term strategies on this type of strength. Over time, this strength may become a minimum condition for long-term success.

(*Continued*)

EXHIBIT 4–5 ***(Continued)***

Is the *Value* of the Strength High or Low? (H/L)	Is the Strength *Rare*? (Y/N)	Is the Strength Easy or Difficult to *Imitate*? (E/D)	Can the Strength be *Sustained*? (Y/N)	Implications
H	Y	E	N	Short-term advantage but not a source of long-term competitive advantage. The strength is easy to imitate but cannot be sustained. The organization should not base long-term strategies on this type of strength but may obtain benefits for a short-term advantage.
H	Y	D	Y	Long-term competitive advantage. This strength is rare in the service area, difficult to imitate by competitors, and can be sustained by the organization. If the value is very high, it may be worth "betting the organization" on this strength.
H	Y	D	N	Short-term competitive advantage but not a strength that can be sustained over the long run. Although rare and difficult to imitate, the strength cannot be sustained. This strength should be exploited for as long as possible.

the possible combinations of the four questions regarding strengths and the implications for strategic leaders.

To further illustrate how this process may be used, the strengths of Medtronic, Inc. (identified in Step 1) are evaluated with regard to the four questions (Exhibit 4–6). From the initial assessment, Medtronic, Inc. appears to have a number of potentially important strengths (those strengths that have a high value in the marketplace). These are: (1) reputation; (2) established presence in market; (3) market leader in selected business segments (e.g., cardiac rhythm devices); (4) operations in more than 120 countries; (5) integrated product lines; (6) state-of-the-art facilities; (7) established service issue notification system; (8) established after-sale service system; (9) entrepreneurial culture; (10) commitment to community; (11) aggressive growth strategy; (12) numerous patents and trademarks; (13) strong intellectual capital behind key products; (14) healthy level of working capital and liquidity; (15) experienced management team and directors; and (16) R&D expenditures at a consistently high rate.

Consider, for example, the profiles of various combinations of Medtronic's strengths listed in Exhibit 4–6. The high-value strengths are examined relative to the three additional questions. Strengths such as number 7 – established system of service issue notification, number 8 – established after-sale service program, number 10 – commitment to community, and number 14 – healthy level of working capital and liquidity are valuable, not rare, easy to imitate, and can be sustained (HNEY). These strengths should be maintained because they are widely possessed and are most likely a minimum condition for success.

EXHIBIT 4–6 Competitive Relevance of the Strengths of Medtronic, Inc.

Strengths	Is the *Value* of the Strength High or Low? (H/L)	Is the Strength *Rare*? (Y/N)	Is the Strength Easy or Difficult to *Imitate*? (E/D)	Can the Strength be *Sustained*? (Y/N)
Service Delivery				
1. Reputation as biomedical engineering company.	H	N	D	Y
2. Established presence in the market.	H	N	D	Y
3. Market leader in selected business segments.	H	Y	D	Y
4. Operations in more than 120 countries worldwide.	H	N	D	Y
5. Integrated product line focused on manufacture and sales of device-based medical therapies.	H	Y	D	Y
6. State-of-the-art facilities with convenient customer access.	H	Y	E	Y
7. Established system of service issue notification.	H	N	E	Y
8. Established after-sales service system.	H	N	E	Y
Culture				
9. Entrepreneurial culture.	H	Y	D	Y
10. Commitment to community through Medtronic Foundation.	H	N	E	Y
11. Aggressive growth strategy based on internal development and acquisitions.	H	N	D	Y
Strategic Resources				
12. Numerous patents, trademarks, and trade names.	H	Y	D	Y
13. Strong intellectual capital behind key products.	H	Y	D	Y
14. Healthy level of working capital and liquidity.	H	N	E	Y
15. Experienced management team and directors.	H	N	D	Y
16. R&D expenditures consistently 9–10 percent net sales.	H	N	D	Y

Opinions and conclusions presented are those of the authors and are intended to be used as a basis for class discussion rather than to illustrate effective or ineffective business practices.

If Medtronic does not maintain them, it will be at a disadvantage relative to competitors.

Medtronic does not have any strengths that are valuable but not rare (are common), are easy to imitate, and cannot be sustained (HNEN). However, strengths, such as number 1 – reputation, number 2 – established market presence, number 4 – worldwide operations, number 11 – aggressive growth strategy, number 15 – experienced management team, and number 16 – R&D expenditures at consistent levels are valuable, not rare among competitors, difficult to imitate, and can be sustained by Medtronic (HNDY). These strengths should be maintained because most likely they have become minimum conditions for long-term success. Medtronic has no strengths that are not rare, are difficult to imitate, and cannot be sustained (HNDN).

Strengths such as number 6 – state-of-the-art facilities with convenient customer access are valuable, rare, easy to imitate, and can be sustained (HYEY). These strengths may be a source of short-term advantage and should be exploited for as long as possible. However, long-term strategies should not be based on this type of strength. Medtronic has no strengths that are highly valued, rare, easily imitated, and not sustainable (HYEN) or valued strengths that are rare, difficult to imitate, and cannot be sustained (HYDN). Finally, highly valued strengths that are rare, difficult to imitate, and sustainable (HYDY) provide the basis for a long-term competitive advantage and should be developed as much as possible. In the case of Medtronic, the company's number 3 – leadership in selected business segments, number 5 – integrated product line focused device-based medical therapies, number 9 – entrepreneurial culture, number 12 – patents and trademarks, and the related strength number 13 – strong intellectual capital underlying key products represent long-term sustainable competitive advantages.

Organizational Weaknesses The strategic relevancy of each weakness can be determined by asking questions similar to those used to evaluate strengths. *Weaknesses* are serious competitive disadvantages if they have high value to patients and other stakeholders (H), are not possessed by competitors (N), cannot be easily eliminated or corrected (D), and competitors can sustain their strengths (Y). Exhibit 4–7 provides a strategic thinking map listing the suggested actions of strategic leaders relative to possible combinations of weaknesses.

An assessment of the value chain for Medtronic, Inc. revealed a number of weaknesses (Exhibit 4–8). These are: (1) vulnerability to diverse cultural mores and regulations; (2) high risk of litigation over patents, trademarks, and product liability; (3) quality and delivery challenges due to worldwide operations; (4) delays in bringing new technologies to market because of FDA regulations; (5) costly distribution of biomedical products; (6) legal threats to financial viability; (7) self-insurance may be inadequate; (8) acquisitions risk culture clash; (9) over 40 percent of sales from global operations involves significant risk; (10) powerful competitors in most product lines; (11) some growth fueled by risky investments; (12) pricing pressures from increasing number of purchasing groups; and (13) significant short-term borrowing.

EXHIBIT 4–7 Strategic Thinking Map of Competitive Disadvantages Relative to Weaknesses

Is the Weakness of High or Low *Value*? (H/L)	Is the Weakness *Common* (Not Rare) Among Competitors? (Y/N)	Is the Weakness Easy or Difficult to *Correct*? (E/D)	Can Competitors Sustain their *Advantage*? (Y/N)	Implications
H	Y	E	Y	No competitive disadvantage. Although a weakness of the organization, most other competitors are also weak in this area. However, the weakness is easy to correct and competitors will likely work to correct the weakness. If the organization fails to correct the weakness, competitors could achieve a short-term competitive advantage. Over time, correcting this weakness is likely to become a minimum condition for long-term success.
H	Y	E	N	No competitive disadvantage. Although a weakness of the organization, most other competitors are also weak in this area. However, the weakness is easy to correct. It is likely that most competitors will work to correct the weakness and therefore no organization will be able to sustain an advantage.
H	Y	D	Y	No competitive disadvantage. Although a weakness of the organization, most other competitors are also weak in this area and it is difficult to correct. However, this situation is dangerous and should be addressed to ensure that competitors do not overcome this difficulty and correct it first. If competitors correct the weakness and continue to sustain their advantage the weakness could become a long-term competitive disadvantage.
H	Y	D	N	No competitive disadvantage. Although a weakness of the organization, most other competitors are also weak in this area and it is difficult to correct. It is likely this weakness is chronic among competitors in the service area as corrections in the weakness tend to erode over time.

(*Continued*)

EXHIBIT 4–7 ***(Continued)***

Is the Weakness of High or Low *Value*? (H/L)	Is the Weakness *Common* (Not Rare) Among Competitors? (Y/N)	Is the Weakness Easy or Difficult to *Correct*? (E/D)	Can Competitors Sustain their *Advantage*? (Y/N)	Implications
H	N	E	Y	Short-term competitive disadvantage. Most competitors are not weak in this area; however, the weakness is easy to correct. The organization should move quickly to correct this type of weakness. Correcting this weakness is likely to become a minimum condition for long-term success.
H	N	E	N	Short-term competitive disadvantage. Competitors are not weak in this area; however, the weakness is easy to correct. The organization should move quickly to correct the weakness. It is likely that all competitors will correct the weakness and therefore cannot sustain any advantage.
H	N	D	Y	Serious competitive disadvantage. The weakness is valuable, most competitors do not have it, it is difficult for the organization to correct, and competitors can sustain their advantage. If the weakness is of very high value, it may threaten the survival of the organization.
H	N	D	N	Short-term competitive disadvantage. The weakness is valuable, most competitors do not have it, it is difficult for the organization to correct; however, competitors cannot sustain their advantage. Until this area becomes a weakness for most competitors in the service area or the weakness corrected by the organization, it will continue to be a serious disadvantage.

As presented in Exhibit 4–8, Medtronic, Inc. possesses one serious strategic weakness (HNDY) that could represent a long-term competitive disadvantage, that is number 6 – ongoing legal claims. This weakness is valuable to customers, most competitors do not possess the same degree of exposure, it is difficult to correct, and competitors that do not have the weakness can sustain their advantage. This weakness requires attention.

The company faces some weaknesses that are not competitive disadvantages but are dangerous in the sense that care must be taken to ensure that competitors do not overcome their own weaknesses in these areas and turn them into an

EXHIBIT 4–8 Competitive Relevance of the Weaknesses of Medtronic, Inc.

Weaknesses	Is the Weakness of High or Low *Value*? (H/L)	Is the Weakness *Common* (Not Rare) Among Competitors? (Y/N)	Is the Weakness Easy or Difficult to *Correct*? (E/D)	Can Competitors Sustain Their *Advantage*? (Y/N)
Service Delivery				
1. Vulnerability to diverse culture mores and regulations.	H	Y	D	Y
2. High risk of litigation from patents, trademarks, and product liability.	H	Y	D	Y
3. Quality and delivery challenges from worldwide operations.	H	Y	D	N
4. Difficult to bring new technologies to market because of FDA regulations.	H	Y	D	N
5. Distribution of biomedical products costly.	H	Y	D	N
6. Ongoing legal claims represent serious financial threat.	H	N	D	Y
7. Self-insurance risks inadequate coverage.	H	Y	D	Y
Culture				
8. Acquisitions risk culture clash.	H	Y	D	N
9. Large commitment to global operations (one-third of net sales) involves considerable risk.	H	Y	D	N
Strategic Resources				
10. Powerful competitors in most product lines.	H	Y	D	N
11. Some growth fueled by risky acquisitions.	H	Y	D	N
12. Pricing pressure for purchasing groups.	H	Y	D	N
13. Significant increases in short-term borrowing.	H	N	E	N

Opinions and conclusions presented are those of the authors and are intended to be used as a basis for class discussion rather than to illustrate effective or ineffective business practices.

advantage they can sustain (HYDY). These weaknesses are number 1 – vulnerability to cultural mores and regulations, number 2 – high risk of litigation from patents, trademarks, and product liability, and number 7 – self-insurance risk.

Many of Medtronic's weaknesses (HYDN) are not competitive disadvantages. The weaknesses are common in the industry and no advantage can be sustained by competitors. These weaknesses are number 3 – quality and delivery

challenges from worldwide operations, number 4 – difficulty in bringing technologies to market because of FDA regulations, number 5 – costly distribution of biomedical products, number 8 – risk of culture clash in acquisitions, number 9 – large commitment to global operations, number 10 – powerful competitors, number 11 – growth fueled by risky acquisitions and number 12 – pricing pressure from purchasing groups. Should Medtronic correct these weaknesses and sustain them, they could create a long-term competitive advantage.

Medtronic does not appear to have a long-term disadvantage in an area where the weakness is highly valued, rare among competitors, difficult for the company to correct, and cannot be sustained (HNDN). Should Medtronic possess this type of weakness it would be a competitive disadvantage until the company could correct the difficult problem or eliminate competitors' ability to sustain the advantage. Similarly, there are no apparent weaknesses where the weakness relates to something that is highly valued, common among competitors, easy to correct and can be sustained (HYEY). The same is true with regard to areas where the weakness relates to something valued, common among competitors, easy to correct, and cannot be sustained (HYEN). Neither of these areas presents a short- or long-term disadvantage. Further, Medtronic does have one weakness (number 13) that relates to something valued, rare among competitors, easy to correct, and cannot be sustained (HNEN) but has no weakness that is valued, rare among competitors, easy to correct, and can be sustained (HNEY). Although these weaknesses would not present a short- or long-term disadvantage, the fact that they are rare among competitors would be a reason for concern since competitors do not possess the same weaknesses.

Focusing on Competitive Advantage

As illustrated in Exhibit 4–3, the final step in exploiting competitive advantage is to determine how each competitively relevant strength and weakness is likely to affect an organization's ability to compete in the marketplace. *Competitively relevant strengths* are those that are valued in the marketplace, are rare, are difficult to imitate, and can be sustained. *Competitively relevant weaknesses* relate to areas that are valued in the marketplace, are not common weaknesses among competitors, are difficult for organizations to correct, and offer advantages that can be sustained by others. Exhibit 4–9 lists each of Medtronic's competitively relevant strengths and weaknesses that have been identified (those displaying the pattern HYDY for strengths and HNDY for weaknesses from Exhibit 4–6 and Exhibit 4–8) and speculates as to whether or not Medtronic has the potential to differentiate itself from its competitors or provide a cost advantage over its competitors.

Note that the assessment indicates that Medtronic's strategic leadership has the ability to differentiate the organization and its services through the breadth of its service line and quality image as supported by its focus on device-based medical therapies. In other words, the organization has the potential to create a value-added image in the minds of patients and other stakeholders. Leaders must be careful, however, because competitors have an advantage in that they have fewer services in their service line and may be able to maintain more consistent quality with a more narrow focus.

EXHIBIT 4–9 Strategic Implications of Medtronic's Competitively Relevant Strengths and Weaknesses

Competitively Relevant Strength or Weakness	Strategic Implications
Strengths	
Market leader in selected business segments.	Economies of scale could be leveraged over competitors with smaller market shares
Integrated product line focused on device-based medical therapies.	Although competitors are strong and have comprehensive product lines, Medtronic appears more focused on manufacture and sale of an integrated line of device-based medical therapies.
Entrepreneurial culture.	History and performance has established firm's reputation for innovation.
Numerous patents, trademarks, and trade names.	Legal protection of products and product names can constitute important aspect of differentiation.
Strong intellectual capital underlying key products.	Same as for patents and trademarks.
Weaknesses	
Ongoing legal claims that could prove a threat to financial viability.	Settlements against the company could result in serious financial consequences.

Opinions and conclusions presented are those of the authors and are intended to be used as a basis for class discussion rather than to illustrate effective or ineffective business practices.

Careful analysis of the internal environment provides a better understanding of where strategic leaders should focus their efforts to compete effectively and where they should be careful to avoid vulnerability relative to competitors. It is not possible to be everything to everyone; an organization must focus its efforts on what it does best.

A Final Challenge

The basic endowment of resources, competencies, and capabilities in a health care organization and the way they are allocated are critical determinants of the organization's ability to compete effectively. Medtronic has strategically developed a position of market leadership in selected segments such as cardiac rhythm devices, has carefully developed an integrated product line around the manufacture and sales of device-based medical therapies, and has maintained its entrepreneurial culture which is manifested by its intellectual capital, patents, and trademarks in key product areas. However, the organization must remain proactive to new and challenging opportunities if it is to remain competitive. Indeed, it has formidable competitors in companies such as Boston Scientific, Johnson & Johnson, and others. To be complacent in the medical

device industry would be fatal. Arguably, the essential character of strategic thinking is the acceptance of "an aspiration that creates, by design, a chasm between ambitions and resources." It is further argued that spanning the chasm and encouraging stretch "is the single most important task senior management faces."[44]

Stretch is accomplished through resource leveraging or systematically achieving the most products and services possible from the available resources. Stretch enables smaller health care organizations that are less rich in resources, competencies, and capabilities to compete against large, powerful, national and regional health networks and managed care organizations. Leveraging is usually thought of in terms of financial leveraging through the use of debt; however, other resources may be leveraged as well.

Leveraging may be accomplished by concentrating, accumulating, complementing, conserving, and recovering resources.[45] Resources, competencies, and capabilities are more effectively directed toward strategic goals when they are concentrated. Prioritizing goals and focusing on relatively few things at one time aids the concentration of limited resources. Successful concentration of resources, competencies, and capabilities requires not only focusing on relatively few things but also focusing on the right things – those activities that make the greatest impact on patients' perceived value. Nurses, receptionists, therapists, maintenance employees, and others come into contact with patients and observe organizational realities in ways that are different from physicians, CEOs, and management personnel. The stockpiles of experience accumulated by the individuals with extensive patient contact are valuable competitive resources if properly mined and extracted.

Complementary resources, competencies, and capabilities can be combined to create synergy or higher-order value. In the value chain, linking activities will provide unique opportunities to integrate functions such as service delivery, organizational culture, and strategic resources. In other words, there is a creative interweaving of different types of skills that assists in creating competitive advantage.

The more often that a particular resource, competency, or capability is used, the greater the potential for leveraging. The ability to quickly switch knowledge from delivering one service to another conserves service development resources and reduces the learning curve in introducing and perfecting service delivery. Conserving and recovering resources by restricting their exposure to unnecessary risks is essential to the conservation of limited resources. An aspiring competitor in a health care market should think carefully before attacking the dominant player at the point of the competitor's greatest strength. Competing directly with a powerful competitor might subject limited resources, competencies, and capabilities to excessive risks and would likely be unsuccessful. Challenging a stronger competitor requires creativity and innovation.

Expediting success – increasing the resource multiplier by reducing the time between expenditure of resources and their recovery through revenue generation – is an important means to leverage resources. Reducing the payback period of technological improvements in health care organizations is a substantial resource recovery challenge. On the one hand, high-quality service delivery depends on state-of-the-art technology. On the other hand, this type of

technology is expensive and usually has a relatively short economic life. Careful planning is required to ensure that paybacks are evaluated and accelerated in every possible way.

Interestingly, as illustrated in Perspective 4–5, even in public sector organizations, a great deal of resource leveraging is a matter of attitude and willingness to take reasonable risks, to do things in new and innovative ways,

PERSPECTIVE 4–5

Building an Entrepreneurial Culture in Public Health

Most informed observers will admit that a primary reason why private sector health care organizations are more efficient and often more effective in achieving their goals than public sector organizations is a result of the culture of the respective organizations. Private sector organizations are particularly skilled at acting quickly and creatively to build and sustain revenue-generating enterprises and programs. Public sector organizations, by contrast, are more often cautious and react slowly to opportunities. Frequently, caution is the result of justified concern about the stewardship of public funds.

As public funds become more scarce and public needs continue to expand, public health managers are increasingly concerned about seeking non-traditional sources of funds. New programs are expected to contribute revenue streams that support and sustain new program initiatives. Obtaining non-traditional funds and maintaining revenue streams will require a new organizational culture.

The Centers for Disease Control, the Health Resources Services Administration, the W. K. Kellogg Foundation, and the Robert Wood Johnson Foundation entered into an experiment with the School of Public Health and the Kenan–Flagler School of Business at the University of North Carolina at Chapel Hill, establishing the Management Academy for Public Health. One of the goals of the Academy was to assist in developing civic entrepreneurs who could improve both the efficiency and effectiveness of public health organizations. Within the public health context, civic entrepreneurship is the ability to combine skills, including assessing needs, marshaling human and other resources, building strategic alliances, using evidence-based planning processes, attracting start-up funds, identifying revenue streams, and planning for post-grant sustainability.

The civic entrepreneurship goal of the Academy is important because traditionally public health organizations have depended upon state or grant funding and have not developed an entrepreneurial culture. Rarely are considerations given to building revenue streams that could sustain programs when the grant funds were expended. An integral part of the team project of the Management Academy for Public Health is a business plan that contains a revenue-generating component. The business plan is intended to address real health issues in communities. The Academy teams use the plans to attract start-up funds and to implement new programs. Evaluators track enhanced revenue as a measure of success. A critical question in evaluating the success of the business plan is "How much money did locally implemented business plans generate from grants, contracts, and fees?"

An example of a successful business plan is that of a team from Dare County, North Carolina. The team developed a business plan to provide dental care to under-served school-age children in a mobile unit that could serve two patients at a time. The plan forecasted a break-even point for the mobile clinic on the basis of such factors as payer mix, case mix, and capacity. The plan was submitted to the Kate B. Reynolds Charitable Trust which provided most of the $277,000 in start-up funds to purchase the van. Program revenue covered ongoing personnel and supply costs.

During the first three years of the Management Academy program, the Academy spent roughly $2 million on training. The business plans implemented during this same period generated more than $6 million in start-up funds and revenue. Interviews with participants after completion of the program indicated that many had become more entrepreneurial in their approach to public health. Civic entrepreneurship is becoming an important part of public health management.

Source: Stephen Orton, Karl Umble, Sue Zelt, Janet Porter, and Jim Johnson, "Management Academy for Public Health: Creating Entrepreneurial Managers," *American Journal of Public Health* 97, no. 4 (2007), pp. 601–605.

to learn from the experiences of others, and generally pursue excellence in all aspects of organizational performance. In fact, Hamel and Prahalad note that traditional strategic as well as behavioral factors may lead to competitive advantage: "Cross-functioning teams, focusing on a few core competencies, strategic alliances, programs of employee involvement, and consensus are all parts of stretch."[46] In the end, determination of competitive advantage requires an integration of what health care strategists know about the external environment with a sophisticated understanding of competitively relevant strengths and weaknesses.

Managing Strategic Momentum

For sustained competitive advantage, strategic momentum must be maintained. After the strategy has been initiated, the internal environment must be continuously evaluated to stay informed and current about the organization's competitively relevant strengths and weaknesses. Sustaining a competitive advantage is difficult in a dynamic market and what might be a competitive advantage today may not be an advantage tomorrow. Carefully evaluating the strengths and weaknesses relative to the four critical questions allows the strategist to focus on the relatively few aspects of the value chain that have the potential for building and sustaining competitive advantage. Care must be exercised, however, to ensure that new and emerging strengths or weaknesses are adequately considered in the continuous assessment of the internal environment.

EXHIBIT 4–10 Questions for Evaluating the Internal Strategic Assumptions

1. Have the strengths and weaknesses been correctly identified?
2. Is there a clear basis on which to compete?
3. Does the strategy exploit the strengths and avoid the major weaknesses of the organization?
4. Are the competitive advantages related to the critical success factors in the service area?
5. Have we protected our short- and long-term competitive advantages?
6. Has the competition made strategic moves that have weakened our competitive advantages?
7. Are we creating new competitive advantages?

The questions presented in Exhibit 4–10 provide for such an ongoing evaluation of the effectiveness of the internal environmental assessment. Ensuring appropriate strategic fit requires that the internal as well as the external environments be continuously assessed and evaluated.

Lessons for Health Care Managers

Competitive advantage resides within the organization, whether it is a hospital, physician's office, or health maintenance organization. Understanding competitive advantage requires a careful analysis of the internal organizational environment through the organization's value chain. The value chain provides an analysis framework for identifying and focusing on areas in a health care organization where value may be added. The value chain is divided into two major components – the delivery of health services and support activities. Service delivery includes pre-service activities, point-of-service activities, and after-service activities. Support activities include organizational culture, organizational structure, and strategic resources.

By investigating all systems and subsystems of the value chain and evaluating the resources, competencies, and capabilities, strategic thinkers are better able to identify possible strengths and weaknesses. Each strength and weakness is evaluated in terms of its value, rareness, imitability, and sustainability to determine those that are competitively relevant. Competitively relevant strengths and weaknesses provide the bases for developing strategies and competitive advantages.

Understanding competitive advantage is important to health care strategists but often more is required of successful organizations. Successful health care organizations must always insist on stretching their resources, competencies, and capabilities to the limit while creatively looking for new opportunities. Sustaining competitive advantage, requires that leaders understand what the environment demands of successful health care organizations, configuring competitively relevant strengths to the organization's greatest advantage, eliminating or minimizing the adverse effects of competitively relevant weaknesses, and establishing demanding aspirations that require strategic assets to be pushed to their limits while constantly searching for new opportunities. Chapter 5 examines the development of directional strategies.

Health Care Manager's Bookshelf

Jay B. Barney and Delwyn N. Clark, *Resource-Based Theory: Creating and Sustaining Competitive Advantage* (New York: Oxford University Press, 2007)

In strategic management there are essentially two explanations of why some organizations are able to consistently outperform others in their industries (enjoy sustained competitive advantage). The first was advocated by Porter and is based to a great extent on industrial organization economics. This view proposes it is the impact of an organization's market power and its ability to charge prices above market levels that leads to competitive advantage. When barriers to entry are high, the organizations with the market power can consistently outperform competitors (p. 3).

The second explanation suggests more efficient and effective organizations can consistently outperform competitors if it is too costly for less efficient and effective organizations to emulate the more efficient and effective organizations. The two explanations are not mutually exclusive since market power may apply in some situations and what has become known as resource-based theory may apply to other situations (p. 4).

In resource-based theory, the term resource has evolved to include not only production, physical facilities, capital, human, and informational resources but invisible resources such as professional competence, organizational capabilities, and organizational culture. Sometimes, as resource-based theory argues, one or more organizations possess a competitive advantage because of the resources they possess or the manner in which they configure and manage their resources. The competitive advantage may be temporary or sustained depending on whether or not competitors can replicate the resources generating the competitive advantage.

The authors develop the VRIO framework for competitive analysis which we modify slightly and use in this chapter. The VRIO framework expresses four key parameters for resource-based analysis based on a series of questions. These are value, rarity, imitability, and organization. We substitute sustainability for organization (p. 69).

Barney and Clark provide a comprehensive overview of the evolution of resource-based theory and focuses a great deal on classical microeconomic price theory. The second part of the book details at a variety of specific resources that may lead to sustained competitive advantage. These potential sources of competitive advantage are:

Culture. An organization's culture can be a source of sustained competitive advantage if it is valuable, rare, and cannot easily be imitated. However, it is difficult to sustain a competitive advantage based on culture because if one organization can change its culture to provide for superior financial performance, competitors can likely change their culture as well and neutralize the advantage. However, a very few organizations with extremely unique and valuable cultures may enjoy a competitive advantage in particular environments (Chapter 4).

Trust. The authors adopt a definition of trust that states, "trust is the mutual confidence that no party to an exchange will exploit another's

vulnerabilities." A variety of trust relationships are examined (e.g., strong, weak); however, it is ultimately concluded that the trustworthiness of exchange partners will vary and it is in this variance that the possibility of competitive advantage may exist (Chapter 5).

Human resources. Organizations create value and ultimately competitive advantage by either decreasing the costs of products/services or differentiating the products/services in a way that allows them to charge a higher price. The authors conclude that organizations should seek employees who are skilled and motivated to deliver high-quality products/services and manage the culture to encourage teamwork and trust (Chapter 6).

Information resources. Increasingly, organizations rely on information resources to smooth out the most basic operations. After examining a series of information technology attributes, the authors conclude that the only likely source of competitive advantage from information resources is the managerial skills of those managing these resources. These skills are frequently differentially distributed among organizations in the same market (Chapter 7).

The last major section of the book moves from a focus on the organization's internal resources and capabilities to the resources and capabilities of other firms and the "boundary decisions" managers make regarding exchange partners. At times an organization may pursue a sustained competitive advantage by entering into competitive alliances, vertically integrating, diversifying, and doing so by mergers and acquisitions. Each of these topics is discussed in detail.

The final section of the book deals with the future of research and theory relating to the resource-based view of competitive advantage. This book represents a definitive work for those interested in learning more about potential ways of building and sustaining competitive advantage.

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KEY TERMS AND CONCEPTS IN STRATEGIC MANAGEMENT

After-Service
Capability
Competency
Competitive Advantage
Competitively Relevant Strength
Competitively Relevant Weakness
Point-of-Service
Pre-Service
Resource-Based View
Resources
Service Delivery
Strategic Capability
Strength
Stretch
Support Activities
Sustained Competitive Advantage
Value
Value Chain
Weakness

Questions for Class Discussion

1. It has been said that the rules for success are written outside the organization but competitive advantage must be found within the organization. Explain this statement.
2. Why is value creation an important concept to health care organizations? Is value creation more or less important in health care than in other industries?
3. Which activities, service delivery or support, are more important in the organizational value chain? Explain your answer.
4. Why is the value chain consistent with systems concepts discussed in Chapter 1? Why is a systems approach to internal environmental analysis important?
5. Why is the concept of competitively relevant strengths and weaknesses so important to internal environmental analysis?
6. What is the difference between an objective and subjective strength and weakness? Give examples of each type of strength and weakness in a health care organization.
7. Discuss the resource-based view of competitive advantage. Why is it important to understand organizational differences in order to use this approach?
8. Briefly define what is meant by competitive advantage. Are competitive advantage and sustained competitive advantage identical concepts? Why or why not?
9. What are the differences between capabilities and competencies? How are capabilities related to both resources and competencies?
10. Why are capabilities referred to as architectural competencies? Would you consider management a capability or a competency? Explain your answer.
11. When searching for competitive advantage, which characteristic of a strength or weakness (value, rareness, imitability, sustainability) is the most important in health care organizations? Discuss your response.
12. Why are some strengths and weaknesses that are not competitively relevant deserving of attention by health care strategists? Provide one example of a strength and weakness that are not competitively relevant but deserve attention.
13. Why is resource leveraging an important concept in internal environmental analysis?

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5 Directional Strategies

"CEOs and boards love a good mission statement – that is, after the pain of writing it is over. They should. A mission statement is literally a defining moment and something you would proudly show your mom."

—MARY GRAYSON

Introductory Incident

Relentlessly Pursuing the Vision

It could have gone either way. On June 4, 2007 the deal was struck and Rite Aid formally acquired Brooks-Eckerd. At the September 2006 annual senior management meeting of Rite Aid, excitement over the proposed Rite Aid acquisition of Brooks–Eckerd was building, as was the insecurity among some Brooks–Eckerd associates. The acquisition created an industry leader with combined revenue of almost $27 billion and made Rite Aid the largest pharmacy chain on the East Coast. Then CEO (now Chairman of the Board) Mary Sammons challenged Rite Aid's associates

to make the company "bigger, better, and faster." Others were not so optimistic and cautioned that success of the consolidation would not be just financial.

At the Brooks–Eckerd managers' meeting in 2007, Sammons stated that "I feel so fortunate to share with you Rite Aid's vision and how we can make this vision a reality." The guiding force, simply stated is "With Us, It's Personal." The goal was to close the gap between Rite Aid and its national competitors, CVS and Walgreens, and make the company the customer's first and only choice when it comes to health and wellness. As worthy as the goal was, some insiders cautioned Rite Aid that "talk is cheap; it's action that delivers results." Vision, "is nothing without execution." Ultimately, success depends on the associates. Sammons agreed, stating that "great vision without great people simply doesn't matter."

The Brooks–Eckerd acquisition was a turning point in Rite Aid's history. At the time of the acquisition, Rite Aid operated about 5,000 stores in 31 states and the District of Columbia. Although the sales growth in the pharmacy industry has slowed significantly in recent years, Rite Aid has maintained its competitive position and currently operates 4,700 stores with a substantial increase in its West Coast operations. Almost 68 percent of its revenues come from prescriptions, with the other 32 percent accounted for by "front-end products" such as over-the-counter medications, cosmetics, health and beauty aids, and so on. The challenge is to continue to gain acceptance of the Rite Aid vision and transfer it to the new and larger organization. According to Mary Sammons, "it stopped being about survival a long time ago and started being about growth. We are in the best financial shape we've ever been in." It is true that the success or failure of the combination will not be in the numbers – financial or growth. The key to success, according to Rite Aid's COO at the time, will be in everyday actions that make the numbers come to life. "Our business is only as strong as we make it." The new Rite Aid is solidly in third place in the retail pharmacy and wellness business. Integrating the existing cultures and building a mutually challenging vision of the future will be the deciding factor.

In 2003, Rite Aid is working hard to distinguish itself from the competition. The company's strategic alliance with GNC, a leading retailer of vitamin and mineral supplements, provides greater opportunities for front-end sales. In 2010 Rite Aid rolled out its *wellness+* card-based loyalty program that provides benefits to cardholders based on the points they accumulate for purchases of prescriptions and front-end products. Currently, *wellness+* cardholders account for about 67 percent of front-end sales and 58 percent of filled prescriptions.

Rite Aid's mission is clear:

> "To be a successful chain of friendly, neighborhood drugstores. Our knowledgeable, caring associates work together to provide a superior pharmacy experience, and offer everyday products and services that help our valued customers lead healthier, happier lives."

In 2003, Rite Aid continues to face challenges in assuring the success of the acquisition. Experts indicated that the 2007 acquisition of Brooks–Eckerd bogged the company down, with debt accounting for much of the $2.9 billion loss in fiscal 2009. First-quarter losses in 2012 were

still at $28 million but projections indicated the company expected a 1 percent increase in 2013 sales. Rite Aid continues to struggle but has done well to maintain its market position during extremely difficult conditions. It is well positioned for the future challenges it and the pharmacy industry, in general, face.

Source: Rite Aid website, 2011 Annual Report, SEC Form 10-K, and Michael Johnsen and Antoinette Alexander, "Rite Aid and Brooks–Eckerd Meetings Set the Vision, Spirit of the Future," *Drug Store News* 28, no. 12 (September 25, 2006), pp. 1–3.

Learning Objectives

After completing the chapter you will be able to:

1. Understand the roles of and relationships among organizational mission, vision, values, and strategic goals and why they are called directional strategies.
2. Recognize the important characteristics and components of organizational mission and be able to write a mission statement.
3. Recognize the important characteristics and components of vision and be able to write an organizational vision statement.
4. Recognize the important characteristics and components and be able to write a values statement.
5. Recognize the important characteristics and components and be able to write strategic goals.
6. Identify service category critical success factors.
7. Develop a set of strategic goals that contribute to the mission, move the organization toward the realization of its vision, and are consistent with the organization's values.
8. Recognize the important issues in the governance of health care organizations and the role of boards of directors in maintaining policy-making direction.

Directional Strategies

Mission, vision, values, and strategic goals are appropriately called directional strategies because they guide strategists when they make key organizational decisions. The *mission* attempts to capture the organization's distinctive purpose or reason for being. The *vision* creates a mental image of what leaders want the organization to achieve when it is accomplishing its purpose or mission. It is the organization's hope for the future. *Values* are the principles that are held dear by members of the organization. These are guiding principles the managers

and employees will not compromise while they are in the process of achieving the mission and pursuing the vision and strategic goals. *Strategic goals* are those overarching end results that the organization pursues to accomplish its mission and achieve its vision. Unfortunately, there is rarely a clear distinction among the concepts and terms actually used in these statements – especially in the mission, vision, and value statements. Studies of actual statements reveal that even though the statements are clearly labeled there is a wide variety of terms used to express the ideas contained in them.[1]

Organizational Purpose and Mission

Chester Barnard, in *The Functions of the Executive*, stated that only three things are needed to have an organization: (1) communication, (2) a willingness to serve, and (3) a common purpose (for more detail, see the Health Care Manager's Bookshelf at the end of this chapter). The inculcation of the "belief in the real existence of a common purpose" is, according to Barnard, "the essential executive function."[2] Purpose, among other things, helps managers make sense of the environment. When the purpose of an organization is clearly understood, the complexity of the environment can be reduced and organized in a way that can be analyzed in light of the goals the organization wishes to achieve. The complex environment is no longer a "mere mess of things."[3] As a statement of purpose, the mission plays an important role in focusing strategists' attention on relevant aspects of the environment.

For example, if the CEO of a long-term care facility simultaneously considers all the turbulence in the organization's environment, the environment will appear confusing and overwhelming. Can anyone effectively track all of the changes taking place in biotechnology, cultural values, demographics, and politics? However, if the CEO focuses on only those aspects of the environment that relate to the mission of the long-term care organization, the task becomes more manageable.

The common purpose (mission) to which Barnard referred is the reason that organizations exist. Some organizations exist to make money for the owners; some are founded to provide health care to indigent patients; others are started to deliver health services in as convenient a way as possible or to provide the care needed by groups of individuals who belong to the same managed care plan.

Mission: A Statement of Distinctiveness

In the hierarchy of goals (end results and organizational plans to accomplish them), the mission captures the organization's distinctive character. Although a well-conceived mission is general, it is more concrete than vision. An organizational mission is not an expression of hope. On the contrary, it is an attempt to capture the essence of the organizational purpose and commit it to writing.

EXHIBIT 5–1 **Mission Statement of the University of Texas M. D. Anderson Cancer Center**

The mission of the University of Texas M. D. Anderson Cancer Center is to eliminate cancer in Texas, the nation and the world through outstanding integrated programs in patient care, research, education and prevention, and through education for undergraduate and graduate students, trainees, professionals, employees, and the public.

Source: University of Texas M. D. Anderson Cancer Center.

DaVita Inc., a Fortune 500 company, is a leading provider of kidney care. In its mission statement, DaVita states that the company is committed "To be the provider, partner, and employer of choice."[4] In this case DaVita chooses to emphasize the way it does business rather than the services it provides. The company attempts to differentiate itself from other kidney care companies by focusing on quality outcomes, building a diverse community as a provider of services, partnering with other organizations, and becoming a good place to work for its almost 37,000 "teammates."

An organizational mission is a broadly defined and enduring statement of purpose that distinguishes a health care organization from other organizations of its type and identifies the scope of its operations in product, service, and market (competitive) terms.[5] The mission statement of the University of Texas M. D. Anderson Cancer Center in Exhibit 5–1, for example, distinguishes the center from other health care organizations in the service area by its relationship with the University of Texas; its emphasis on a specific disease (cancer); and its commitment to the integration of patient care, research, education, and prevention and its intention to accomplish these through education at the undergraduate as well as graduate levels. M. D. Anderson employs an effective logo on its website that states it is the M. D. Anderson Cancer Center with a bold red line through the word "cancer," thus emphasizing its commitment to eliminating cancer. Although mission statements are relatively enduring, they must be flexible in light of changing conditions. The changes facing academic medicine will continue to impose pressures on specialized centers of excellence such as M. D. Anderson because of the substantial costs involved in integrating patient care with the teaching and research mission and the increasing reluctance of payers to reimburse for educational costs.

Mission statements are sometimes not the true "living documents" that are capable of encouraging high performance. Studies of mission statements confirm that the full potential of this directional strategy is rarely achieved.[6] Often mission statements appear to be obligated to make reference to specific stakeholder groups such as patients or communities because of institutional pressures and refer to pressing social issues because of policy decisions within the organization.[7] To be effective, service delivery and support strategies must be designed to contribute to mission accomplishment.

One study of hospital mission statements found that almost 85 percent of the respondents had mission statements; however, some of the executives who completed the survey did not perceive a high level of commitment to the statement by employees or that specific actions were influenced very much by the mission.[8]

Another study of state-level departments of public health indicated that more than 90 percent had formal, written mission statements. Despite the frequency with which formal mission statements are encountered, a great deal of confusion exists regarding their value and the influence that these statements actually have on behavior within organizations. This confusion is unfortunate because the mission statement is a crucially important part of strategic goal setting. It is the superordinate goal that stands the test of time and assists top management in navigating through periods of turbulence and change. It is, in other words, the "stake in the ground" that provides the anchor for strategic planning. It must be emphasized, however, that mission statements, even at their best, can never be substitutes for well-conceived and carefully formulated strategies.[9] Moreover, a sense of mission is not a guarantee of success. As illustrated in Perspective 5–1, a nice sounding mission statement is not enough. The organization has to adhere to the mission and regularly review it to be sure that it remains relevant in changing times. When the mission is carefully crafted, mission fulfillment influences a variety of key psychological states related to employee motivation (e.g., employment engagement, organizational identification, and so on).[10] It has also been suggested that "mythopoetic leaders," who use the mission of the organization to anchor behaviors, can be instrumental in building robust cultures that can lead to a competitive advantage.[11]

Mission statements remind managers in health care organizations to ask questions of themselves and their colleagues. It is important to ask individuals throughout the organization the following questions as the answers radically affect how the organization performs. These questions include:

1. *Are we not doing some things now that we should be doing?* A rehabilitative medicine center, after analyzing the environment and studying its own referral patterns, might determine that it should enter a joint venture with a group of surgeons to provide outpatient surgery services. The rehabilitative medicine center, located in a professional building adjacent to an acute care hospital, had simply referred patients requiring surgery to the hospital. However, insurance company policies and patient preferences suggested that the majority of surgeries could be performed on an outpatient basis.
2. *Are we doing some things now that we should not be doing?* The rehabilitative medicine center, after extensive analysis, concluded that it should divest its rehabilitative equipment business and contract with medical and sports equipment suppliers for needed services.
3. *Are we doing some things now that we should be doing, but in a different way?* Throughout its history the rehabilitative medicine center required patients to come to the facility for services. For many patients, particularly those with serious injuries, travel to the facility was difficult and often impossible. Recently, the center purchased a mobile trailer with a fully equipped diagnostic and treatment facility that can transport services to local high schools and industrial locations.[12]

An organization should carefully evaluate strategic decisions with the use of its mission statement. When new opportunities are presented it can use the three key questions to determine whether or not the new opportunity is consistent

PERSPECTIVE 5–1

Do Mission Statements Matter?

Prominent displays of mission statements in the elevator, on employees' name badges, and business cards are not enough to ensure that the message is taken to heart. Some managers wonder why organizations spend so much time talking about mission statements when they are often not taken seriously. Do organizations actually plan their future based on the mission (directional strategy) or do they simply respond to changing conditions?

Undoubtedly, some mission statements are not very good. They may sound fine and even have been crafted by an astute consultant or public relations firm; however, if they do not speak the language of employees and stakeholders they will not have much influence on behavior or performance. Organizations must think seriously about the future of their industry and their unique role in capitalizing on the opportunities created by changing times. This distinctiveness must then be captured in the mission statement.

Mission statements sometimes suffer from the following problems:

- Mission statements are written solely for their public relations value.
- Mission statements describe the purpose of all the organizations in the service category.
- Mission statements may have more time invested in their crafting than in their implementation.

Mission statements, if they are to be useful, must state the purpose of the organization and provide a good sense of what makes the organization different and what it is devoted to accomplish. A mission statement should help the organization focus on its uniqueness. Writing a mission statement is important; however, living it is more important. Whatever is incorporated into the mission statement must be credible, realistic, attainable, and assist in differentiating the organization from all its competitors.

Sources: Greg Kitzmiller, "Do Mission Statements Matter? Reviewing the Importance of a Mission Statement and, More Importantly, Sticking to It," *Nutraceuticals World* 6, no. 10 (October 2003), p. 22; Tracy Turner, "Mission Statement Useful, Expert Says 'Companies Benefit by Defining, Acting on Their Goals'," *Knight Ridder Tribune Business News* (May 13, 2007), p. 1.

with its essential distinctiveness. Moreover, these three questions are important guards against *mission drift*, which tempts many health care organizations to go into businesses and programs that are not in line with their stated mission.[13] As an example, Express Scripts' mission statement (see Exhibit 5–2) provides guidance for its strategic leaders and 13,000 employees in determining whether or not new opportunities should be pursued. To be consistent with the mission, opportunities need to involve services or processes that make prescription drugs safer and more affordable to the members of the health plans. Adherence to the mission has led the company to be an industry leader – striving for the lowest net cost to provide better health and value at the consumer level. The company notes that its generic fill rate leads the industry.

EXHIBIT 5–2 Mission Statement of Express Scripts

Express Scripts makes the use of prescription drugs safer and more affordable for tens of millions of consumers through thousands of employers, government, union, and health plans.

Source: Express Scripts.

Characteristics of Mission Statements

The mission statement of St. Jude Medical in St. Paul, Minnesota (Exhibit 5–3) illustrates some of the important characteristics of an effective mission statement. St. Jude Medical produces implantable cardioverter defibrillators, cardiac resynchronization therapy devices, pacemakers, spinal cord stimulation, deep pain stimulation devices, and so on. The product portfolio is carefully stated in the mission statement so the interested individuals can see immediately that St. Jude Medical competes with companies such as Medtronic in selected product lines. St. Jude Medical attempts to lessen risk and increase control by collaborating with physicians on product design, seeking simpler solutions to complex problems, designing products that help lessen procedural risks, expanding education and product training, and developing expertise in all employees that assists them in fulfilling the mission. Four important characteristics of effective mission statements are:

1. Missions are broadly defined statements of purpose. Well-formulated mission statements are written and communicated to those involved in doing the work of the organization. They are broad but also, in a sense, specific. The St. Jude Medical mission makes it clear that the company's focus is on selected medical products and technologies but at the same time outlines a number of ways the mission can be accomplished. That is, mission statements should be general enough to allow for innovation and expansion into new activities when advisable, yet narrow enough to provide direction.[14]
2. Mission statements are enduring. The purpose, and consequently the mission, of an organization does not change often and should be enduring. People are committed to ideas and causes that remain relatively stable over time.
3. Mission statements should underscore the uniqueness of the organization. Mission statements distinguish the organization from all others of its type. The important uniqueness for St. Jude Medical is the focus on selected

EXHIBIT 5–3 Mission Statement of St. Jude Medical

It is our mission to develop medical technology and services that put more control into the hands of those who treat cardiac, neurological, and chronic pain patients worldwide. We do this because we are dedicated to advancing the practice of medicine by reducing risk wherever possible and contributing to successful outcomes for every patient.

Source: St. Jude Medical.

medical technologies, increased control by those who treat cardiac, neurological, and chronic pain patients.

4. Mission statements should identify the scope of operations in terms of service and market. It is important for the mission statement to specify what business the organization is in (health care) and who it believes are the primary stakeholders. Note that St. Jude Medical is specific in its commitment to physicians that use its products.

Although missions are enduring, this should not imply that the mission will never, or should never, change. New technologies, demographic trends, and so on might be very good reasons to rethink the mission of an organization. For example, a number of hospitals have incorporated the desire to be an "independent provider of health care" in their mission statement. In today's managed-care-oriented health care environment, that aspect of mission may need to be revisited. In some markets, alignment with managed care organizations might become a necessity for survival and the mission statement should not stand in the way.

These characteristics illustrate the essential properties of well-conceived and communicated mission statements.[15] They outline worthy ideals that are always in the process of being achieved by strategic leaders in health care institutions. The mission provides direction. Mission statements are not easy to write, but fortunately there is general agreement on what they should include.

Components of Mission Statements

There is no single way to develop and write mission statements. Studies of Canadian not-for-profit hospitals indicate that they emphasize a variety of factors in their mission statements.[16] To define the distinctiveness of an organization, mission statements must highlight those things that constitute uniqueness. Some of the more important components of a mission are discussed and illustrated with the use of mission statements from a variety of health care institutions.[17]

1. Mission statements target customers and markets. Frequently the mission statement provides evidence of the kind of customers or patients the organization seeks to serve and the markets where it intends to compete. The mission statement of the Little Clinic states that it will "offer America's most convenient and accessible delivery of affordable non-emergency health and wellness care for the whole family." To this end the clinic diagnoses and treats minor illnesses for patients 18 months of age (24 months in Kentucky) and up with certified nurse practitioners or physician assistants in its 80 locations in select Kroger, Fry's, and King Sooper stores in Ohio, Kentucky, Tennessee, Arizona, Georgia, and Colorado. Exhibit 5–4 provides the mission statement of St. Jude Children's Research Hospital. This mission statement clearly states the target patients served by this prestigious health care organization.
2. Mission statements indicate the principal services delivered or products provided by the organization. A specialized health care organization might

EXHIBIT 5–4 Mission Statement of St. Jude Children's Research Hospital

The mission of St. Jude Children's Research Hospital is to advance cures, and means of prevention, for pediatric catastrophic diseases through research and treatment. Consistent with the vision of our founder Danny Thomas, no child is denied treatment based on race, religion, or a family's ability to pay.

Source: St. Jude Children's Research Hospital.

EXHIBIT 5–5 Mission Statement of Alcon

To provide innovative products that enhance quality of life by helping people see better. As the global leader in eye care, this mission means that we strive to make significant contributions in the fight to prevent and, one day, eliminate blindness.

Source: Alcon.

EXHIBIT 5–6 Mission Statement of Aurora Health Care

The mission of Aurora Health Care, as a not-for-profit Wisconsin health care system, is to promote health, prevent illness, and provide state-of-the-art diagnosis and treatment, whenever and wherever we can best meet people's individual and family needs.

Source: Aurora Health Care.

highlight the special services it provides in its mission statement. The mission statement of Alcon illustrates a statement built around innovative primary services designed to enhance the quality of life by helping people see better and hopefully one day to eliminate blindness (see Exhibit 5–5).

3. Mission statements specify the geographical area within which the organization intends to concentrate. This element is most frequently included when there is a local, state, or regional aspect to the organization's service delivery. Aurora Health System, for example, specifically mentions that it is a Wisconsin not-for-profit health care system in its mission statement (see Exhibit 5–6).
4. Mission statements identify the organization's philosophy. Frequently the mission of an organization will include statements about unique beliefs, values, aspirations, and priorities. Beliefs and values are often included in mission statements for health facilities operated by religious denominations. The mission statement of Resurrection Health Care in Exhibit 5–7 illustrates the faith-based philosophy of this health services organization.
5. Mission statements include confirmation of the organization's preferred self-image. The manner in which a health care organization views itself may constitute a uniqueness that should be included in the mission. The mission statement of Unitedhealth Group emphasizes the organization's desire to help people live happier lives and make better health care decisions (see Exhibit 5–8).

EXHIBIT 5–7 Mission Statement of Resurrection Health Care

Faithful to the spirit of our sponsors, Resurrection Health Care exists to witness God's sustaining love, through compassionate, family-centered care. Motivated by a reverence for life and respect for those we serve, we are committed to improving the health and well-being of our community. We promote a climate that empowers all of us to effectively steward our human and financial resources.

Source: Resurrection Health Care.

EXHIBIT 5–8 Mission Statement of Unitedhealth Group

Our mission is to help people live happier lives. Our role is to help make health care work for everyone.

- We seek to enhance the performance of the health system and improve the overall health and well-being of the people we serve and their communities.
- We work with health care professionals and other key partners to expand access to quality health care so people get the care they need at an affordable price.
- We support the physician/patient relationship with the information, guidance and tools they need to make personal health choices and decisions.

Source: UnitedHealth Group.

6. Mission statements specify the organization's desired public image. This image customarily manifests itself in statements such as the organization's desire to be a "good citizen" or a leader in the communities where its operations are located or a similar concern. However, organizations may have a unique approach or focus that they want to communicate to the public. The mission statement of Universal Health Services, Inc. clarifies the organization's commitment to its multiple stakeholders (see Exhibit 5–9).

Not every one of the characteristics can or should be included in the mission statement. Any particular statement will likely include one or several of these characteristics but seldom will all of the components be included. The organization must decide which of these, or some other characteristics, really account for its distinctiveness and emphasize them in the mission statement. Interestingly, studies have found that higher-performing organizations generally have more comprehensive mission statements. Moreover, it seems that components such as

EXHIBIT 5–9 Mission Statement of Universal Health Services, Inc.

To provide superior healthcare services that patients recommend to families and friends, physicians prefer for their patients, purchasers select for their clients, and investors seek for long-term returns.

Source: Universal Health Services, Inc.

organizational philosophy, self-concept, and desired public image were particularly associated with higher-performing organizations in the sample studied.[18]

Building a Mission Statement

For a mission statement to be useful there has to be a leader who begins the discussion concerning the need to examine or re-examine the organization's mission to clearly state its purpose. This statement helps all employees focus their efforts on the most important priorities. One process that has been useful in building mission statements is to convene a group of interested employees (administrative and non-administrative) to begin the task of developing or rethinking a mission statement. This group should be composed of individuals who understand the issues facing the health care industry as well as the strengths and weaknesses of the organization.

Prior to actually writing the mission statement, a series of meetings should be held to ensure that there is a desire for a well-understood and widely communicated statement of organizational distinctiveness. Once commitment has been established, assessments should be made of what makes the organization successful from the perspectives of employees and other key stakeholders. Further, consideration should be given to what these perceptions of success would likely be in the future.

After the group has been given time to think about the organization, its distinctiveness in its environment, and the likely future it will face, the group may meet in a planning retreat. Often it is useful to remove the participants from the office, phones, and beepers to have the opportunity to truly focus on the organization's mission. To stimulate strategic thinking, each person should be asked to reflect on the mission statement components listed in Exhibit 5–10. Recognizing that some members may not have been previously involved in writing a mission statement, this exhibit was developed to encourage initial thought without introducing too much structure into the process. Group members should be asked to present key words relative to each of the components. The key words should be recorded and eventually used as the raw material for the mission statement. Participants are encouraged to generate the key words through a series of fill-in-the-blank statements listed under each mission statement component.

After discussion and fine-tuning the language, a draft of the mission statement can be developed. The draft should be refined and rewritten by the group until there is consensus on the wording and meaning of the mission statement. Once the group is satisfied with the statement, it should be circulated among key individuals to gain their input and eventually their support for the mission. Moreover, as illustrated by Perspective 5–2, the mission must be continuously re-examined to ensure it remains relevant.

Top-Level Leadership: A Must for Mission Development

For a mission statement to be a living document, employees must develop a sense of ownership and commitment to the mission of the organization. For this reason, employees should be involved in the development and communication of the mission. However, top-level leadership must be committed if the process is to actually begin. Top-level management must stay engaged in the mission

EXHIBIT 5–10 Strategic Thinking Map for Writing a Mission Statement

Component	Key Words Reflecting Component		
1. Target customers and clients:			
"The individuals and groups we attempt to serve are…" Do not be limited to only the obvious.			
2. Principal services delivered:			
"The specific services or range of services we will provide to our customers are…"			
3. Geographical domain of the services delivered:			
"The geographical boundaries within which we will deliver our services to our customers are…"			
4. Specific values:			
"Specific values that constitute our distinctiveness in the delivery of our services to customers are…."			
5. Explicit philosophy:			
"The explicit philosophy that makes us distinctive in our service area is…"			
6. Other important aspects of distinctiveness:			
"Any other factors that make us unique among competitors are…"			

development process but not dominate it. Board rooms and executive suites can be places where great ideas for mission development originate but people at all levels must be involved if commitment to the mission is to be obtained.[19]

Developing a mission statement is a challenging task. Frequently, attempts are made to formulate "blue sky" statements of environmental and competitive constraints and little more. For example, it is of little real value to state that a health care organization is devoted to being a good citizen in the community and to paying wages and benefits comparable to those of other organizations in the area. Realistically, the organization must be a good citizen and, if it wants employees, its wages and benefits must be competitive.

The role of the chief executive officer in formulating the mission should not be underestimated. Mission statement development is not a task that should be delegated to a planning staff. The CEO, the leadership team, and other key individuals who will be instrumental in accomplishing the mission should have input into the document.

Although the process appears to be simple, the actual work of writing a mission statement is time consuming and complex, with many "drafts" before the final document is produced. The strategic thinking map (Exhibit 5–10) is a useful

PERSPECTIVE 5–2

Redefining the Organization's Purpose

Threats often create opportunities and sometimes the greater the threat, the greater the opportunity. Some people believe that scandals, although a threat to the competitive enterprise system, create an opportunity to carefully re-evaluate and redefine the purpose of the organization. An important competitive advantage may be gained for those who redefine themselves and become more responsive to the environment. Self-reform is almost certain to effect more fundamental change than externally imposed regulations. The agenda for self-reform consists of five important actions:

1. *Develop consensus on a revised statement of purpose and values.* The terms "profit making" and "creating shareholder value" do not reflect the reality of today's environment. The function of the profit-oriented concern is economic but its purpose is social. Profit-oriented firms in health care or any other industry exist at the discretion of society and must serve society's needs.
2. *Clarify the true role of profit.* Organizations must have profits (revenues in excess of expenses). If they do not generate a profit, they cease to exist (over the long run). Profit is a means, a motivator, and a measure of performance. Moreover, profit is an important incentive for entrepreneurial action and innovation. It provides the reward for taking the risks that are critical to success.
3. *Articulate and communicate the distinctions between the old purpose, values, and behaviors, and the new.* Once the new mission and values are crafted, they require a cheerleader and advocate to emphasize the importance of the value shift. Strategic leaders must use every opportunity to explain and, if necessary, defend the importance of the culture and value shifts.
4. *Set a strong personal example.* A culture balances the interests of employees, customers, the community, and other relevant stakeholders; it also requires that leaders embody in action, as well as in pronouncements, the qualities of the new culture.
5. *Revise the management measurement and reward system.* If the purpose is defined broadly and responsibly, measures have to be refined and utilized. The triple-bottom-line approach – focusing on economic performance as well as on social and environmental outcomes – is a step in the right direction.

George Merck, founder of the pharmaceutical giant, stated, "We try never to forget that medicine is for people. It is not for profits. The profits follow, and we have to remember that they have never failed to appear. The better we have remembered that, the larger they have been."

Source: Ian Wilson, "The Agenda for Redefining Corporate Purpose: Five Key Executive Actions," *Strategy & Leadership* 32, no. 1 (2004), pp. 21–27.

aid to thinking about clients, services, and domain; however, the development and communication of a well-conceived mission statement requires use of the compass (leadership) as well. Although developing a mission statement is not an easy task, it is a necessary one. Missions must be relevant not only to the present but also to the future.

Vision: Hope for the Future

The mission is developed from the needs of all the stakeholders – groups who have a vested interest in the success and survival of the organization. Vision, on the other hand, is an expression of hope. It is a description of the organization when it is fulfilling its purpose.[20] Vision involves creating compelling images of the future and produces a picture of what could be and, more important, what a leader wants the future to be.[21]

Effective visions possess four important attributes: idealism, uniqueness, future orientation, and imagery.[22] Visions are about ideals, standards, and desired future states. The focus on ideals encourages everyone in the organization to think about possibilities. It is dynamic and collaborative, a process of articulating what the members of an organization want to create.[23] Vision communicates what the organization could be if everyone worked diligently to realize the potential. Health care organizations need leaders who are forward looking. Effective visions are statements of destination that provide a compass heading to where the organization's leadership collectively wants to go. Finally, visions are built on images of the future. When people are asked to describe a desirable place or thing, they almost always do so in terms of images. Rarely do they focus on tangible outcomes. Images motivate people to pursue the seemingly impossible.

Origins of Vision

Health care leaders acquire vision from an appreciation of the history of the organization, a perception of the opportunities present in the environment, and an understanding of the strategic capacity of the organization to take advantage of these opportunities. All these factors work together to form an organization's hope for the future.

History and Vision An organization's history is comprised of a variety of events and activities that affect the development of vision. For example, the founder's philosophy might be important. The Mayo Clinic in Rochester, Minnesota, is an organization that is rich in history and tradition. Children's books tell successive generations how a destructive tornado in Rochester one night caused the Sisters of Saint Francis to aid the elder Dr. Mayo in caring for storm victims and encouraged his two sons, Will and Charlie, to follow in their father's footsteps. Mayo Clinic's website presents the story as well in rich and passionate terms. The result is a world-famous research, teaching, and patient care facility that continues to thrive and expand far beyond the boundaries of Minnesota. Anyone

who hopes to succeed at the Mayo Clinic and understand its unique vision must be aware of the founders and the past. The history of an organization is instrumental in the formation of its image and its vision or hope for what it is capable of becoming.[24]

Vision and the Environment Another important determinant of an organization's vision is the leader's view of the environment. Some organizations have negative experiences with environmental forces such as the government. Many private physicians and health care managers look at government attempts to set rates, regulate quality, and so on as unnecessary and unwarranted interventions in private enterprise. When this view is adopted, adversaries are seen in the environment and the vision becomes altered accordingly.[25] The vision is compromised and lack of accomplishment is blamed on these external forces. Sometimes the past experiences of organizations and the uncontrollable nature of environmental forces cause managers to either over- or under-react.

The vision must bear a relevant relationship to the larger system in that it must be sensitive to the changes taking place in the general and health care environments. As illustrated in Perspective 5–3, future trends of health systems are key considerations in formulating the health care strategist's vision.

Vision and Internal Capacity A leader's vision is related to the perceived strengths and weaknesses of the organization. The challenge to reconcile vision with internal capacity is illustrated by Senge's integrative principle of creative tension.[26] Creative tension comes into play when leaders develop a view of where they want to be in the future (vision) and tell the truth about where they are now. The current reality is heavily determined by the organization's present internal capacity and how this capacity relates to its aspirations.

Organizations deal with this creative tension in different ways. If the organization has been successful in the past, it may be aggressive about the future and raise its current aspirations in pursuit of the vision. If it has experienced failure, limited success, or merely has a cautious philosophy, management may choose instead to revise and reduce the vision to bring it more in line with current reality.

Leaders have visions; organizations gain and lose competitive advantage based on how the vision fits the environment and the strategic capability of the organization to capitalize on opportunities. However, developing a vision is "messy work," and for this reason it is necessary to examine more closely what organizational vision actually means.[27]

Health Care Strategists as Pathfinders

The job of building a vision for an organization is frequently referred to as pathfinding.[28] When the leader of a health care organization functions as a pathfinder, the focus is on the long run. The goal of the pathfinder is to provide a vision, find the paths the organization should pursue, and provide a clearly marked trail for those who will follow. As Senge notes, pathfinders have an ability to create a natural energy for changing reality by "holding a picture of what might be that is more important to people than what is."[29]

PERSPECTIVE 5–3

If You Want to Be a Visionary, Be Sensitive to Trends

Formulating a vision requires one to be sensitive to trends. However, predicting the future of health care is a risky business. Some major trends or changes predicted by health care experts contacted by *Hospitals & Health Networks* are listed below. These experts envision a health care future with larger, more integrated systems, more patient-centered care, new relationships between hospitals and physicians, and a shift of many inpatient procedures to outpatient or home settings.

Financing the future. Paying for technological and procedural improvements will not be cheap. But the investments will be worth the cost. The impact of potentially high-value technologies on operating costs, staffing capacity, physician relations, infrastructure and support requirements, and quality and safety will far outstrip the cost of capital investments.

Fewer, larger, better systems. Larger organizations will likely be able to cope better with future demands because of their resource base. Smaller systems are likely to find it more difficult to attract needed capital. Larger organizations with stronger balance sheets will be preferred by lenders and investors. Moreover, these larger systems could do a better job of overhauling the currently fragmented delivery system.

Hospital–physician relationships. Reimbursement trends, technological changes, and physician entrepreneurship are causing changes in hospital–physician relationships and could even pose competitive threats to hospitals. A specific challenge is the extent to which physicians set up large practices independent of hospitals and duplicate services offered in the hospital. Some experts see physician competition for outpatient services as a bigger threat than the creation of specialty hospitals.

Patient-centered. Health care organizations are paying more attention to the needs of patients and their families, especially the elderly. This segment of the population is becoming ever more important as the first of America's baby boomers are reaching retirement age. There are approximately 78 million baby boomers.

Cost and collaboration. According to the Centers for Medicare and Medicaid Services, the cost of health insurance will increase about 6.4 percent annually for the next decade. Cost containment will continue to be at the top of the list for politicians and policy makers. Pressure from baby boomers, continuation of the cost squeeze, and increased numbers of uninsured seem certain to be part of the health care future.

What does all this have to do with vision? Visions need to take into account the reality of the health care environment and its evolution. Regardless of the type of health care organization, leaders should formulate their vision based on a likely health care future.

Source: Dave Carpenter, "Visions of Health Care's Future: Bigger, More Patient-Focused Systems?" *Hospitals & Health Networks* 81, no. 5 (May 2007), pp. S4–S7.

Strategic leaders are the key to establishing a vision for an organization. A vision-led organization is guided by a philosophy to which leaders are committed but has not yet become obvious in the daily life of the organization. The *vision-led approach* hopes for higher levels of performance that are inspiring

although they cannot yet be achieved.[30] A primary role of management under this approach is to clarify goals and priorities and to ensure that they are understood and accepted by employees.[31] Individuals become engaged in the organization when they see a clear line of sight between vision, performance objectives, and personal contributions to the purpose of the organization.[32]

The role of the strategic leader, however, is more than pathfinding. As Barnard noted, because executives are responsible for inculcating the purpose into every employee, the leader must also be the *keeper of the vision* – a cheerleader who holds on to the vision even when others lose hope. Employees want to believe that what they are doing is important, and nothing convinces employees of the importance of their jobs more than a leader who keeps the inspirational vision before them (especially when things are not going well).

Strategic leadership has traditionally focused on top management, particularly the CEO. This individual is considered the person most responsible for scanning and influencing the environment, developing adaptive strategies, and managing key constituencies.[33] Unfortunately, the exclusive focus on the CEO's role in strategic leadership has implied that middle management has little or no involvement in determining the strategic direction of the organization. Admittedly, the primary responsibility of middle management is strategy implementation; however, certain strategic directions require middle-management involvement. The increasing importance of quality as a strategic goal and middle management's role in keeping this goal before all employees is a good example.[34] Quality has become an important value to which employees at all levels can be committed; middle managers are in the best position to encourage and reinforce this commitment.

Another important area in which middle management should be involved is in the redefinition of organizational vision. Grand strategies and futuristic visions are important for health care organizations. If the vision is to become meaningful to nurses, pharmacists, medical laboratory technicians, and others, middle and first-line managers must take the lead in helping to redefine the organizational vision in terms that are meaningful to departments and work groups. Finally, with regard to building involvement and commitment to service and quality, middle managers are in the best position to appeal to the social and economic motives important to health care employees.

Characteristics of Effective Vision

If vision is based on hope, it is – in reality – a snapshot of the future that the health care leader desires to create. It has been said that for an organizational vision to be successful it must be clear, coherent, consistent, have communicative power, and be flexible.[35]

A clear vision is simple. Basic directions and commitments should be the driving forces of a vision, not complex analysis beyond the understanding of most employees.[36] A vision is coherent when it "fits" with other statements, including the mission and values. It is consistent when it is reflected in decision-making behavior throughout the organization.[37] A vision "communicates" when it is shared and people believe in the importance of cooperation in creating the future that managers, employees, and other stakeholders desire. Finally, to be meaningful, a vision must be flexible. The future, by definition,

is uncertain. Therefore, an effective vision must remain open to change as the picture of the future changes and as the strategic capabilities of the organization evolve over time.

According to Tom Peters, to effectively outline the future and facilitate the pursuit of organizational and individual excellence, visions should possess certain characteristics:

1. Visions should be inspiring, not merely quantitative goals to be achieved in the next performance evaluation period. In fact, visions are rarely stated in quantitative terms. They are, however, nothing less than revolutionary in character and in terms of their potential impact on behavior. The vision of Tenet Healthcare, for example, states the lofty vision to "redefine health care delivery." It also speaks to the passion of Tenet's people and partners (Exhibit 5–11).
2. Visions should be clear, challenging, and about excellence. There must be no doubt in the manager's mind about the importance of the vision. If the "keeper of the vision" has doubts, those who follow will have even more. The vision statement of Princeton HealthCare System provides a great deal of "specifics" in its guidance for executive decision makers. It makes it clear the Princeton HealthCare is an integrated system that is dedicated not only to responding to the lifelong needs of residents; however, providing leadership in anticipating these needs (see Exhibit 5–12).
3. Visions must make sense in the relevant community, be flexible, and stand the test of time. If the vision is pragmatically irrelevant, it will not inspire high performance.
4. Visions must be stable, but constantly challenged and changed when necessary. The vision statement of Hebrew Health Care illustrates the manner in which a vision can be formulated so as to provide focus but remain broad enough to allow for changing conditions and developments (see

EXHIBIT 5–11 Vision of Tenet Healthcare

Tenet will distinguish itself as a leader in redefining health care delivery and will be recognized for the passion of its people and partners in providing quality, innovative care to the patients it serves in each community.

Source: Tenet Healthcare.

EXHIBIT 5–12 Vision Statement of Princeton HealthCare System

Princeton HealthCare System is a premier, integrated healthcare system that strives to anticipate and respond to the lifelong needs of the residents of Central New Jersey and beyond by providing excellent clinical care. Princeton HealthCare System is recognized for its commitment to enhancing the health of its community; providing superior services to its patients, delivering outstanding value, embracing clinical innovations; providing exceptional medical and health education; and supporting a knowledgeable, skilled and caring medical and employee staff.

Source: Princeton HealthCare System.

EXHIBIT 5–13 Vision Statement of Hebrew Health Care

In all of our programs and services, we will strive to be the provider of choice.

We will collaborate with educational, medical institutions and other providers with similar goals and philosophies to establish model centers of excellence.

We will seek recognition as a progressive system of quality services.

We will pursue creative means to enhance the organization's financial health so that we may fulfill our mission.

Source: Hebrew Health Care.

Exhibit 5–13). Future advances in health care can easily be accommodated with only minor changes in the vision statement.

5. Visions are beacons and controls when everything else seems up for grabs. A vision is important to provide interested people with a sense of direction. A well-formulated vision statement guides decision making because it provides inspiration for success in the future. More than three-quarters of a century ago, the founders of the Cleveland Clinic Foundation set out to develop an institution where diverse specialists would be able to think and act as a unit. This can only be realized when everyone understands the vision and accepts the legitimacy of the direction it offers.
6. Visions empower employees (the organization's own people) first and then the clients, patients, or others to be served. Because visions are about inspiration and excellence, it is critical to recognize that employees are the ones who must be inspired first. Employees must ultimately be inspired to achieve excellence. Many health care organizations make a mistake by devoting resources to pre-service promotion programs designed to enhance potential patients' image of the organization only to disappoint them when they arrive and are greeted by the same lack of service they experienced before the advertising campaign. The vision statement of Optima Healthcare Insurance Services is simple and to the point. It states that our vision is "To make a positive difference in health care." With proper orientation this simple vision statement can convey to employees the importance of making a positive difference individually if the organization is to achieve its vision of making a positive difference in health care.
7. Visions prepare for the future while honoring the past. Although vision is the hope an organization has for the future, it is important to always acknowledge and honor a history of distinction and service. The University of Texas M. D. Anderson Cancer Center acknowledges its commitment to making history using a play on words: "We shall be the premier cancer center in the world, based on the excellence of our people, our research-driven patient care, and our science. We are 'Making Cancer History.'" Not only is Anderson making history through its continued

commitment to cancer research, but, as noted earlier, the center also expects to eliminate cancer. This is an example of an ambitious and industry-changing vision.

8. Visions come alive in details, not in broad generalities. The accomplishment of the vision eventually has to lead to tangible results, whether in health care, business, government, or education. Although visions are futuristic and based on hope, they require strategic leaders who can articulate the vision and translate it into terms that everyone in the organization understands and accepts. Details should be provided in words that relevant parties understand.[38]

In the past decade more and more attention has been given to written vision statements. Vision statements are difficult to write because they require insights into the future. However, there are some useful aids that can assist managers in thinking about their vision and the direction they desire for the future. Exhibit 5–14 provides a strategic thinking map to assist in developing a vision statement and provides a series of questions that are a useful aid in thinking about the vision statement.

EXHIBIT 5–14 Strategic Thinking Map for Writing a Vision Statement

Component	Key Words Reflecting Component		
1. Clear hope for the future:			
"If everything went as we would like it to go, what would our organization look like five years from now? How would we be different/better than today?"			
2. Challenging and about excellence:			
"When stakeholders (patients, employees, owners) describe our organization, what terms would we like for them to use?"			
3. Inspirational and emotional:			
"When we think about the kind of organization we could be if we all contributed our best, what terms would describe our collective contributions?"			
4. Empower employees first:			
"How can we ensure that employees understand and are committed to the vision? What needs to be done to get everyone's buy in?"			
5. Memorable and provides guidance:			
"What types of words should be included to ensure all organizational stakeholders remember and behave in accordance with the vision?"			

Planning retreats can be used as effective forums for gaining insights into the thinking of organization stakeholders regarding their hopes for the future.

A Cautionary Note: The Problem of Newness

Strategic leaders are one of the most important elements in the strategically managed organization. Visionary leaders provide their greatest service by making the organization flexible and able to enter new markets, disengage from old ones, and experiment with new ideas. By entering into a new market first, organizations may achieve *first-mover advantages*. *Pioneering* organizations seek first-mover advantages. A reputation for pioneering can be generated and market position can be more easily established when there are no, or only a few, competitors. Sometimes it is expensive (monetarily and emotionally) for clients and patients to switch to other providers once loyalty and mutual trust have been developed.

However, visionary change, when directed toward early entry into markets, has its disadvantages. This has been referred to as the *liability of newness*.[39] Innovators often experience pioneering costs. Pioneers make mistakes that others learn from and eventually correct. First movers face greater uncertainty because the demand for the service has not been proven. Patient and client needs may change and, particularly when large technological investments are required, the first mover may be left with expensive equipment and little demand. Therefore, it is important that the demand for visionary management be tempered with realistic knowledge of the market, consumers, and other factors that will affect the organization. The rewards often go to the first mover, but the risks are greater.

Research confirms some of the dangers of being the first mover. Studies of companies that were first in their markets exclude those firms that failed by focusing only on those that survived, prospered, and eventually dominated their markets.[40]

Arguably, market pioneers rarely endure as market leaders. Market leadership has less to do with an organization's entry into the market and more to do with will and vision. Enduring leaders seem to have inspiring visions and the will to realize the vision. These enduring leaders are persistent in the pursuit of their vision, innovative, committed financially to the vision, and know how to leverage their assets.

Values as Guiding Principles

Values are the fundamental principles that organizations and people stand for – along with the mission and vision, they shape organizational culture. Most often, discussions of organizational values relate to ethical behavior and socially responsible decision making. Ethical and social responsibility values are extremely important, not just to a single hospital, HMO, or long-term care facility, but to all citizens. There are, however, other values that may be specific to an organization and characterize its members' behavior in the past or the behavior

PERSPECTIVE 5–4
Organizational Values Statements

Ethics and values are fundamental aspects of the culture of health care organizations. Ethically driven organizations have a shared mission and vision and strong core values in their culture. Health care organizations are extremely complex and it is impossible to provide policies and guidelines to direct all clinical and administrative behaviors. An organization's core values can set the standards of conduct that are considered important. Unfortunately, the importance of mission, vision, and values receives less attention from most leaders than other topics such as strategy, operations, and structure.

Effective values statements clarify how the organization will conduct its activities to achieve its mission and vision. Values statements frequently reflect common morality, and emphasize respect, integrity, trust, caring, and excellence. These statements represent the core principles within the organization's culture. All staff should be aware of, accept, and integrate the organization's values into their decision making and behavior. Values statements are particularly useful when an organization faces trade-offs among goals such as profits or quality. The organization's values will drive the choice.

Although some organizations develop and live by effective values statements, in other organizations the statement is carefully crafted and adopted, yet set aside and generally ignored. The worst statements are those that clearly conflict with the organization's practices and behaviors. These statements undermine staff morale, breed cynicism, and sometimes lead to the acceptance of unethical practices.

Similar to other documents, values statements should be reviewed regularly to ensure they are effectively assimilated into the organization's day-to-day activities. The object of the review is not to change or modify the statement, but to ensure an in-depth assessment of the organization's values. The most effective reviews are undertaken by work groups of individuals within the organization. Participation in the review process not only ensures appropriate guidelines for behavior but also involves individuals in better understanding and thereby encouraging ownership of the values.

In the same way, top leadership must own and participate in the values review process. The values statement should be a living document that is frequently referred to and referenced. The educational aspect of the review is more than merely handing out copies of the core values. Individuals at all levels should foster discussion of the values and illustrate how they apply to behaviors and decisions throughout the organization.

Source: William A. Nelson and Paul B. Gardent, "Organizational Values Statements," *Healthcare Executive* 26, no. 2 (2011), pp. 56–59.

to which members collectively aspire. For example, total quality management or continuous improvement is a value, as is entrepreneurial spirit, teamwork, innovation, and so on.[41] It is important that managers, employees, and key stakeholders understand the values that are expected in an organization. It is also important, as Perspective 5–4 makes clear, that values be more than slick public relations statements. "Talking the talk" is insufficient, "walking the walk" is what matters when it comes to values.

Core values, beliefs, and philosophy seem to be clear during the early stages of an organization's development but become less clear as the organization matures.[42] Therefore, statements such as Universal Health Services' perpetuate important values such as service excellence, continuous improvement, employee development, ethical and fair treatment, teamwork, and service innovation. Its statement of values (principles) makes explicit how the organization intends to conduct its business (see Exhibit 5–15).

Exhibit 5–16 illustrates American Dental Partners' (a provider of services to multidisciplinary dental practices) well-developed and articulated set of organizational values. These values focus on what the organization believes are its key responsibilities to people, communities, shareholders, and so on. Throughout the values statement are references to ideals such as honesty, respect, dignity, and excellence. Anyone reading this set of guiding principles can understand the motivational force such a statement of values might have on employees and the comfort it might provide consumers.

EXHIBIT 5–15 Statement of Principles of Universal Health Services, Inc.

Service excellence

- Provide timely, professional, effective, and efficient services to our customers.

Continuous improvement in measurable ways

- Identify key needs and assess how well we meet those needs.
- Continuously improve services and measure progress.

Employee development

- Hire talented and driven people.
- Increase skills through training and development.
- Provide opportunities for growth within UHS.

Ethical and fair treatment of all

- We are committed to fairness and trust with our patients, the physicians, purchasers of our services, and employees.
- We conduct our business according to the highest ethical standards.

Teamwork

- Work together to provide ever-improving customer service.
- Our team approach supersedes traditional departmental organization and creates a true customer focus.
- People at all levels of the organization participate in decision making and process improvements.

Compassion

- Never lose sight of the fact that we provide care and comfort for people in need.
- Patients and families who rely on us receive respectful and dignified treatment at all times.

Innovation in service delivery

- Invest in the development of new and better ways of delivering our services.

Source: Universal Health Services, Inc.

EXHIBIT 5–16 Core Values of American Dental Partners

We believe in five core values which provide the foundation on which our American Dental Partners is built. These values represent the way we intend to do business, and we endeavor to uphold them at all times.

Ethical – A promise to conduct business in an honest, fair manner and with the utmost integrity.

Relationship – Put people first. A commitment to treat all people with respect and human decency.

Social responsibility – A commitment to act in a responsible manner with total regard for our families, communities, and environment.

Fiscal responsibility – An obligation to act in a financially prudent manner for the benefit of our patients, shareholders, affiliates, and employees.

Excellence – In all we do, commitment to achieving the best results.

Source: American Dental Partners.

EXHIBIT 5–17 Core Values of Becton, Dickinson, and Company

We treat each other with respect.
We do what is right.
We always seek to improve.
We accept personal responsibility.

Source: Becton, Dickinson, and Company.

Not all statements of values or guiding principles are as elaborate as that of American Dental Partners, however, they need to be as well conceived. Values statements can be useful in clarifying to employees the specific behavioral norms that are expected of them as members of the organization. This clarification is effectively accomplished in the values of Becton, Dickinson, and Company, a medical technology company serving health care institutions, life science researchers, clinical laboratories, and the general public with offices in more than 50 countries. This statement of core values focuses specifically on how organizational members are expected to behave and conduct the company's business (see Exhibit 5–17).

Mission, vision, and value statements are tools for "becoming better at what we do." The usefulness of any of these statements is through the ownership taken by employees and their observed actions by stakeholders. Framed mission, vision, values, and slogans are merely exercises – and futile ones at that – if they are not made real by commitment and action.[43] The point is to motivate and guide all employees, managerial and non-managerial; provide high-quality care and respond to external as well as internal customers; to distinguish the organization from others in the perceptions of key stakeholders; and to let everyone know the organization stands for something important.

Values and beliefs are directional strategies that provide the focus and parameters for strategic goals. In addition, directional strategies provide a means of

determining the essentials that must be accomplished if the organization is to be effective. To be most effective, the values statement for an organization should capture the guiding principles by which the staff is expected to function while achieving the organization's mission.[44]

From Mission, Vision, and Values to Strategic Goals

Once strategic leaders are confident that the mission, vision, and values are well formulated, understood, communicated, and expressed in writing, they are able to focus on the activities that will make the most progress toward accomplishing the mission and moving the organization toward a realization of its vision – strategic goals. Well-written mission statements are the beginning point for strategic goal setting. Goal setting should be focused on those areas that are critical to mission accomplishment. Steven Hillestad and Eric Berkowitz recommend the following questions when attempting to ensure that mission statements and strategic goals are consistent:

1. Does the mission of the organization reflect a broad enough orientation and provide flexibility to make required changes?
2. Did all important constituencies have an opportunity to provide input or comment on the mission?
3. Did the organization work through possible alternative operations scenarios to see how the mission might be applied?
4. Does the mission provide for the formulation of a set of goals that are specific enough to give guidance to the organization yet broad enough to provide for the necessary flexibility?[45]

Critical success factors provide the foundation for strategic goal setting. The strategic goals, in turn, become the anchors for objectives and action plans.

Critical Success Factors for the Service Category

Critical success factors are those things that organizations must accomplish if they are to achieve high performance.[46] Critical success factors for the service category, as the term implies, are similar for all members of a strategic group; however, the factors may vary from one service category to another and one strategic group to another.[47] The critical factors for success in a medical practice are not the same as the critical success factors in acute care hospitals.

As an example, Alex. Brown & Sons, Inc., an investment research service, indicated that there are five critical success factors for providers of health care services: (1) ability to serve a market; (2) strong information systems; (3) low-cost structure; (4) ability to replicate its services in other geographical markets; and (5) ability to accept near-term risks. The critical success factors for the service category provide an important bridge between external and internal environmental analysis.[48] Strategic leaders must continually ask themselves whether the

EXHIBIT 5–18 Critical Success Factors Related to a Service Category

Critical Success Factors	Related to Individual Organizations
Ability to serve entire market	Complete range of services demanded in a given market. One-stop shopping for health services provides an important advantage.
Strong information systems	State-of-the-art, integrated administrative and clinical information systems are required to manage a network of health care organizations (underscores the importance of electronic medical records).
Lowest cost structure	Specialized service categories ensure low cost relative to the competition to be successful, especially true in specialty areas.
Ability to replicate services in other geographical markets	Successful competitors are able to develop business models that apply to diverse markets.
Ability to accept near-term risks	Financially conservative leadership maintains liquidity and allows for resources to pursue new opportunities.

mission, vision, and values of the organization are compatible with the critical success factors. Once compatibility is ensured, leaders must identify a relatively small number of activities that are absolutely essential to accomplish the mission and build momentum to realize the vision.

Additional detail is provided on the requirements for health care organizations competing in a given service category (as identified by Alex. Brown & Sons, Inc.) in Exhibit 5–18. The application of the critical success factors relative to individual organizations is briefly noted in the second column. Strategic leaders need to ensure that they address the factors that lead to success in the service category.

Strategic Goals

Strategic goals should relate to critical success factor activities, providing more specific direction in accomplishing the mission and vision. At the same time, strategic goals should be broad enough to allow considerable discretion for managers to formulate their objectives for individual units.[49] The most appropriate strategic goals possess the following characteristics:

1. Strategic goals should relate specifically to activities that are critical to accomplish the mission. Strategic goals that focus on activities that are not mission critical have the potential to divert leadership attention and employee energy.
2. Strategic goals should be the link between critical success factors and strategic momentum (carrying out unit objectives).

3. Strategic goals should be limited in number. When too many goals are pursued, the "trivial many" rather than the "critical few" activities are accomplished.
4. Strategic goals should be formulated by leaders but should be stated in terms that can be easily understood and appreciated by everyone in the organization.

American Dental Partners developed a set of seven strategic goals that address the company's mission and are consistent with its core values. These goals concern partnerships in management, operating excellence, integration of technology, continuous growth, financial performance, quality of work life, and quality of care and service. More specifically, American Dental Partners' goals are as follows:

1. *Partnership in management*. To ensure the appropriate sharing of operating governance and financial risk and reward in the organization and operation of each affiliate.
2. *Operating excellence*. To pursue continuous improvements in the performance and profitability in each affiliate.
3. *Integration of technology*. To optimize the provision of dental care and service through the integration of technology.
4. *Continuous growth*. To progressively increase the market share and geographic presence of each affiliate.
5. *Financial performance*. To achieve attractive returns on capital, which will allow continuous reinvestment.
6. *Quality of worklife*. To foster a work environment that is rewarding and motivating to team members.
7. *Quality care and service*. To ensure the provision of high-quality, high-value dental care and service.

American Dental Partners has maintained its strategic focus through its goals.

Governing Boards and Directional Strategies

The discussion of directional strategies has emphasized the importance of the involvement and participation of as many people as practical. The governing board is an important group that should be involved in the development of the strategic direction of the health care organization. The board members should be regularly informed about the strategic goals and the progress being made toward their accomplishment. Governing boards have taken on particular importance in the past several years as ethical issues have escalated. Health care has not been exempt, as evidenced by major corporate scandals involving companies such as HEALTHSOUTH and the stock option scandal at United Health Care. Increasingly, the question of the role and responsibility of governing boards is discussed in health care management.

Historically, three modes of governance have been applied to boards of directors. The first is the fiduciary responsibility mode or stewardship of assets; the second is the strategic mode which involves collaboration with management to develop a vision for the future; and the third is the generative mode where the board engages in shared creative thinking to make sense of data available to decision makers. More recently, the idea of the progressive board has been added. Here the focus is on contributions of individual members to a cohesive and comprehensive whole. The board is viewed as engaging in lively debate, discussion of important issues, and learning from one another.[50]

In the strategic mode, boards of directors or boards of trustees are responsible for making policies – providing general guidelines under which the organization will operate. Therefore, boards are important in formulating the mission, vision, and value statements of the organization (see Perspective 5–5). Board members are not likely to be directly involved in the process although, in some cases, members do participate. More likely, board members are interviewed during the formulation of the mission, vision, and values and their input is incorporated into the statements. The board should be informed about the statements and involved in the strategic thinking that results in their formulation; therefore, the selection and composition of board members is a critical strategic decision.[51]

Health Care Performance and the Usual Suspects

Much of the discussion regarding governing boards has related to issues that have been referred to as the "usual suspects."[52] Primary attention has been given to questioning how these usual suspects influence the financial performance of an organization. Some usual suspects are the number of outsiders on the board, shareholdings of board members, board size, and CEO duality (CEO simultaneously functioning as the chief executive and board chair).[53] An issue of particular interest has been board size. A comparative study of board composition by the executive search firm Spencer Stuart looked at the boards of the S&P 500. The results were reported in the *Harvard Business Review.* The authors noted that today boards of these leading corporations are smaller in size and composed of older members, and are more independent compared with 1987. Board independence has been particularly influenced by the Sarbanes–Oxley Act.[54]

Generally two different types of governing boards – *philanthropic governing boards* (those that are service oriented and concerned primarily with fundraising) and *corporate governing boards* (those that are more involved in strategic planning as well as policy making). Philanthropic boards are larger and more diverse to gain as much community representation as possible. The inclusion of different types of stakeholders is important and requires that board members be selected from among business leaders, physicians, local politicians, consumers of health care services, and so on. The corporate board is smaller and composed of individuals who possess expertise that will aid the organization in accomplishing its strategic goals.[55] Membership diversity is important, but less so than the actual skills or expertise possessed by the members.

PERSPECTIVE 5–5

Board's Role in Strategy

Boards of trustees and executive teams share greater responsibility in building more robust and adaptive strategies that support strategic planning and decision making. Health care as an industry is affected by many changes that are of direct relevance to governing boards. The contemporary agenda embraces a more focused board mindset for guiding growth, improving performance, and leading change.

A strategic agenda is a narrative that provides the context for purpose, vision, and mission. It creates a process for developing a culture that reflects the organization's values and beliefs. Moreover, it provides a protocol for the ongoing direction, integration, and execution of the system's priorities.

The board's role is that of a navigator that organization into focus with regard to short- and long-term realities of the marketplace. Strategic leadership brings together three elements that boards govern and executives manage. These are:

1. *Strategic direction* – provides focus for the organization as it makes strategic choices. Strategic direction provides the platform for short- and long-term planning and decision making. It represents the ideas that shape an organization's values.
2. *Strategic integration* – involves matching programs and resources with processes and priorities and is instrumental in "making things happen." Health care delivery presents a number of integration challenges such as quality, cost management, care coordination, and so on.
3. *Strategy execution* – links specific actions with outcomes and adapts to external conditions. Strategy execution connects the dots between board and executive team intentions and the capacity to provide outstanding patient care.

The strategic agenda encourages deeper thinking about key issues and problems and provides a bridge among assumptions, options, and preferences. Boards need to have a major role in strategic direction because it sets the focus for all major decisions. In addition, boards must be confident that the executive leadership has the ability, assets, and urgency to effectively manage strategic integration. Finally, boards must leave leaders free to manage while ensuring their support and engagement.

The ultimate goal of the strategic agenda is to drive economic and strategic value for a system. Strategic value is the composite of the system's reputation, operating competence, innovative capacity, and key resources. Boards have an "appetite" for strategy and oversight of the strategy is one of the board's primary responsibilities. Involving the board in strategic direction, integration, and execution is a fundamental challenge of executive leadership.

Source: Daniel Wolf, "The Board's Role in Strategy," *Trustee* 64, no. 10 (2011), pp. 21–23.

The current trend in health care organizations is toward the corporate board. To a great extent, the trend is the result of the increasingly competitive environment facing health care organizations and the need for expertise in dealing with the complexities of the economic environment.[56] However, it should be noted

that virtually no research confirms any positive relationship between the size and nature of board membership and organizational financial performance.[57]

Research findings on boards of directors suggest that when profound or radical organizational change confronts a health care organization, the corporate board is more likely to propose effective, positive responses. Philanthropic boards, on the other hand, are more likely to be associated with either no change or negative responses to profound change.[58] Boards of directors in health care organizations undergoing corporate restructuring (defined as the segmentation of the organization's assets and functions into separate corporations to reflect specific profit, regulatory, or market objectives) tend to become less philanthropic and more corporate, not only in composition but also in the way they operate.[59]

Other research provides additional information about various types of governing boards in health care organizations. When compared with boards of directors of successful high-technology firms, for example, governing boards in a sample of multihospital health care systems were almost twice as large (11 to 15 members).[60] In fact, boards are frequently too large to be effective aids in decision making, and where the goal is stakeholder representation, board members often know so little about health care that CEOs are forced to spend a great deal of their time informing and educating lay members.

Another study examined the issue of outside directors in large investor-owned health care organizations. Four major subsamples were examined, including hospitals, elder care organizations, HMOs, and alternative care facilities such as psychiatric clinics and ambulatory care centers.[61] This study found that, in general, governing boards of health care organizations were composed of more members from outside, rather than inside, the organization. Outside representatives were primarily physicians, financial professionals, attorneys, and academics. The inclusion of physicians was found to be particularly significant in terms of bottom-line performance. The presence of physicians on governing boards enhanced the support of the medical community, improving the organization's market share and quality.

The evidence to date is underwhelming with regard to the usual topics of board independence (percentage of outside members), board size, CEO duality, and so on.[62] Although it is dangerous to generalize, some inferences can be drawn from the research on governing boards in health care organizations. In not-for-profit health care organizations, governing boards are more in line with the philanthropic model. They are generally large (in fact, too large to be effective aids in strategic decision making), do not compensate members, select members primarily as stakeholder representatives, and do not hold the CEO formally accountable for performance. In this case, the primary motivation for board membership is service and recognition. When health care organizations are profit oriented, their boards take on more corporate characteristics. They tend to be smaller, compensate members for service, select members for specific expertise, involve the CEO as a voting member, make him or her formally accountable to the board, and require the participation of board members in strategic decision making. From the perspective of the individual board member, the motivation to be on the hospital's board may be to provide a valuable service to the community, but board membership may be a source of income as well.

Primarily because of corporate scandals of recent years and the passage of the Public Company Accounting Reform and Investor Protection Act of 2002 (Public Law 107-240), also known as the Sarbanes–Oxley Act, board of director research has been reignited.[63] This law, which applies to publicly traded corporations, dramatically impacts the fiduciary responsibility of chief executive officers and boards of directors. Some states have considered enacting similar legislation that would apply to not-for-profit organizations.

Board Process: Missing Link?

The lack of consistent association between factors such as board size, independence, CEO duality, member expertise, and organizational performance on financial measures has encouraged researchers to look at different variables. Of particular interest is the board process – the means by which boards of directors undertake their work.[64]

Interviews with experienced board members indicate that several behaviors lead to more effective boards:

1. *Engage in constructive conflicts (especially with the CEO).* It is important that board members hold and debate diverse views among themselves and with the CEO. An overabundance of insiders on a board may diminish the presence of constructive conflict since debate with the CEO amounts to debate with the boss.
2. *Avoid destructive conflict.* Personal friction and tension in the boardroom should be minimized. There must be a clear distinction between constructive debate and destructive conflict.
3. *Work together as a team.* The most important component of board process is teamwork and is the primary characteristic of the progressive board. The development of strong team norms, however, is hard to accomplish because board members are busy and spend little time together. Given the often limited time available, maximizing board member interaction is critical.
4. *Know the appropriate level of strategic involvement.* Board members should limit their involvement to major strategic decisions. They should be very careful not to become too involved in the day-to-day management of the organization.
5. *Address decisions comprehensively.* Board members should consciously attempt to address issues with sufficient depth to make sound decisions. Too often, time demands and conflicting priorities tempt boards to deal superficially with important issues. Effective boards find the time needed for important strategic decisions.[65]

The work of boards of directors is extremely important. Boards are created to ensure that strategic leaders have additional expertise available to them for making policy decisions that provide direction to the organization. The effectiveness of the board is a key factor in the effectiveness of the organization.

Managing Strategic Momentum – Evaluating Directional Strategies

As part of managing strategic momentum, managers assess the performance of the organization and try to determine whether the mission, vision, values, and goals are – and continue to be – appropriate. To illustrate, hospices today reap billions of dollars annually in Medicare reimbursement. In just two decades since hospices began receiving reimbursement for their services, end-of-life care has emerged as an integral part of the health care system. Palliative care (end-of-life and comfort care) has become so important that hospitals and other providers have seized opportunities in this area. One hospice states that its mission is to provide care for dying patients and their families in their homes. The second hospice, aware of the changes in the environment and concerned with managing strategic momentum, has slightly revised its mission to reflect the change in the competitive environment. Its new mission is to provide end-of-life and palliative care services. If both organizations should decide to offer services to Alzheimer's patients living in nursing homes, only the second hospice would be acting in accordance with its mission.[66]

Decisions to change an organization's mission, vision, values, and goals are complex and involve many variables. To manage strategic momentum, questions should be asked that concern the fundamental activities and direction of the organization. Exhibit 5–19 provides guidance through several questions that will aid managers in their strategic thinking concerning the appropriateness of the organization's directional strategies. Perhaps the best approach for managing the directional strategies is to place the vision for the future, the existing mission statement, statement of values, and the organization's goals next to the questions in Exhibit 5–19 and ask the board of directors/trustees and the strategic

EXHIBIT 5–19 Managing Strategic Momentum – Evaluating Directional Strategies

- Are we not doing some things now that we should be doing?
- Are we doing some things now that we should not be doing?
- Are we doing some things now that we should do but in a different way?
- Are our organization's mission and vision unique in some way?
- Is our mission relatively enduring?
- Do our mission and vision allow for innovation?
- Do our mission and vision allow for expansion?
- Is our scope of operations clear (market, products/services, customers, geographic coverage)?
- Do our mission, vision, and values fit the needs of our stakeholders?
- Do our fundamental values make sense?
- Are our strategic goals moving us toward achievement of our mission?
- Are our strategic goals moving us toward achievement of our vision?
- Have we addressed the critical success factors?
- Based on the mission, vision, and values, is the image of the organization what it should be?

management team to freely discuss and reach a consensus on each question. This process will either validate the existing mission, vision, values, and goals or indicate that there should be changes to maintain strategic momentum. This process invites clarification, understanding, and reinforcement of exactly "what this organization is all about" or "what this organization should be about."

Lessons for Health Care Managers

Directional strategies allow leaders to state what they believe the organization should be doing and make explicit how they intend to conduct their business. Every attempt should be made to develop and communicate well-conceived and written statements of the organization's mission, vision, values, and strategic goals.

Directional strategies are the superordinate goals or outcomes that health care organizations plan to accomplish. Strategic leaders should recognize that strategic planning is a logical process. The progression of directional strategies illustrates the importance of the logic. The mission of the organization drives decision making because it is the organization's reason for existing. The vision provides hope for the future and values tell everyone – employees, stakeholders, patients, and so on – how the organization will operate. The strategic goals more specifically state what the leaders believe is required to achieve the mission.

A mission alone is not enough. The mission, as a statement of purpose that distinguishes the organization from all others of its type, such as the care given to patients, physical location of the facility, the unusual commitment of physicians to research as well as to healing, or any other factor that is important in the minds of those served, is only the first step. The mission may motivate a few physicians and department managers, but real motivation comes from visionary leadership.

The vision is a hope that says what key stakeholders think the organization should look like and be like when the mission is being achieved. Values, as guiding principles, can be powerful motivating forces, as well.

Even a well-developed and communicated mission is likely to leave the health care strategist with far too many areas of responsibility, resulting in an impossible task. For this reason, critical success factors for the service category must be identified and strategic goals must be set to accomplish the mission. Strategic goals help to make the strategist's job feasible and help focus strategists on those tasks that really make a difference with respect to organizational success.

Management research shows that the existence of goals can be extremely motivating. Clearly stated and communicated strategic goals provide a sense of direction – they specify what leaders are expected to accomplish and remove anxiety from those who want to succeed. Formulating mission, vision, values, and strategic goals and identifying critical success factors are often "messy" and unappreciated. In the end, however, setting directional strategies is a major responsibility for all strategic leaders.

Engaging as many groups as practical in the process of developing directional strategies is important. The board of directors should be involved in the thinking that ultimately results in the mission, vision, and value statements. In addition,

board members should be regularly informed about the strategic goals of the organization and the progress being made in their accomplishment. Most importantly, the board should engage in a process that contributes to organizational effectiveness. Research confirms that merely electing or selecting a board of directors/trustees comprising an appropriate percentage of outsiders, of individuals with the appropriate expertise, and small enough to be manageable, will not ensure its effectiveness. The board must also be willing to engage in constructive conflict, minimize destructive interpersonal tensions, avoid micromanagement, and devote the time required to make important strategic decisions. Chapter 6 addresses strategy formulation and the strategic alternatives available to health care organizations.

Health Care Manager's Bookshelf

Chester I. Barnard, *The Functions of the Executive* (Cambridge, MA: Harvard University Press, 1938)

Some people might think that the discussion of directional strategies is something new. Actually, there is a rich history of concern for the purpose and mission of organizations that dates at least to 1938. Chester Barnard in *The Functions of the Executive* (1938) made no less than 45 references to the topic of purpose in this classic work and "set the stage" for much of our modern thinking on the subject.[1]

Barnard's most cited reference concerning purpose has to do with the essence of organizations themselves. He contends that an organization exists when there are people who communicate with one another and are willing to contribute action to accomplish a *common purpose* (p. 83). He concludes that the three essential components of organization are communication, willingness to serve, and purpose.

At a practical level the most important role of the purpose, objective, or aim relates to the nature of cooperative systems or complex organizations made up of specialized parts.[2] Complex organizations necessarily specialize to accomplish their purpose.[3] The primary function of the purpose is to coordinate the efforts of individuals and functional units so that the purpose of the "whole" or the *general purpose* [mission] may be accomplished (p. 136). When the purpose of the cooperative system is attained, the organization is *effective*. When the purpose is not attained, the organization is *ineffective*. Thus, Barnard gave us one of our earliest definitions of effectiveness as goal accomplishment (p. 43).

Organizations progress toward the accomplishment of their missions by redefining the *general purpose* into purposes for specialized units such as medicine, nursing, pharmacy, and so on (in the case of a hospital). The purpose is the *unifying element* of formal organizations and provides an *ends–means chain* (p. 137) (discussed in Chapter 6).

Barnard provides an exceptionally interesting observation by pointing out that it is not "essential" for the specialized units to understand completely the general purpose of the

complex or corporate-level organization.[4] Each unit must, however, understand and accept its own purpose as derived from the general purpose. The more complete the understanding of the general purpose, the more likely the unit will enthusiastically pursue the organization's mission. When a specialized unit believes the whole organization depends on the achievement of its unit's purpose, the "intensity of its actions will ordinarily be increased" (p. 138).

Barnard argues that the "most important inherent difficulty" in operating complex organizations is "the necessity for indoctrinating those at lower levels (in specialized units) with the general purpose of the organization so they can 'remain cohesive' and make decisions consistent with the purpose of the larger system" (p. 233). This is a primary responsibility of strategic leaders.

The Functions of the Executive remains a genuine classic of management and, as such, it is not surprising that a major portion is devoted to the role of the purpose or, in today's terms, the mission of the organization. Its message is as relevant today as it was the day it was published. It is significant to note that the publisher distributed almost four times as many copies annually 30 years after its original publication as it did during the first year of its publication.

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KEY TERMS AND CONCEPTS IN STRATEGIC MANAGEMENT

Corporate Governing Boards
Critical Success Factor
First-Mover Advantage
Liability of Newness
Mission
Mission Drift
Philanthropic Governing Boards
Pioneering
Strategic Goals
Values
Vision
Vision-Led Approach

Questions for Class Discussion

1. Is it necessary for organizational mission statements to include all the components discussed in this chapter? How do you decide what components to include?
2. Think of an organization that you know relatively well and attempt to construct a mission statement in light of the components of missions discussed in this chapter.

What components did you choose to emphasize in the statement? Why? What component do you think really embodies the distinctiveness of the organization?

3. Where do organizational missions originate? How do you explain the evolution of organizational missions as an organization grows and matures? If mission statements are "relatively enduring," how often should they be changed?
4. Indicate two ways in which an organizational vision is different from other types of directional strategies.
5. It has been said that vision is necessarily a responsibility of leaders. Why is it important for health care organizations to have "keepers of the vision?"
6. Who determines the values of the health care organization? What values do you think should be shared by all health care organizations? Why?
7. Why are values referred to as an organization's guiding principles? In what sense do values constitute a directional strategy for the organization?
8. How many strategic goals should a health care organization develop?
9. How can health care managers more effectively use directional strategies to stimulate higher levels of performance among all personnel?
10. Why is the board of directors an important group to include in the formulation of directional strategies? What is the board's proper role in formulating these strategies?
11. What is the best way to involve the board in the development of directional strategies? Explain your answer.
12. What are critical success factors for an organization? How are they developed? How may they be used?
13. List three reasons why boards of directors or trustees have become increasingly important factors in the effectiveness of health care organizations.

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6 Developing Strategic Alternatives

"The most serious mistakes are not being made as a result of wrong answers. The truly dangerous thing is asking the wrong question."

—PETER F. DRUCKER

Introductory Incident

The Leapfrog Group

Private employers understood that frequent and systemic errors in hospitals were placing a significant number of employees at risk. They recognized that dysfunction existed in the health care marketplace – they were spending billions of dollars on health care for their employees with no way of assessing its quality or comparing health care providers. In addition, years of experience with total quality management had provided these leaders with a sense that low-quality and high-practice variance were contributing to continued inflation in health insurance premiums. As a result, the 1998 Business Roundtable – an association of CEOs from 200 of the Fortune

500 companies – came together to discuss how they could work together to use the way they purchased health care to have an influence on its quality and affordability.

A year later, the 1999 Institute of Medicine report, "To Err Is Human: Building a Safer Health System," gave Leapfrog its initial focus – reducing preventable medical mistakes. The report found that up to 98,000 Americans die every year from preventable medical errors made in hospitals alone. In fact, there are more deaths in hospitals each year from preventable medical mistakes than there are from vehicle accidents, breast cancer, and AIDS combined. The report actually recommended that large employers provide more market reinforcement for the quality and safety of health care. The Business Roundtable founders realized that they could take "leaps" forward with their employees, retirees, and covered families by rewarding hospitals that implemented significant improvements in quality and safety. The Leapfrog Group was officially launched in November 2000.

The Leapfrog Hospital Survey compares hospitals' performance on national standards of safety, quality, and efficiency that are most relevant to consumers and purchasers of care. Hospitals that participate in The Leapfrog Hospital Survey achieve hospital-wide improvements that translate into millions of lives and dollars saved. Leapfrog's purchaser members use survey results to inform their employees and purchasing strategies. In 2012, more than 2,650 hospitals across the country were surveyed. Leapfrog ratings are posted on its website and are free to the public at www.leapfroggroup.org/cp.

Endorsed by the National Quality Forum (NQF), the practices (or "leaps") are:

1. **Computerized Physician Order Entry (CPOE).** With CPOE systems, hospital staff enter medication orders via computers linked to software designed to prevent prescribing errors that occur because of illegible handwriting, decimal point errors, wrong medicine for the patient, overlooked drug interactions, and patient allergies. CPOE has been shown to reduce serious prescribing errors by more than 50 percent.
2. **Evidence-Based Hospital Referral (EHR).** Consumers and health care purchasers should choose hospitals with the best track records. By referring patients needing certain complex medical procedures to hospitals offering the best survival odds based on scientifically valid criteria – such as the number of times a hospital performs a procedure each year or other process or outcomes data – studies indicate that a patient's risk of dying could be significantly reduced.
3. **Intensive Care Unit (ICU) Physician Staffing.** Staffing ICUs with intensivists – doctors who have special training in critical care medicine – has been shown to reduce the risk of patients dying in the ICU by 40 percent.
4. **Leapfrog Safe Practices Score.** The National Quality Forum is a not-for-profit organization created to develop and implement a national strategy for health care quality measurement and reporting. Leap 4 is based on the National Quality Forum's (NQF) *Safe Practices for Better Healthcare: A Consensus Report*. The NQF published *Safe Practices* in May 2003, and updated the report in 2006, 2009, and 2010. The most recent version of the report endorsed

34 practices that should be universally used in applicable clinical care settings to reduce the risk of harm to patients. Included in the 34 practices are the three Leapfrog leaps; leap 4 incorporates hospitals' progress on a targeted subset of 17 of the 34 safe practices.

All of the leaps adhere to four criteria. (1) There is scientific evidence that their implementation would significantly reduce preventable mistakes. (2) Implementation by the health industry is feasible in the near term. (3) Consumers can appreciate their value. (4) Health plans, purchasers, and/or consumers can easily ascertain their presence or absence when assessing health care providers. Because the health care industry needs time to meet these standards, Leapfrog works with the provider community to arrive at aggressive but feasible target dates for implementation of Leapfrog's recommended quality practices.

Continuing to make hospital results available on the level of implementation of the safe practices will provide important information to consumers, enabling them to make more informed hospital choices. Purchasers and health plans can promote the Safe Practices Score by educating employees and consumers and calling attention to the importance of choosing the right hospital. Purchasers, through their community involvement in health care settings (as board members, volunteers, donors), can also be persuasive with health care providers about the need to extend their efforts in safety and quality.

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Learning Objectives

After completing the chapter you will be able to:

1. Understand and discuss the steps involved in the decision logic of strategy development.
2. Synthesize and integrate strategic thinking accomplished in situational analysis into a strategic plan for an organization.
3. Identify the hierarchy of strategies and strategic decisions required in strategic planning.
4. Understand the nature of directional strategies, adaptive strategies, market entry strategies, and competitive strategies.
5. Identify strategic alternatives available to health care organizations.

6. Provide the rationale as well as advantages and disadvantages for each of the strategic alternatives.
7. Understand that strategies may have to be used in combination to accomplish the organization's goals.
8. Map strategic decisions showing how they are linked as an ends–means chain.

Developing a Strategy

Strategic thinking involves an awareness of the environment; intellectual curiosity that is always gathering, organizing, and analyzing information; and a willingness to be open to creative ideas and solutions. Strategic planning concerns reaching conclusions about the information, setting a course of action, and documenting the plan. Therefore, strategic planning is essentially decision making – determining which strategy from among the many available alternatives the organization will pursue.

There are many strategic alternatives available to a health care organization and a particular organization may pursue several different types of strategies simultaneously or sequentially. Therefore, decision logic is required for strategy development. For instance, hospitals selecting to pursue various Leapfrog leaps, as discussed in the Introductory Incident, are making strategic choices that will both limit and create opportunities to pursue several different strategies. Similarly, the decision to adopt telehealth or telemonitoring is a strategic choice (see Perspective 6–1). In what order should strategic decisions be made? A merger or affiliation decision is part of a series of decisions rather than a single decision or an end in itself. In other words, there is a broader strategy that precipitated the merger or affiliation decision; and there will be subsequent strategic decisions that will have to be made to support the decision and make it successful.

Strategy formulation includes development of strategic alternatives, evaluation of alternatives, and strategic choice. This chapter classifies the types of strategies and develops a hierarchy of strategic alternatives. The hierarchy provides a strategic thinking map as guidance in decision making and strategic planning. Chapter 7 discusses strategic thinking methods for analyzing these alternatives to make a strategic choice.

PERSPECTIVE 6–1

Telehealth and Telemonitoring

The Centers for Medicare and Medicaid Studies define telehealth as remote health care delivery via monitoring. Telehealth is specifically defined as phone monitoring of the implementation of scheduled and prescribed encounters. Telemonitoring relates to the collection and transmission of vital signs and clinical data through electronic information-processing

technologies. Quality improvement organizations have been particularly supportive of home health agencies in implementing telehealth tools to reduce acute care and hospitalization. Using these techniques, a health care provider can stay in contact with patients and monitor via telephone the extent to which recommendations are being followed and track compliance rates. These techniques support the assumption that proactively reaching out to patients with chronic disease will encourage people to change unhealthy behaviors and adopt more healthy lifestyles.

In many cases patients make poor or less-informed decisions about their personal health. The ability to accurately access a patient's condition via telemonitoring makes it possible to intervene when appropriate and provide equally important education regarding healthy living in a manner that is more convenient for both provider and patient.

Research has shown that the primary advantage of telemonitoring is that it increases patient compliance. Often, changes in a patient's condition can be detected at or before the onset of a serious event in much the same way as nurses monitor patients in an inpatient setting. Of course, real-time monitoring of data, direct patient feedback, and high levels of provider/patient interaction depends on digital proficiency on the part of both parties as well as effective multimodal communication.

Home patient monitoring assumes two things: (1) the rise of the responsible patient who can self-manage her/his long-term medical condition and (2) availability of mobile devices as effective go-betweens for clinicians and patients. Telemonitoring congestive heart failure patients, for example, has been shown to be successful in reducing hospitalizations and trips to the emergency department.

Telemonitoring allows patients more choices about how and when to react to changes in medical conditions before a genuine emergency occurs. Regardless of where a patient may be, wireless monitoring supports a more mobile lifestyle. Providers have made effective use of digital monitoring in home health by reducing the frequency of nursing visits and thereby reducing the cost of home health care. Because health care costs are growing so rapidly, the telehealth equipment market is growing as well. Many experts see great promise in the ability of telehealth to decrease the cost of health care delivery and possibly improve quality as compliance rates increase. There is little debate that telemonitoring has and will continue to improve the quality of life available to large numbers of patients worldwide.

Source: "Research and Markets: Tele-Health Monitoring: Market Shares, Strategies, and Forecasts Worldwide, 2011–2017," *Telemedicine Business Week* (June 29, 2011), pp. 82–83.

Linking Strategy with Situational Analysis

As demonstrated by the check list in Exhibit 6–1, the strategies selected by an organization should address external issues, draw on competitive advantages or fix competitive disadvantages, keep the organization within the parameters of the mission and values, move the organization toward the vision, and make progress toward achieving one or more of the organization's strategic goals. This check-list procedure is an important part of the strategic

EXHIBIT 6–1 Check List for Linking Strategic Alternatives with Situational Analysis

Strategic Alternative	Addresses an External Issue?	Draws on a Competitive Advantage or Fixes a Competitive Disadvantage?	Fits with Mission, Values?	Moves the Organization Toward the Vision?	Achieves One or More Strategic Goals?
Strategy 1	Yes	Yes	Yes	Yes	Yes
Strategy 2	Yes	Yes	Yes	Yes	Yes
Strategy 3	Yes	Yes	Yes	Yes	Yes

thinking process and helps to assure consistency of analysis and action. Each selected strategy should be tested against these questions. Strategies that do not have a "yes" in each column should be subject to additional scrutiny and justification.

The Decision Logic of Strategy Development

The decision logic of strategy formulation is illustrated in Exhibit 6–2. Decisions concerning five categories of strategies – directional strategies, adaptive strategies, market entry strategies, competitive strategies, and implementation strategies – should be addressed sequentially with each subsequent decision more specifically defining the activities of the organization. The first four of these strategy types make up strategy formulation and specify how the organization will define and attempt to achieve its mission and vision. Implementation strategies include objectives and plans for the organizational units to accomplish the strategies (managing strategic momentum).

As demonstrated in Exhibit 6–2, strategies form an *ends–means chain*. Thus, the organization must first establish or reaffirm and reach consensus on its mission, vision, values, and strategic goals (directional strategies) – the ends. Next, the adaptive strategies must be identified and are the means to accomplishing the directional strategies. *Adaptive strategies* are concerned with the type and scope of operations and specify how the organization will expand, reduce,

EXHIBIT 6–2 The Decision Logic of Strategy Formulation

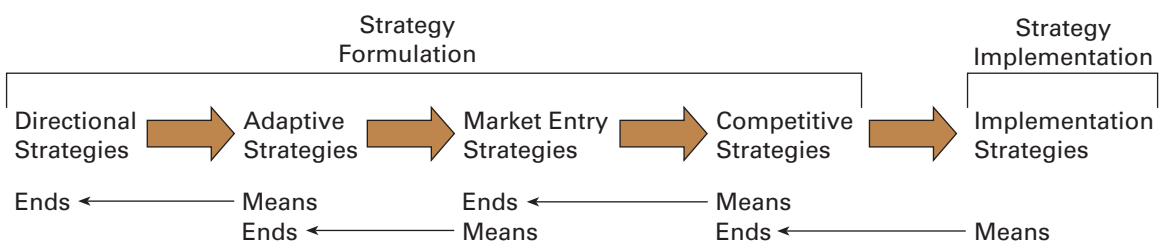


EXHIBIT 6–3 Scope and Role of Strategy Types in Strategy Formulation

Strategy	Scope and Role
Directional Strategies	The broadest strategies that set the fundamental direction of the organization by establishing a mission for the organization (Who are we?) and vision for the future (What should we be?). In addition, directional strategies specify the organization's values and the strategic goals.
Adaptive Strategies	These strategies are more specific than directional strategies and provide the primary methods for achieving the vision (adapting to the environment). These strategies determine the scope of the organization and specify how the organization will expand scope, reduce scope, or maintain scope.
Market Entry Strategies	These strategies provide the method of carrying out the adaptive strategies (expansion of scope and the maintenance of scope strategies) through purchase, cooperation, or internal development. Market entry strategies are not used for reduction of scope strategies.
Competitive Strategies	Two types of strategies, one that determines an organization's strategic posture and one that positions the organization *vis-à-vis* other organizations within the market. These strategies are market oriented and best articulate competitive advantage.
Implementation Strategies	These strategies are the most specific strategies and are directed toward value-added service delivery and the value-added support areas. In addition, individual organizational units develop objectives and action plans that carry out the value-added service delivery and value-added support strategies.

or maintain operations. Third, market entry strategies must be selected and are the means to accomplish the adaptive strategies. *Market entry strategies* indicate the method for carrying out the adaptive strategies. Fourth, competitive strategies must be determined and are the means to carrying out the market entry strategies. *Competitive strategies* determine the organization's strategic posture and identify the basis for competing in the market. Finally, *implementation strategies* (value-adding service delivery strategies, value-adding support strategies, and action plans) must be developed to carry out the adaptive, market entry, and competitive strategies. The scope and role of the four strategy formulation types and the implementation strategies are summarized in Exhibit 6–3.

At each stage in the ends–means decision chain, previous upstream decisions and the implications for subsequent downstream decisions must be considered and perhaps reconsidered. As strategic managers work through strategic decisions, new insights and perspectives may emerge (strategic thinking) that suggest reconsideration of previous strategic decisions. Therefore, although the decision

logic for strategic decisions is generally sequential, in practice it is very much an iterative process. Strategy includes a plurality of inputs, a multiplicity of options, and an ability to accommodate more than one possible outcome. Where mission and vision are ignored, or where there is no ends–means linkage between vision and strategy, strategy has no end object. In these situations, strategy suffers from being a means without an end, an end in itself, or a means of achieving an operational end, rather than being a design or plan for achieving the organization's mission and vision.[1]

Strategic decisions should be based on as much information and strategic thinking as possible. Sometimes strategic thinking occurs in situational analysis and at other times it occurs when managing strategic momentum. Before the strategic plan is adopted, it is important to remember that organization-wide understanding of, and commitment to, the strategies must be developed if they are to be managed successfully (strategic momentum). The choice of a strategic alternative creates additional direction for an organization and subsequently shapes its internal systems (organization, technology, information systems, culture, policies, skills, and so on). Strategic momentum is reinforced as managers understand, commit, and make decisions according to the strategy.

Exhibit 6–4 presents a comprehensive strategic thinking map of the hierarchy of strategic alternatives. The hierarchy represents a number of strategic alternatives available to health care organizations. This map not only identifies the alternatives but also the general sequential relationships among them. Using this organizing framework or decision logic in strategy formulation keeps it from becoming overwhelming and focuses strategic thinking. As strategic managers work through the strategic decisions, new understandings,

EXHIBIT 6–4 Strategic Thinking Map – Hierarchy of Strategic Decisions and Alternatives

Directional Strategies	Adaptive Strategies	Market Entry Strategies	Competitive Strategies	Implementation Strategies
	Expansion of Scope	***Purchase***	***Strategic Posture***	***Service Delivery***
Mission	Diversification	Acquisition	Defender	Pre-service
Vision	Vertical Integration	Licensing	Prospector	Point-of-service
Values	Market Development	Venture Capital Investment	Analyzer	After-service
Goals	Product Development		***Positioning***	***Support***
	Penetration	***Cooperation***	*Marketwide*	Culture
	Reduction of Scope	Merger	Cost Leadership	Structure
	Divestiture	Alliance	Differentiation	Strategic Resources
	Liquidation	Joint Venture	*Market Segment*	***Unit Action Plans***
	Harvesting	***Development***	Focus/Cost Leadership	Objectives
	Retrenchment	Internal Development	Focus/Differentiation	Actions
	Maintenance of Scope	Internal Venture		Timelines
	Enhancement	Reconfigure the Value Chain		Responsibilities
	Status Quo			

insights, and strategies may (and in fact, should) emerge. Therefore, decision makers must work through the decision logic and back again, ensuring that all the proposed strategies make sense together. Strategic thinkers must always be able to see the bigger picture. Decision makers should be prepared to adjust and refine earlier decisions in the decision logic as they make "downstream" decisions.

How-to formulas, techniques, or a linear process, of course, can never replace strategic thinking. Many of the greatest achievements in science, law, government, medicine, or other intellectual pursuits are dependent on the development of rational, logical thinkers; however, linear thinking can limit potential.[2] Leadership is essential to foster creativity and innovation and allow for the reinvention of the strategy formulation process. Strategy formulation involves managing dilemmas, tolerating ambiguity, coping with contradictions, and dealing with paradox.[3] Often leaders must creatively resolve the tension between competing information and alternatives and generate new options and solutions.[4] In addition, strategy development cannot ignore the entrepreneurial spirit, politics, ethical considerations, and culture in an organization. The strategy formulation decision logic discussed in this chapter provides a starting point. It should foster strategic thinking, not limit it. The map starts the decision makers on their journey.

Directional Strategies: Mission, Vision, Values, and Goals

Chapter 5 explored mission, vision, values, and strategic goals and indicated that these elements are part of both situational analysis and strategy formulation. They are a part of situational analysis because they describe the current state of the organization and codify its basic beliefs and philosophy. In many ways, it provides the context for the organization to operate and includes its leaders' ethical and moral framework (see Perspective 6–2). In addition, these directional strategies are a part of strategy formulation because they set the boundaries and indicate the broadest direction for the organization. The directional strategies should provide a sensible and realistic planning framework for the organization.

Because formulation of the mission, vision, values, and strategic goals provides the broad direction for the organization, directional strategic decisions must be made first. Then the adaptive strategies provide further progression by specifying the type and scope of product/market expansion, reduction, or maintenance. The adaptive strategies form the core of strategy formulation and are most visible to those outside the organization. After the adaptive strategies have been selected, the directional strategies should be re-evaluated. Seeing the directional strategies (ends) and the adaptive strategies (means) together may suggest refinements to either or both. This broader perspective is essential in strategic thinking.

PERSPECTIVE 6–2

Ethics, Strategy, and a Changing Health Care Environment

Ethics are guidelines for action that are based on values, moral principles, or moral rights and duties, such as honesty, respect, and compassion. Some ethical guidelines are reflected in laws, whereas others are norms, customs, and social expectations that develop and are maintained by mutual consent.

It is useful to distinguish two categories of ethics in the health care environment: professional ethics and applied ethics. Professional ethics are the customs, norms, expectations, values, rights, and duties that guide individuals as they carry out particular work roles in society. Professional ethics reflect the expectations that society has for people who perform specific roles. We expect physicians and nurses to help rather than harm patients. We expect administrators and business officers to accept fiduciary responsibility (act for the benefit of the organization rather than themselves) and to be accountable to stockholders or boards of trustees for their decisions.

The norms guiding professional behavior can change over time, as society's expectations change. For example, over the past few decades, physicians' roles have evolved away from the expectation that doctors will make decisions on behalf of patients and for their health benefit to the expectation that they will provide all relevant information to patients and families and help them to make decisions about their treatment. As another example, the implementation of the Health Insurance Portability and Accountability Act (HIPAA) in April 2003 represented the legal enforcement of a social expectation that health-related information on patients will be kept strictly confidential; some widely accepted practices of information sharing in health care organizations had to be altered under the HIPAA guidelines because they were not perceived to reflect the priority that members of society placed on confidentiality.

Health care organizations involve the interaction of many sets of health professionals who, by definition, are bound by differing sets of ethics and norms. Decisions that must be made by the organization as a whole must be negotiated across these norms. For example, the imperative to help anyone in need of medical care must be balanced with the imperative to operate organizations that are financially sound. Organizations are best served when professionals are able both to represent their own guiding values and principles and to comprehend the values and principles that guide their colleagues.

In contrast to professional ethics, applied ethics is the application of values, principles, and expectations to broader social choices, such as whether all residents of a society have a right to some basic level of health care, or whether health care is a commodity that individuals can choose to purchase or not. Some social choices have a broad consensus. In the United States the responsibility of society to cover the costs of health care for the elderly is generally accepted. Other social choices are the subject of considerable disagreement and conflict, even when one set of values or expectations has been codified into laws. The rights of individuals to have abortions or to enforce their preferences on care at the end of life are examples of areas of ethical conflict that impact health care organizations. Organizations whose decision-making processes are affected by social choices that

are the basis of ethical conflicts must consider carefully the values and norms that guide their constituents and the laws that represent the current societal consensus on the issue.

All actions have an ethical component, but often the underlying values for a decision are so widely shared that we do not recognize the ethical choices that we make. For example, we do not question the principle that health care is meant to benefit those who are sick. When faced with a decision about whether to provide effective or harmful treatment to someone who is sick, we automatically make the ethical decision to help rather than to harm the person. On the other hand, we sometimes face situations where alternative courses of action reflect contrasting values. For example, we value individuals' autonomy and their right to make decisions about their own health. If an individual wants a treatment that we believe to be harmful, should we respect his or her wishes and provide the treatment, or refuse the treatment and adhere to the principle that treatment should not be provided if it is known to cause harm?

Source: Janet M. Bronstein, PhD, School of Public Health, University of Alabama at Birmingham.

Adaptive Strategies

From a practical standpoint, whether the organization should expand, reduce, or maintain scope is the first decision that must be made once the direction of the organization has been set (or reaffirmed). As shown in Exhibit 6–5, several alternatives are available to expand, reduce, or maintain the scope of operations. These alternatives provide major strategic choices for the organization.

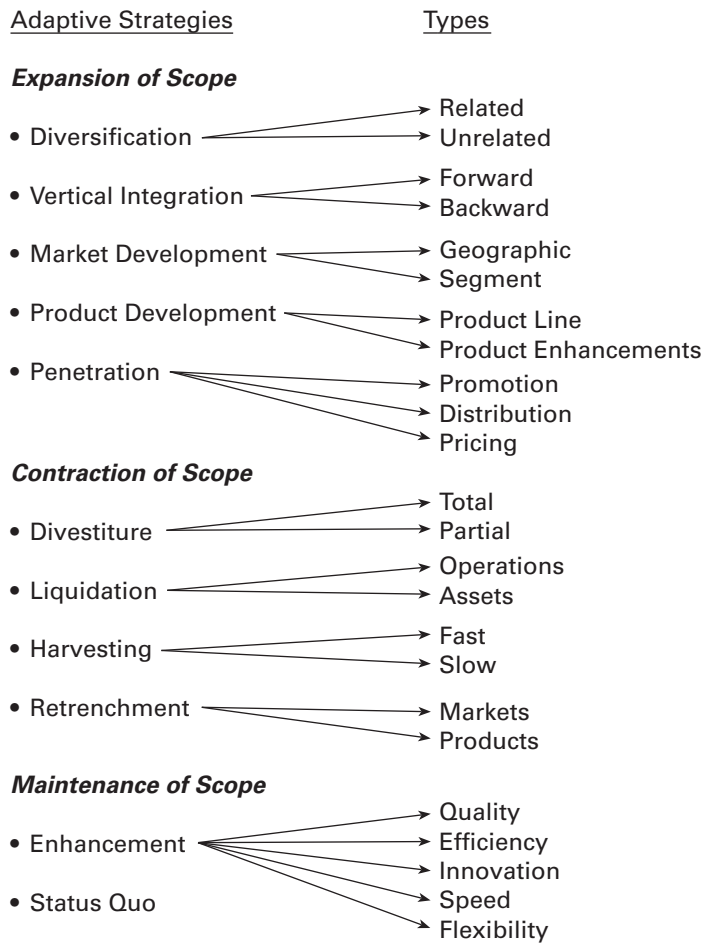
Expansion of Scope Strategies

If expansion is selected as the best way to perform the mission and realize the vision of the organization, several alternatives are available. The *expansion of scope strategies* include:

- diversification,
- vertical integration,
- market development,
- product development, and
- penetration.

Diversification *Diversification* strategies, in many cases, are selected because markets have been identified outside the organization's core business that offer potential for substantial growth. Often, an organization that selects a diversification strategy is not achieving its growth or revenue goals within its

EXHIBIT 6–5 Strategic Thinking Map of Adaptive Strategic Alternatives

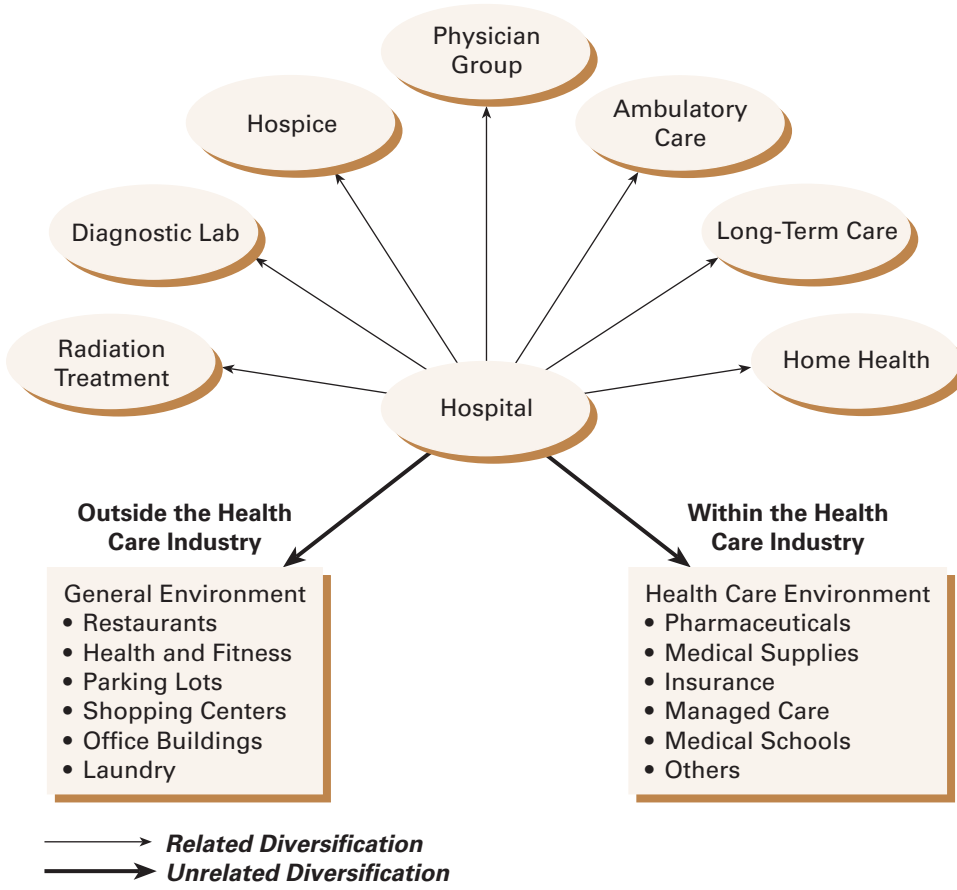


current market, and these new markets provide an opportunity to achieve them. There are, of course, other reasons why organizations decide to diversify. For instance, health care organizations may identify opportunities for growth in less competitive or less regulated markets such as medical office buildings, long-term care facilities, or outpatient care.

Diversification is generally seen as a risky alternative because the organization is entering relatively unfamiliar markets or new businesses that are different from its current activities. Organizations have found that the risk of diversification can be reduced if markets and products are selected that complement one another. Therefore, managers engaging in diversification seek synergy between corporate divisions (SBUs).

There are two types of diversification: related (concentric) and unrelated (conglomerate) diversification. Exhibit 6–6 illustrates possible related and unrelated diversification strategies for one type of primary health care organization.

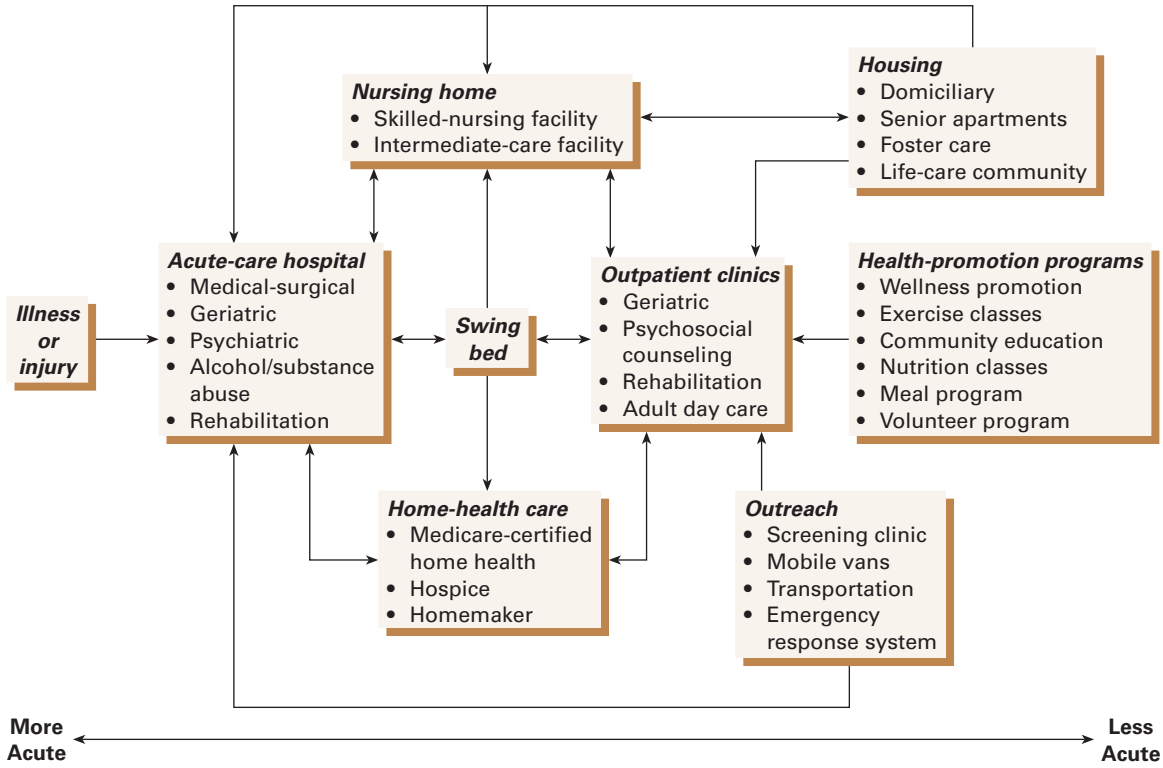
EXHIBIT 6–6 **Related and Unrelated Diversification by a Primary Provider**



In *related diversification*, an organization chooses to enter a market that is similar or related to its present operations. This form of diversification is sometimes called *concentric diversification* because the organization develops a "circle" of related businesses (products/services). Exhibit 6–7 illustrates the circle of related products for a hospital that is interested in diversifying into another segment of the health care market, the long-term care market.

The general assumption underlying related diversification is that the organization will be able to obtain some level of synergy (a complementary relationship where the total effect is greater than the sum of its parts) between the production/delivery, marketing, or technology of the core business and the new related product or service. For hospitals, the two primary reasons for diversifying are to introduce non-acute care or sub-acute care services that reduce hospital costs, or to offer a wider range of services to large employers and purchasing coalitions through capitated contracts.[5] The movement of acute care hospitals into skilled-nursing care is an example of related diversification.

EXHIBIT 6–7 Long-Term Care Options for Hospital Diversification



Source: *Health Care Management Review* 15, no. 1, p. 73. Copyright © 1990. Reprinted by permission of Aspen Publishers, Inc.

On the other hand, in *unrelated diversification*, an organization enters a market that is unlike its present operations. This action creates a "portfolio" of separate products/services. Unrelated diversification, or *conglomerate diversification*, generally involves semi-autonomous divisions or strategic service units. An example of unrelated diversification would be a hospital diversifying into the operation of a restaurant, parking lot, or medical office building. In such a case, the new business is unrelated to the provision of health care although it may be complementary (synergistic) to the provision of health services.

Research on diversification indicates that financial performance increases as organizations shift from single-business strategies to related diversification, but performance decreases as organizations change from related diversification to unrelated diversification.[6] Single-business organizations may suffer from limited economies of scope whereas organizations using related diversification can convert underutilized assets and achieve economics of scope by sharing resources and combining activities along the value chain. Unrelated diversification has been found to increase strain on top management in the areas of decision making, control, and governance. In addition, unrelated diversification makes it difficult to share activities and transfer competencies between units. Sharing

activities and transferring competencies has been particularly difficult in hospital diversification.[7] Unrelated diversification has been generally unsuccessful in generating revenue for acute care hospitals.

Vertical Integration A *vertical integration* strategy is a decision to grow along the channel of distribution of the core operations. Thus, a health care organization may grow toward suppliers or toward patients. When an organization grows along the channel of distribution toward its suppliers (upstream), it is called *backward vertical integration*. When an organization grows toward the consumer or patient (downstream), it is called *forward vertical integration*.

A vertically integrated health care system offers a range of patient care and support services operated in a functionally unified manner. The expansion of services may be arranged around an acute care hospital and include pre-acute, acute, and post-acute services or might be organized around specialized services related solely to long-term care, mental health care, or some other specialized area.[8] The purpose of vertical integration is to increase the comprehensiveness and continuity of care, while simultaneously controlling the channel of demand for health care services.[9]

Vertical integration can reduce costs and thus enhance an organization's competitive position. Cost reductions may occur through lower supply costs and better integration of the "elements of production." With vertical integration, management can better ensure that supplies are of the appropriate quality and delivered at the right time. For instance, some hospitals have instituted technical educational programs because many health professionals (the major element of production in health care) are in critically short supply.

Because a decision to vertically integrate further commits an organization to a particular product or market, management must believe in the long-term viability of the product/service and market. As a result, the opportunity costs of vertical integration must be weighed against the benefits of other strategic alternatives such as diversification or product development. Examples of vertical integration would be a hospital chain acquiring one of its major medical products suppliers (backward integration) or a drug manufacturer moving into drug distribution (forward integration).

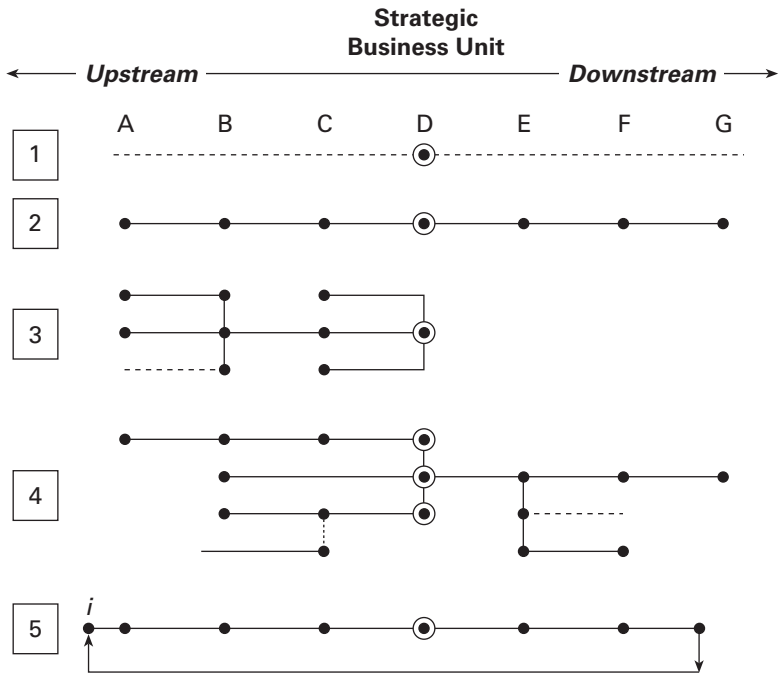
Whether a strategic alternative is viewed as vertical integration or related diversification may depend on the objective or intent of the alternative. For instance, when the primary intent is to enter a new market in order to grow, the decision is to diversify. However, if the intent is to control the flow of patients to various units, the decision is to vertically integrate. Thus, a decision by an acute care hospital to acquire a skilled-nursing unit may be viewed as related diversification (entering a new growth market) or vertical integration (controlling downstream patient flow). Vertical integration is the fundamental adaptive strategy for developing integrated systems of care and is central to many health care organizations' strategies.

Numerous extensive health networks are the result of integration strategies. One study showed that over 89 percent of US hospitals belong to health networks or systems.[10] The major reason that hospitals join networks and systems is to help to secure needed resources (financial, human, information systems, and technologies), increase capabilities (management and marketing), and

gain greater bargaining power with purchasers and health plans.[11] However, it appears that the pace of integration has slowed. In fact there has been some degree of "disintegration," with health care systems divesting health plans, physician groups, home health care companies, as well as selling or closing hospitals and divesting themselves of skilled care services or facilities.[12]

To expand the supply of patients to various health care units, several patterns of vertical integration may be identified.[13] In Exhibit 6–8, an inpatient acute care facility is the strategic service unit or core technology that decides to vertically integrate. Example 1 represents a hospital that is not vertically integrated. The hospital admits and discharges patients from and to other units outside the organization. Example 2 illustrates a totally integrated system in which

EXHIBIT 6–8 **Patterns of Vertical Integration Among Health Care Organizations**



A = wellness/health promotion unit
B = primary care unit
C = urgent care unit
D = hospital (inpatient acute care unit)
E = skilled-nursing unit
F = rehabilitation unit
G = home-health unit

Solid lines depict fully internal transfers

Dashed lines depict market or external transfers

Sources: Adapted in part from K. R. Harrigan, "Formulating Vertical Integration Strategies," *Academy of Management Review* 9, no. 4 (1984), pp. 638–652. Reprinted by permission of Academy of Management. And adapted in part from Stephen S. Mick and Douglas A. Conrad, "The Decision to Integrate Vertically in Health Care Organizations," *Hospital and Health Services Administration* 33, no. 3 (fall 1988), p. 351. Reprinted by permission from Health Administration Press, Chicago.

integration occurs both upstream and downstream. In this case, patients flow through the system from one unit to the next, and upstream units are viewed as "feeder" units to downstream units.

Example 3 represents a hospital that has vertically integrated upstream. In addition, more than one unit is involved at several stages of the integration. For instance, there are two wellness/health promotion units, three primary care units, and three urgent care units. The dashed line represents the receipt of patients via external or market transfers. Example 4 illustrates a multihospital system engaged in vertical integration. Three hospitals form the core of the system, which also contains three nursing homes, two rehab units, a home-health unit, three urgent care facilities, three primary care facilities, and a wellness center. It is important to note that simply adding members to create an integrated health system is not enough. Institutions must be truly integrated and create a "seamless" system of care to achieve the desired benefits for patients (effectiveness) and cost savings (efficiency).

Finally, some health care systems are closed systems with fixed patient populations entirely covered through prepayment. Thus, whereas in Example 2, the health care organization is vertically integrated, in Example 5, patients are a part of the system. This insurance function is shown as an additional unit and identified by the letter *i* in the example.

Market Development

Market development is a divisional strategy used to enter new markets with present products or services. Specifically, market development is a strategy designed to achieve greater volume, through geographic (service area) expansion or by targeting new market segments within the present geographic area (market niche strategies). Typically, market development is selected when the organization is fairly strong in the market (often with a differentiated product), the market is growing, and the prospects are good for long-term growth. A market development strategy is strongly supported by the marketing, financial, information systems, organizational, and human resources functions. An example of a market development strategy would be a chain of outpatient clinics opening a new clinic in a new geographic area (present products and services in a new market).

One type of market development is called horizontal integration. *Horizontal integration* is a method of obtaining growth across markets by acquiring or affiliating with direct competitors rather than using internal operational/functional strategies to take market share from them. Many hospitals and medical practices engaged in horizontal integration, creating multihospital systems. Such systems were expected to offer several advantages such as increased access to capital, reduction in duplication of services, economies of scale, improved productivity and operating efficiencies, access to management expertise, increased personnel benefits, improved patient access, improvement in quality, and increased political power.[14] However, many of these benefits did not materialize and the growth of horizontal integration strategies slowed.

Another special type of market development is a market-driven or focused factory strategy. The fundamental principle underlying a market-driven or *focused factory* strategy is that an organization that focuses on only one function is likely to perform better. This strategy involves providing comprehensive

services across multiple markets (horizontal integration) for one specific disease such as diabetes, renal disease, asthma, or cardiac disease. Such focus allows an organization to achieve very high levels of effectiveness and efficiency. Regina E. Herzlinger explains the shift as:

> . . . replacing giant providers and huge managed care networks, located in hard-to-reach sites with what I call "focused factories" (a nomenclature borrowed from the manufacturing sector) that provide convenient, specialized care for victims of a certain chronic disease, or for those who need a particular form of surgery, or for those who require a diagnosis, checkup, or treatment for a routine problem.[15]

Focused factories become so effective (high quality, convenient, and so on) and efficient (less costly) that other providers are "forced" to use their services. Thus, these other providers can obtain higher-quality services at less cost by outsourcing to the focused factory. In turn, the focused factory commands a place in the payment systems. Herzlinger's focused factory tools for providers of health care services are outlined in Perspective 6–3.

PERSPECTIVE 6–3

Focused Factory Tools for Providers of Health Care Services

The health care providers who flourish in this market-driven environment will give customers the mastery and convenience as well as the focused, cost-effective services they want by following the rules of successful service entrepreneurs:

- *Pay Attention to the Customer* – don't call them patients, don't fight their assertiveness, don't give them hype, give them real convenience and quality.
- *Focus*, *Focus*, *Focus* – throw out the general-purpose, everything-for-everybody model; *focus* on your strengths; design the system that will lower costs and optimize quality.
- *Learn from the Rockettes* – make sure that all the elements of your operating systems are integrated, resembling a well-choreographed dance, where disparate elements have been integrated into a harmonious whole.
- *Resist the Edifice Complex* – bricks and mortar are distractions; fixed costs drag the enterprise down; many assets are really liabilities (money pits that consume your time and capital).
- *Lower Your Costs, Don't Raise Your Prices* – successful enterprises succeed by achieving more output from every unit of input, not by raising prices; enterprises that lower their costs create sustainable competitive advantage.
- *Use Technology Wisely* – use technology to enhance the productivity of the health care process, not as a marketing tool.
- *Don't Let the Dogma Grind You Down* – be open to new and different ways of thinking; don't

be a prisoner of your own thinking; obtain advice from the widest possible range of sources about what works and what doesn't.

- *Be Ethical* – don't seek competitive advantage in unethical ways such as discriminating against sick or poor people or by denying people the health care services they need.
- *Breadth Beats Depth* – don't fall for the lure of vertical integration; remember all the problems you have experienced in running just your corner of the health services world; a horizontally integrated chain of focused factories will amplify your strengths in each of the separate units that comprise the chain.
- *Don't Get Big for Bigness's Sake* – don't think of horizontal integration as a way of blocking competitors; think of it as getting really good at what you do.
- *Measure Results: Your Own and Your Competitors'* – what gets measured gets done: don't ignore results you don't like and don't bury the results in a file – use them actively in continually recreating your operations; don't believe your own press – you are at your most vulnerable when your measurement results are at their most flattering.

Source: Regina E. Herzlinger, *Market-Driven Health Care: Who Wins, Who Loses in the Transformation of America's Largest Service Industry* (Reading, MA: Addison-Wesley Publishing Company, 1997), pp. 283–287.

In health care, focused factories have not escaped criticism. The success of some focused factories (cardiac surgery and treatment) has led some states to propose legislation restricting them. The Federal Medicare Prescription Drug Improvement and Modernization Act became law in 2003. An important part of the law included a moratorium that limited physician investments in specialty hospitals. Specifically identified were cardiac, orthopedic, surgical, and "other" hospitals owned by physicians. The focused factories have targeted profitable procedures from insured patients, requiring local not-for-profits to care for less profitable diseases/treatments without being able to offset the costs through the more profitable procedures being captured by focused factories. Therefore, many politicians are opposed to specialty hospitals and advocated for the federal legislation to become permanent.

There has also been concern as to whether health care-focused factories really reduce costs and in turn prices. Some experts suggest that price reductions are offset by the tendency of physicians with financial interest in the hospital to increase their volume with elective procedures. As for increasing quality, most experts agree that it is too early to judge. Some suggest that physicians referred easy cases to specialty hospitals and more complex patients to general hospitals, but there is no data to support the claim. Further, most experts agree that specialty hospitals initiated a "medical arms race" that might eventually drive up health care costs. The fear is that as general hospitals perceive the need to compete with the physician-owned specialty hospitals, they will develop dedicated centers as "hospitals-within-hospitals" or as freestanding facilities, forcing up overall costs.[16]

Product Development *Product development* is the introduction of new products/services to present markets (geographic and segments). Typically, product development takes the form of product enhancements and product line extension. Product development should not be confused with related diversification. Related diversification introduces a new product category (though it may be related to present operations), whereas product development may be viewed as refinements, complements, or natural extensions of present products. Product development strategies are common in large metropolitan areas where hospitals vie for increased market share within particular segments of the market, such as cancer treatment and open heart surgery. Another good example of product development is in the area of women's health. Many hospitals have opened clinics designed to serve the special needs of women in the present market area.

Penetration An attempt to better serve current markets with current products or services is referred to as a market *penetration strategy*. Similar to market and product development, penetration strategies are used to increase volume and market share. A market penetration strategy is typically implemented by marketing strategies such as promotional, distribution, and pricing strategies, and often includes increasing advertising, offering sales promotions, increasing publicity efforts, or increasing the number of salespersons.

Although still using their sales force to pursue expansion strategies, some pharmaceutical companies have recently moved toward e-detailing (electronic physician education concerning drugs) as a key component of their penetration strategies. The use of e-detailing by pharmaceutical companies is on the rise because increasingly physicians prefer to replace sales calls with other forms of communication and are accessing physician-only websites, online sources of information, and other interactive communication formats. For example, one study of health physicians and other medical professionals found that when e-detailing was used in combination with occasional visits by professional service representatives the results were particularly effective. The argument was made that e-detailing and periodic, in-person visits are complimentary in nature, less expensive, and using them in combination multiplied the effects of either approach on its own.[17]

Reduction of Scope Strategies

Reduction of scope strategies decrease the size and scope of operations. Reduction strategies include:

- divestiture,
- liquidation,
- harvesting, and
- retrenchment.

Divestiture *Divestiture* is a contraction strategy in which an operating strategic service unit is sold off as a result of a decision to permanently and completely leave the market despite its current viability. Generally, the business

to be divested has value and will continue to be operated by the purchasing organization.

Within the past decade, the strategy of "unbundling" (divesting by a hospital of one or more of its services) has become common. Thus, hospitals are carving out non-core services previously performed internally and divesting them. Typical services and products produced in a hospital that are not necessarily part of the core bundle of activities include laboratory, pharmacy, X-ray, physical therapy, occupational therapy, and dietary services.[18] In addition, "hotel" services (laundry, housekeeping, and so on) formerly performed by hospitals are being contracted to outsiders. Even medical services in such specialty areas as ophthalmology are increasingly being performed outside the hospital in "surgicenters" and may be candidates for divestiture.

Divestiture decisions are made for a number of reasons. See Perspective 6–3. An organization may need cash to fund more important operations for long-term growth or the division/SSU may not be achieving management's goals. In some cases health care organizations are divesting services that are too far from their core business or area of management expertise. For example, many multihospital systems have divested their HMO (purchased only a few years earlier) to concentrate on care delivery. A multihospital system purchasing a managed care organization actually represents unrelated diversification. Although the strategy appears logical and synergistic, managed care businesses are difficult to manage and there is little skill transfer from managing provider organizations.

Liquidation *Liquidation* involves selling the assets of an organization. The assumption underlying a liquidation strategy is that the unit cannot be sold as a viable and ongoing operation. However, the assets of the organization (facilities, equipment, and so on) still have value and may be sold for other uses. Organizations, of course, may be partially or completely liquidated. Common reasons for pursuing a liquidation strategy include bankruptcy, the desire to dispose of non-productive assets, and the emergence of a new technology that results in a rapid decline in the use of the old technology.

On leaving a market, an aging hospital building may be sold for its property value or an alternative use. In a declining market, a liquidation strategy may be a long-term strategy to be carried out in an orderly manner over a period of years. Recently many hospitals have been liquidating their emergency helicopter operations, which had historically been allowed to operate as loss leaders because they brought prestige and positive public relations to the hospital. However, because of increasing costs and limited reimbursements, many hospitals have shut down and liquidated such operations.

Harvesting A harvesting strategy is selected when the market has entered long-term decline. The reason underlying such a strategy is that the organization has a relatively strong market position but industry-wide revenues are expected to decline over the next several years. Therefore, the organization will "ride the decline," allowing the business to generate as much cash as possible. However, little in terms of new resources will be invested.

In a *harvesting* strategy, the organization attempts to reap maximum short-term benefits before the product or service is eliminated. Such a strategy allows the

organization an orderly exit from a declining segment of the market by planned downsizing. Harvesting has not been widely used in health care but will be more frequently encountered in the future as markets mature and organizations exit various segments. For instance, some regional hospitals that have developed rural hospital networks have experienced difficulty in maintaining their commitment to health care in small communities. The 20-bed hospitals frequently found in rural networks tend to struggle financially because of a lack of support from specialists and primary care physicians, an aging population, and flight of the young to urban areas. Twenty-bed rural hospitals are probably in a long-term decline with little hope for survival. On the other hand, 50-bed hospitals have managed to maintain or improve their financial position because of effective physician recruitment, good community image, and the continued viability of the communities themselves. Therefore, regional hospitals with rural networks may have to employ a harvesting strategy for the 20-bed hospitals while using development or maintenance of scope strategies for the 50-bed and larger hospitals.

Retrenchment A *retrenchment* strategy is a response to declining profitability, usually brought about by increasing costs. The market is still viewed as viable, and the organization's products/services continue to have wide acceptance. However, costs are rising as a percentage of revenue, placing pressure on profitability. Retrenchment typically involves a redefinition of the target market and selective cost elimination or asset reduction. Retrenchment is directed toward reduction in personnel, the range of products/services, or the geographic market served and represents an effort to reduce the scope of operations.

Over time, organizations may find that they are overstaffed given the level of demand. As a result, their costs are higher than those of competitors. When market growth is anticipated, personnel are added to accommodate the growth, but during periods of decline, positions are seldom eliminated. A reduction in the staff members who have become superfluous or redundant is often central to a retrenchment strategy.

Similarly, in an attempt to "round out" the product or service line, products and services are added. Over time, these additional products/services may tend to add more costs than revenues. In many organizations, less than 20 percent of the products account for more than 80 percent of the revenue. In these circumstances, retrenchment may be in order.

Finally, there are times when geographic growth is undertaken without regard for costs. Eventually, managers realize they are "spread too thin" to adequately serve the market. In addition, well-positioned competitors are able to provide quality products/services at lower costs because of their proximity. In this situation, geographic retrenchment (reducing the service area) is appropriate. In many cases, a retrenchment strategy is implemented after periods of aggressive market development or acquisition of competitors (horizontal integration).

Maintenance of Scope Strategies

Often organizations pursue *maintenance of scope strategies* when management believes the past strategy has been appropriate and few changes are required in the target markets or the organization's products/services. Maintenance of scope

does not necessarily mean that the organization will do nothing; it means that management believes the organization is progressing appropriately. There are two maintenance of scope strategies: enhancement and status quo.

Enhancement When management believes that the organization is progressing toward its vision and goals but needs to "do things better," an *enhancement* strategy may be used; neither expansion nor reduction of operations is appropriate but "something needs to be done." Typically, enhancement strategies take the form of quality programs (CQI, TQM) directed toward improving organizational processes or cost-reduction programs designed to render the organization more efficient. In addition to quality and efficiency, enhancement strategies may be directed toward innovative management processes, speeding up the delivery of the products/services to the customer, and adding flexibility to the design of the products or services (marketwide customization).

Many times after an expansion strategy, an organization engages in maintenance/enhancement strategies. Typically after an acquisition, organizations initiate enhancement strategies directed toward upgrading facilities, reducing purchasing costs, installing new computer systems, enhancing information systems, improving the ability to evaluate clinical results, reducing overhead costs, or improving quality.

Status Quo A *status quo* strategy is often based on the assumption that the market has matured and periods of high growth are over. In this situation, the organization has secured an acceptable market share and managers believe the position can be defended against competitors. In addition, a status quo strategy may be appropriate when an organization is in a period of "active waiting." Active waiting is a temporary strategy for organizations operating in dramatically changing or volatile markets. During periods of active waiting, leaders must remain alert to market anomalies that signal potential threats and opportunities, build financial reserves, and be ready to make strategic changes.[19]

In a status quo strategy, the goal is to maintain market share and keep services at their current level. Environmental influences affecting the products or services should be carefully analyzed to determine when significant change is imminent. Typically, organizations attempt a status quo strategy in some areas while engaging in market development, product development, or penetration in others to better utilize limited resources. For instance, a hospital may attempt to hold its market share (status quo) in slow-growth markets such as cardiac and pediatric services and attempt market development in higher-growth services such as intense, short-term rehabilitation care, renal dialysis, ophthalmology, or intravenous therapy.

In mature markets, industry consolidation occurs as firms attempt to add volume and reduce costs. Therefore, managers must be wary of the emergence of a single dominant competitor that has achieved a significant cost differential. A status quo strategy is appropriate when there are two or three dominant providers in a stable market segment because, in this situation, market development or product development may be quite difficult and extremely expensive.

A brief definition of the adaptive strategies and their rationales for selection are summarized in Exhibit 6–9.

EXHIBIT 6–9 Definition and Rationales of the Adaptive Strategies

Adaptive Strategy	Definition	Rationale
Related Diversification	Adding new related product or service categories. Often requires the establishment of a new division.	• Pursuit of high-growth markets. • Entering less-regulated segments. • Cannot achieve current objectives. • Synergy is possible from new business. • Offset seasonal or cyclical influences.
Unrelated Diversification	Adding new unrelated product or service categories. Typically requires the establishment of a new division.	• Pursuit of high-growth markets. • Entering less-regulated segments. • Cannot achieve current objectives. • Current markets are saturated or in decline. • Organization has excess cash. • Antitrust regulations prohibit expansion in current industry. • Tax loss may be acquired.
Backward Vertical Integration	Adding new members along the distribution channel (toward a later stage) for present products and services or controlling the flow of patients from one institution to another.	• Control the flow of patients through the system. • Scarcity of raw materials or essential inventory/supplies. • Deliveries are unreliable. • Lack of materials or supplies will shut down operations. • Price or quality of materials or supplies variable. • Industry/market seen as profitable for long term.
Forward Vertical Integration	Adding new members along the distribution channel (toward an earlier stage) for present products and services or controlling the flow of patients from one institution to another.	• Control the flow of patients through the system. • Faster delivery required. • High level of coordination required between one stage and another – secure needed resources. • Industry/market seen as profitable for long term. • Gain bargaining power.
Market Development	Introducing present products or services into new geographic markets or to new segments within a present geographic market.	• New markets are available for present products. • Provide comprehensive services across the market (focus factory). • New markets may be served efficiently. • Expected high revenues. • Organization has cost leadership advantage. • Organization has differentiation advantage. • Current market is growing.
Product Development	Improving present products or services or extending the present product line.	• Currently in strong market but product is weak or product line incomplete. • Market tastes are changing. • Product technology is changing. • Maintenance or creation of differentiation advantage.

EXHIBIT 6–9 *(Continued)*

Adaptive Strategy	Definition	Rationale
Penetration	Seeking to increase market share for present products or services in present markets through marketing efforts (promotion and price).	• Present market is growing. • Product/service innovation will extend product life cycle (PLC). • Expected revenues are high. • Organization has cost leadership advantage. • Organization has differentiation advantage.
Divestiture	Selling an operating unit or division to another organization. Typically, the unit will continue in operation.	• Industry in long-term decline. • Cash needed to enter new, higher-growth area. • Lack of expected synergy with core operation. • Required investment in new technology seen as too high. • Too much regulation. • Unbundling.
Liquidation	Selling all or part of the organization's assets (facilities, inventory, equipment, and so on) to obtain cash. The purchaser may use the assets in a variety of ways and businesses.	• Organization can no longer operate. • Bankruptcy. • Trim/reduce assets. • Superseded by new technology.
Harvesting	Products or services typically in late stages of the product life cycle (late maturity and decline) where industry-wide revenues are expected to decline. These products or services will ultimately be discontinued but may generate revenue for some time. Few new resources are allocated to these areas.	• Late maturity/decline of the product life cycle. • Consider divestiture or downsizing. • Short-term cash needed.
Retrenchment	Reducing the scope of operations, redefining the target market, cutting geographic coverage, reducing the segments served, or reducing the product line.	• Market has become too diverse. • Market is too geographically spread out. • Personnel costs are too high. • Too many products or services. • Marginal or non-productive facilities.
Enhancement	Seeking to improve operations within present product or service categories through quality programs, increasing flexibility, increasing efficiency, speed of delivery, and so on.	• Organization has operational inefficiencies. • Need to lower costs. • Need to improve quality. • Improve internal processes.
Status Quo	Seeking to maintain relative market share within a market.	• Maintain market share position. • Maturity/late maturity stage of the product life cycle. • Product/market generating cash but has little potential for future growth. • Extremely competitive market.

Market Entry Strategies

The expansion adaptive strategies specify entering or gaining access to a new market and the maintenance of scope strategies may call for obtaining new resources. Therefore, the next important decision that must be made for these strategies concerns how the organization will enter or develop the market – the *market entry* strategies. If a reduction adaptive strategy is selected, normally there is no market entry decision and market entry strategies are not used.

There are three major methods to enter a market. As illustrated in Exhibit 6–4, an organization can use its financial resources to purchase a stake in the new market, team with other organizations and use cooperation to enter a market, or use its own resources to develop its own products and services. It is important to understand that market entry strategies are not ends in themselves but serve a broader aim – supporting the adaptive strategies. Any of the adaptive strategies may be carried out using any of the market entry strategies but each one places different demands on the organization.

Purchase Strategies

Purchase strategies allow an organization to use its financial resources to enter a market quickly, thereby initiating the adaptive strategy. There are three purchase market entry strategies: acquisition, licensing, and venture capital investment.

Acquisition *Acquisitions* are entry strategies for expansion through the purchase of an existing organization, a unit of an organization, or a product/service. Thus, acquisition strategies may be used to carry out both corporate and divisional strategies such as diversification, vertical integration, market development, or product development. There are many reasons to purchase another organization, such as to obtain real estate or other facilities, to acquire brands, trademarks, or technology, and even to access employees. However, the most common reason is to acquire customers.[20]

The acquiring organization may integrate the operations of the newly acquired organization into its present operations or may run it as a separate business/service unit. Acquisitions offer a method for quickly entering a market, obtaining a technology, or gaining a needed channel member to improve or secure distribution. It is usually possible to assess the performance of an organization before purchase and thereby minimize the risks through careful analysis and selection. The "build internally" versus "acquire" decision is one where strategic leaders must determine whether the benefits of ownership justify the costs and whether the acquiring organization has the product and process knowledge to capitalize on an opportunity quickly. If the acquiring organization does not have the expertise or capability and there is an organization that provides a good strategic fit that does have such expertise then purchase may be warranted.[21] However, even a small acquired organization can be difficult to integrate into the existing culture and operations. Often it takes several years to "digest" an acquisition or to combine two organizational cultures.

Despite the difficulties of combining organizational cultures, the creation of health systems with unified ownership has been an effective strategy. Health

systems have been better able than health networks (looser contractual- or alliance-based strategies) to provide needed resources, competencies, and capabilities. Direct ownership of assets enables systems to achieve greater unity of purpose and develop more focused strategies, on average, than more loosely organized networks. In addition, hospitals in health systems that have unified ownership generally have better financial performance than hospitals in contractually based health networks.[22]

Much of the growth of the for-profit hospital chains has been via a market development acquisition strategy (also called horizontal integration or buying market share). Aggressive market development through acquisition of independent hospitals has been used to build the nation's largest private for-profit hospital chains. For example, in California the seven largest hospital systems control more than one-third of the hospitals and licensed beds in the state.[23] In the past two decades, horizontal integration and vertical integration through acquisitions and alliances have been key entry strategies for initiating rapid market growth by health care organizations.

Licensing Acquiring a technology or product through *licensing* may be viewed as an alternative to acquiring a complete company. License agreements obviate the need for costly and time-consuming product development and provide rapid access to proven technologies, generally with reduced financial and marketing risk to the organization. However, the licensee usually does not receive proprietary technology and is dependent on the licensor for support and upgrade. In addition, the up-front dollar costs may be high.

Another common form of licensing is a franchise – the granting of an exclusive territorial license assuring the licensee all rights that the licensor has with respect to a defined activity.[24] This practice is most commonly found in the field of trademark licensing. Franchisees benefit from exploitation of the goodwill, uniform format, and uniform quality standards symbolized by the franchisor's trademark. The license agreement by and between Blue Cross and Blue Shield Association and the various regional Blue Cross and Blue Shield Plans provides an example. Blue Shield Plans are granted the right to use the Blue Cross and Blue Shield names and trademarks in its trade and corporate name and the right to use the licensed marks in the sale, marketing, and administration of health care plans and related services within a geographic area. In such agreements no other health insurance provider can encroach upon the Plans' license under the Blue Cross and Blue Shield name within the stated territory.[25]

Venture Capital Investment *Venture capital investments* offer an opportunity to enter or "try out" a market while keeping risks low. Typically, venture capital investments are used to become involved in the growth and development of a small organization that has the potential to develop a new or innovative technology. By making minority investments in young and growing enterprises, organizations have an opportunity to become close to and – possibly later – enter into new technologies.[26]

In addition, venture capital investments are a way for new health care organizations to grow. Venture capital investments in health care companies (including biotechnology, pharmaceuticals, medical devices, and health care) in early

2012 fell to its lowest level since 2010; however, the number of deals remains relatively high. Venture capital investment in health care technology firms was strong throughout the decade of the 1990s but e-health (Internet-related) companies began receiving a large share of health care venture capital beginning in 2000. During 2012 most of the venture capital investments were made in firms located in California and Massachusetts. By far most investments were in mature companies rather than seed money for start-ups. Unlike the 1990s, 2010s venture capital investments involved firms in genomic research (Warp Drive Bio), noninvasive prenatal testing (Ariosa Diagnostics), radiation therapy (Mevion Medical Systems), and endoscopic surgery (Apollo Endosurgery).[27]

Cooperation Strategies

Probably the most used – and certainly the most talked about – strategies of the late 1990s and early 2000s were *cooperation strategies*. Since 2006, cooperation strategies have slowed; however, with ACA supported (mostly) by the Supreme Court in 2012 more activity is expected. Many organizations have carried out adaptive strategies – particularly diversification, vertical integration, product development, and market development strategies – through cooperation strategies. They include mergers, alliances, and joint ventures.

Mergers *Mergers* are similar to acquisitions. In mergers, however, the two organizations combine through mutual agreement to form a single new organization, often with a new name. Mergers have been used most often in the health care segment to combine two similar organizations (horizontal integration) in an effort to gain greater efficiency in the delivery of health care services, reduction in duplication of services, improved geographic dispersion, increased service scope, restraint in pricing increases, and improved financial performance.[28] See Perspective 6–4. The other primary use of merger strategies (as well as acquisitions and alliances) in health care has been to create integrated delivery systems (vertical integration). There are four motives underlying such mergers:

1. *Improve efficiency and effectiveness* – by combining available resources and operations it is possible to exploit cost-reducing synergies and to take fuller advantage of risk-spreading managed care opportunities.
2. *Enhance access* – by providing a broader range of sophisticated programs and services and offering services at a greater number of sites, quality of patient care is improved.
3. *Enhance financial position* – by gaining market share, the sole or one of the dominant providers in the region's health delivery system is able to increase total revenue.
4. *Overcome concerns about survival* – by merging, a free-standing health care organization is better able to survive in an increasingly aggressive, market-driven environment where huge and powerful networks are experiencing cutbacks in managed care, Medicare, and Medicaid reimbursement.[29]

PERSPECTIVE 6–4

Mergers and Acquisitions

Hospital mergers and acquisitions declined throughout the decade of the 1990s and continued through the first decade of the 21st century both in terms of the number of deals and number of hospitals involved. Despite the decline, the hospital sector has had more mergers and acquisitions than any other health care services sector that includes hospitals, physician groups, and managed care (but does not include health care technology, a separate sector in the health care industry).

The number of hospital merger and acquisition deals declined by 60 percent from 1998 to 2006. However, the period 2004 through 2006 saw the number of deals rise slightly and level off through 2006 with fewer than 60 deals but with a dramatic increase in the number of hospitals involved. In the first quarter of 2012, the dollar value of hospital mergers was $600 million for 21 transactions, the largest being Highmark Blue Cross Blue Shield's $245 million acquisition of controlling interest in Pittsburgh's Jefferson Regional Medical Center. The quarter was off the record pace set in the second quarter of 2010 when 32 transactions valued at $3.5 billion was reported. The two large deals reported in 2010 were the acquisition of West Penn Alleghaney Health Systems by Highmark ($1.5 billion value) and HCA Holdings' acquisition of the remaining interest in HealthOne ($1.4 billion).

Levin Associates expects an uptick in M&A activity by the end of 2012 since the Supreme Court upheld the individual mandate and most of the rest of the ACA. Cost of capital is low and the potential for tax increases could spur end-of-year activity, especially in the long-term care category which is dominated by small, private firms and individuals who may be more interested in cashing in rather than taking a big tax hit.

Hospitals are not the only health care organizations involved in mergers. Physicians' group deals were increased to $4.2 billion from 21 transactions during first-quarter 2012. The largest deal was the $3.7 billion agreement between DaVita, a Denver-based dialysis chain with 1,800 locations, and HealthCare Partners that operates medical groups and physician networks with more than 2,500 employed or affiliated physicians in California, Florida, and Nevada. The DaVita–Healthcare Partners acquisition reflects the continuing efforts by providers to position themselves to rein in costs and to create alignments that enable greater control across the continuum of care.

Managed care posted nine deals valued at $730 million during second-quarter 2012 with the largest valued at $435 million for Towers Watson's acquisition of Extend Health, operator of a private Medicare exchange. The deal positions Towers Watson, a consulting firm primarily for employee benefits, to capitalize on the growing interest in private health exchanges. Managed care deals in 2011 were bigger with Wellpoint acquiring CareMore for $800 million and Aetna's acquisition of Prodigy Health for $600 million.

Source: Based on Irving Levin Associates, Inc., *The Health Care Acquisition Report*, 17th edn, 2011 and Dick Tocknell, "Healthcare M&A Activity Surges in Q2," *HealthLeaders Media*, July 26, 2012.

However, managing organizations that merge to create integrated systems has been difficult. There are several reasons why integrated health systems encounter significant obstacles in realizing the proposed benefits. The most frequently cited relate to the difficulty of creating an effective strategic fit, giving away too much money and power with respect to governance to the local governing board, inability to achieve operating efficiencies, and experiencing difficulties in realigning resources.[30]

As in acquisitions, a major difficulty in a merger is the integration of two separate organizational cultures. Mergers offer a more difficult challenge than acquisitions because a totally new organization must be forged. In an acquisition, the dominant culture remains and subsumes the other. In a merger, a totally new organizational culture (the way we do things) must be developed. Typically there are significant changes in the organizational structure, governance, senior and middle management, service mix, product mix, and outside relationships. Therefore, merging two distinctly different corporate cultures requires a great deal of time to be spent in communications at all levels in the organization. Medical staff and employees should engage in a reformulation of the vision, mission, and statement of the shared values of the new organization. Work groups must be formed to address how to effectively and efficiently meet the needs of patients. As well as communicating internally, external communications must be given top priority. Even with such efforts, truly merging the two organizational cultures into one will take years to complete.

Mergers and acquisitions and other forms of combination continue to be important market entry strategies for health care organizations. An environment conducive to large health care combinations, institutional coordination, demands for efficiency, and the continuum of care (seamless care) has fostered many of these mergers and acquisitions. In the early 2010s, low interest rates and the uncertainty of going it alone in the ACA future may increase cooperation strategies.

Alliances *Alliances* are loosely coupled arrangements among existing organizations that are designed to achieve some long-term strategic purpose not possible by any single organization. Alliances include configurations such as federations, consortiums, networks, and systems.[31] Strategic alliances are cooperative contractual agreements that go beyond normal company-to-company dealings but fall short of merger or full partnership.[32] Alliances have been used to create health networks – loosely coupled or organized delivery systems. They are an attempt to strengthen competitive position while maintaining the independence of the organizations involved.

Some research suggests that organizations that develop these cooperative relationships are likely to have similar status in the marketplace and have complementary resources, competencies, and capabilities.[33] For example, two organizations may establish an alliance when each one possesses strength in a different stage of the service category value chain – one organization has expertise in service delivery and another controls the distribution channel. Further, organizations may form coalitions to defray costs and share risk when they undertake high-cost capital or development-intensive initiatives. Finally, it has been suggested that the resources available from an alliance partner can facilitate an organization's effort to alter its strategic position.[34] For instance, research

indicates that biotechnology start-up organizations could enhance their initial performance and strategic position by establishing upstream and downstream alliances.[35]

In health care, the term "alliance" is sometimes used to refer to the voluntary organizations that hospitals join primarily to achieve economies of scale in purchasing. For some, this type of alliance provides the benefit of being part of a large system, yet allows them to exist as free-standing, self-governing institutions. Examples of some major hospital alliances include Premier, Voluntary Hospitals of America (VHA), and University HealthSystem Consortium. Purchasing alliances are a different type of alliance from that based on an expansion/cooperation strategy.

Strategic alliances, although not mergers, have many of the same problems – previously unrelated cultures have to learn to cooperate rather than compete; numerous "sessions" are required to determine what will be shared and what is proprietary, and how to balance the two; and efforts must be made to maintain cooperation over time within such a "loose" cooperative effort. On the other hand, strategic alliances offer several opportunities, including shared learning, access to expertise not currently "owned" by the organization, strengthened market position, and direction of competitive efforts toward others instead of each other. In addition, one of the advantages of integrated networks and strategic alliances is the increased access to resources to obtain new technology or reduce the need to purchase duplicate equipment. Further, it has been suggested that these arrangements are promising mechanisms to reduce technology-driven health care cost inflation.[36] In some cases, an alliance can lead to a merger. For example, Breech Medical Center in Lebanon, Missouri moved its affiliation agreement with St. John's Health System of Springfield, Missouri to a full-asset merger over a several-year period (now St. John's Beech Regional Medical Center).

As the environment becomes more unpredictable, a number of health care providers have been seeking strategic alliances. Many primary providers have turned to alliances as vehicles for providing services, soliciting physician loyalty, and reducing investments in operations.[37] Hospitals appear to form alliances with physicians for several reasons. Alliances serve to contract with the growing number of HMOs, to pose a countervailing bargaining force of providers in the face of HMO consolidation, and to accompany hospital downsizing and restructuring efforts.[38] However, strategic alliances between physicians and hospitals should be anchored in their common purpose – improving patient care. The physicians involved may not concur with the hospital in its management of facilities, staffing, and so forth. In addition, conflict may emerge as hospitals diversify into areas that compete more directly with the physicians' own clinics, ambulatory care centers, and diagnostic centers. Finally, although the hospital would prefer to have many qualified physicians admitted to the staff (who could refer more patients), allied physicians would prefer to limit credentialing of outside physicians (controlling competition).

Joint Ventures When projects get too large, technology too expensive, internal resources, competencies or capabilities too scarce, or the costs of failure too high for a single organization, joint ventures are often used.[39] A *joint venture* (JV) is the combination of the resources of two or more separate

organizations to accomplish a designated task. A joint venture may involve a pooling of assets or a combination of the specialized talents or skills of each organization. The four most common organizational forms used in health care joint ventures are:

1. *Contractual agreements*. Two or more organizations sign a contract agreeing to work together toward a specific objective.
2. *Subsidiary corporations*. A new corporation is formed (called an equity JV), usually to operate non-hospital activities.
3. *Partnerships*. A formal or informal arrangement in which two or more parties engage in activities of mutual benefit.
4. *Not-for-profit title-holding corporations*. Tax legislation enacted in 1986 allowed not-for-profit organizations to form tax-exempt title-holding corporations (providing significant benefits to health care organizations engaged in real estate ventures).[40]

Because of the dynamic health care environment, hospitals engage in joint ventures to lower costs and to improve and expand services. Joint ventures can be an innovative way to generate revenues, supplement operations, and remain competitive.[41] Through the first half of the 2000s, the most common joint venture was between hospitals and physicians. Hospital/physician joint ventures are popular because they allow the hospital to pre-empt physicians as competitors and, at the same time, stabilize the hospital's referral base. Often joint ventures with hospitals increase physicians' profitability. Physicians enter joint ventures with hospitals to protect their incomes and autonomy, whereas hospitals are motivated to form joint ventures as a means of controlling medical care costs and gaining influence over physician utilization of hospital services. Changes in third-party payments have created competition based on price – joint ventures enable hospitals to reduce costs and compete more effectively.[42]

Although there are benefits to creating joint ventures, they have their own unique set of challenges. These challenges revolve around strategy, governance, economic interdependencies, and organization. For example, the parent organizations may hold different strategic interests and maintaining strategic alignment across separate organizations with different goals, market pressures, and stakeholders can be difficult. In addition, sharing governance can complicate decision making, particularly with separate reporting systems and methods for measuring success. Further, problems develop in providing services, staffing, and other resources. Finally, building a cohesive, high-performing organization with a unique culture has proven difficult for many joint ventures.[43]

Development Strategies

Organizations may enter new markets by using internal resources in what are called *development strategies*. This entry strategy takes the form of internal development, internal ventures, or reconfiguring the value chain. Diversification and vertical integration through internal development or internal ventures usually take considerably longer to achieve than through acquisition (although the

costs may be lower). Reconfiguring the value chain finds new ways to deliver value to customers and changes the "business model."

Internal Development *Internal development* uses the existing organizational structure, personnel, and capital to generate new products/services or distribution strategies. Internal development may be most appropriate for products or services that are closely related to existing products or services. Internal development is common for growing organizations, particularly when they can exploit existing resources, competencies, and capabilities (leveraging existing resources and other assets).

Internal Ventures *Internal ventures* typically set up separate, relatively independent entities (businesses) within the organization. Internal ventures may be most appropriate for products or services that are unrelated to the current products or services. For instance, internal ventures may be appropriate for developing vertically integrated systems. Thus, initial efforts by a hospital to develop home health care may be accomplished through an internal venture.

Reconfiguring the Value Chain An organization may *reconfigure the value chain* by changing the activities or sequence of activities it performs and therefore change how value is delivered to the customer.[44] Value chain reconfiguration requires rethinking the ways in which existing organizations serve customers. For the most part, reconfiguration takes place in the service delivery components of the values chain (pre-service, service delivery, after-service) and thus is marketing and operations focused.

In many cases reconfiguring the value chain involves using new technology or organizations to perform activities in ways that were not possible in the past.[45] For example, using pod casts for physician education by pharmaceutical companies might create a whole new way to provide value to physicians. Therefore, reconfiguration of the value chain is the development of a completely new business model, applying a business model from another industry, or in some cases, a dramatic modification of the existing value chain creating an entirely new way of producing value or lowering costs.

Market entry and penetration strategies coupled with reconfiguring the value chain can be powerful combinations for creating new business models and effectively entering the market. For example, when an organization bypasses brick-and-mortar outlets and sells its products (penetration strategy – channel of distribution) through a website, it is reconfiguring the value chain.[46]

Market Entry Strategy Linkage

The definition, major advantages, and disadvantages of the market entry strategies are summarized in Exhibit 6–10. The adaptive and market entry strategies work in combination. The market entry strategies are the means for accomplishing the adaptive strategies. This relationship is demonstrated as organizations struggle with cost containment and their managed care strategies. Health care organizations are opting for a variety of adaptive and market entry strategies to

EXHIBIT 6–10 Definition, Advantages, and Disadvantages of Market Entry Strategies

Market Entry Strategy	Definition	Major Advantages	Major Disadvantages
Acquisition	Strategy to grow through the purchase of an existing organization, unit of an organization, or a product/service.	• Rapid market entry. • Image already established. • Performance known before purchase.	• New business may be unfamiliar to parent. • Takes a long time to assimilate organization's culture. • New management team may be required. • High initial cost.
Licensing	Acquiring or providing an asset (technology, market, equipment, etc.) through contract.	• Rapid access to proven technology. • Reduced financial exposure. • Access to brand name. • Exclusive territory.	• Not a substitute for internal technical competence. • Not proprietary technology. • Dependent on licensor. • Rules and regulations.
Venture Capital Investment	Financial investment in an organization to participate in its growth or receipt of venture capital for start-up or expansion.	• Can provide window on new technology or market. • Low risk.	• Alone, unlikely to be a major stimulus of growth. • Extended time to profitability.
Merger	Combining two (or more) organizations through mutual agreement to form a single new organization.	• Uses existing resources. • Retains existing markets and products. • Reduces competition.	• Takes a long time to merge cultures. • Merger match often difficult to find.
Alliance	Formation of a formal partnership.	• Fills in gaps in product line. • Creates efficiencies (e.g., bargaining power). • Reduces competition in weak markets. • Stabilizes referral base. • Shared risk.	• Potential for conflict between members. • Limits potential markets/products. • Difficult to align resources. • Governance issues.
Joint Venture	Combination of the resources of two or more organizations to accomplish a designated task.	• Technological/marketing joint ventures can exploit small/large organizational synergies. • Spreads distribution risks.	• Potential for conflict between partners (shared vs. proprietary). • Objectives of partners may not be compatible.

EXHIBIT 6–10 *(Continued)*

Market Entry Strategy	Definition	Major Advantages	Major Disadvantages
Internal Development	Products or services developed internally using the organization's own resources.	• Uses (leverages) existing resources. • Organization maintains a high level of control. • Presents image of developing (growth) organization.	• Time lag to break even. • Unfamiliarity with new markets. • Obtaining significant gains in market shares against strong competitors may be difficult.
Internal Venture	Establishment of an independent entity within an organization to develop products or services.	• Uses existing resources. • May enable organization to hold a talented entrepreneur. • Isolates development from organization's bureaucracy.	• Mixed record of success. • Organization's internal climate (culture) often unsuitable.
Reconfigure the Value Chain	Changing the activities or sequence of activities in the value chain and therefore changing how value is delivered to the customer.	• New approach may not be seen as a threat by existing competitors. • Captures a special niche of the market. • May create a low-cost business model.	• Not always possible. • Initially must focus on a niche rather than the entire market. • Must be first to recognize the new business model.

deal with the changing health care environment. Together the adaptive (scope of the organization) and market entry strategies (means to achieve that scope) are shaping the health care landscape.

Competitive Strategies

Having selected the adaptive strategies and market entry strategies, managers must decide the strategic posture of the organization and how the products and services will be positioned *vis-à-vis* those of competitors. Strategic posture concerns the organization's fundamental behavior within the market – defending market position, prospecting for new products and markets, or balancing market defense with careful entry into selected new product areas and markets. In addition, an organization must consciously position its products and services within a market through one of the marketwide or market segment positioning strategies (generic strategies).

Strategic Posture

Organizations may be classified by how they behave within their market segments or industry – their *strategic posture*. Research by Miles, Snow, Meyer, and

Coleman has shown that there are at least four typical strategic postures for organizations – defenders, prospectors, analyzers, and reactors. Defenders, prospectors, and analyzers are explicit strategies that result in a pattern of consistent and stable behavior within a market. Defender, prospector, or analyzer strategic postures may be appropriate for certain internal, market, and environmental conditions. Reactors, on the other hand, do not seem to have a strategy and demonstrate inconsistent behavior; however, unless an organization exists in a protected environment, such as a monopolistic or highly regulated market segment, it cannot continue to behave as a reactor indefinitely.[47] Furthermore, an organization's strategic posture should not be left to chance. Health care organizations are able to change their strategic postures to match the demands of their environmental context and improve their performance.[48] Therefore, strategic decision makers should examine the current market behavior, explicitly delineate the appropriate organization strategic posture, and redirect resources and competencies needed to transform themselves into a better environmentally suited posture.

Defender Strategic Posture Stability is the chief objective of a defender strategic posture. Managers using this strategy attempt to seal off a portion of the total market to create a stable domain. A *defender posture* focuses on a narrow market with a limited number of products or services and aggressively attempts to defend this market segment through pricing or differentiation strategies.

Defenders are organizations that engage in little search for additional opportunities for growth and seldom make adjustments in existing technologies, structures, or strategies. They devote primary attention to improving the efficiencies of existing operations. Thus, cost efficiency is central to the defender's success. In addition, defenders often engage in vertical integration to protect their market, control patient flow, and create stability. Defenders grow through penetration strategies and limited product development strategies.

Prospector Strategic Posture *Prospectors* are organizations that frequently search for new market opportunities and regularly engage in experimentation and innovation. A prospector's major capability is that of finding and exploiting new products and market opportunities. As a result, the prospector's domain is usually broad and in a continuous state of development. Prospectors are typically in rapidly changing environments or service categories such as health care technology and frequently engage not only in diversification and product and market development expansion strategies but also divestment and retrenchment strategies. One of the principal competitive advantages of a prospector strategic posture is that of creating change within the service category/service area.

Analyzer Strategic Posture The *analyzer posture* is a combination of the prospector and defender strategic postures. The analyzer tries to balance stability and change. Analyzers are organizations that maintain stable operations in some areas, usually their core products or businesses, but also search for new opportunities and engage in market innovations. Characteristically they watch competitors and rapidly adopt those strategic ideas that appear to have the

greatest potential. Analyzers tend to use penetration strategies in their stable core products and markets whereas related diversification, product development, and market development are used to enter new promising areas.

Reactor Strategic Posture The defender, prospector, and analyzer postures are all proactive strategies. However, the *reactors* really do not have a strategy or plan and therefore such organizations are both inconsistent and unstable in their response to the environment. Reactors are organizations that perceive opportunities and turbulence but are not able to adapt effectively. They lack consistent approaches to strategy and structure and make changes primarily in response to environmental pressures. Miles, Snow, Meyer, and Coleman identified three major reasons that organizations become reactors:

1. Top management may not have clearly articulated the organization's strategy.
2. Management does not fully shape the organization's structure and processes to fit a chosen strategy.
3. Management tends to maintain the organization's current strategy–structure relationship despite overwhelming changes in environmental conditions.[49]

If the internal analysis reveals that the organization has been reactive without a clear strategy or that there is a mismatch between the strategy and implementation, changes will have to be made to move the organization toward a more effective strategic posture. There is some evidence that reactors may be able to hone their competencies and transform themselves into more viable strategic postures over time.[50]

Understanding the organization's preferred strategic posture and communicating it throughout the organization provides decision guidelines and will shape the culture of the organization. It is important that the strategic posture be consistent with the directional, adaptive, market entry, and positioning strategies. The definition, major advantages, and disadvantages of the strategic posture strategies are summarized in Exhibit 6–11.

Positioning Strategies – Marketwide or Focus

Michael Porter, a well-known strategic management writer, proposes that an organization may serve the entire market using marketwide strategies or serve a particular segment of the market using focus strategies. Porter called these *generic strategies* because they were general strategies that any organization could use to position itself in the marketplace.[51] For both marketwide and market segment focus there are two fundamental *positioning strategies* – cost leadership and differentiation.[52]

Marketwide strategies determine a product or service's place in the market vis-à-vis competitors and position the products/services of the organization to appeal to a broad audience (the entire market). For example, a community hospital may be positioned to serve all area residents – serve a broad market with a broad range of services. These products and services, therefore, are not tailored exclusively to the needs of any special segment of the population such

EXHIBIT 6–11 Definition, Advantages, and Disadvantages of Strategic Postures

Strategic Posture	Definition	Major Advantages	Major Disadvantages
Defender	Focus on a narrow market with limited number of products or services and aggressively attempt to keep others out of this segment through pricing or differentiation.	• Focus on limited set of products and services. • Focus is on narrow market segment. • Stable environment. • Difficult for competitors to enter this segment.	• Reliance on the success of narrow product line. • Must have long/sustaining product life cycles. • Market segment must be stable – slow change. • May be unable to respond to major market/industry shifts. • Difficult to enter new markets or technologies.
Prospector	Continuously seek out new products and new markets.	• Always involved in "cutting-edge" developments. • Organization shifts with changing environment. • Allows for a rapid response to a changing environment.	• Organization is in a constant state of change. • New products and markets always being developed. • Multiple technologies being employed, seldom able to achieve efficiency. • Tend to have lower profits because of continuous change. • Tend to overextend resources. • Tend to underutilize financial, human, and physical resources.
Analyzer	Balance defense in some markets with selectively entering a limited number of new markets or products.	• Allows for the maintenance of a core of stable traditional products and services. • Allows for high-risk products and services to be borne by prospectors. • Lower investment in research and development.	• Difficult strategy to pursue. • Must respond quickly to follow lead of key prospectors while maintaining efficiency in core products/services. • Complex structure (matrix). • Management of both stable and dynamic products and markets. • Communication is often difficult.
Reactor	Reacts to the strategies of competitors.	• Little strategic planning required (monopolistic or highly regulated environment).	• Inconsistency in response to environmental change. • Instability in organization. • Organization becomes both ineffective and inefficient. • No effective guide for decision making.

EXHIBIT 6–12 Porter's Matrix

Strategic Target	Strategic Advantage: *Uniqueness Perceived by the Customer*	Strategic Advantage: *Low-Cost Position*
Marketwide (broad)	Differentiation	Overall Cost Leadership
Particular Segment Only (narrow)	Differentiation/Focus	Cost/Focus

Source: Michael E. Porter, *Competitive Strategy: Techniques for Analyzing Industries and Competitors*. Copyright © 1980 by the Free Press. All rights reserved. Reprinted with permission of the Free Press, a division of Simon & Schuster Adult Publishing Group.

as children or the aged. As shown in Exhibit 6–12, marketwide positioning strategies can be based on differentiation or cost leadership. Thus, the community hospital may try to differentiate itself from other hospitals by emphasizing quality or convenience or may compete as a low-cost provider.

Market segment strategies are directed toward the particular needs of a well-defined market segment, such as pediatric oncology or women's health, and often are called *focus strategies*. Thus, a focus strategy identifies a specific, well-defined "niche" in the total market that the organization will concentrate on or pursue. Because of its attributes, the product or service, or the organization itself, may appeal to a particular niche within the market. Similar to marketwide strategies, focus strategies may be based on cost leadership (cost/focus) or differentiation (differentiation/focus).

Because of the complexity of medicine and the entire health care industry, focus strategies are quite common. Just as physicians have specialized, the institutions within the field have tended to focus on specialized segments. Examples of focus strategies are rehabilitation hospitals, psychiatric hospitals, ambulatory care centers, Alzheimer's centers, and so on. These specialty organizations may be further positioned based on cost leadership or differentiation. Each of the generic strategies results from an organization making consistent choices for product/services, markets (service areas), and distinctive competencies – choices that reinforce each other.

Cost Leadership

Cost leadership is a positioning strategy designed to gain an advantage over competitors by producing a product or providing a service at a lower cost than competitors' offerings. The product or service is often highly standardized to keep costs low. Cost leadership allows for more flexibility in pricing and relatively greater profit margins.

Cost leadership is based on economies of scale in operations, marketing, administration, and the use of the latest technology. Cost leadership may be used effectively as the generic strategy for any of the adaptive strategies and seems particularly applicable to the primary providers segment of the health care industry. As Porter suggests:

> Cost leadership requires aggressive construction of efficient-scale facilities, vigorous pursuit of cost reduction from experience, tight cost and overhead control, avoidance of marginal customer accounts, and cost minimization in areas such as R&D, service, sales force, advertising, and so on.[53]

Therefore, in order to use cost leadership effectively, an organization must be able to develop a significant cost advantage and have a reasonably large market share. However, low cost is only an advantage if the organization has the lowest cost and competitors know they cannot match it. Sustaining lowest cost is extremely difficult to achieve without extraordinary scale or market share advantages or unique factor cost benefits.[54] Such a strategy must be used cautiously within health care because consumers often perceive low price as meaning low quality. However, cost leadership allows the organization the greatest flexibility in pricing.

An industry segment where cost leadership is being used successfully is in the area of long-term care. Long-term care facilities are a "thin-margin business" in which profit margins range from approximately 1.2 percent to 1.7 percent. However, long-term care facilities that have been able to drive costs down while maintaining quality have enjoyed higher margins. In addition, many of these facilities have been upgraded to be more efficient and have instituted tight cost controls. Advertising has been used to keep occupancy above 95 percent, which is often required in the industry to be profitable.

Differentiation *Differentiation* is a strategy to make the product or service different (or appear so in the mind of the buyer) from competitors' products or services. Thus, consumers see the service as unique among a group of similar competing services. Differentiation is of no benefit unless that difference is both valuable to buyers and capable of being sustained against competitors.[55]

The product or service may be differentiated by emphasizing quality, a high level of service, ease of access, convenience, reputation, and so on. There are a number of ways to differentiate a product or service, but the attributes that are to be viewed as different or unique must be valued by the consumer. Therefore, organizations using differentiation strategies rely on brand loyalty (reputation or image), distinctive products or services, and the lack of good substitutes.

The most common forms of differentiation in the health care industry have been based on quality and image. Many acute care hospitals emphasize and promote quality care to differentiate them from other hospitals in their service area. However, consumers expect to receive high-quality care at every hospital, making quality a difficult differentiating factor. A "high-tech" image is another basis for differentiation among health care organizations. Affiliation with a medical

school – which performs the most sophisticated procedures or uses the latest (often expensive) technology – may promote the image of "the best possible care." Exhibit 6–13 presents the definition, advantages, and disadvantages of each of the positioning strategies.

Combination Strategies

Combination strategies are often used, especially in larger complex organizations, because no single strategy alone may be sufficient. Zook and Allen have observed that "…profitable growth comes when a company pushes out the boundaries of its core business into adjacent space."[56] They identified several ways to grow into an adjacent space – expand along the external value chain (penetration), grow new products and services (product development), enter new geographies (market development), and address new customer segments (market development). Therefore, successful strategies often mix and match approaches, deploying strategies simultaneously or sequentially. For example, an organization may concurrently divest itself of one of its divisions and engage in market development in another. Perhaps the most frequent combination strategy

EXHIBIT 6–13 Definition, Advantages, and Disadvantages of Positioning Strategies

Positioning Strategy	Definition	Major Advantages	Major Disadvantages
Cost Leadership	Low-cost/price strategy directed toward entire market.	• Provides clear competitive advantage. • Provides clear market position. • Provides opportunities to spend more than competition.	• Must obtain large volume. • Product/service must be standardized. • Product/service may be viewed as low quality.
Differentiation	Development of unique product/service features directed toward entire market.	• Product/service viewed as unique. • Often viewed as high quality. • Greater control over pricing.	• Often difficult to adequately differentiate product or service. • Product/service may be higher priced.
Focus – Cost Leadership	Low-cost/price strategy directed toward a particular market segment.	• Appeals to market segment seeking low price. • May develop good relations with market.	• Low quality may be associated with low price. • Expansion of market may be difficult.
Focus – Differentiation	Development of unique product/service features directed toward a particular market segment.	• Product/service may be customized to the special needs of the segment. • May develop close relationship with market segment.	• Market segment may remain small. • Price will probably be high.

PERSPECTIVE 6–5

Integration at Carolinas Healthcare System

Carolinas Healthcare System (CHS), the largest system in the Carolinas and the second largest system in the nation, is overseen by the Charlotte/Mecklenburg Hospital Authority. An outgrowth of a lone community hospital originally founded in 1940, CHS provides a full spectrum of health care and wellness programs throughout North and South Carolina (and one hospital in Georgia). It is a diverse network including academic medical centers, hospitals, health care pavilions, physician practices, destination centers (such as cancer, outpatient surgery, imaging, endoscopy, and so on), surgical and rehabilitation centers, home health agencies, nursing homes, and hospice and palliative care. In 2011, CHS had 29 disease-specific certifications awarded by the Joint Commission.

CHS's flagship facility is the 874-bed Carolinas Medical Center (CMC), which includes a Level 1 trauma center, a research institute, the Levine Children's Hospital, a rehabilitation facility, and a large number of special treatment units including heart, cancer, and organ transplant. CMC serves as one of North Carolina's five Academic Medical Center Teaching Hospitals providing residency training and fellowships for 377 physicians in 15 specialties.

Carolinas Healthcare System's total revenue grew 500 percent between 2000 and 2012. In 2011, CHS built six new free-standing emergency departments, a new replacement hospital in Wadesboro, NC, and spent $12.3 million on the first phase of a virtual critical care program. CHS has 457 intensive care unit (ICU) beds and 52 board-certified critical care physicians (28 of them located at the main CMC hospital in Charlotte). With this new system, critical care specialists will be able to monitor ICU patients at any of the CHS facilities.

CMC is the first hospital in North Carolina to be recognized by *J. D. Power and Associates* for excellence in maternity care, and has been recognized for emergency services and women's services as well. CMC has been named the "Consumer Choice Preferred Hospital" in the Charlotte market by the National Research Corporation 14 times, and *US News & World Report* named CMC in its ranking of "America's Best Hospitals" for urology and orthopedics in 2008. In 2011, *US News & World Report* listed Levine Children's Hospital among America's Best Children's Hospitals for kidney care. In 2008, CMC won the Joint Commission's Ernest Amory Codman Award (hospital category) because of its achievement in the use of process and outcomes measures to improve organization performance and, ultimately, the quality and safety of care. In 2009, CMC received the Joint Commission's Franklin Award of Distinction for Clinical Care Management.

As of July 1, 2012 (when a management agreement with Cone Health became effective), CHS owned or managed nearly 40 hospitals, garnered about $8 billion in annual revenue, employed or managed more than 57,400 employees, and owned or managed 7,200 licensed beds. Further, CHS employed or managed more than 2,000 physicians and served patients from more than 700 care locations.

Over the past 70-plus years, CHS has incorporated every type of growth strategy and most of the maintenance of scope strategies; however, they have rarely used any of the reduction of scope strategies.

Source: Carolinas Healthcare Systems Annual Report 2011, its website, and news releases.

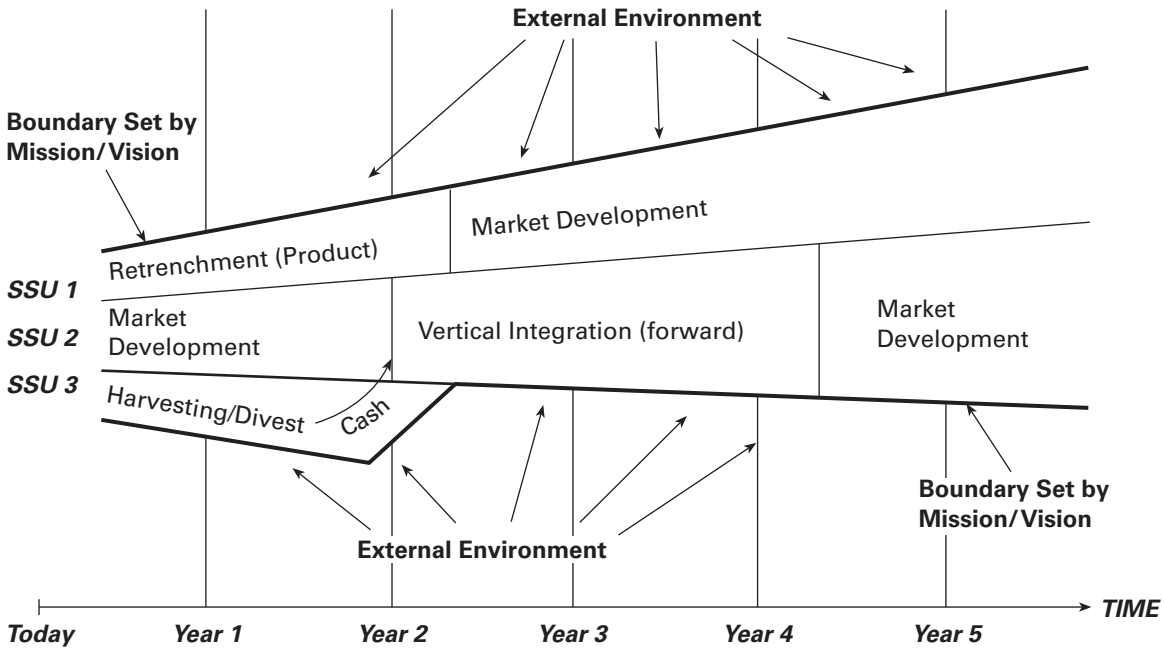
for hospital-based systems has been vertical integration through acquisition and alliances combined with market development through acquisition (horizontal integration). The intent of these strategies has been to create regional, fully integrated systems with wide market coverage and a full range of services (often referred to as providing the continuum of care).

As illustrated in Perspective 6–5, Carolinas Healthcare System, previously known as Charlotte/Mecklenburg Hospital Authority, demonstrates the successful use of combination strategies. Beginning with a single county hospital as the base, Carolinas Healthcare System used practically every type of adaptive and market entry strategy to achieve its vision of a fully integrated regional health system with Carolinas Medical Center as its foundation.

In addition to an organization using several different strategies at once, a strategy may have several phases. It may be necessary to "string together" several strategic alternatives as phases or elements to implement a broader strategic shift. In a two-phase strategy, an organization may employ a retrenchment strategy in phase one and an enhancement strategy in phase two. As illustrated in Exhibit 6–14, the strategic manager's vision often extends through several strategic alternatives or phases. Such vision helps to provide long-term continuity for the entire management team. However, the strategic manager must be aware that, in a dynamic environment, circumstances may change and later phases may have to be modified or revised to meet the needs of the unique and changing situation. Strategic management is a continuous process of assessment and decision making.

The decision logic for the formulation of the strategic plan was illustrated in Exhibit 6–2. At this point, it would be useful to return to Exhibits 6–2 and 6–4

EXHIBIT 6–14 Vision of Strategy Combinations and Phases



to review the complete strategy formulation process. After all the strategy formulation alternatives have been selected, creation of a strategy map showing the selected directional, adaptive, market entry, and competitive strategies together will help to ensure their consistency and fit. However, it is not enough to know the strategic logic and range of strategic alternatives. The strategic alternative (or set of alternatives) should be selected that best meets the requirements of the external environment, strengths and weaknesses of the organization, and the directional strategies. Chapter 7 will discuss methods for evaluating the strategic alternatives presented in this chapter.

Lessons for Health Care Managers

To understand the decisions that have to be made in strategy formulation, a strategic thinking map depicting a hierarchy of strategic alternatives is useful. There are several types of strategies, and within each type, several strategic alternatives are available to health care organizations. In addition, there is a general sequential decision logic in the strategy formulation process. First, directional strategies must be articulated through the organization's mission, vision, values, and goals. Second, adaptive strategies are identified, evaluated, and selected. The adaptive strategies are central to strategy formulation and delineate how the organization will expand, reduce, or maintain the scope of operations. Expansion strategies include diversification, vertical integration, market development, product development, and penetration. Reduction strategies include divestiture, liquidation, harvesting, and retrenchment. Finally, maintenance of scope strategies includes enhancement and status quo.

The third type of strategic decision concerns the market entry strategies. Expansion and maintenance of scope strategies call for a method to carry out the strategy in the marketplace. Therefore, some method for entering or gaining access to that market is required. Market entry strategies include acquisitions and mergers, internal development, internal ventures, reconfiguring the value chain, alliances and joint ventures, licensing, and venture capital investments. Any of the market entry strategies may be used to carry out an expansion or maintenance of scope adaptive strategy.

The fourth category of strategy includes the competitive strategies. Competitive strategies specify strategic posture of the organization and position the products and services *vis-à-vis* competitors. The strategic posture should be well thought through by strategic leadership. Strategic posture specifies the organization/market relationship and provides decision and culture guidelines for management. Strategic postures that may be adopted by an organization include defender, analyzer, prospector, or reactor (although the latter usually indicates the lack of a strategy). In addition, there are the positioning strategies (often called generic strategies). These include cost leadership and differentiation, both of which can be applied as marketwide strategies or focus strategies (a market segment strategy). Each of the generic strategies places different demands on the organization and requires unique resources, competencies, and capabilities.

The strategy formulation decision logic provides a sequence for making the strategic decisions. However, the selected strategic alternatives must be viewed

together to ensure their fit and consistency. In addition, it is unlikely that a single strategy will suffice for an organization. Several strategic alternatives may have to be adopted and used in combination. For instance, one service category may require market development whereas a different service category may require harvesting. One division may be a defender positioned as a cost leader and another may be a prospector pursuing differentiation. Furthermore, several strategic alternatives may be seen as phases or sequences in a broader strategic shift. Chapter 7 presents several frameworks to help managers think about which strategic alternatives are most appropriate given the organization's external environmental issues, competitive advantages and disadvantages, and directional strategies.

Health Care Manager's Bookshelf

Jack Trout with Steve Rivkin, *Differentiate or Die: Survival in Our Era of Killer Competition* (New York: John Wiley & Sons, 2001)

Customers have more choices than ever before. For example, in 1970 there were less than 20 over-the-counter pain relievers. Today there are more than 140. In 1970 there were no websites. Today there are almost 5 million.[1] The story is not so different in health care. In the early 1970s there was one type of contact lens. Today there are 36. In the "old days" when considering health care, the typical patient thought about a doctor, the local hospital, and a single insurer such as Blue Cross. Today, Cigna, Kaiser, Medicare, and Medicaid may be important parts of the health care equation. Despite the concentration in pharmaceuticals, doctors also have a greater number of choices, generic and brand name, when prescribing drugs for high blood pressure, high cholesterol, or chronic headaches (p. 6). In 1970 there were about 6,000 prescription drugs. Now there are more than 7,500. How do organizations and individuals survive and prosper in an era of killer competition with all these choices? One way is to create "blue oceans" and simply not compete or make the competition irrelevant. More often there are a group of competitors who cannot be ignored or marginalized.

A strategy for surviving in an era of killer competition, according to these authors, is to overcome the temptation to be everything to everyone. Being different is much more important today than it was 30 years ago (p. 13). Strategic leaders cannot ignore the importance of uniqueness. Chevrolet tried to appeal to everyone and, as a result, the company lost its "difference" along with its loyal customers.

The central thesis of *Differentiate or Die* is that anything can be differentiated, even health services. However, be careful not to try to differentiate by just being creative, cheap, patient-oriented, or quality-driven. Competitors read the same books you do and can learn to do these things equally well.[2] The real key is to create uniqueness.

Consider, for example, boutique doctor practices. Many affluent health care

consumers have lost "patience" with mass production medicine where people travel to the doctor's office only to find a crowded waiting room or call the doctor's answering service at night and hope in vain for a follow-up phone call. A solution, for those who can afford it, is to purchase concierge care and "retain" their physician by paying an annual fee in addition to fees for services to ensure that their doctor has a limited number of patients they agree to see on an as-needed basis. These retainers range from $1,000 to $20,000 per year.

Concierge care can be used to demonstrate the steps to differentiation. First, the concept must make sense in the business context (p. 67). As personal health services become more bureaucratic and cumbersome people begin to look for alternatives. Personalized health service rings a bell with frustrated health care consumers. Second, the impersonality of the practice of medicine that accompanies patient panels of 2,500 to 3,000 patients begins to stimulate an entrepreneurial search for a differentiating idea (p. 67). Third, a select number of qualified providers with appropriate credentials propose to limit their practice to 600 to 800 patients and provide personalized services to those willing to pay an annual fee in addition to normal charges for services provided. Finally, the providers effectively communicate the merits of boutique medicine to the market segment with the financial resources necessary to afford these services. The bottom line is that "you cannot over communicate your difference" (p. 69).

Making a service different involves sacrifice. To target a particular market segment it is necessary to sacrifice other market segments (p. 179). A physician's practice cannot be both a concierge provider and a high-volume producer. If it tries, it is likely to be unsuccessful in both undertakings.

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KEY TERMS AND CONCEPTS IN STRATEGIC MANAGEMENT

Acquisition
Adaptive Strategy
Alliance
Analyzer Strategic Posture
Backward Vertical Integration
Combination Strategy
Competitive Strategy
Concentric Diversification
Conglomerate Diversification
Cooperation Strategy
Cost Leadership
Defender Strategic Posture
Development Strategy
Differentiation
Diversification
Divestiture
Ends–Means Chain
Enhancement
Expansion of Scope Strategy
Focused Factory
Focus Strategy
Forward Vertical Integration
Generic Strategy
Harvesting
Horizontal Integration
Implementation Strategy
Internal Development
Internal Venture
Joint Venture
Licensing

Liquidation
Maintenance of Scope Strategy
Market Development
Market Entry Strategy
Marketwide Strategy
Merger
Penetration Strategy
Positioning Strategy
Product Development
Prospector Strategic Posture
Purchase Strategy
Reactor Strategic Posture
Reconfigure the Value Chain
Reduction of Scope Strategy
Related Diversification
Retrenchment
Status Quo
Strategic Posture
Strategy Formulation
Unrelated Diversification
Venture Capital Investment
Vertical Integration

Questions for Class Discussion

1. What four types of strategy make up the strategy formulation process? Describe the role each plays in developing a strategic plan.
2. Why are the directional strategies both a part of situational analysis and a part of strategy formulation?
3. How is strategy formulation related to situational analysis?
4. Name and describe the expansion, reduction, and maintenance of scope strategies. Which of the adaptive strategies are corporate and which are division level? Under what conditions may each be appropriate?
5. Why does the selection of the strategic alternatives create "direction" for the organization?
6. What is the difference between related diversification and product development? Provide examples of each.
7. What is a market-driven or focused factory strategy? Identify some organizations that have employed this type of market development strategy.
8. Many health care organizations have engaged in vertical and horizontal integration. What is the rationale for these strategies?
9. Describe vertical integration in terms of patient flow.
10. Explain the difference between an enhancement strategy and a status quo strategy.
11. How is market development different from product development? Penetration? Provide examples of each.
12. Compare and contrast a divestiture strategy with a liquidation strategy.
13. Which of the market entry strategies provides for the quickest entry into the market? Slowest?
14. What is strategic posture? How does a decision concerning the strategic posture help create decision guidelines for management and affect the organization's culture?
15. Explain Porter's generic strategies. How do they position the organization's products and services in the market?
16. How might a retrenchment strategy and a penetration strategy be linked together? What are some other logical combinations of strategies? How may a combination of strategies be related to vision?

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7 Evaluation of Alternatives and Strategic Choice

"One does not plan and then try to make the circumstances fit these plans. One tries to make plans fit the circumstances."

—GEORGE PATTON

Introductory Incident

Analytical Tools for Strategic Managers

In 1993, Bain & Company began surveying executives around the world concerning the analytical management tools they use and how effective the tools are in delivering the desired results. To be included in the survey, the tools have to be relevant to senior management, topical, and measurable. Bain & Company has now completed its 13th survey and has a database of more than 11,000 respondents. Bain research identifies 25 of the most popular and pertinent management tools and conducts one-on-one follow-up interviews to learn the circumstances in which

each tool is most likely to produce the desired results. Bain & Company added four tools to its 2011 survey: change management programs, enterprise risk management, rapid prototyping, and social media programs.

The three tools that managers say they will start using in 2011 include open innovation, scenario and contingency planning, and price optimization. Open innovation allows companies to expand the sources of breakthrough products; scenario and contingency planning helps managers test "what ifs" to prepare for the future and minimize risks; and price optimization addresses future concerns about rising commodity prices. Used correctly, price optimization models will help identify optimal price points that consumers are willing to pay for products.

Although just 29 percent of executives in the survey reported that they had used social media in 2010, 56 percent expected to use it in 2011. Bain cautions that using a tool simply because competitors are using it can be risky, especially if the tool is not fully understood, causing the experience to be a failure. Social media is very new and challenging to measure; therefore, Bain advises organizations to be thoughtful about why they are using it, to invest enough to make it successful, and to measure whether they are receiving the desired return.

Although it was not unexpected because during tough times companies cut back on everything (including tools), worldwide tool usage was an average of just 10 tools – the lowest number since Bain began its survey in 1993. The most widely used tools were benchmarking, strategic planning, and mission and vision statements – all top 10 rated tools over the years regardless of the economic climate. Strategic planning is the tool with the highest satisfaction rating; others with above-average satisfaction ratings include mission and vision statements, total quality management, customer segmentation, and strategic alliances.

The least used tools for 2011 include open innovation, price optimization models, decision rights tools, rapid prototyping, and the surprise – mergers and acquisitions. Only 35 percent of executives took advantage of M&As in 2010; however, more than half say they expect to use M&As in 2011. The tools with the lowest satisfaction rating were downsizing, outsourcing, shared service centers, knowledge management, and social media programs.

Based on more than a decade of experience, Bain & Company offers four suggestions for the use of analytical management tools:

1. **Get the facts**. Every management tool has unique strengths and weaknesses. To be used successfully, executives have to understand the effects and side-effects of each tool to combine the right tools in the right ways at the right times.
2. **Champion enduring strategies, not fleeting fads**. Managers who promote fads undermine employees' confidence that they can create change when needed. Executives are better served by championing realistic strategic directions.
3. **Choose the best tools for the job**. Use a rational system for selecting, implementing, and integrating tools that are appropriate. A tool will improve results only to the extent that it helps to discover unmet needs, build distinctive capabilities, exploit the vulnerabilities of competitors.
4. **Adapt tools to the system**. No tool comes with a guarantee. Every tool must be adapted to an organization's particular circumstance.

Over the past three decades, management tools have become a common part of executives' lives. Whether trying to boost revenues, innovate, improve quality, increase efficiencies, or plan for the future, executives have looked for tools to help them. The current environment of globalization and economic turbulence has increased the challenges executives face and, therefore, the need to find the right tools to meet these challenges. They must choose the tools that will best help them make the business decisions that lead to enhanced processes, products, and services – and result in superior performance and profits.

Over time, Bain believes its research has provided a number of important insights. Among them:

- Overall satisfaction with tools is moderately positive, but the rates of usage, ease of implementation, effectiveness, strengths, and weaknesses vary widely.
- Management tools are more effective when they are part of a major organizational effort.
- Managers who switch from tool to tool undermine employees' confidence.
- Decision makers achieve better results by championing realistic strategies and viewing tools simply as a means to a strategic goal.
- No tool is a cure-all.

Source: Darrell Rigby and Barbara Bilodeau, *Management Tools & Trends 2011* (Bain & Company, 2011).

Learning Objectives

After completing the chapter you will be able to:

1. Understand the rationale underlying the various strategic thinking maps used to evaluate strategic alternatives.
2. Discuss, evaluate, and select appropriate adaptive strategic alternatives for a health care organization.
3. Discuss, evaluate, and select appropriate market entry strategic alternatives.
4. Discuss, evaluate, and select appropriate strategic posture and generic positioning alternatives.
5. Determine whether selected strategies are consistent, coordinated, and fit the situation.
6. Understand the role of the service delivery and support strategies.

Evaluation of the Alternatives

Fundamental to strategic management is the need to change strategies over time.[1] There are several frameworks or maps that may be used to guide strategic thinking about the appropriate strategic alternatives for an organization. These strategic thinking maps incorporate the results of external and internal analyses, as well as the development of directional strategies. Thoughtful analysis to understand the internal requirements and external conditions of the strategic alternatives is essential to assure a coherent and integrated strategy.

Although the evaluation of strategic thinking maps fine-tunes the manager's perspective and organizes thinking, ultimately, the strategic manager must make the decision. Strategic managers need to understand the risks, make judgments, and commit the organization to some course of action. Therefore, the strategic thinking maps cannot be used to obtain "answers," but they can be used to gain perspective and insight into a complex relationship between organization and environment. There is often no right answer. As Peter Drucker has pointed out, "It is a choice between alternatives. It is rarely a choice between right and wrong. It is at best a choice between 'almost right' and 'probably wrong' – but much more often a choice between two courses of action neither of which is probably more nearly right than the other."[2] The various strategic thinking maps help to structure the thought processes of decision makers. It is important that managers think strategically and, almost as important, have some imagination and employ sound judgment. As suggested in Perspective 7–1, in order to have the proper perspective, it is important that strategic managers be involved with customers, vendors, and the organization and talk to people to get a real feel for the culture, competitive advantage, and organizational opportunities and threats.

PERSPECTIVE 7–1

Creating a Productive Organizational Culture

Although understanding the external environment is profoundly important in strategic thinking, leaders must also understand and actively manage their organizations. Leadership and management are not practiced from a distance but rather are "hands-on" activities. An understanding of the resources, competencies, and capabilities of the organization as an input to strategic thinking comes through listening, empathizing, staying in touch, communicating, and personal problem solving – developing and managing the organization culture. Therefore, in developing a collegial culture without excessive barriers to communication, it is important for leaders to remember:

Less management is generally better than more management

- Develop self-managed teams – ask folks to think.
- Develop fewer rules, policies, procedures, rather than more and don't try to fix everything with a new rule or policy.

- Don't try to control the small stuff – tracking costs more than it saves.
- Routines and rules drive out innovation and flexible thinking.
- Avoid micro-management.

Strive for broad strokes rather than narrow strokes

- Dream and think big – leadership is more about the "big picture."
- Vision and a future orientation are essential.
- Seek effectiveness *before* efficiency.
- It's called leadership – management without leadership is called bureaucracy.

Simple systems are preferable to complex systems

- Always strive to simplify.
- Make no system more complex than it has to be.
- Complex systems deteriorate faster than simple systems and need constant (much more) maintenance.
- In complex systems small disruptions can create big disruptions, even systems failure (the butterfly effect).

All solutions are temporary

- Don't work so hard for closure to a problem – there is too much change for a solution to last very long.
- One of the lessons of strategic management is that to be successful, you must change.
- Don't always seek perfection – perfection may be the enemy of change.

Processes are not ends in themselves but tend to be viewed that way over time

- People often focus on process elements rather than the objectives of the process (particularly after they've done it for a while).
- Too much focus on the process prevents change/adaptability.
- Process orientation inhibits innovation and, ultimately, survival.
- Be open to changing the process (challenge the current thinking/process).
- Manage the objective(s) not the process(es).

Practice "one-level" leadership

- Everyone in an organization should be treated as a peer (equality). Peers can and will share and discuss ideas, opinions, and solutions.
- Folks deserve respect and simple courtesies are important (be polite and always say "hello").
- Casual is better than formal – casual reduces barriers; formal raises barriers.

Organizational culture is the key

- Organizations are mostly about people and not about things.
- Shape the organization's habits, customs, values, and mores.
- Inspire and motivate.
- Be the keeper and communicator of the vision.
- Make it interesting and fun.
- Make sure everyone learns something.

Organize for flexibility

- Most workers expect a formal organization; use these building blocks to create ad hoc structures as needs dictate.
- Job designs should be as broad as possible.
- Small is better than large – organize into small units.

Measure only those things that are important

- Identify the few important acceptance criteria of customers (internal as well as external).
- Establish precise, accurate, easy-to-accomplish measurements of these criteria.
- Enable those whose judgment, skill, and craft determine the outcomes to act on the measurements.
- Reward behaviors that improve process characteristics to achieve the criteria.
- Manage the measures.

Personal touches are better than impersonal touches

- Personal notes are better than formal memos/letters.
- Hand-written notes are better than typed letters.
- Personal contact (face-to-face) is better than email.
- Talk to people and visit them in their space.
- Thank people.

Allow folks to "fail forward"

- Change, creativity, and innovation require some risk taking.
- Press for innovation until failure.
- Promote and deliver on life-long learning for everyone.

Evaluation of the Adaptive Strategies

As discussed throughout Chapter 6, once the directional strategies have been developed, consideration is given to the adaptive strategies. The adaptive strategies are central to strategy formulation and are the broadest interpretation of the directional strategies. This level of strategic decision making specifies whether the organization wants to grow (expansion of scope), become smaller (contraction of scope), or remain about the same (maintenance of scope). Once the decision has been made to grow, contract, or remain the same, the methods to accomplish expansion, contraction, or maintenance of scope (diversification, divestiture, enhancement, and so on) must be formulated. New environmental forces may dictate the need to re-evaluate the adaptive strategies. Academic Health Centers (AHCs), although able to maintain their unique research focus for decades, increasingly have felt the pressures of a paradigm shift (see Perspective 7–2).

PERSPECTIVE 7–2

Health Care Reform: A New Paradigm for AHCs

Academic health centers (or academic medical centers) typically have been independent, not-for-profit institutions of higher learning, research, and patient care with most being state supported or private university affiliated. AHCs have multiple missions that are different from other hospitals, including research, teaching, patient care, and providing more than 40 percent of the indigent care in the United States. Accustomed to having the most difficult cases referred to them for treatment, they have not been a major part of "managed care" but rather dealt with these high-cost patients to further their unique mission. Additionally, they only saw other AHCs as competitors. With the changing reimbursement landscape from the Affordable Care Act of 2010 (ACA) health care reform, AHCs must engage in a paradigm shift.

According to Larry Shapiro, MD chair of the board of directors of the Association of Academic Health Centers, AHCs are among the largest employers in their regions, creating significant economic impact as an employer but also as a purchaser of goods and services and delivering the highest-quality health care services. In addition, ACHs develop intellectual property through research and educate the next generation of physicians, scientists, and other allied health professionals. He acknowledged that the next decade was going to provide major challenges for AHCs because of legislative change and policy uncertainty, economic pressures from constrained resources, and workforce challenges including changes in medical education, biomedical and clinical research, and changing priorities to develop and replicate best practices to provide quality care at lower costs.

Ten recommendations for AHCs to make this shift were offered by Dr. Samuel Shomaker:

1. Train the workforce needed in their own service area rather than selecting medical students based on faculty preferences or hospital service needs. They must be creative to inspire physicians to enter primary care to meet the needs in rural and urban areas.
2. Expand the number of physicians that are being trained and shorten the time needed to educate fully certified doctors.
3. Commit to training more mid-level providers to manage the huge influx of new patients (approximately 32 million new beneficiaries will result from the ACA, of which more than half will be new Medicaid enrollees requiring more intense care as they enter the system). Before the passage of ACA, predictions were for a shortage of between 100,000 and 200,000 primary care physicians.
4. Work harder to improve the diversity of medical school classes to enhance the training and composition of the physician workforce.
5. Revise their medical school and residency curricula to provide trainees with the skills they will need to successfully practice in tomorrow's health care environment. Poor performance in safety requires educating new physicians in quality improvement; poor performance in health status requires students to understand public health and prevention; poor performance in cost containment means that students need to be able to work in teams to

generate effective and cost-efficient care (central features of the medical home model of care).
6. Explore new partnerships or shore up existing ones with safety net providers, particularly Federally Qualified Health Centers.
7. Create actual or virtual integrated care networks with community providers in their regions to improve cost efficiency. ACA mandates Medicare pilot programs around accountable care organizations, medical homes, and bundled reimbursement programs. Strong relationships with regional health care payors, physicians, and health systems will enable AHCs to be early adopters of such reforms and to position themselves to establish integrated care networks (actual or virtual).
8. Maximize revenues and reduce expenses to survive financial challenges.
9. Move aggressively to improve clinical quality and safety. Preventing avoidable readmissions and medical errors will be rewarded under ACA.
10. Lead the way in bench-to-bedside research.

Investigating the last recommendation illustrates to a small extent the magnitude of the paradigm shift facing AHCs. As research institutions, AHCs seek medical faculty that have the ability to attract research dollars to push medical science and AHCs have the infrastructure to support large-scale research; however, these faculty are not trained in the economics of health care delivery.

Sources: Association of Academic Health Centers 2011 Annual Report; T. Shomaker and M. D. Samuel, "Preparing for Health Care Reform: Ten Recommendations for Academic Health Centers," *Academic Medicine* 86, no. 5 (2011), pp. 555–558.

Several constructs help strategic managers to think about adaptive strategic decisions. However, as expressed previously, these constructs help to show relationships of the organization to its markets and competitors; they do not make the decision. Methods to evaluate the adaptive strategies include:

- external/internal strategy matrix;
- product life cycle (PLC) analysis;
- Boston Consulting Group (BCG) portfolio analysis;
- extended portfolio matrix analysis;
- strategic position and action evaluation (SPACE); and
- program evaluation.

External/Internal Strategy Matrix

SWOT (strengths, weaknesses, opportunities, and threats) analysis has been popular as a way to display pertinent external issues and internal strengths and weaknesses. SWOT analysis involves listing the organization's strengths and weaknesses as well as perceived external opportunities and threats. SWOT, however, does not provide much insight into what strategy decisions might result from the

list of strengths and weaknesses and opportunities and threats. As a result, the TOWS (threats, opportunities, weaknesses, and strengths) matrix was developed to provide a better way to develop and evaluate specific adaptive strategic alternatives.[3] In the TOWS approach, internal strengths and weaknesses are matched against external environmental opportunities and threats to foster strategic thinking concerning adaptive strategy alternatives. However, both SWOT analysis and the TOWS matrix approach required strategic managers to classify external issues as opportunities or threats.

As discussed in Chapter 2, the designation of external issues as opportunities or threats is often arbitrary and opportunities are often presented as strategic alternatives rather than independent external issues affecting the organization. Further, many external issues may be both opportunities and threats. Therefore, a better approach is to match the external issues identified in the three external environments (general, health care, and service area) discussed in Chapters 2 and 3 with long-term and short-term competitive advantages and disadvantages (discussed in Chapter 4). Exhibit 7–1 shows the strategic thinking map for matching external issues with internal competitive advantages and disadvantages.

In the *External/Internal Strategy Matrix*, adaptive strategic alternatives are suggested by the interactions of the seven sets of variables (long- and short-term competitive advantages, long- and short-term competitive disadvantages, and general, health care, and competitive issues). In this example, the primary concern is the adaptive strategic alternatives, but this analysis could also be applied to the development of any type of strategy. In practice, particularly in open discussion sessions, some of the alternatives developed through the strategy matrix may be adaptive, market entry, competitive, or value-adding service delivery and support strategies.

EXHIBIT 7–1 **External/Internal Strategy Matrix**

		External Issues		
		General Environment Issues 1. 2. 3.	Health Care Environment Issues 1. 2. 3.	Service Area & Competitive Issues 1. 2. 3.
Internal Advantages & Disadvantages				
Long-Term Competitive Advantages	1. 2. 3.	Strategies 1. 2. 3.	Strategies 1. 2. 3.	Strategies 1. 2. 3.
Short-Term Competitive Advantages	1. 2. 3.	Strategies 1. 2. 3.	Strategies 1. 2. 3.	Strategies 1. 2. 3.
Long-Term Competitive Disadvantages	1. 2. 3.	Strategies 1. 2. 3.	Strategies 1. 2. 3.	Strategies 1. 2. 3.
Short-Term Competitive Disadvantages	1. 2. 3.	Strategies 1. 2. 3.	Strategies 1. 2. 3.	Strategies 1. 2. 3.

The strategies developed by matching the long-term competitive advantages with issues from the three external environments – general, health care, and service area and competitive – represents the primary adaptive strategies of an organization. The long-term competitive advantages are valuable, rare among competitors, difficult to duplicate, and sustainable. The short-term competitive advantages may soon be duplicated, particularly if the service areas and competitors are undergoing change, but these advantages must still be maintained. The long-term competitive disadvantages represent areas where internal "fix-it" strategies will have to be addressed because they are valuable in the external environments. The short-term competitive disadvantages are fixable but still represent a significant impediment to success.

Product Life Cycle Analysis

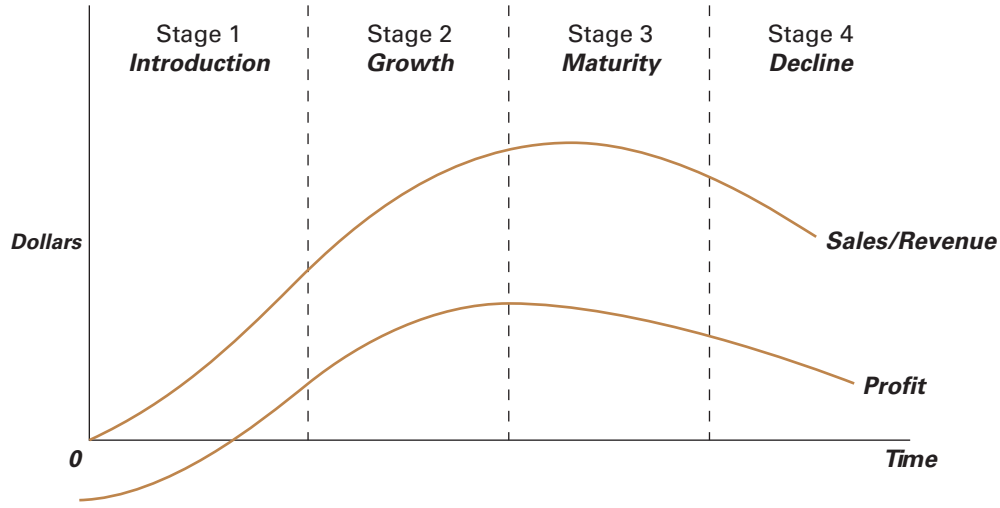
Product life cycle (PLC) analysis can be useful in selecting strategic alternatives based on the principle that all products and services go through several distinct stages. These stages relate primarily to the changing nature of the marketplace, the product development process, and the types of demands made on management. In evaluating product life cycles, the evolution of service category sales and profits (or a surrogate for sales such as the number of subscribers, hospital visits, or competitors) is tracked over time. This evolution will have strategic implications for the organization. A typical PLC and the attributes of each stage are presented in Exhibit 7–2.

Products and services have an introductory stage during which sales are increasing yet profits are negative. In this stage, there are few competitors (prospectors), prices are usually high, promotion is informative about the product category, and there are limited distribution outlets. In the growth stage, sales and profits are both increasing and, as a result, competing organizations enter the market (analyzers) to participate in the growth. During this stage, prices are still high but may begin to decline, promotion is directed toward specific brands, and there is rapid growth in the number of outlets.

The maturity stage of the PLC marks the end of rapid growth and the beginning of consolidation. In addition, market segmentation (defining narrower and narrower segments of the market) occurs. In this stage, prices have stabilized or declined, price promotion becomes common, distribution is widespread, and competitors are concerned with maintaining market share (defenders). In the decline stage, total revenues and profits for the product or service are declining and will likely continue to decline over the long term.

Tracking the enrollment of health maintenance organizations (HMOs) illustrates the PLC. HMOs had an extended introductory period. The first HMO prototype, the Ross-Loos Clinic in Los Angeles, became operational in 1929. Forty years later, in 1970, there were only 33, generally not-for-profit, HMOs in the United States, serving approximately 3 million enrollees.[4] The boost that pushed HMOs from introduction to growth included the passage of the Health Maintenance Organization and Resources Act of 1974. In addition to the federal funding for development and growth, HMOs sought additional capital in the early 1980s. One method to accomplish this was to convert from a not-for-profit to a for-profit HMO.

EXHIBIT 7–2 The Product Life Cycle



PLC Stage Characteristics

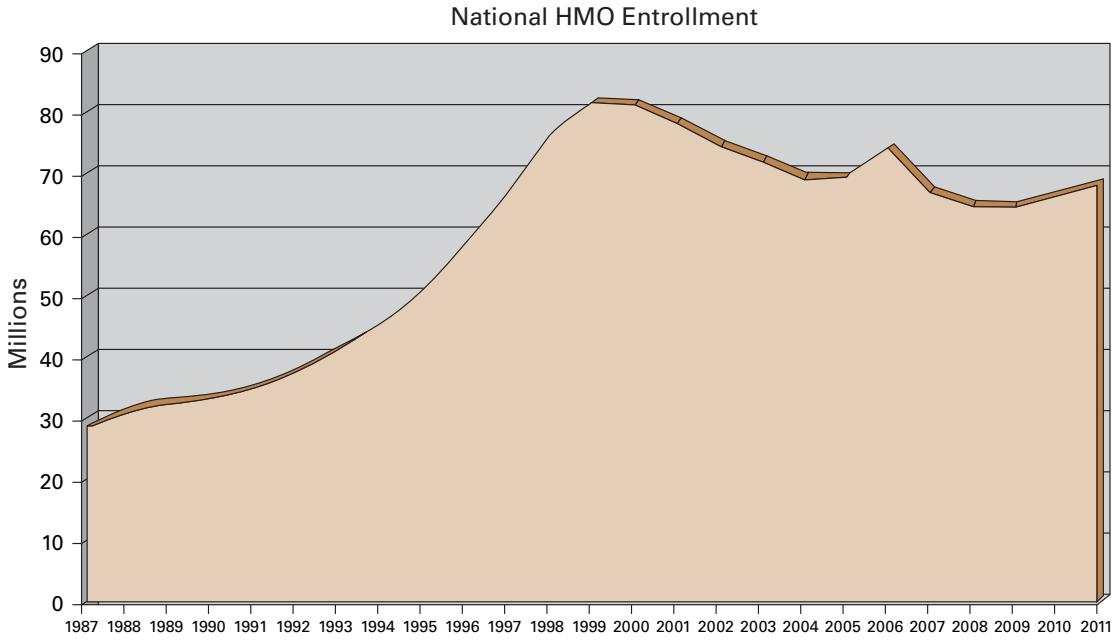
	Introduction	*Growth*	*Maturity*	*Decline*
Sales/Revenue	Low	Rapid growth	Slow growth	Declining
Profits	Negative	Peak levels	High	Low
Competitors	Few	Growing	Many	Declining
Cost/Customer	High	Average	Low	Low
Capital Access	Venture	Equity/debt	Debt/internal	Minimal

Source: Adapted from Philip Kotler and Kevin Lane Keller, *Marketing Management,* 12th edn (2006), p. 332. Reprinted by permission of Simon & Schuster.

Exhibit 7–3 shows the national HMO enrollment from 1987 through 2011. The HMO enrollment growth stage extends through 1999 and then enters the mature stage. By the late 1990s, many urban markets experienced high managed care penetration, signifying local maturity. HMO consolidation in major markets continued and company strategies were typical of market maturity – price competition, extensive distribution development, aggressive promotion, and product differentiation. In addition, few new players were entering the market in these areas. Confusing the picture are the rural and non-urban markets that continue to adopt managed care very slowly because of a lack of economies of scale and an insufficient number of providers. In addition, few new players are entering the market in these areas. Overall enrollment shows some growth, but the overall picture may hide two separate HMO life cycles that are in different stages – urban maturity, perhaps toward decline, along with rural/non-urban late-stage growth.

Despite its limitations, PLC analysis is a useful tool for strategic planning. It provides a framework for assessing existing activities as well as new

EXHIBIT 7–3 National HMO Enrollment



Source: http://www.mcareol.com/factshts/factnati.htm

products/services. The decomposition and critical review of market characteristics in conjunction with the PLC can serve as a guideline for strategy development. A PLC framework is particularly useful for product, marketing, and management strategies.

In the consideration of new product/service lines, a PLC analysis can help to answer questions not only about whether an activity is attractive for the organization, but also what might be the best market entry strategy. Historically, hospitals have developed the businesses or services that they offer. However, development makes sense only if the business is in introductory or growth stages of the life cycle. If the hospital chooses to enter a mature business, it is usually better to joint-venture the business with an experienced party or acquire an existing provider. Introducing new product variations during late maturity or decline carries great risk unless the variations are sufficient to create an entirely new life cycle.

There are two important questions for strategy formulation when using product life cycles: "In what stage of the life cycle are the organization's products and services?" and "How long are the stages (and the life cycle itself) likely to last?" To determine the stage of the PLC, management must use a great deal of judgment. Total service category revenues and profits may be monitored as an initial indicator. In addition, information obtained in external environmental analysis concerning technological, social, political, regulatory, economic, and competitive change is valuable in assessing both the current stage and the expected length of the cycle.

EXHIBIT 7–4 Strategic Choices for Stages of the Product Life Cycle

Stage 1

Introduction

Market Development
Product Development

Stage 2

Growth

Market Development
Product Development
Penetration
Vertical Integration
Related Diversification

Stage 3

Maturity

Market Development
Product Development
Penetration
Enhancement
Status Quo
Retrenchment
Divestiture
Unrelated Diversification

Stage 4

Decline

Divestiture
Liquidation
Harvesting
Unrelated Diversification

The stage in the product life cycle for a product or service indicates a likely strategic response and the level of resources that might be committed to a particular product or service. Exhibit 7–4 shows logical strategic alternatives for each stage of the PLC.

The relevance of the strategies shown in Exhibit 7–4 depends on management's perception of the timing of the cycle. Products and services that management determines have lengthy stages (or a long PLC) will require dramatically different strategies from those that management concludes have short stages or a short PLC. For instance, extensive vertical integration may be justified in the growth stage and even in the mature stage of the PLC if the cycle is judged to be a long one. However, the investment in and commitment to the product required in vertical integration may not be justified when the PLC is viewed as being relatively short.

Portfolio Analysis

Strategic thinkers often think in portfolio terms because it is useful to have a framework for analyzing the mix of products and services.[5] As a result, portfolio analysis, popularized by the Boston Consulting Group (BCG), has become a fundamental tool for strategic analysis. Portfolio analysis allows for the assessment of the market position of the health care organization as a whole or its separate programs. As illustrated in Exhibit 7–5, traditional *BCG portfolio analysis* graphically portrays differences among the various products/services (stars, cash cows, problem children, and dogs) in terms of relative market share and market growth rate.

Relative market share may be thought of as the market share held by the largest rival organization compared with the market share held by others in the service category. Growth rate can be measured by the changes in level of gross revenues or by population or service utilization growth (such as admissions or inpatient days). Classification as high, medium, or low may be determined

EXHIBIT 7–5 BCG Portfolio Analysis

Stars

Products and services that fall in this quadrant (high market growth and high market share) represent the organization's best long-run opportunity for growth and profitability. These products and services should be provided resources. Market development, product development, penetration, vertical integration, and related diversification are appropriate strategies for this quadrant.

Cash Cows

Products and services in this quadrant have low market growth (probably in maturity and decline stages of the PLC) but the organization has a high relative market share. These products and services should be maintained but should consume few new resources. For strong cash cows, appropriate strategies are status quo, enhancement, penetration, and related diversification. For weak cash cows, strategies may include retrenchment, harvesting, divestiture, and perhaps liquidation.

Problem Children

Problem children have a low relative market share position, yet compete in a high-growth market. Managers must decide whether to strengthen the products in this quadrant with increased investment through market development or product development or get out of the product/service area through harvesting, divestiture, or liquidation. A case may also be made for retrenchment into specialty niches.

Dogs

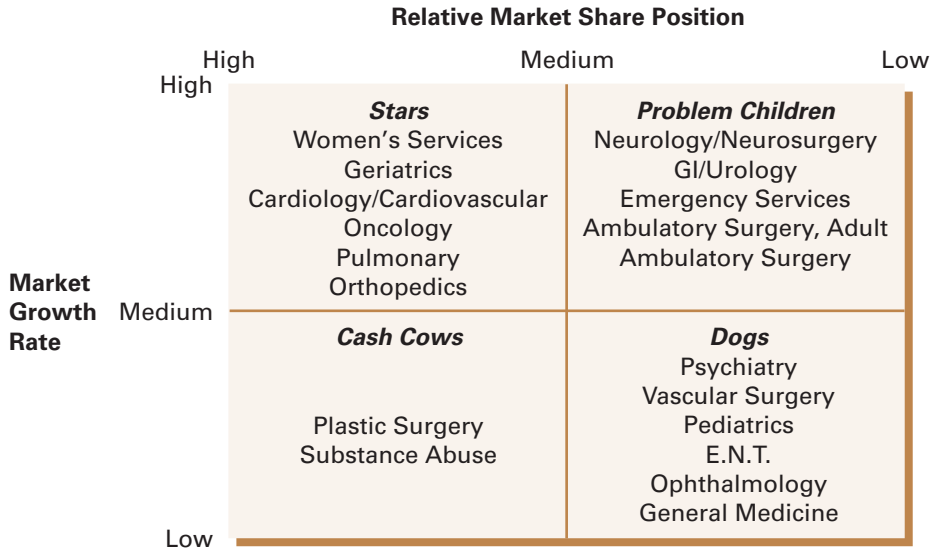
These products and services have a low relative market share position and compete in a slow- or no-growth market. These products and services should consume fewer and fewer of the organization's resources. Because of their weak position, the products or services in this quadrant are often liquidated or divested or the organization engages in dramatic retrenchment.

through comparison with national or regional health care growth figures, return on alternative investments, or the stage in the product life cycle.[6]

The evaluation of products and services in portfolio analysis can be a dynamic process and used for the long-run planning of service and product life cycles. Therefore, portfolio management might be concerned with several time horizons. Horizon one corresponds to managing the current fiscal reporting period, with short-term considerations. Horizon two might be concerned with ramping up the next generation of growth opportunities, and horizon three with incubating new products and services that will sustain the organization far into the future. This time-horizon perspective is especially valuable for leaders trying to ensure that the organization will grow over the long term.[7]

An example of portfolio analysis for one institution is illustrated in Exhibit 7–6. Cash cow services, such as plastic surgery and substance abuse (lower left quadrant), have achieved high market share but the growth rate has slowed. These

EXHIBIT 7–6 BCG Portfolio Analysis for a Health Care Institution



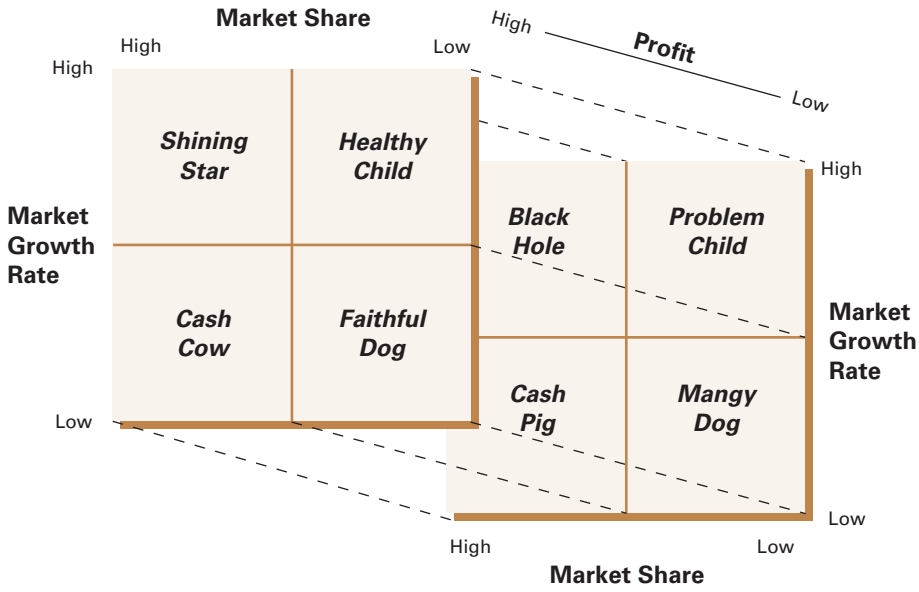
Source: Adapted from Doris C. Van Doren, Jane R. Durney, and Colleen M. Darby, "Key Decisions in Marketing Plan Formulation for Geriatric Services," *Health Care Management Review* 18, no. 3, pp. 7–20. Copyright © 1993, Aspen Publishers, Inc. Adapted by permission.

services should generate excess cash that may be used to develop stars and problem children services. Service lines in the upper left quadrant, such as women's services, geriatrics, cardiology, and so on, have high market growth and a relatively high market share (and most likely high profitability). These services are the most attractive for the institution and should be provided additional resources and encouraged to grow (and become cash cows). Services in the upper right quadrant (neurology/neurosurgery, GI/urology, emergency services, and so on) over time will move into the stars quadrant or the dogs quadrant. It is important to nurture the services that will most likely move to the stars quadrant. Services such as psychiatry, vascular surgery, pediatrics, and so on, have low growth rates as well as a low relative market share (and most likely low profitability) and may be targets for contraction strategies. However, in health care some "dog" quadrant services may be slated for maintenance of scope or even expansion because of community needs.

Extended Portfolio Matrix Analysis

Although the BCG matrix may be used by health care organizations, portfolio analysis must be applied with care. For example, health care organizations typically have interdependent programs, such as orthopedics and pediatrics, that make a strategic service unit (SSU) difficult to define. Additionally, underlying the

EXHIBIT 7–7 Expanded Product Portfolio Matrix



Source: Adapted from Gary McCain, "Black Holes, Cash Pigs, and Other Hospital Portfolio Analysis Problems," *Journal of Health Care Marketing,* 7, no. 2 (June, 1987), p. 58. Reprinted by permission of the publisher, the American Marketing Association.

BCG matrix is an assumption that high market share means high profitability and that profits may be "milked" to benefit other programs with growth potential. In health care organizations, however, it is quite possible to have a high market share and no profit. For example, because of reimbursement restrictions, a high number of Medicaid patients may cause a physician practice to be unprofitable. Similarly, programs such as obstetrics, pediatrics, neonatal intensive care, and psychiatry may have high market share but be unprofitable for a hospital.[8]

The profitability issues suggest that portfolio analysis for health care organizations might better utilize an *extended portfolio matrix analysis* that includes a profitability dimension. The profitability dimension is measured by high or low profitability according to positive or negative cash flow or return on invested capital. The expanded matrix is presented in Exhibit 7–7.

Shining Stars Shining stars have high market growth (typically in the early stages of the PLC), a high market share, and high profitability. This quadrant represents the best situation for a health care organization; however, it is likely that high profitability will attract competitors. Therefore, aggressive enhancement or product development will be required, yet market development may be difficult because of the already high market share. In addition, the organization will want to consider vertical integration and related diversification.

Cash Cows Cash cow products and services have low market growth but a high market share and high profitability. In this situation, the organization

has a dominant position in the market (perhaps 100 percent) and further growth is unlikely. Again, the high profitability may attract competition, and the organization may have to defend its market share. Thus, strategies should be directed toward maintaining market dominance through enhancement. If the PLC is viewed as being long, the organization may want to engage in vertical integration or related diversification.

Healthy Children Healthy children products and services have high market growth, a low market share, and high profitability. This quadrant demonstrates that there are situations in which it is possible to have a low share of the market and be profitable (at least in the short term or through segmentation). This situation is potentially attractive to the organization, which may be able to move the product or service into the shining star and, ultimately, cash cow quadrant. These products and services will require investment to nurture them and gain relative market share. Strategies may include market development, product development, penetration, and vertical integration coupled with strong functional support.

Faithful Dogs In this situation, the products and services have low market growth and a low market share, but have been profitable. For example, many hospital services involve less-dominant units showing slow growth. However, if they are profitable, such units make a positive contribution to the overall health of the hospital and provide a full service line.[9]

For faithful dogs, managers must assess if increased market share will add to profitability. For instance, if profitable segments can be identified, it may be more advantageous to withdraw from broader markets, concentrate on a smaller segment, and maintain profitability. In such situations, a status quo or retrenchment strategy may be appropriate. If profitability is likely to decline over time, a harvesting or divestiture strategy may be employed.

Black Holes Black hole products and services have high growth and a high market share but low profitability. Not all high-growth, high-share programs are profitable in health care. For instance, costly technological equipment may make an organization the sole provider of a service whose high cost cannot be recovered from individual patients. However, such services may contribute to the overall image of the organization and increase the profitability of other services.

Nevertheless, having a high share for a service with low or negative profitability is quite disturbing. There must be a concentrated effort to reduce costs (enhancement strategy) or to add revenue without adding costs to such a program. "When circumstances prevent a service from generating most of its own cash inflow, it becomes a 'black hole' – a collapsed star sucking in light (profit or cash) – rather than shining and generating cash or profits."[10]

If a black hole product or service cannot be made into a shining star, it is likely to become a cash pig. Therefore, enhancement and retrenchment strategies may be most appropriate. In addition, action plan strategies should be employed to reduce costs and increase revenue.

Problem Children Problem children are low-share, high-growth, and low-profitability products and services that present both challenges and problems. Some of the products and services represent future shining stars and cash cows, although others represent future black holes and mangy dogs. Management must decide which products and services to support and which to eliminate. For supported products, market development with strong financial commitment is appropriate. For products that management does not feel can become shining stars, divestiture and liquidation are most appropriate.

Cash Pigs Cash pig products and services have a high or dominant share, are experiencing low growth, and have low profitability. Health care cash pigs are likely to be those well-established SSUs with dominant shares that once were considered to be cash cows. Typically, they have well-entrenched advocates in the organizational hierarchy who support their continuance.[11]

A possible solution to the cash pig problem is to cut costs and raise prices. Therefore, aggressive retrenchment may be required. This strategy may allow the organization to give up the market share to find smaller, more profitable segments and thus create a smaller cash cow.

Mangy Dogs Products and services with low growth, a low share, and poor profit have a debilitating effect on the organization and should be eliminated as soon as possible. In this situation, it appears that other providers are better at serving the market. Probably the best strategy at this point is liquidation, as it will be difficult to find a buyer for products and services in this quadrant.

Strategic Position and Action Evaluation

Strategic position and action evaluation (SPACE), an extension of two-dimensional portfolio analysis (BCG), is used to determine the appropriate strategic profile of the organization. By using SPACE, the manager can incorporate a number of factors into the analysis and examine a particular strategic alternative from several perspectives.[12]

SPACE analysis suggests the appropriateness of strategic alternatives based on factors relating to four dimensions: service category strength, environmental stability, the organization's relative competitive advantage, and the organization's financial strength. The SPACE chart and definitions of the four quadrants are shown in Exhibit 7–8. Listed under each of the four dimensions are factors to which individual numerical values ranging from 0 to 6 can be assigned. The numbers are then added together and divided by the number of factors to yield an average. The averages for environmental stability and competitive advantage each have the number 6 subtracted from them to produce a negative number. The average for each dimension is then plotted on the appropriate axis of the SPACE chart and connected to create a four-sided polygon. Factor scales for each dimension are presented in Exhibit 7–9, which has been filled in for a regional hospital. The resulting shape of the polygon can be used to identify four strategic profiles – aggressive, competitive, conservative, and defensive.

The quadrant with the largest area is the most appropriate general strategic position.

The factor scales shown in Exhibit 7–9 are for a California-based regional hospital system specializing in health services for the elderly and chemically dependent. This hospital system is operating in a fairly turbulent environment with many competitive pressures and many technological changes (environmental stability axis).

EXHIBIT 7–8 Strategic Position and Action Evaluation (SPACE) Matrix

Aggressive Profile

This profile is typical in an attractive service category with little environmental turbulence. The organization enjoys a definite competitive advantage, which it can protect with financial strength. The critical factor is the entry of new competitors. Organizations in this situation should take full advantage of opportunities, look for acquisition candidates in their own or related areas, increase market share, and concentrate resources on products having a definite competitive edge.

Competitive Profile

This profile is typical in an attractive service category. The organization enjoys a competitive advantage in a relatively unstable environment. The critical factor is financial strength. Organizations in this situation should acquire financial resources to increase marketing thrust, add to the sales force, extend or improve the product line, invest in productivity, reduce costs, protect competitive advantage in a declining market, and attempt to merge with a cash-rich organization.

Conservative Profile

This profile is typical in a stable market with low growth. Here, the organization focuses on financial stability. The critical factor is product competitiveness. Organizations in this situation should prune the product line, reduce costs, focus on improving cash flow, protect competitive products, develop new products, and gain entry into more attractive markets.

Defensive Profile

This profile is typical of an unattractive service category in which the organization lacks a competitive product and financial strength. The critical factor is competitiveness. Organizations in this situation should prepare to retreat from the market, discontinue marginally profitable products, aggressively reduce costs, cut capacity, and defer or minimize investments.

Source: Adapted from Alan J. Rowe, Richard O. Mason, Karl E. Dickel, and Neil H. Snyder, *Strategic Management: A Methodological Approach*, 4th edn (Reading, MA: Addison-Wesley Publishing, 1994), pp. 145–150. Reprinted by permission of Pearson Education Inc., Upper Saddle River, NJ.

EXHIBIT 7–9 Strategic Position and Action Evaluation Factors

Factors Determining Environmental Stability

Technological changes	Many	0	(1)	2	3	4	5	6	Few
Rate of inflation	High	0	(1)	2	3	4	5	6	Low
Demand variability	Large	0	1	2	3	(4)	5	6	Small
Price range of competing products/services	Wide	0	(1)	2	3	4	5	6	Narrow
Barriers to entry into market	Few	0	1	2	(3)	4	5	6	Many
Competitive pressure	High	0	1	(2)	3	4	5	6	Low
Price elasticity of demand	Elastic	0	1	2	3	(4)	5	6	Inelastic
Other: _____	_____	0	1	2	3	4	5	6	_____

Average – 6 = –3.7

Critical factors

Fairly turbulent environment; strong competition: many technological changes.

Comments

Necessary to maintain financial stability because of turbulence in the environment; demand in market segments relatively stable; protect market niche against competition.

Factors Determining Service Category Strength

Growth potential	Low	0	1	2	3	(4)	5	6	High
Profit potential	Low	0	1	2	3	4	(5)	6	High
Financial stability	Low	0	1	(2)	3	4	5	6	High
Technological know-how	Simple	0	1	2	3	4	(5)	6	Complex
Resource utilization	Inefficient	0	1	2	3	(4)	5	6	Efficient
Capital intensity	High	0	1	(2)	3	4	5	6	Low
Ease of entry into market	Easy	0	(1)	2	3	4	5	6	Difficult
Productivity, capacity utilization	Low	0	1	2	3	4	(5)	6	High
Other: *Flexibility, adaptability*	Low	0	1	2	3	4	(5)	6	High

Average = 3.7

Critical factors

Good growth and profit potential; strong competition.

Comments

Very attractive service category, but strong competition; degree of capital intensity increasing.

EXHIBIT 7–9 *(Continued)*

Factors Determining Competitive Advantage

Market share	Small	0	1	(2)	3	4	5	6	Large
Product quality	Inferior	0	1	2	3	4	5	(6)	Superior
Product life cycle	Late	0	1	2	(3)	4	5	6	Early
Product replacement cycle	Variable	0	1	2	3	(4)	5	6	Fixed
Customer/patient loyalty	Low	0	1	2	3	(4)	5	6	High
Competition's capacity utilization	Low	0	1	2	3	(4)	5	6	High
Technological know-how	Low	0	1	2	3	(4)	5	6	High
Vertical integration	Low	0	1	(2)	3	4	5	6	High
Other: _____	_____	0	1	2	3	4	5	6	_____

Average – 6 = –2.4

Critical factors

Market share low; product/service quality very good.

Comments

The organization still enjoys slight competitive advantage because of quality and customer loyalty; can be expected to diminish, however, because of improving performance of competitive organizations.

Factors Determining Financial Strength

Return on investment	Low	0	1	2	3	(4)	5	6	High
Leverage	Imbalanced	0	(1)	2	3	4	5	6	Balanced
Liquidity	Imbalanced	(0)	1	2	3	4	5	6	Balanced
Capital required/capital available	High	0	(1)	2	3	4	5	6	Low
Cash flow	Low	0	(1)	2	3	4	5	6	High
Ease of exit from market	Difficult	0	1	2	3	(4)	5	6	Easy
Risk involved in business	Much	0	(1)	2	3	4	5	6	Little
Other: *Inventory turnover*	Slow	0	(1)	2	3	4	5	6	Fast

Average = 1.6

Critical factors

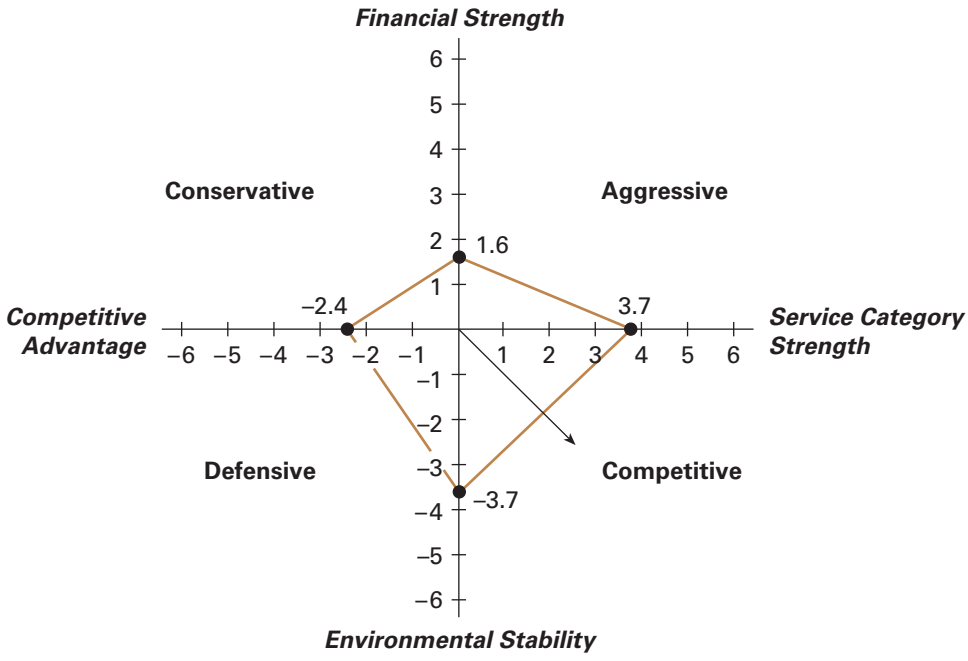
Very little liquidity; too much debt.

Comments

Financial position very weak; cash inflow has to be increased in order to improve liquidity; outside financing difficult because of high leverage.

Source: Adapted from Alan J. Rowe, Richard O. Mason, Karl E. Dickel, and Neil H. Snyder, *Strategic Management: A Methodological Approach*, 4th edn (Reading, MA: Addison-Wesley Publishing, 1994), pp. 148–149. Reprinted by permission of Pearson Education Inc., Upper Saddle River, NJ.

EXHIBIT 7–10 SPACE Profile for a Regional Hospital System



However, the hospital's service category segments show good growth potential that attracts strong competition. Increasing competition requires increased investment in new facilities and technology. The hospital still has a competitive advantage (competitive advantage axis) derived from early entry into the market and it has been able to retain customer loyalty because of high-quality service. However, the hospital's financial position (financial strength axis) is weak because it financed new facilities through a substantial amount of debt. Its liquidity position has eroded and cash flow continues to be a problem.

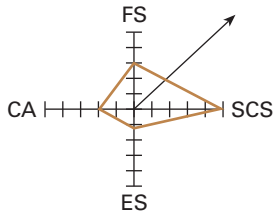
Which of the adaptive strategic alternatives is most appropriate for this regional system? The dimensions for this organization are plotted on the SPACE matrix shown in Exhibit 7–10, demonstrating that the hospital is competing fairly well in an unstable but attractive service category segment. This organization cannot be too aggressive because it has few financial resources and the environment is a bit unstable. Therefore, it should adopt a competitive profile.

It is important to remember that the SPACE chart is a summary display; each factor should be analyzed individually as well. In particular, factors with very high or very low scores should receive special attention.[13] Exhibit 7–11 examines various possible strategic profiles that may be obtained in a SPACE analysis and Exhibit 7–12 shows the adaptive alternatives for each strategic profile.

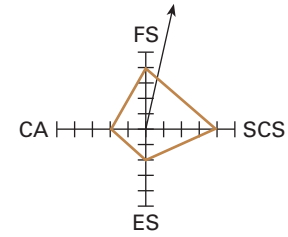
The SPACE plot for the regional hospital system examined previously resulted in a competitive profile. Accordingly, the most appropriate strategic alternatives are penetration, market development, product development, status quo, or enhancement, with the most likely being enhancement. The hospital should continue to differentiate itself but must rectify its financial position because an

EXHIBIT 7–11 Space Strategy Profiles

Aggressive Profiles

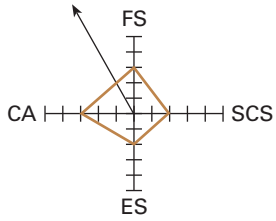


A financially strong organization that has achieved major competitive advantages in a growing and stable service category

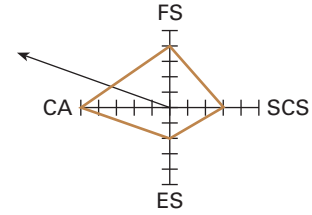


An organization whose financial strength is a dominating factor in the service category

Conservative Profiles

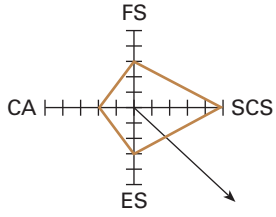


An organization that has achieved financial strength in a stable service category that is not growing; the organization has no major competitive advantages

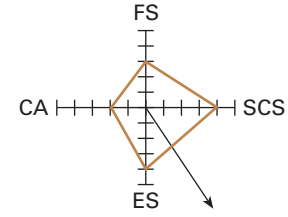


An organization that suffers from major competitive disadvantages in a service category that is technologically stable but declining in revenue

Competitive Profiles

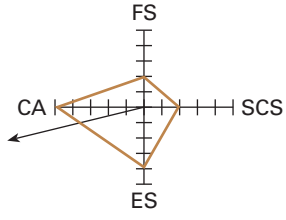


An organization with major competitive advantages but limited financial strength in a high-growth service category

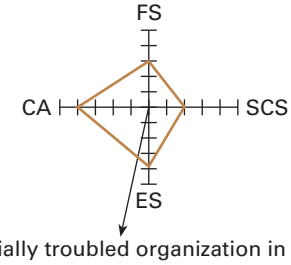


An organization that is competing fairly well in a service category where there is substantial environmental uncertainty

Defensive Profiles



An organization that has a very weak competitive position in a negative-growth, stable but weak service category



A financially troubled organization in a very unstable and weak service category

Source: Adapted from Fred R. David, *Strategic Management*, 2nd edn (Columbus, OH: Merrill Publishing Co., 1989), p. 216.

EXHIBIT 7–12 Strategic Alternatives for SPACE Quadrants

Conservative • Status Quo • Unrelated Diversification • Harvesting	**Aggressive** • Related Diversification • Market Development • Product Development • Vertical Integration
Defensive • Divestiture • Liquidation • Retrenchment	**Competitive** • Penetration • Enhancement • Product Development • Market Development • Status Quo

unstable environment may place unanticipated demands on the organization that will require an additional infusion of capital. In light of its financial problems, the hospital may have to pursue its goals (for example, market development) through a cooperation market entry strategy. A cooperation strategy – joining a network – may be important in an environment where health care systems, continuums, and referral networks are the key to market development and penetration. In the end, the adaptive and market entry strategic decisions are inextricably linked.

Program Evaluation

Program evaluation is especially useful in organizations where market share, service category strength, and competitive advantage are not particularly important or are not relevant. Such organizations are typically not-for-profit, state- or federally-funded institutions such as state and county public health departments, state mental health departments, Medicaid agencies, community health centers, and public community hospitals. Despite the fact that these organizations are public and not-for-profit, they should develop explicit strategies and evaluate the adaptive strategic alternatives open to them. Although the internal/external strategy matrix and a form of portfolio analysis may be used to evaluate public health programs,[14] evaluation methods that consider increasing revenue and market share may be inappropriate or difficult to use. Perspective 7–3 provides an overview of the public health system and its essential services.

Public and not-for-profit institutions typically maintain any number of programs funded through such sources as state appropriations, federal grants, private donations, fee for service, and so on. In a public health department, such programs might include HIV/AIDS education, disease surveillance, disease control, immunizations, food sanitation inspection, on-site sewage inspection, and many more. Usually, these programs have been initiated to fill a health care need within the community that has not been addressed through the private sector. These "health care gaps" have occurred because of federal or state requirements for coordination and control of community health and because of the large number of individuals without adequate health care insurance or means to pay for services.

PERSPECTIVE 7–3

Overview of Public Health in the United States

The work of public health developed over time in response to community need and is carried out at federal, state, and local levels. In 1988, after an intense study of public health in six states, the Institute of Medicine defined the basic functions of public health as assessment, policy development, and assurance. The Centers for Disease Control and Prevention (CDC) proposed organizational practices to implement the three core functions. In spring 1994, a national working group composed of representatives of the Public Health Services Agencies and the major public health organizations developed a consensus list of the "essential services of public health." The new statement on essential services provided a vision for public health in America – "Healthy People in Healthy Communities" – and stated the mission of public health – "Promote physical and mental health and prevent disease, injury, and disability." The statement described what public health seeks to accomplish in providing essential services to the public and how it carries out these basic public responsibilities.

THE ESSENTIAL SERVICES

The fundamental obligation or purpose of public health agencies responsible for population-based health is to:

- prevent epidemics and the spread of disease,
- protect against environmental hazards,
- prevent injuries,
- promote and encourage healthy behaviors and mental health,
- respond to disasters and assist communities in recovery, and
- assure the quality and accessibility of health services.

Part of the function of public health is to assure the availability of quality health services. Both distinct from and encompassing clinical services, public health's role is to ensure the conditions necessary for people to live healthy lives, through community-wide prevention and protection programs.

Public health serves communities (and individuals within them) by providing an array of essential services. Many of these services are invisible to the public. Typically, the public only becomes aware of the need for public health services when a problem develops (for instance, when an epidemic occurs). The practice of public health is articulated through the list of "essential services."

***Assessment services* include:**

- Monitoring health status to identify community health problems.
- Diagnosing and investigating health problems and hazards in the community.
- Researching for new insights and innovative solutions to health problems.

***Policy development services* include:**

- Informing, educating, and empowering people about health issues.
- Mobilizing community partnerships and actions to identify and solve health problems.
- Developing policies and plans that support individual and community health efforts.

***Assurance services* include:**

- Enforcing laws and regulations that protect health and ensure safety.
- Linking people to needed personal health services and ensuring the provision of health care when otherwise unavailable.
- Assuring a competent public and personal health care workforce.
- Evaluating effectiveness, accessibility, and quality of personal and population-based health services.

Source: Ray M. Nicola, MD, MHSA, FACPM, Senior CDC Consultant to the Turning Point National Program Office.

Within the context provided by an understanding of the external environment, internal environment, and directional strategies, these not-for-profit institutions must chart a future through a set of externally and internally funded programs. The set of programs maintained and emphasized by the organization constitutes its adaptive strategy. The degree to which they are changed (expansion of scope, contraction of scope, maintenance of scope) represents a modification of the adaptive strategy. The fundamental question is, "Does our current set of programs effectively and efficiently fulfill the mission and vision for the future?" This question may be addressed through a process of program evaluation. Two program evaluation methods that have been used successfully are needs/capacity assessment and program priority setting.

Needs/Capacity Assessment The set of programs in not-for-profit organizations such as public health departments are determined by (1) community need and (2) the organization's capacity to deliver the program to that community. Of course, some programs may be mandated by law, such as disease control, disease surveillance, and the maintenance of vital records (birth and death records).

However, the assumption is that the legislation is a result of an important need and, typically, the mandate is supported by non-discretionary or categorical funding (funding that may be used for only one purpose). Therefore, in developing a strategy for a public health organization or not-for-profit organization serving the community, a *needs/capacity assessment* must be undertaken – community needs must be assessed *vis-à-vis* the organization's ability (capacity) to address those needs.

Community need is a function of (1) clear community requirements (environmental, sanitation, disease control, and so on) and personal health care (primary care) gaps; (2) the degree to which other institutions (private and public) fill the identified health care gaps; and (3) public/community health objectives. Many not-for-profit institutions enter the health care market to provide services to those who otherwise would be left out of the system. Despite efforts to reform health care, these gaps are likely to remain for some time. Health care gaps are identified through community involvement, political pressure, and community assessments such as those carried out by the Centers for Disease Control and Prevention (CDC). These gaps exist because there are few private or public institutions positioned to fill the need. Where existing institutions are willing and able to fill these gaps, public and not-for-profit organizations should probably resist entering the market. In addition, public and community health objectives must be considered when developing strategy. National, state, and community objectives such as the Healthy People 2020 objectives should be included as part of a community needs assessment.[15]

Organizational capacity is the organization's ability to initiate, maintain, and enhance its set of adaptive strategy programs. Organizational capacity is composed of (1) funding to support programs, (2) other organizational resources and skills, and (3) the program's fit with the mission and vision of the organization. Availability of funding is an important part of organizational capacity. Many programs are supported with categorical funding and accompanying mandates (program requirements dictated by a higher authority, usually federal or state government). Often, however, local funds supplement federal- and state-funded programs. For other programs, only community funding is available. Thus, funding availability is a major consideration in developing strategy for public and not-for-profit organizations. In addition, the organization must have the skills, resources, facilities, management, and so on to initiate and effectively administer the program. Finally, program strategy will be dependent upon the program's fit with the organization's mission and vision for the future. Programs outside the mission and vision will be viewed as luxuries, superfluous, or wasteful.

Exhibit 7–13 presents the adaptive strategic alternatives indicated for public organizations as they assess community needs and the organization's capacity to fill the identified needs. Where the community need is assessed as high (significant health care gaps, few or no other institutions addressing the need, and the program is part of the community's objectives) and the organization's capacity is assessed as high (adequate funding, appropriate skills and resources, and fit with mission/vision), then the organization should adopt one of the expansion of scope adaptive strategies (upper left quadrant). Appropriate strategies might include vertical integration, related diversification, product development, market development, and penetration. When the community need assessment is low

EXHIBIT 7–13 Public Health and Not-for-Profit Adaptive Strategic Decisions

Community Need	Organizational Capacity: *High*	Organizational Capacity: *Low*
High	**Expansion of Scope** • Vertical Integration • Related Diversification • Product Development • Market Development • Penetration	**Maintenance/Contraction of Scope** • Enhancement • Status Quo • Retrenchment • Harvesting
Low	**Contraction/Maintenance of Scope** • Related Diversification • Retrenchment • Harvesting • Status Quo	**Contraction of Scope** • Liquidation • Harvesting • Divestiture • Retrenchment

(no real need, the need has abated, need is now being addressed by another institution, or the need does not fit with community objectives) but organization capacity is high (adequate funding, appropriate skills and resources, and fit with mission/vision), there should be an orderly redistribution of resources, suggesting contraction and maintenance of scope adaptive strategies (lower left quadrant). Contraction of scope strategies should be given priority as the community need diminishes. However, phasing out a program may take some time or, alternatively, the uncertainty concerning the changing community needs may dictate maintenance in the short term. Appropriate adaptive strategies might include related diversification, retrenchment, harvesting, and status quo.

Where community needs have been assessed as low (no real need, the need has abated, need is now being addressed by another institution, or the need does not fit with community objectives) and the organization has few financial or other resources to commit to programs (low organization capacity), one of the contraction of scope adaptive strategies should be adopted (lower right quadrant). These strategies include liquidation, harvesting, divestiture, and retrenchment. When community needs have been assessed as high but organizational capacity is low, maintenance and contraction of scope strategies are appropriate (upper right quadrant). Maintenance of scope strategies should be given priority because of the high community need but, if resources dwindle or funding is reduced, contraction may be required. Appropriate adaptive strategic alternatives include enhancement or status quo (maintenance of scope) and retrenchment or

harvesting (contraction of scope). As resources become available, and organizational capacity increases, programs in this quadrant will move to the upper left quadrant, enabling more aggressive (expansion) strategies to be selected.

Program Priority Setting The second method of developing adaptive strategies for not-for-profit or public programs involves ranking programs and setting priorities. *Program priority setting* is significant because community needs (both the need itself and the severity of the need) are constantly changing and organizational resources, in terms of funding and organization capacity, are almost always limited. Invariably, more programs have a higher community need than resources are available. Therefore, the most important programs (and perhaps those with categorical funding) may be expanded or maintained. The organization must have an understanding of which programs are the most important, which should be provided incremental funding, and which should be the first to be scaled back if funding is reduced or eliminated.

The nature and emphasis on programs is the central part of strategy formulation in many public and not-for-profit organizations. However, a problem in ranking these programs is that typically all of them are viewed as "very important" or "essential." This is particularly true when using Likert or semantic differential scales to evaluate the programs. Therefore, it is necessary to develop evaluation methods that further differentiate the programs. One method that can be used is to list all the programs of the agency or clinic, each on a separate sheet of paper posted in different areas of the room. Use three different colors or types of sticker, one for each of the adaptive strategies – expand the scope, contract the scope, and maintain the scope. Each member of the management team is asked to sort the organization's programs into categories – those that should be expanded, those that should be reduced, or those to remain the same – based on the perceived importance of each to the organization's mission and vision. The group may agree on several programs. Discussions can then be focused on those programs where there is disagreement. After points have been raised and discussed, the programs can be ranked again, hopefully leading to greater consensus from the group.

The Q-sort method provides a more formal method of differentiating the importance of programs and setting priorities. Q-sort is a ranking procedure that forces choices along a continuum in situations where the difference between the choices may be quite small. The *program Q-sort evaluation* is particularly useful when experts may differ on what makes one choice preferable over another. By ranking the choices using a Q-sort procedure, participants see where there is wide consensus (for whatever reasons used by the experts) and have an opportunity to discuss the choices for which there is disagreement (and, hopefully, reach greater consensus).

Q-sort is part of the Q-methodology, a set of philosophical, psychological, statistical, and psychometric ideas oriented to research on the individual. Q-sort evaluation helps overcome the problem of all programs being ranked as very important by forcing a ranking based on some set of assumptions. Fred N. Kerlinger, in *Foundations of Behavioral Research*, characterized Q-sort as "a sophisticated way of rank-ordering objects."[16] Once Q-sort has rank-ordered a series of objects (programs), then numerals may be assigned to subsets of the objects for statistical purposes.

Q-sort focuses particularly on sorting decks of cards (in this case each card representing a program) and the correlations among the responses of different individuals to the Q-sorts. Kerlinger reports good results with as few as 40 items (programs) that have been culled from a larger list. However, greater statistical stability and reliability usually results from at least 60 items, but not more than 100.[17]

For ranking an organization's programs, only the first step in using the Q-methodology is used – Q-sort. In the Q-sort procedure, each member of the management team is asked to sort the organization's programs into categories based on their perceived importance to the organization's mission and vision. To facilitate the task, the programs are printed on small cards that may be arranged (sorted) on a table. To force ranking of programs, managers are asked to arrange the programs in piles from most important to least important. The best approach is that the number of categories be limited to nine and the number of programs to be assigned to each category be determined in such a manner as to ensure a normal distribution.[18] Therefore, if a public health department had 49 separate programs that management wished to rank (culled from a larger list of programs), they may be sorted as shown in Exhibit 7–14. Notice that to create a normal distribution (or quasi-normal), 5 percent of the programs are placed in the first pile or group, 7.5 percent in the second group,

EXHIBIT 7–14 Department of Public Health Q-Sort Results*

				Cancer Prevention 4.88				
			Seafood Sanitation 6.11	Lodging/Jails Inspection 4.88	Microbiology 4.44			
			Infection Control 5.77	Injury Prevention 4.77	Home Health 4.22			
		Immunization 6.99	Health Education 5.66	Disaster Preparedness 4.77	Quality Assurance 4.11	Administrative Support 3.99		
		Tuberculosis Control 6.88	Family Planning 5.66	Public Health Nursing 4.75	Primary-Care Support 4.11	Vector Control 3.99		
	Sewage Regulation 7.22	Licensure and Certification 6.77	Child Health 5.55	Lead Assessment 4.62	School Health Education 4.0	Dental Health 3.87	Medicaid Waiver 3.33	
	STD Control 7.22	Newborn Screening 6.62	Emergency Medicine 5.50	HMO Regulation 4.55	WIC 4.0	Diabetes 3.77	Swimming Pools 3.11	
Food Sanitation 8.0	Milk Sanitation 7.0	Health Statistics 6.44	Radiation Control 5.44	Hypertension 4.55	Vital Records 4.0	Indoor Air Quality 3.66	Adolescent Health 2.66	Hearing Aid Regulation 1.88
Epidemiology 8.0	HIV/AIDS Planning and Control 7.0	Solid Waste 6.33	Maternity 5.22	Myco-bacteriology 4.55	Serology 4.0	Public Health Social Work 3.44	Plumbing Inspection 2.55	Animal Control 1.44
Most Important	***Next Most Important***	***Next Most Important***	***Next Most Important***	***Next Most Important***	***Next Most Important***	***Next Most Important***	***Next Most Important***	***Next Most Important***
5%	7.5%	12.5%	15%	20%	15%	12.5%	7.5%	5%

*Program name and mean score in each box.

12.5 percent in the third, and so on. In this case, there are two programs in the first group, four programs in the second group, six in the third, and so on.

Depending on the group in which it is placed, each program is assigned a score ranging from 1 to 9, where 1 is for the lowest- and 9 is for the highest-ranked programs. The score indicates an individual's perception of that program's importance to the mission and vision of the organization. A program profile is developed by averaging individual members' scores for each program.

Based on the results of the Q-sort, programs may be designated for expansion, contraction, or maintenance of scope. For the public health programs in Exhibit 7–14, food sanitation and epidemiology, sewage planning and operation, sexually transmitted disease (STD) control, and so on, might be earmarked for expansion. Cancer prevention, lodging/jail inspection, injury prevention, and so on might be slated for maintenance of scope, whereas plumbing inspection, hearing aid dealer board regulation, and animal control may be marked for contraction.

The Q-sort procedure works well using several different sets of strategic assumptions or scenarios. For example, the programs may be sorted several times, each based on a different scenario. Then the group can determine which of the scenarios is most likely and make decisions accordingly.

Evaluation of the Market Entry Strategies

Once expansion of scope or maintenance of scope through enhancement adaptive strategies are selected, one or more of the market entry strategies must be used to break into or capture more of the market. All of the expansion adaptive strategies require some activity to reach more consumers with the products and services. Similarly, enhancement strategies indicate that the organization must improve what it is already doing, which requires market entry analysis. Contraction of scope strategies are methods to either rapidly or slowly leave markets and therefore do not require a market entry strategic decision.

The market entry strategies include acquisition, licensing, venture capital investment, merger, alliance, joint venture, internal development, internal venture, and reconfiguring the value chain. Although any one (or several) of these strategies may be used to enter the market, acquisitions, mergers and alliances received most of the media attention over the past decade. Acquisition is the principal purchase strategy and mergers and alliances are the principal cooperation strategies.

The specific market entry strategy considered to be appropriate depends on (1) the external conditions; (2) the pertinent internal strengths and weaknesses based on the organization's resources, competencies, and capabilities; and (3) the goals of the organization. Each of these three areas should be scrupulously evaluated.

External Conditions

The first consideration in the selection of the market entry strategy is the evaluation of the environment. A review of the external environmental issues and supporting documentation (see Chapters 2 and 3) should provide information to determine which of the market entry strategies is most appropriate. Exhibit 7–15 provides a list of representative external conditions appropriate for each of the market entry strategies.

EXHIBIT 7–15 External Conditions Appropriate for Market Entry Strategies

Market Entry Strategy	Appropriate External Conditions
Acquisition	• Growing market. • Early stage of the product life cycle or long maturity stage. • Attractive acquisition candidate. • High-volume economies of scale (horizontal integration). • Distribution economies of scale (vertical integration).
Licensing	• High capital investment to enter market. • High immediate demand for product/service. • Early stages of the product life cycle.
Venture Capital Investment	• Rapidly changing technology. • Product/service in the early development stage.
Merger	• Attractive merger candidate (synergistic effect). • High level of resource required to compete.
Alliance	• Alliance partner has complementary resources, competencies, capabilities. • Alliance partner has similar status. • Market demands complete line of products/services. • Market is weak and continuum of services is desirable. • Mature stage of product life cycle.
Joint Venture	• High capital requirements to obtain necessary skills/expertise. • Long learning curve in obtaining necessary expertise.
Internal Development	• High level of product control (quality) required. • Early stages of the product life cycle.
Internal Venture	• Product/service development stage. • Rapid development/market entry required. • New technical, marketing, production approach required.
Reconfiguring the Value Chain	• Competition dominated by a few traditional providers. • Specialized market niche identified. • New technology, marketing, production approach required.

Resources, Competencies, and Capabilities

As illustrated in Exhibit 7–16, each market entry strategy requires somewhat different resources, competencies, and capabilities. Before selecting the appropriate market entry strategy, a review of the internal competitively relevant strengths and weaknesses should be undertaken (see Chapter 4). A market entry strategy might be selected if the required skills and resources, competencies, and capabilities (competitive advantages) are possessed by the organization. On the other hand, if they are not present, another alternative should be selected or a combination strategy of two or more phases should be adopted. The first phase would be directed at correcting the weakness (competitive disadvantages) prohibiting selection of the desired strategy, and the second phase would be the initiation of the desired market entry strategy. In some cases a total redesign, or *re-engineering*, of a process may be required before a strategy can be implemented. Perspective 7–4 provides some insight into the requirements of re-engineering.

EXHIBIT 7–16 Appropriate Internal Resources, Competencies, and Capabilities for the Market Entry Strategies

Market Entry Strategy	Appropriate Resources, Competencies, and Capabilities (Strengths)
Acquisition	• Financial resources. • Capability to manage new products and markets. • Capability to merge organizational cultures and organizational structures. • Rightsizing capability for combined organization.
Licensing	• Financial resources (licensing fees). • Support organization to carry out license. • Capability to integrate new product/market into present organization.
Venture Capital Investment	• Capital to invest in speculative projects. • Capability to evaluate and select opportunities with a high degree of success.
Merger	• Management willing to relinquish or share control. • Rightsizing capacity. • Complementary service/product line. • Capability to merge organizational cultures and organizational structures.
Alliance	• Lack of competitive skills/facilities/expertise. • Desire to create vertically integrated system. • Need to control patient flow. • Capability to coordinate boards. • Willing to relinquish some control.
Joint Venture	• Lack of a distinctive competency. • Additional resources/capabilities are required. • Not enough time to develop internal resources, competencies, or capabilities. • Venture is far removed from core competency. • Lack required skills and expertise.
Internal Development	• Technical expertise. • Marketing competency. • Operational capacity. • Research and development capability. • Strong functional organization. • Product/service management expertise.
Internal Venture	• Financial resources. • Entrepreneurial organization. • Capability to isolate venture from the rest of the organization. • Technical expertise. • Marketing competency. • Operational capacity.
Reconfiguring the Value Chain	• New technology available. • Entrepreneurial organization. • Capability to rearrange value chain. • Capability to adapt business model.

Organizational Goals

Along with the internal and external factors, organizational goals play an important role in evaluating the appropriate market entry strategies. As shown in Exhibit 7–17, internal development, internal ventures, and reconfiguring the value chain offer the greatest degree of control over the design, production, operations, marketing, and so on of the product or service. On the other hand, licensing, acquisition, mergers, and venture capital investment offer the quickest market entry but control over design, production, marketing, and so on is low in the short term (in the longer term the organization may take complete control). Alliances and joint ventures offer relatively quick entry with some degree of control. The trade-off between speed of entering the market and organizational control over the product or service must be assessed by management in light of organizational goals.

PERSPECTIVE 7–4

Re-engineering – Rethinking Health Care Delivery

Re-engineering has been used as part of strategic planning to help organizations rethink the way processes are managed in organizations. Many health care organizations are using re-engineering to cut across departmental lines to completely redesign a process. Its founders and leading proponents, Michael Hammer and James Champy, define re-engineering as "the fundamental rethinking and radical redesign of process to achieve dramatic improvements in critical, contemporary measures of performance, such as cost, quality, service, and speed." Key words in this definition are *radical* and *process*.

Re-engineering goes beyond quality improvement programs that seek marginal improvements. It asks a team to "start over" and completely and radically redesign a process. It does not mean tinkering with what already exists or making incremental changes that leave basic structures intact. It ignores what is and concentrates on what should be. The clean sheet of paper, the breaking of assumptions, the throw-it-all-out-and-start-again flavor of re-engineering has captured and excited the imagination of managers from all industries. Radical redesign requires creativity and a willingness to try new things, questions the legitimacy of all tasks and procedures, questions all assumptions, breaks all the rules possible, and draws upon customer desires and needs.

A process is a complete end-to-end set of activities that together create value for a customer. Many organizations have become so specialized that few people understand the complete process of creating value for the customer. In the past, organizations have focused on improving the performance of individual tasks in separate functional units rather than on complete processes that typically cut across many functions. Everyone was watching out for task performance, but no one was watching to see whether all the tasks together produced the intended results for the customer. Dramatic improvements can be achieved only by improving the performance of the entire process.

To be successful, management must be willing to destroy old ways of doing things and start

anew. Many changes take place in an organization or unit when re-engineering is initiated:

- Work units change – from functional departments to process teams.
- Jobs change – from simple tasks to multidimensional work.
- People's roles change – from controlled to empowered.
- Job preparation changes – from training to education.
- The focus of performance measures and compensation change – from activity to results.
- Advancement criteria change – from performance to ability.
- Attitudes change – from protective to productive.
- Managers change – from supervisors to coaches.
- Organizational structure changes – from hierarchical to flat.
- Executives change – from scorekeepers to leaders.

Michael Hammer identified seven principles for organizational re-engineering:

1. Organize around outcomes, not tasks. By focusing on the desired outcome, people consider new ways to accomplish the work.
2. People who use the output should perform the process.
3. Include information processing in the "real" work that produces the information.
4. Treat geographically dispersed resources as if they were centralized.
5. Link parallel activities rather than integrate them. By coordinating similar kinds of work while it is in process rather than after completion, better cooperation can be fostered and the process accelerated.
6. Let "doers" be self-managing. By putting decisions where the work is performed and building in controls, organizations can eliminate layers of managers.
7. Capture information once and at its source.

Sources: Michael Hammer and James Champy, *Reengineering the Corporation: A Manifesto for Business Revolution* (New York: HarperBusiness, 1994); Michael Hammer, *Beyond Reengineering: How the Process-Centered Organization Is Changing Our Work and Lives* (New York: HarperBusiness, 1996); Michael Hammer, "Reengineering Work: Don't Automate, Obliterate," *Harvard Business Review* 68, no. 4 (July–August, 1990), pp. 104–112.

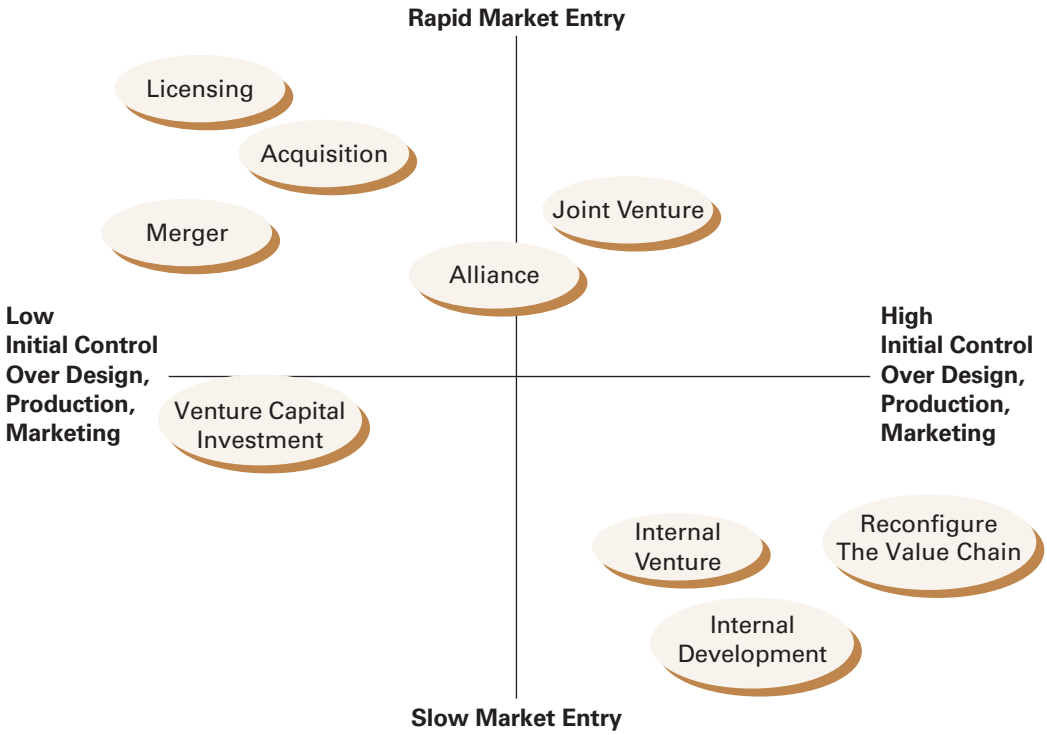
Evaluation of the Competitive Strategies

After the market entry strategies have been selected, the strategic posture must be specified and the products/services positioned within the market using the generic strategies of cost leadership, differentiation, or focus. All the adaptive strategies (expansion, contraction, and maintenance of scope) require explicit strategic posture and positioning strategies.

Strategic Posture

Strategic posture concerns the relationship between the organization and the market and describes the pattern of strategic behavior. Appropriate strategic postures include defender, prospector, and analyzer. Any of these may be appropriate, subject to: the external environment; the changing nature of the market; competition;

EXHIBIT 7–17 Market Entry Strategies and Organizational Goals



the resources, competencies, and capabilities (competitive advantages) of the organization; and its vision and values. It is important to make sure the strategic posture is linked to and fits the adaptive and market entry strategies.

External Conditions External conditions are very important in the selection of strategic posture. Defender strategies tend to be successful when the external environment is relatively stable (change is slow and reasonably predictable). In such environments competitive rivalry is low and the barriers to entering the market are high. Indeed, the cost-efficiency strategy of the defender tends to push entry barriers even higher. Because defender organizations focus on a narrow product line, the strategy works best when relatively long product life cycles are expected. In addition, long product life cycles allow the organization to commit to vertical integration, develop cost efficiency, and create routine processes. Defender strategies are most effective in the mature stage of the product life cycle. The risks associated with the defender posture are that the product life cycle will be dramatically shortened by external change (new technology, for instance) or that a competitor can somehow unexpectedly take away market share.

Prospectors operate well in rapidly changing, turbulent environments. In these environments change is coming so rapidly that there are few rewards for efficiency. Rather, the ability to incorporate the latest technology, feature, or design will reap the greatest rewards. In addition, prospectors are successful by utilizing a technology across several markets (prospecting in new high-growth markets).

Products are usually in the introductory and early growth stages of the PLC and the cycle tends to be relatively short. As a result, entry barriers may be low and the intensity of rivalry typically is low (there is room for everybody). As products or services mature, prospector organizations move on to new products and services, typically in introductory stages of the PLC. Prospectors divest their maturing products and services to successful defender organizations that are consolidating.

Analyzers operate well in environments where there is moderate change with some product categories that are quite stable and some that are changing. Competitive rivalry tends to be relatively high and these organizations cannot afford to ignore new product developments, markets, or product categories. PLCs for their stable products are moderately long but there are periodic innovations and disruptions. Therefore, these organizations must enter new markets and new product areas. Analyzers typically do not enter the market in the introductory stage of the PLC. Instead, they carefully watch product and market developments (the prospectors) and enter the most promising ones in the early growth stage of the product life cycle (using one of the market entry strategies). Analyzers attempt to maintain balance with both mature- and growth-stage products or services and markets.

The external conditions appropriate for each of the strategic postures are summarized in Exhibit 7–18.

EXHIBIT 7–18 External Conditions Appropriate for Strategic Postures

Posture Strategy	Appropriate External Conditions
Defender	• Stable external environment. • Predictable political/regulatory change. • Slow technological and competitive change. • Products or services in mature stage of PLC. • Relatively long PLCs. • High barriers to entry.
Prospector	• Turbulent environment. • Rapid technological, political/regulatory, economic change. • Introduction and early growth stages of PLC. • Technology may be employed across markets. • Low intensity of competitive rivalry. • Numerous market and product opportunities. • Fairly low barriers to market entry.
Analyzer	• Moderately changing environment. • Technological, regulatory, economic, social, and competitive change open new opportunities. • Some competitive rivalry in old and new markets. • Some stable products and markets. • Some new market and product opportunities. • Growth and mature stage of PLC for existing products. • Growth stage of PLC for new products.

Internal Resources, Competencies, Capabilities As shown in Exhibit 7–19, there are certain strengths associated with each of the strategic postures. For the defender posture the organization must be able to develop a core technology and be very cost efficient. Defender organizations try to drive costs down through vertical integration, specialization of labor, a well-defined organization structure, centralized control and standardization, and cost reduction while maintaining quality. Prospectors, on the other hand, are continuously moving in and out of products and markets looking for high growth. Therefore, they need organization structures, systems, and procedures that are flexible. Prospectors rely on decentralized control. These types of organizations do not concentrate on developing efficiency but, rather, focus on the development and early adoption of new products and services. Analyzers attempt to balance defender strategies in stable markets with some prospecting in selected developing markets. Managing these organizations is often difficult because they must mix high levels of standardization and routinization with flexibility and adaptability.

EXHIBIT 7–19 **Appropriate Internal Resources, Competencies, and Capabilities for Strategic Postures**

Posture Strategy	Appropriate Resources, Competencies, and Capabilities (Strengths)
Defender	• Capability to develop a single core technology. • Capability to be very cost efficient. • Capability to protect market from competitors. • Capacity to engage in vertical integration strategy. • Management emphasis on centralized control/stability. • Structure characterized by division of labor. • Well-defined hierarchical communications channels. • Cost control expertise. • Well-defined procedures and methods. • High degree of formalization, centralization.
Prospector	• Capability to adjust organization to a variety of external forces. • Technological and administrative flexibility. • Capability and competency to develop and use new technologies. • Capability to deploy and coordinate resources among numerous decentralized units. • Decentralized planning and control. • Flexible structure. • Marketing plus research and development expertise. • Low degree of formalization (few well-defined procedures and methods).
Analyzer	• Capability to mix high levels of standardization and routinization of core products/markets with flexibility and adaptation for new products/markets. • Structure accommodates both stable and dynamic areas of operation. • Effective lateral and vertical communication channels. • Many different management skills required. • Effective strategy and planning team.

Positioning Strategies

As discussed in Chapter 6, products/services may be positioned marketwide or for a particular market segment. Cost leadership and differentiation are used as marketwide strategies or they are used to focus on a specific segment of the market.

Presence in a market requires that the products and services be positioned *vis-à-vis* competing products and services. Similar to the other strategy types, positioning depends upon the strengths and weaknesses (competitive advantages and disadvantages) of the organization and the issues in the external environment. In other words, how a product or service is positioned depends on the organization's competitive situation. Therefore, the positioning strategies must be selected on the basis of resources, competencies, and capabilities (competitive relevant strengths), as well as environmental risks. For example, it would be difficult for an urban public community hospital dependent on limited county funding to be positioned as the high-technology hospital in the region (differentiation strategy). Conversely, a well-funded hospital using the latest technology is unlikely to be positioned as the cost leader.

External Conditions Each of the generic positioning strategies has its own external risks that must be evaluated by the organization (see Exhibit 7–20). Perhaps the biggest risk for cost leadership is technological change. Technological change in processes may allow competitors to achieve cost advantages. Technological change in products/services may result in differentiation, making the cost leader's product less desirable.

The most significant risks for the organization that chooses a differentiation strategy are that emphasis on differentiation pushes costs too high for the market or that the market fails to see, understand, or appreciate the differentiation. In addition, there are risks for the organization adopting a focus strategy. Often, the focusing organization is dependent on a small segment that may diminish in size, or purchasers may turn to the broader market for products or services. Movement toward marketwide products and services will occur if the differences in cost or differentiation become blurred.

Internal Resources, Competencies, and Capabilities Exhibit 7–21 presents the appropriate internal strengths for each of the positioning strategies. For an organization to use a cost leadership strategy, it must have or develop the ability to achieve a real cost advantage (not price) through state-of-the-art equipment and facilities and low-cost operations. This competitive advantage must be maintained through tight controls and emphasis on economies of scale.

Differentiation requires the ability to distinguish the product or service from other competitors. Typically, this requires technical expertise, strong marketing, a high level of skill, and an emphasis on product development. A focus strategy is directed toward a particular segment of the market; however, either cost leadership or differentiation may be used. Therefore, the appropriate competencies are the same for either market segment or marketwide strategies. It is important that organizations adopting a focus strategy closely monitor their market so that specialized needs may be fully addressed and changes in the segment carefully

EXHIBIT 7–20 External Risks Associated with Positioning Strategies

Generic Strategy	External Risks
Cost Leadership	• Technological change that nullifies past investments or learning. • Low-cost learning by industry newcomers or followers, through imitation or through their ability to invest in state-of-the-art facilities. • Inability to see required product or marketing change because of the attention placed on cost. • Inflation in costs that narrow the organization's ability to maintain sufficient price differential to offset competitors' brand images or other approaches to differentiation.
Differentiation	• The cost differential between low-cost competitors and the differentiated firm is too great for differentiation to hold brand loyalty; buyers therefore sacrifice some of the features, services, or image possessed by the differentiated organization for large cost savings. • Buyers' need for the differentiating factor diminishes, which can occur as buyers become more sophisticated. • Imitation narrows perceived differentiation, a common occurrence as the industry matures.
Focus	• Cost differential between broad-range competitors and the focused organization widens to eliminate the cost advantages of serving a narrow target or to offset the differentiation achieved by focus. • Differences in desired products or services between the strategic target and the market as a whole narrows. • Competitors find submarkets within the strategic target and outfocus the focuser. • Focuser grows the market to a sufficient size that it becomes attractive to competitors that previously ignored it.

Source: Adapted from Michael E. Porter, *Competitive Strategy: Techniques for Analyzing Industries and Competitors* (1980), pp. 40–41. Copyright © 1980, 1998 by the Free Press. All rights reserved. Adapted by permission of Simon & Schuster Adult Publishing Group.

tracked. Otherwise, changes in the market may negate the differentiation or cost leadership. Often *benchmarking* (see Perspective 7–5) can be used to assess current internal strengths for successfully implementing strategies.

Fit with Situational Analysis and Strategy Mapping

After all the strategy formulation decisions have been made, they should be evaluated in combination to ensure that they are logical and fit together. As suggested at the beginning of Chapter 6 and illustrated in Exhibit 6–1, the strategies selected must address an external issue, draw on an internal and competitively relevant strength or fix a competitively relevant weakness, maintain the organizational mission, move the organization toward the vision, and make progress toward achieving one or more of the organization's goals. Each strategy should be checked to determine if it meets these criteria.

EXHIBIT 7–21 **Appropriate Internal Resources, Competencies, and Capabilities for the Positioning Strategies**

Generic Strategy	Resources and Competencies	Organizational Capabilities
Cost leadership	• Sustained capital investment and access to capital. • Process engineering skills. • Intense supervision of labor. • Products and services that are simple to produce in volume. • Low-cost delivery system.	• Tight cost control. • Frequent, detailed control reports. • Structured organization and responsibilities. • Incentives based on meeting strict quantitative targets.
Differentiation	• Strong marketing abilities. • Product/service engineering. • Creative flair. • Capability and competency in basic research. • Reputation for quality or technological leadership. • Long tradition in the industry or unique combination of skills. • Strong cooperation from channels.	• Strong coordination among functions in R&D, product/service development, and marketing. • Subjective measurement and incentives instead of quantitative measures. • Amenities to attract highly skilled labor, scientists, or creative people.
Focus	• Combination of the preceding competencies and resources directed at a particular strategic target.	• Combination of the preceding organizational requirements directed at a particular strategic target.

Source: Michael E. Porter, *Competitive Strategy: Techniques for Analyzing Industries and Competitors* (1980), pp. 40–41.

PERSPECTIVE 7–5

Benchmarking: A Valuable Tool for Health Care Managers

Benchmarking is a management process of comparing one organization with a set of its peers. Benchmarking is generally considered to be part of an organization's "learning" or continuous improvement efforts. In a sense, benchmarking is similar to "taking a picture" of one's organization and comparing it with pictures of other organizations. Some organizations simply identify a peer organization and try to emulate it. However, a better approach is to view benchmarking as an ongoing, long-lived process for senior management that is designed to gather and disseminate both process and performance information throughout an organization.

The benchmarking process begins with the identification of a set of peers. The peers should be organizations that are similar, but not necessarily identical, to the organization and should operate on a scale that will not distort the understandings. The peers should not be direct competitors because of the collaborative nature of the process that will ensue. For example, a large health care system might use a telecommunications company as a benchmarking peer

or a multifacility nursing home might seek a hotel chain.

Senior management of the peer organizations should be contacted to initiate a dialog. The initiator of the benchmarking process is seeking a group of senior managers with whom every intimate detail concerning the strategies of the organizations may be shared. In other words, the initiator should describe the desire to share strategies, financial data, personnel data, and so on, as though the benchmarking participants were part of the senior management team of each organization. The number of participants in a benchmarking group probably should be limited to seven or fewer to allow all participants equal opportunities to participate and gain from the experience.

Once a set of willing participants has been recruited, an initial meeting should be scheduled for the purpose of establishing protocol – a set of ground rules for the operation of the benchmarking group. Although there is no well-established standard for such a protocol, it should focus on creating an atmosphere in which full disclosure and frank discussion is facilitated. The meeting can be held at the location of one of the participants or it can be at a neutral site. Ground rules should deal with frequency of meetings, confidentiality, format of the meetings, processes for establishing the agenda for subsequent meetings, and the process of choosing the locations for meetings.

It may be useful to hire a professional facilitator for the first meeting and to determine whether such a person would be helpful in further meetings of the group. Each participant should leave the first meeting with the agenda for the second meeting and a set of work assignments to be completed by the next meeting. Work assignments might include detailed descriptions of the handling of customer complaints, how supplies are inventoried, and how customer billing is processed, or other activities identified as worthy of discussion by the group. At each meeting, detailed minutes (perhaps a transcript) of the meeting should be taken, produced, and distributed to the participants in a timely manner. The purpose of the minutes is to formalize the process and to minimize misunderstandings that may arise from failed memories.

The formal agenda for subsequent meetings should include reports from each of the participants. The frequency of meetings should be such that they impact the practices and procedures of the participants. For the most positive impact, meetings should occur at least on a quarterly basis.

The benchmarking process is not completed when the meetings end. The lessons learned and the insight gained must be shared with subordinates. Participants in the benchmarking process should schedule regular meetings with subordinates for dissemination of information. In other words, the lessons should be shared widely within the organization to gain the greatest impact.

Source: Andrew C. Rucks, PhD, School of Public Health, University of Alabama at Birmingham.

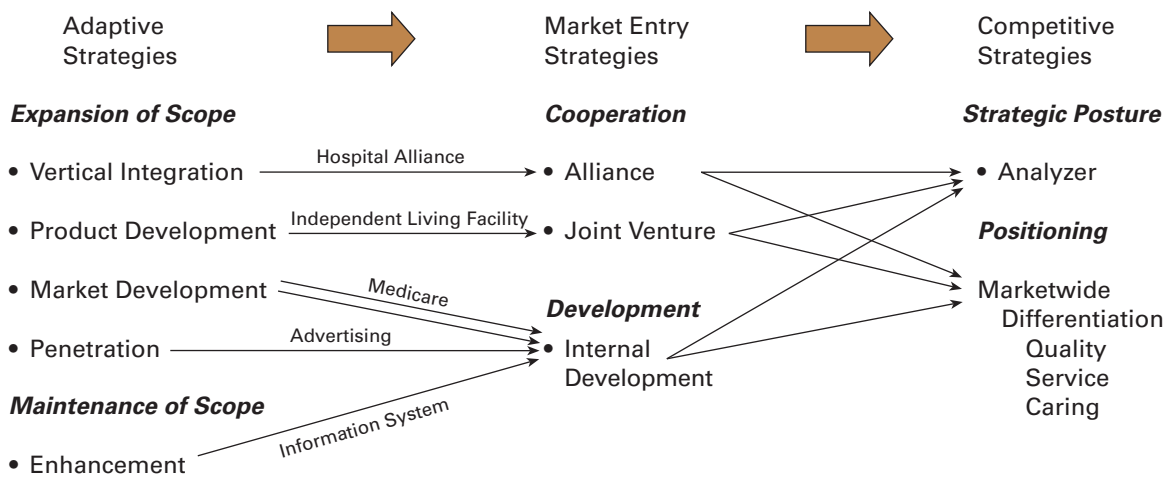
The strategies of the organization should be mapped and evaluated. Each strategy ends–means chain should be clearly shown. The interdependence of strategies requires managers to evaluate them in concert for consistency and compatibility. Evaluating all the strategic decisions together provides the "big picture" of where the organization is going and helps to determine if the vision is really being achieved. In the process of evaluating the strategic map, adjustments may be made and the strategies (each ends and means) reconsidered. For example, a vertical integration adaptive strategy and a prospector strategic

posture may not work together well. Similarly, a product development or diversification adaptive strategy through an internal development market entry strategy may be inconsistent with an analyzer strategic posture. In addition, the map provides useful shorthand for communicating and discussing the strategy of the organization.

Strategic Map: An Example

A strategic map for a long-term care organization is shown in Exhibit 7–22. This long-term care organization has been a free-standing, independent institution for some time. However, because of the growth of integrated health systems in the area, the organization's leadership has decided that it needs to be part of a system to provide a steady referral base. Therefore, vertical integration as an adaptive strategy was selected. To accomplish the vertical integration strategy, management decided to develop an alliance with a nearby local hospital. The strategic posture is one of aggressively defending the organization's traditional market (private pay and insurance), but management is willing to enter new products and markets if the viability seems reasonable (analyzer). In addition, management has selected market development directed toward entering into the Medicare segment of the market and has decided that the organization has the internal resources to accomplish Medicare certification. Furthermore, product development has been selected and management is planning to add an independent living facility on the organization's campus to complement the current assisted living and nursing facilities. The product development strategy will be accomplished through a joint venture with a regional hotel chain. The organization's leadership believes the market and product development strategies are consistent with their analyzer strategic posture. The organization plans on developing an extensive advertising campaign (penetration strategy) aimed at communicating its highly effective differentiation strategy based on quality, high level of service, and caring. The organization has committed to install a

EXHIBIT 7–22 Map of Selected Strategies for Long-Term Care Organization



sophisticated information system including bedside terminals to further differentiate itself from its competition.

Such a strategy map provides a broad overview of the organization's direction and a basis for the development of effective implementation strategies to carry out the organization's overall strategy. These maps need not be complicated. Indeed, at this level, simple is better. In stable markets, strategic managers can rely on complicated strategies built on detailed predictions of the future; however, in complicated, fast-moving markets where significant growth can occur, unpredictability reigns. When "business" becomes complicated, strategy should be simple.[19]

Managing Strategic Momentum – Adaptive, Market Entry, and Competitive Strategies

Managing strategic momentum at this level is not a matter of keeping the organization on track: rather, it entails deciding if a completely new track or approach is warranted. Managers must decide if conditions require a change in the organization's fundamental strategies. Lorange, Morton, and Ghoshal have called this decision "managing the strategic leap." They suggest:

> Here the challenge is to reset the trajectory of the strategy as well as to decide on the relative levels of thrust and momentum for the new strategic direction. The critical underlying assumptions that underpin the strategy are no longer viable, and the rules that govern the strategy must be redefined. This situation involves a mental leap to define the new rules and to cope with any emerging new environmental factors. Such a recalibrating of strategy requires a personal liberation from traditional thinking, an ability to change one's mindset and confront the challenge of creating advantage out of discontinuity. The question now is how to achieve a quantum leap in one's strategy to capitalize on emerging environmental turbulence. One must proceed by redefining the rules rather than by clinging to the unrealistic hope that the old rules are still valid.[20]

Changes in one organization's adaptive strategy create significant changes for other organizations, especially those in the same strategic group. Such dramatic change is relatively rare in stable environments but somewhat more frequent in dynamic environments. Signals that the basic strategy for the organization needs to be changed must be carefully monitored because the change will have serious long-term consequences. The questions presented in Exhibit 7–23 are helpful in surfacing such signals, and they provide a starting point for discussion of the appropriateness of the organization's adaptive strategy. The assumption underlying Exhibit 7–23 is that the mission, vision, values, and goals are still appropriate but that the organization's adaptive strategy should be questioned.

Changes in market entry strategies represent a "new way of doing business" for an organization. For example, developing alliances as a means of accomplishing

EXHIBIT 7–23 Managing Strategic Momentum – Adaptive Strategies

1. Are all the important assumptions on which the strategy is based realistic (external environment, competitive environment, internal environment)?
2. Has the strategy been tested with appropriate strategic thinking tools?
3. Have the major stakeholders, inside and outside the organization, that will be most influential in ensuring the success of the strategy been identified and evaluated?
4. If the adaptive strategy is to fill a currently unfilled niche in the market, has the organization investigated whether the niche will remain open long enough to return the capital investment?
5. Has the adaptive strategy been tested with appropriate analysis, such as return on investment and the organization's ability and willingness to bear the risks?
6. Is the payback period acceptable in light of potential environmental change?
7. Does the strategy take the organization too far from its current products and markets?
8. Is the adaptive strategy appropriate for the organization's present and prospective position in the market?

EXHIBIT 7–24 Managing Strategic Momentum – Market Entry Strategies

1. Is the market entry strategy the most appropriate way to achieve the mission, vision, and goals of the organization?
2. Is the market entry strategy consonant with the values of the organization?
3. Is the market entry strategy the best way to accomplish the adaptive strategy?
4. Is the market entry strategy compatible with the adaptive strategy?
5. Does management understand the unique requirements of the market entry strategy (purchase, cooperation, development)?
6. Does management understand the important market forces?
7. Have adequate financial resources been allocated to enter the market?
8. Does the selection of the market entry strategy affect the ability of the organization to effectively position its products/services in the market?
9. Is the market entry strategy compatible with the competitive strategies?
10. Does the market entry strategy place unusual strains on any of the functional areas?
11. Have new stakeholder relationships developed as a result of the market entry strategy (customers, vendors, channel institutions, and so on)?
12. Has the relationship between the desire and need for rapid market entry been properly analyzed?
13. Has the relationship between the desire and need for control over the products and services been achieved?
14. Have the trade-offs between costs and control been properly analyzed?

market development is quite different from an internal development strategy and changes the whole orientation of the organization. Evaluation of the effectiveness of the market entry strategies provides insight into how well the adaptive strategies are being carried out in the marketplace (see Exhibit 7–24). Similarly, a change

in an organization's strategic posture or positioning represents a revolutionary change. For example, moving from a differentiation strategy to cost leadership initiates substantial change throughout the organization. The adaptive strategies and market entry strategies may be appropriate, but if the product or service does not have the appropriate strategic posture or is not positioned effectively, the organization may not achieve its goals (see Exhibit 7–25).

EXHIBIT 7–25 Managing Strategic Momentum – Competitive Strategies

Strategic Posture

1. Is the strategic posture sustainable?
2. Have there been external developments (technological, social, regulatory, economic, or competitive) that have shortened product life cycles of important services?
3. Are there new market opportunities that suggest the organization should move more toward a prospector posture? Analyzer strategy? Defender strategy?
4. Has the organization developed the right mix of centralization and decentralization of decision making for the selected strategic posture?
5. Is the level of standardization and administrative flexibility appropriate for the strategic posture?
6. Is the level and type of communication appropriate for the strategic posture?
7. Is the strategic posture appropriate given the barriers to market entry?
8. Has the level of vertical integration been appropriate for the strategic posture?
9. Has the organization been caught by surprise too often?
10. Are the overall strategy, strategic posture, and value-adding strategies compatible?
11. Does the organization need to evolve its strategic posture?

Positioning

1. Is the product or service positioning believable to the customer?
2. Can the organization use one of the other generic positioning strategies?
3. Is the positioning strategy appropriate considering the external opportunities and threats?
4. Will competitors allow the selected positioning?
5. Is the positioning strategy best suited to capitalize on the organization's strengths and minimize its weaknesses?
6. Is the positioning of the organization's products and services unique in the marketplace?
7. Is the positioning strategy defensible against new players trying to position themselves in a similar fashion?
8. Is the positioning strategy compatible with the market entry strategy?
9. Does the positioning strategy provide the appropriate image for the organization?
10. Is the positioning strategy sustainable?
11. Is the appropriate distribution channel being used?
12. Is the current promotional strategy appropriate?
13. Is the pricing strategy appropriate?

Lessons for Health Care Managers

Several strategic alternatives are available to health care organizations. To initiate strategic thinking and planning, it is important that the organization has a process in place for understanding the internal and external environments and methods for evaluating strategic alternatives. There are several methods for deciding which of the adaptive strategic alternatives is most appropriate for an organization, including the external/internal strategy matrix, product life cycle (PLC) analysis, portfolio analyses (BCG and extended), strategic position and action evaluation (SPACE) analysis, and program evaluation. Using these methods, managers can classify internal and external factors to gain perspective on which adaptive strategic alternative or combination of alternatives is most appropriate.

Once the most appropriate adaptive strategy (or combination of adaptive strategies) has been determined, a market entry strategy must be selected. Expansion and maintenance of scope strategies are initiated through one or more of the market entry strategies. Entry strategies include acquisition, licensing, venture capital investment, merger, alliance, joint venture, internal development, internal venture, and reconfiguration of the value chain. The organization's internal resources, competencies, and capabilities (competitively relevant strengths), the external conditions, and the organization's objectives will determine which of these strategies is most appropriate.

After the market entry strategy has been selected, competitive strategies, which include strategic posture and positioning strategies, should be evaluated and selected. Strategic postures include defender, prospector, and analyzer strategies. Positioning strategies include marketwide or focus strategies of cost leadership or differentiation. The external conditions and internal resources, capabilities, and competencies influence strategic posture and positioning strategies. Therefore, the most appropriate strategic posture and positioning strategy may be selected through an evaluation of the internal skills and resources of the organization and the external conditions.

Chapters 8 through 10 discuss implementation strategies. Chapter 8 will address strategy implementation through value-adding service delivery strategies.

Health Care Manager's Bookshelf

Michael A. Mische, *Strategic Renewal: Becoming a High-Performance Organization* (Upper Saddle River, NJ: Prentice-Hall, 2001)

Strategic choice is an important assumption of strategic management. The idea of strategic choice is that, although the environment is highly influential on decision makers, it is not deterministic. That is, strategic leaders make the choices to grow or contract, to remain in or gravitate to another environment, how to design their organizational system to pursue the strategy, and so on.[1] Often the decisions

of leaders reveal similar responses to similar environments and sometimes they differ significantly. Therefore, the choices require evaluation and analysis.

As discussed in *Strategic Renewal: Becoming a High-Performance Organization*, high-performing organizations, regardless of the industry, share five *strategic pillars*. These are information technology, innovation, leadership, knowledge, operational excellence, and agility.[2] In order to be successful, strategic leaders need to understand and anticipate what things are changing in the environment, how they are changing, how fast they are changing, the extent (depth and breadth) of the changes, and why things are changing (p. 3). Not all organizations are good at "reading the environment" and understanding the changes, taking place around them. When they fail to anticipate and understand the changes they suffer severe consequences. To illustrate, based on market capitalization, in 1972 IBM was the largest company in the world. In 2000 it ranked number 10. Kodak was number 3 in 1972 and 206 in 2000. General Motors was number 4 in 1972 and number 80 in 2000. Microsoft was not in existence in 1972 but was number 1 in 2000 (p. 4). Great organizations are ones that "dictate the terms for others by constantly introducing new factors into the marketspace [which either exist in multiple domains or are waiting to be created] which others must react and adjust to" (p. 21).

In formulating a strategy for change and achieving a competitive advantage, organizations have six strategic choices. Organizations may choose to:

1. Innovate and reinvent. This is the most demanding because it requires an entrepreneurial culture.
2. Withhold from competing. This is sometimes called the turtle strategy. This strategy is chosen when, among other things, the organization is abandoning the market, is unsure of itself, does not have the leadership or resources to compete, and so on.
3. Substitute themselves for the competitors. This choice is direct and confrontational. The goal is to go head-to-head with rivals, occupy their market space, and eliminate them from the market.
4. Imitate competitors. The organization that chooses to imitate does not aspire to occupy the market space of competitors but rather to obtain a share of it by copying the leaders. As followers, the best they can hope for is parity.
5. Complement competitors. This is sometimes referred to as peaceful coexistence. The organization does not directly challenge competitors and this choice requires that the organization follow the actions of the market leaders.
6. Collaborate with competitors. Organizations come together to pursue a mutually attractive project requiring trust and coordination (pp. 31–37).

Successful organizations employ any one or a combination of these strategies [choices], although priority is usually given to one or more of the choices. The actual choices are influenced by a number of factors such as industry dynamics, age of the organization, and so on.

The strategic choices that organizations make are ultimately determined by their knowledge. The president of Johnson & Johnson stated that "we are not in the product business. We are in the knowledge business" (p. 163). This is an important recognition since the author argues that "knowledge is

the only truly unique asset that any organization has" (p. 163). Virtually everything else it has can be replicated by competitors. Knowledge, therefore, is unique and can be strategic.

High performance requires constant renewal and regeneration. Successfully competing in today's health care market(s) is not just about competing better. It "is about competing to be the best and, most importantly, competing differently" (p. 2).

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KEY TERMS AND CONCEPTS IN STRATEGIC MANAGEMENT

BCG Portfolio Analysis
Benchmarking
Community Need
Extended Portfolio Matrix Analysis
External/Internal Strategy Matrix
Needs/Capacity Assessment
Organizational Capacity
Product Life Cycle (PLC) Analysis
Program Evaluation
Program Priority Setting
Program Q-Sort Evaluation
Re-engineering
SPACE Analysis

Questions for Class Discussion

1. Explain the rationale underlying the external/internal strategy matrix.
2. Describe the product life cycle. How is it useful for thinking about the adaptive strategy of a health care organization?
3. Why is the length of the product life cycle important for strategy formulation?
4. What adaptive strategic alternatives are indicated for each stage of the product life cycle?
5. Is BCG portfolio analysis useful for developing adaptive strategic alternatives for health care organizations?
6. Explain the rationale for expanding the traditional BCG portfolio matrix.
7. Identify appropriate adaptive strategic alternatives for each quadrant in the expanded portfolio matrix.

8. Explain the strategic position and action evaluation (SPACE) matrix. How may adaptive strategic alternatives be developed using SPACE?
9. Why should program evaluation be used for public health and not-for-profit institutions in the development of adaptive strategies?
10. What are the critical factors for determining the importance of programs within a not-for-profit organization?
11. Why should public health and not-for-profit organizations set priorities for programs?
12. Describe program Q-sort. Why would an organization use program Q-sort?
13. How are market entry strategies evaluated? What role do speed of market entry and control over the product or service play in the market entry decision?
14. How are the strategic postures and the product life cycle related?
15. How may the positioning strategic alternatives be evaluated?
16. Do health care organizations change directional and adaptive strategies often?
17. How can "doing the strategy" (managing the strategic momentum) provide information about changing the strategy?
18. As managers learn by doing, what strategies are most likely to change: adaptive, market entry, or competitive?

Notes

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8 Value-Adding Service Delivery Strategies

"Strategy is like trying to ride a bicycle while you're inventing it."

—IGOR ANSOFF

Introductory Incident

Using Dashboards to Improve Service

Dashboards in health care have been described as "a wave everybody is jumping on." Dashboards aggregate information from a variety of sources to provide a tool to detect performance trends and solve small problems before they become big problems.

The Hartford Hospital uses a dashboard developed by CarePx. Information from the hospital's electronic medical record and its financial system are combined and used as a management tool. Executives use the dashboard to track data in three key areas. These are:

- Patient data including length of stay and percentage of early morning discharges.

- Bed availability including the types of beds open and the percentage of beds not available for patients, which includes those being cleaned and those in a room occupied by a patient in isolation.
- Readmission rate for patients brought back to the hospital in less than 30 days from discharge.

These data are then broken down by individual groups of physicians quarterly to show the group's length of stay and readmission rates. The goal is to take the high-performing groups, see what is working for them, and model their behavior to others. Nursing managers receive the same information so they can see how each unit is performing relative to the others.

Health First, a four-hospital system in Rockledge, Florida uses a dashboard from McKesson to aggregate data from the clinical, financial, and administrative systems. The dashboard has aided in monitoring registration activities and upfront collections from patients for copays and deductibles. One routine task is a registration audit which monitors the performance of 100 staff handling patient registration. One of the primary goals of the audit is to encourage collecting as much as possible before the service is actually rendered. This is no easy task, since most patients prefer to be billed for what they owe. Delaying collection, unfortunately, increases the likelihood that the bill will end up in bad debts. The system is working well. From 2009 to 2010, Health First increased its point-of-service collections by 22 percent or about $1.1 million.

One of the major challenges of monitoring the revenue cycle in health care is the number of payers. Legacy Health, a five-hospital system in Portland, Oregon works with more than 600 payers. Legacy uses a dashboard, developed by Huron Consulting, to help track the primary payers and show the cash flow for 24 key payers including Medicare, Medicaid, and larger commercial contracts. One time the dashboard revealed a drop in payments from a Blues plan. The issue was raised in a meeting with the payer. It was noted that the reason for the delay involved staffing issues. A similar problem with Medicaid was caused by a system conversion. In each case the dashboard was instrumental in resolving the issues. Legacy was able to present the payers with objective data to illustrate the problems and secure faster resolutions.

A dashboard used at Concord (New Hampshire) Hospital has been effective in speeding up the resolution of claim denials. The dashboard aggregates the claims status from 14 payers that constitute the majority of Concord's claims. Since implementation of the dashboard, Concord has significantly decreased its billing write-offs that originated with missing or inaccurate information.

In Arlington, Texas, Northstar Anesthesia contracts with 42 hospitals in six states. Northstar uses a dashboard to monitor the productivity and quality performance of the 460 physicians and nurses it dispatches for assignments. Excel Eye Center in Provo, Utah uses a dashboard that displays data on the total number of claims submitted, rejections, claims pending, and claims paid. Since switching to the dashboard, Excel Eye Center has reduced its average days in accounts receivable from 45 to 29. Other health care organizations, such as the Seattle Children's Hospital, have successfully used the dashboard as a tool to improve productivity and performance.

Source: Gary Baldwin, "Dashboards in Action," *Health Data Management* 19, no. 10 (2011), pp. 34–38.

Learning Objectives

After completing the chapter you will be able to:

1. Understand the decision logic for developing implementation strategies.
2. Understand that the service delivery portion of the value chain is key in the implementation of strategy.
3. Link the results of internal analysis and the development of service delivery implementation strategies.
4. Understand how the pre-service, point-of-service, and after-service strategies of an organization are the means to achieve directional, adaptive, market entry, and competitive strategies.
5. Understand that competitive advantage may be created inside the organization through implementation of the service delivery strategies.
6. Understand that through service delivery strategies the organization itself is changed, strengthening competitive advantages and improving competitive disadvantages.
7. Create service delivery strategies that carry out the directional, adaptive, market entry, and competitive strategies.

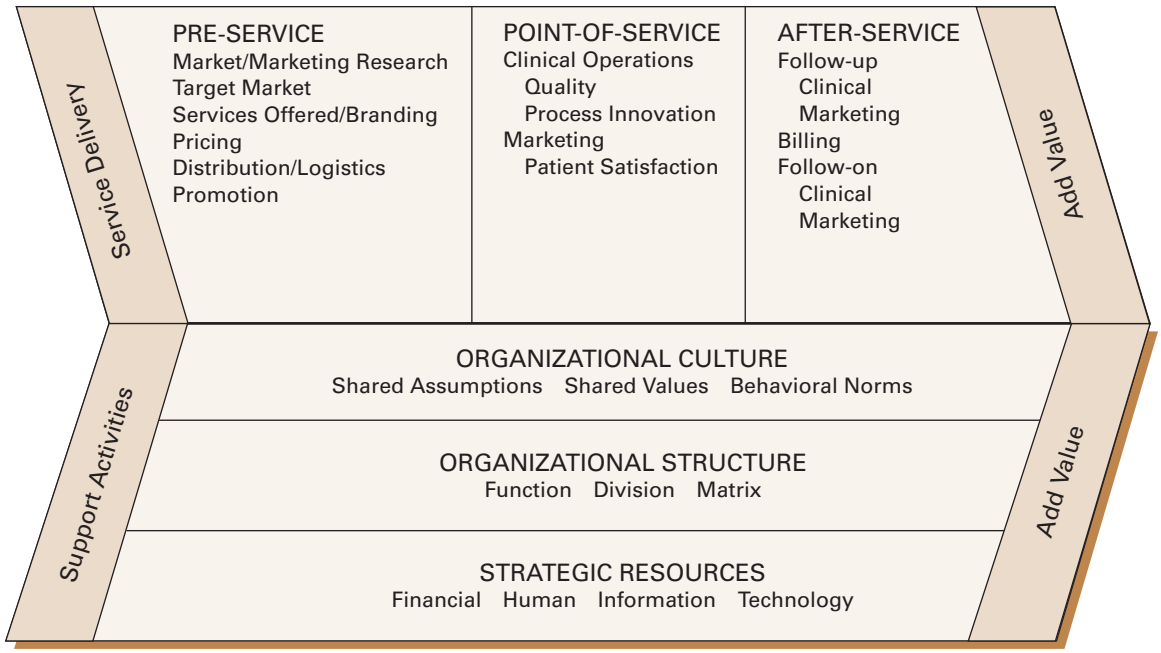
Implementation Strategies

Once the directional, adaptive, market entry, and competitive strategies have been planned, planning for implementation strategies commences. Further strategic thinking is required to determine how to achieve the decisions previously made in strategy formulation. A leader can announce a strategy but that strategy will only be realized if it is in line with the pattern of resource allocation decisions made at every level of the organization.[1] As introduced in Chapter 1 (refer to Exhibit 1–1), the implementation strategies include two different sets of value-adding strategies – value-adding service delivery strategies and value-adding support strategies. In addition, planning strategy implementation includes the setting of organizational unit objectives, development of plans, and agreement on budgets that in concert, translate the organization's overall strategy into specific action plans.

Strategies Based on the Value Chain

Chapter 4 presented strategic thinking maps for evaluating the strengths and weaknesses of the organization. This approach focused on evaluating those components of the organization that create value and, ultimately, competitive advantage – the value chain (see Exhibit 8–1). Recall that the upper portion of the value chain focuses explicitly on the primary activities of the organization – the

EXHIBIT 8–1 The Value Chain



Source: Adapted from Michael E. Porter, *Competitive Advantage: Creating and Sustaining Superior Performance* (New York: Free Press, 1985), p. 37.

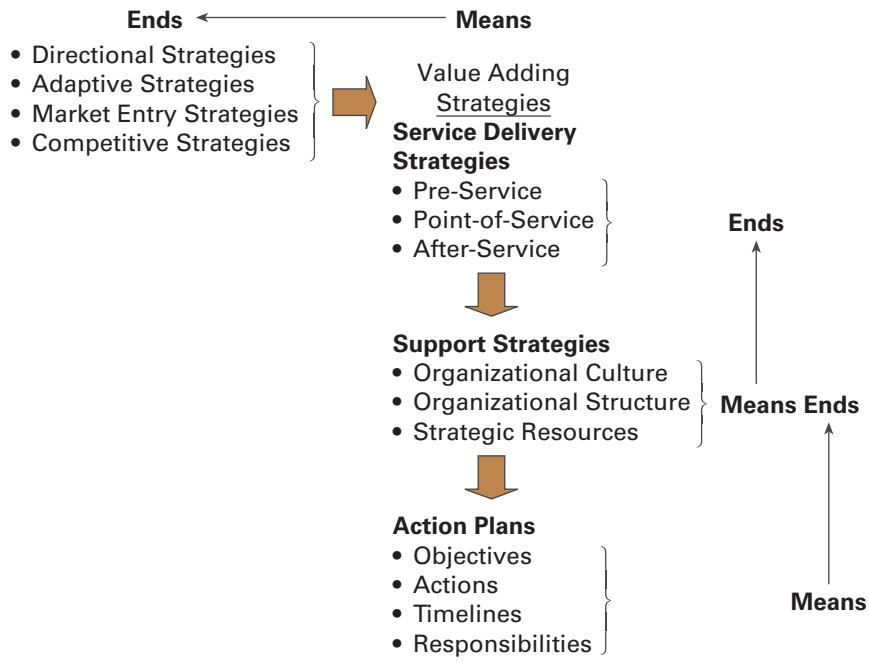
delivery of services. The lower portion of the value chain contains the value-adding support activities that include the organization's culture, structure, and strategic resources. The components depicted in the value chain are the principal means of creating value for the organization and developing competitive advantages.[2] These activities are major elements of strategy implementation and are shaped by strategic thinking and strategic planning.

Remember that service delivery strategies and support strategies are not separate but, rather, interact and complement each other. The organization's culture, structure, and strategic resources are in reality an inherent part of the pre-service, point-of-service, and after-service activities. Thus, a change in the culture of the organization – human competencies – is reflected in service delivery. Further, an enhanced information system – a resource – can benefit all aspects of service delivery as well as other strategic resources.

Planning Logic for Implementation Strategies

As with strategy formulation, there is a planning logic for developing implementation strategies, as illustrated in Exhibit 8–2. The value-adding strategies (service delivery and support) must be developed first, followed by unit action plans. The value-adding strategies are planned first because they are the broadest of the implementation strategies, establishing the processes and context for accomplishing the mission and achieving the vision and goals.

EXHIBIT 8–2 Planning Logic for the Value-Adding Strategies



The value-adding service delivery strategies specify the pre-service activities, point-of-service configurations and processes, and after-service activities required by the strategies developed during strategy formulation. These strategies must be coordinated and consistent. The value-adding support strategies create and shape the working environment and behavioral norms, reporting relationships and structure, as well as information flows, financial needs, and human resource requirements for carrying out the selected strategies. Organizations that do not have the appropriate culture, structure, or strategic resources cannot implement effective plans. Finally, for the organizational units, specific objectives may be developed, activities necessary to accomplish the objectives established, and financial resources committed to the activities. The culture, structure, and strategic resources must be shaped and provided direction by strategic managers developing the overall strategic plans of the organization.

As with the strategy formulation phase, implementation strategies form an ends–means relationship. The value-adding strategies must accomplish the directional, adaptive, market entry, and competitive strategies and the action plans must accomplish the value-adding strategies. The action plans link the individual organizational units to the overall strategy. Units are typically functional, such as operations (e.g., surgical units, Alzheimer's units, well-baby care), marketing, finance, human resources, and so on. Operations and marketing are the primary work of the organization – the value-adding service delivery activities – because providing a product/service and delivering it to customers are the central activities of organizations. The major emphasis of human resources, finance, facilities management, and information systems typically will be directed toward

achieving the support strategies. These functions support the accomplishment of the primary work of the organization.

Developing Value-Adding Strategies

Each area of the value chain was evaluated during internal analysis as part of situational analysis (Chapter 4) and the conclusions used as inputs to strategy formulation. Each of the strategic decisions (directional, adaptive, market entry, and competitive) made to this point moves the organization closer to accomplishing its mission and vision and at the same time makes special demands on the organization that require explicit action. The requirements of directional, adaptive, market entry, and competitive strategies have been discussed in Chapters 5 through 7. Based on the results of the comparison of the current situation and what strategic managers want the organization to be, value chain components may need to be maintained or changed to carry out the strategy.

The logic of developing specific strategies for each component of the value chain is illustrated in the strategic thinking map in Exhibit 8–3. The resulting decision matrix is shown in Exhibit 8–4. As suggested by the decision matrix, for each component of the value chain, a strategic decision must be made (maintain or change) and general direction provided to the organizational units as to how that decision is to be accomplished. Later, more specific organizational unit strategies (action plans) that carry out the value-adding strategies will be developed.

Implementation of a strategy is often the most difficult part of strategic management. New strategies may call for changes in service delivery, marketing, organizational structure, or strategic resources. Such changes typically require new systems and new ways of doing things. Therefore, successful change in the value-adding strategies requires leaders to establish a sense of urgency for change and to clearly articulate the connections between the new ways of doing things and success of the selected strategies.[3] However, as pointed out

EXHIBIT 8–3 The Process of Developing Value-Adding Strategies

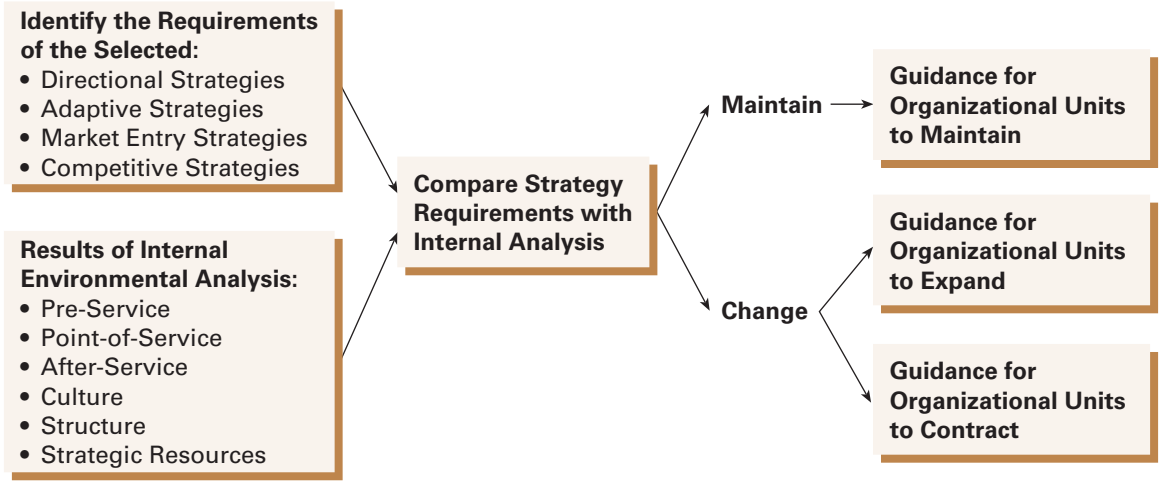


EXHIBIT 8–4 Strategic Thinking Map for Developing Value-Adding Strategies

Value-Adding Service Delivery Strategies	Results of Internal Analysis	Requirements of Selected Strategies	Comparison of Strategy Requirements and Internal Analysis	Maintain or Change
Pre-service				
Market/marketing research				
Target market				
Branding				
Pricing				
Distribution/logistics				
Promotion				
Point-of-service				
Clinical operations				
Marketing				
After-service				
Follow-up activities				
Billing				
Follow-on activities				
Value-adding support strategies				

in Perspective 8–1, there still may be some resistance to change. This chapter discusses the organizational requirements for the value-adding service delivery strategies. Value-adding support strategies will be discussed in Chapter 9 and the translation of the value-adding strategies into specific organizational objectives, action plans, and budgets will be discussed in Chapter 10.

PERSPECTIVE 8–1

Stages of Resistance to Change

Often people do not like change and their first reaction may be to resist any changes management may wish to make. When instituting changes in an organization, whether it is initiating the strategic planning process, changing the strategy, or attempting to change the culture, managers find people in various stages of resistance. It is often necessary to "pull" people through these stages if the change is to be successful.

STAGE ONE: RESISTANCE

Often the first reaction to something new is to resist the change. Because organizations have frequent changes and in many instances management has tried several techniques before, employees may see a new program or management effort as another fad that will soon go away (as have the others). Therefore they openly resist (or even sabotage) the proposed change. Managers often hear such comments as

"Here we go again, new manager, new program, new technique" or "This will never work" and "We tried this ten years ago."

STAGE TWO: PASSIVENESS

In stage two, employees are not resistant; they simply do not want to get involved. These people do not like change and believe that if they "bury their heads in the sand" (go about their usual work), the change will just go away. In many cases these people do not understand the vision for the future, or they have never been told about it or how they fit into it. In this stage, managers often hear such comments as "This is just a job" or "I put in my eight hours" or "I'll be here when they're gone."

STAGE THREE: CONVINCE ME

Some people in organizations are ready to change and will work hard if they believe it will really improve the organization; however, they have been "let down" by the organization before. Perhaps programs were started or promises were made but management neither completed the programs nor fulfilled the promises. These people will give it their best if management can show them that the result will be worth their effort. In this stage, managers often hear such comments as "Show me that we can improve the way we work and I'll be your biggest supporter" or "Give me some indication that this can be an interesting and challenging place to work, and I'll give it a shot."

STAGE FOUR: HOPE

Many people, especially when they start their careers, want to be a part of something important – to make a difference. They have hope that they can make the organization better and be a part of something significant. These people are usually willing to try anything and want to be a part of meaningful change. However, the managers should follow through because if previously proposed changes have not occurred, these people will be difficult to convince the next time management wants to change something. In this stage, managers often hear such comments as "I don't know if we can succeed but look at the possibilities if we do" or "Wouldn't it be great if we actually pulled it off?"

STAGE FIVE: INVOLVEMENT

In this stage, people typically understand that the organization must change and continually renew itself if it is to succeed. They are willing to get involved and be a part of any change that will keep the organization viable. They understand that some new things do not work very well and therefore other change agents must be tried. In this stage, managers often hear such comments as "I don't know if this will work, but we have to try something" or "The world is changing and we have to change with it."

STAGE SIX: ADVOCACY

People in this stage believe not only that change is vital in a changing world but that this program can really make an important difference. They are ready for a long-term commitment to the program or process and will lead and be responsible for its implementation and progress. These people will convince others to be a part of the change and will keep the process on track. In this stage, managers often hear such comments as "This is our chance for real long-term success" or "I'm a believer; this can work if we stay committed over the long term."

Value-Adding Service Delivery Strategies

The *value-adding service delivery strategies* include pre-service, point-of-service, and after-service strategies. Value-adding service activities are critical to the success of the organization because they are the principal methods for creating value. Therefore, explicit strategies must be developed for each. The components must be coordinated and work in concert. It is the role of strategic managers responsible for developing and managing the strategic plan to ensure the compatibility of pre-service, point-of-service, and after-service strategies.

Pre-Service Activities

Pre-service entails the planning and activities that enable the organization to determine its customers and the services that will be offered to them as they enter the system. Marketing is central in developing pre-service strategies. Pre-service marketing entails market and marketing research that enables the organization to determine the appropriate customer (target market), design services that will satisfy that customer, identify the service through branding, price the service at a level that is acceptable to the customer while allowing the organization to survive, and offer the service where the customer wants it or is able to obtain it.

Market and Marketing Research

Market research is any data gathering about the market itself – potential customers, their wants, needs, and habits in terms of health care, and the services an organization could provide that would satisfy those wants and needs. Market research aids in identifying the target market but must be done in conjunction with identifying the services the organization will deliver.[4] For example, a group of physicians in a medical clinic has internal resources, competencies, and capabilities to provide care. If all the physicians are board certified in plastic surgery, the group could decide to provide comprehensive care including reconstructive and cosmetic surgery, or the physicians could decide to focus only on cosmetic surgery "to the stars" with extreme confidentiality in a remote but very comfortable location. The target market has to want or need the services and the organization must have the resources, competencies, and capabilities to provide the services.[5]

Beyond information concerning potential customers, marketing research provides information concerning desired attributes of the product or service, appropriate price, the most convenient place to obtain the product or service, and type of promotional activity to best inform potential customers (the four Ps of marketing: product, price, place, and promotion). Therefore, once the internal assessment has highlighted the organization's competitive relevant strengths and weaknesses, the external analysis has identified the issues in the marketplace, and the organization has identified the strategies it wants to pursue, pre-service strategies attempt to identify the specific target market and define the services to be offered.[6]

Identifying the Health Care Customer – Target Market

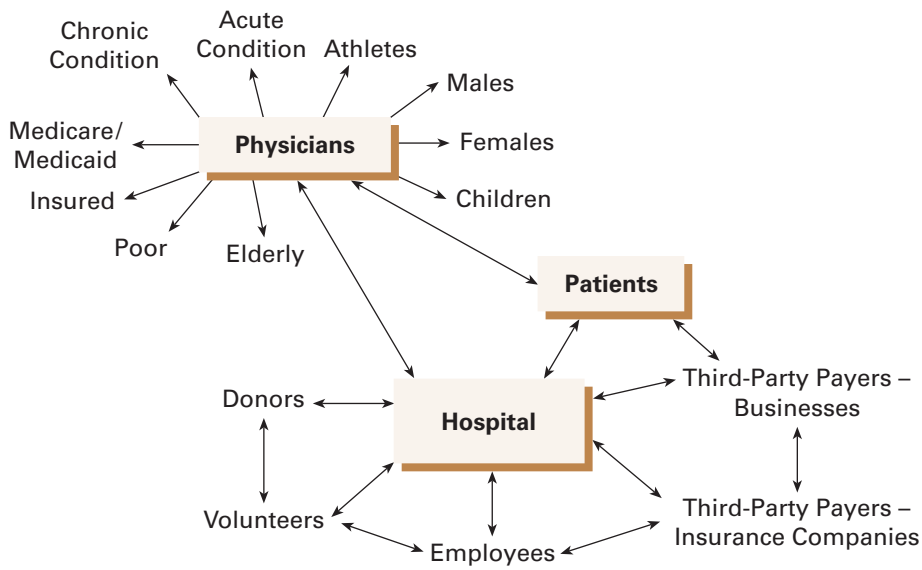
One of the difficulties with health care marketing is that there are many, very diverse customers to satisfy – physicians, health care consumers (patients) and their friends and families, other health care organizations, third-party payers, and so on. In addition, there are multiple services categories – long-term care, emergency medicine, oncology, dermatology, and so on – that determine who the customer will be.[7] Furthermore, within these specializations are customers with varying needs, wants, and desires.

Segmentation is the process of identifying recognizable groups that make up the market and then selecting a group as the *target market*. Several groups may be targeted, but each one requires different marketing activities to achieve customer satisfaction. Exhibit 8–5 illustrates the many customers for a hospital and the segments a physician (one of the hospital's customers) may consider. The process of segmentation for a general medical practice service category would be more challenging than for an oncology (cancer) practice, which is more specialized. However, many segments can be identified among cancer patients – those with leukemia, skin cancer, lung cancer, and so on. Specialization of the hospital, nursing home, or physician's practice would be a first step in the segmentation process, but other demographic, psychographic, geographic, and benefits factors must be considered as well.

Physicians, Patients, and Third-Party Payers as Customers

Physicians are a major target for marketing efforts because they recommend other health care providers for their patients. Estimates are that physicians control 80 percent of health care costs, as they prescribe pharmaceuticals and medical equipment, and determine hospitalization, diagnostic, and surgical procedures. Physicians are an important customer base for hospitals because almost

EXHIBIT 8–5 Determining the Health Care Customer



all patients are admitted by physicians who have staff privileges at the hospital. If physicians choose not to admit patients to a given hospital, the hospital will have no patients.

The patients themselves are customers. However, the buyer–seller relationship of traditional exchange processes has to be modified in much of health care because the patient has a professional dependency on the doctor. Most people have no knowledge of medical terminology, or the complexity of medical diagnosis or care, and cannot accurately evaluate the medical care provided.

At one time, patients would never have questioned their doctor's choice of a hospital. Today, a patient whose physician does not have privileges at the hospital of the patient's choice may change physicians. In a national study by Professional Research Consultants and American Hospital Publishing, Inc., more than 42 percent of the participants said they would change physicians to be admitted to the hospital they preferred.[8] When considering maternity care, 58 percent of pregnant women select a hospital before choosing a physician.[9]

Third-party payers (insurance companies and employers) are also customers. These companies must be satisfied that the health care provider is efficiently treating patients or they will use their substantial financial influence to dictate that patients go elsewhere. Considerable insight concerning third-party payers can be gained through quality monitoring organizations.

The National Committee for Quality Assurance (NCQA) is an independent, not-for-profit organization started by a number of large employers in 1991 with a mission to "improve health care quality everywhere." NCQA uses three different methods to assess quality: (1) voluntary accreditation (currently about 50 percent of HMOs are accredited); (2) Healthplan and Employer Data and Information Set (HEDIS), a tool used to measure performance in key areas such as immunizations and mammograms; and (3) a comprehensive member satisfaction survey. NCQA maintains an up-to-date website available to consumers and employers to determine whether they want to use a specific plan. Because of NCQA's success in the private sector it has expanded to the public sector as well – Medicaid HEDIS is being used in various states.[10] The rate of change in health care is rapid and, therefore, health care employees must stand ready to adopt new ways of doing things even if they feel threatened by the change. Often changing conditions and ways of doing things require that value and quality have to be viewed in entirely new ways.[11]

To Brand or Not to Brand Services

A brand represents three things: what an organization offers to the market, what an organization does, and what an organization is.[12] All three are critically important for health care organizations because the brand is intangible – it is simply a set of promises. It implies trust, consistency, and a defined set of expectations. The strongest brands have a unique position in the mind of the buyers and can usually be articulated. Mayo Clinic and Johns Hopkins are examples of brands that have value for customers. Every person who has contact with a patient at these clinics represents that brand as illustrated in Perspective 8–2. If housekeeping is poorly performed, it hurts the brand; if admitting is poorly done, it hurts the brand; if clinical care is done less well than customers expect,

it hurts the brand. Thus, it is critical that every member of the organization realizes that the brand is owned and should be managed by every employee. Another way to define brand is that it is every touch point the organization has with its ultimate customer.[13]

To develop a good branding strategy, answers to three questions have to be understood:

1. How do consumers choose one brand over another?
2. How does your brand stack up against competition?
3. What possibilities exist for potential brand growth and expansion?

A brand is everything a service organization stands for but it does not have any merit if customers do not value it. Customers evaluate every service experience by dividing quality by price to arrive at a sense of value. It may not be a perfect method, or very accurate, but it is real as far as that consumer is concerned. For services the brand is more important than for tangible products, especially because if performance falls short, the service brand's image and positioning deteriorate rapidly.[14]

PERSPECTIVE 8–2

Branding Begins at Home

How patients perceive a medical practice, hospital, or long-term care facility involves focus, hard work, and lots of employee support. Brand identity can be of considerable value to a health care organization. For example, the Millward Brown consulting company stated that Apple, Inc. has the world's most valuable brand. It estimated that the Apple brand was worth more than $153 million. Many would argue that building a brand for a company with a product is less complex than building a brand identity for a service such as health care. Arguably the greatest impact in any service organization, particularly health care organizations, comes through interactions that patients and their families have with the staff.

Building a successful brand involves more than a logo, website, or printed materials. One branding consultant states that "For a brand to endure it must be easily understood, internalized, and acted on by employees at all levels. Words must be matched with deeds. Employees at all levels must walk the walk."

In health care organizations it is important to assist the staff to understand what the brand represents in concrete terms. If the medical practice says that extraordinary care is its key brand attribute, what does that mean in terms of day-to-day behavior? Employees have a critical brand – ambassador role as they interact with people who come to the health care organization. The chair of the Public Relations Society of America defines a brand ambassador as "employees or customers who advocate for the company and its products or services."

The Chairman and CEO of Private Health Management, a network of physician-led medical doctors, points out five areas where primary care practices can positively or negatively affect

the brand perception of their practices. These are:

1. Create a culture of service. Help callers avoid voice mail by providing real people when a patient calls.
2. Check in on sick patients. It is important for doctors to stay updated on a patient's progress.
3. Provide more information on specialists to whom you refer patients. Preparing an information sheet on the specialists with biographical information, picture, and a map to their office can greatly reduce the anxiety patients often feel when referred to another doctor.
4. If you haven't already done so, convert to an electronic medical record. This greatly streamlines the experience of the patient.
5. Consider evolving the practice to become a patient-centered medical home. It is valuable to be the medical practice people seek to coordinate all their medical care.

Once the brand identity has been established, the leader must ensure that every employee who interacts with patients reinforces the brand image. Even employee appearance can influence the brand image. One brand consultant jokingly asked, "Would you go to a dentist if the receptionist had two front teeth missing?"

Training and education are important in ensuring employees effectively serve as brand ambassadors. Employees must be provided with the tools they need. Now is a particularly good time for health care organizations to explore and strengthen their brand images. Thinking about the desired brand image and how it can be supported by employees is an essential consideration for every medical practice.

Source: Lin Grensing-Pophal, "Practice Branding Starts from Inside," *Medical Economics* 88, no. 14 (2011), pp. 36–38.

Much branding activity in health care has centered on promoting and creating identities for health care systems. However, customers are not interested in abstract systems, but rather the physician and nurses who care for them in a hospital that they have been aware of and perhaps preferred for decades. Although preference for a new brand can be built over time, in most cases it is less expensive and more effective to leverage and extend the existing brand name. HCA – HCA Holdings, Inc. – has used this strategy effectively.

Pre-Service Pricing Decisions

Pricing health care is extremely difficult because it is a service that consumers would rather not have to purchase. Consumer perceptions of "high price equals high quality and low price means low quality" and "you get what you pay for" operate in health care, yet most consumers do not have the ability to judge quality. In addition, consumers rarely know upfront pricing and payments must be met regardless of outcomes making price and quality comparisons difficult. Further, in many instances third-party payers separate consumers from the actual costs of care. Finally, health care providers have a great deal of difficulty determining their costs and then deciding on a price. Competitive negotiations with third-party payers looking for lower prices have led some health care providers to prices that are too low, thereby threatening the provider's long-term viability.

Government reductions for Medicare and Medicaid patients have resulted in reimbursements that are frequently below the cost of providing care. Thus, some providers have opted not to serve Medicare or Medicaid patients.

In health care, low-price strategies must be selected carefully because few people want to think that they are receiving "cheap" (poor-quality) care. Although cost leadership strategies are generally associated with having low costs that can be translated into low prices, a high-price strategy can effectively position an organization as a high-quality health care provider; however, the consumer must perceive that the benefits (esthetically pleasing surroundings, attentive care, latest technology, and so on) are worth the high price.

Based on the services offered, the ability of the consumer to pay, and the cost to deliver the service, the health care organization determines a price. No magic formulas exist to determine prices and some government mandates about serving every patient that shows up at the emergency room door regardless of the ability to pay, for example, make pricing an even more challenging task.

Pre-Service Distribution/Logistics

The location of the health care provider will impact the number of people who seek its services. A location that is attractive because of its proximity to patients' homes and work is a valuable asset, especially if other health care providers cannot duplicate the location. Because people do not want to travel great distances for most health care, demographic studies of population are an important part of choosing a location for a facility. Satellite offices and hospital branches have become increasingly important as busy patients value convenience. Although satellite offices/hospitals do not typically cut costs for the organization, they do cut costs for the patient, which can lead to an increased market share and improved efficiency for the health care provider.

Some hospitals are finding it worthwhile to establish education centers in shopping malls. Other health care organizations have established limited primary care facilities in grocery stores. Furthermore, many hospitals have established urgent care centers in multiple locations throughout a city; extended hours and a known "brand" name from the local hospital are appealing to consumers. Urgent care facilities have been used to draw people away from using the hospital emergency room, a costly place to deliver primary care. In Louisville, Kentucky, for example, FastCare (now The Little Clinic) began operating medical kiosks offering basic services in two Kroger grocery stores. According to the vice president for diagnostic services, "The convenience factor is what really drives people in."[15]

Mobile units are another method of achieving the optimum in health care delivery. Long practiced by the Red Cross to gain more blood donations, other institutions are using movable diagnostic equipment to be closer to patients. Numerous mobile mammography units are in operation in the United States to increase women's use of this excellent but expensive tool.[16]

Pre-Service Promotion

Promotion includes: advertising; public relations events (baby birthday parties, health fairs, cancer survivor celebrations, and so on); personal selling; sales promotion (contests, participation in trade shows, and so on); and direct marketing (internet, direct mail, and so on.) The promotional elements work in combination

to be able to communicate a message to various consumers and stakeholders of health care organizations. For example, hospitals have learned that increased amounts of advertising alone will not fill more beds and that great advertising might set customer expectations higher than the organization could deliver. Advertising works best when there is an identified product or service that meets consumers' needs. Branding helps consumers to know the service to seek and reminds them where they can obtain health care when they have a need for it.

Personal selling has been used more extensively in health care as various organizations compete to be the provider of choice in managed care plans. In addition, personal selling has come into play as health care providers compete for employees that are in short supply. Direct marketing through social media (Facebook, Twitter, LinkedIn, Pinterest, blogs, and so on) provides another touch point for consumers to interact with a health care provider and each other, to share experiences – good and bad. Many potential consumers will check for "reviews" and find them a credible tool for information.

Matching Pre-Service to the Strategy

It is important that service characteristics and the target market are appropriate for the selected strategy. In addition, the price, brand, promotional activities, and logistics for services must contribute to the accomplishment of the directional, adaptive, market entry, and competitive strategies. The services delivery activities were assessed and classified as competitive advantages or competitive disadvantages in the internal analysis phase of situational analysis. As shown earlier in Exhibit 8–3, the attributes of the current pre-service activities must be compared with the service characteristics, target market, price, brand, promotional activities, and services logistics that are required by the strategy. Results of this assessment will determine whether the strategic managers need to create implementation strategies to maintain or change the pre-service activities.

Maintaining Pre-Service Activities When the requirements of the strategy match the current pre-service strengths and needs of the customers, then strategic managers should focus on maintaining those strengths, giving particular attention to those areas that have created competitive advantage. For example, if during internal environmental analysis, a brand name was evaluated as a strength having high value (H), was rare (Y), was difficult to imitate (D), and was sustainable (Y), resulting in HYDY, maintaining the effectiveness of the brand name is particularly important. Allowing such a strength to weaken may lead to the loss of an important competitive advantage. Similarly, maintaining a strong brand name would be important when strong brand names are common (not rare) among competitors (HNDY). In this situation, strong brands have likely become a minimum condition for success. Therefore, in maintaining pre-service activities, strategic managers should:

- Engage in periodic customer focus groups and market research to understand the wants, needs, and desires of the organization's target markets and whether they are or are not being satisfied.
- Monitor the demographic, psychographic, and health status characteristics of the service area (with particular attention to trends in the target markets).

- Continually communicate to physicians, patients, third-party payers, and others concerning the type and range of services offered, pricing, and branding.
- Monitor promotional effectiveness.
- Monitor customer ease of system entry (logistics).

Changing the Pre-Service Activities Pre-service activity changes can be difficult and may require considerable market research as well as promotion. In internal environmental analysis, where the requirements of the strategy call for different services, a different or additional target market, changes in pricing, branding, or promotional activities, change strategies should be initiated. In addition, where significant competitive disadvantages have resulted because of ineffective pre-service activities, it is likely that change strategies will have to be initiated. For example, where the promotional strategy was viewed in internal analysis as a weakness, of high value, the weakness is common among competitors, difficult to correct, and competitors can sustain their advantage (HYDY), change strategies should be initiated particularly where competitors may act to develop an effective promotional strategy and achieve a significant competitive advantage. Similarly, where an organization has a weak promotional strategy and other organizations have effective promotions that are difficult to imitate and can be sustained (HNDY), strategic managers will need to initiate change. Strategic managers who want to change pre-service activities should:

- Change the services attributes to better match the expectations of the target market.
- Train employees to better provide the new services.
- Redefine the target market to match the changing demographic, psychographic, and health status characteristics of the service area.
- Provide price discounts or price classes among members of the target market.
- Change the balance among advertising, personal selling, and direct marketing (one-to-one marketing).
- Brand individual products (as opposed to the organization's name as the brand).
- Redesign accommodations, dining experience, parking lots and signage.

Point-of-Service Activities

Point-of-service is a transformational process that incorporates an organization's resources, competencies, and capabilities – its assets – into value-adding service delivery. Health care was a cottage industry for centuries. Specialization, cost pressures, and the actual work being done have taken health care from being totally customized for the individual patient in his or her home to an attempt to treat patients more similarly so as to develop economies of scale. Placing people in hospitals, outcomes measures, formularies, and so on, focus on treating patients more alike – the industrialization of health care. Most Americans and their physicians do not like it. Moreover, the system has become so complex

and technical that it is difficult for providers to communicate effectively with patients, as illustrated in Perspective 8–3. The best service delivery differs for each organization depending on their strategies developed during strategy formulation.

PERSPECTIVE 8–3

Do Patients Really Understand What You Are Saying?

When researchers at Boston University Medical Center (BUMC) redesigned their discharge process, they wanted to be absolutely sure every detail in the written materials was clear to everyone – patients with limited literacy skills to technically oriented clinicians. To ensure this, they convened focus groups to vet the paperwork for medical jargon and unclear instructions. The researchers learned not to assume anything. One staff person related that after observing several focus groups he was horrified when one participant stated "I really like this stuff and I think it's nice and understandable. But what part of the body is this discharge coming from?" Now the discharge paperwork that patients receive has a new title: After Hospital Care Plan.

The project director says this story illustrates the sometimes hidden comprehension gaps that can hamper optimal medical care. The federal government estimates that 80 million Americans navigate the complexities of the health care system without sufficient literacy skills.

BUMC and numerous other hospitals are assisting patients to navigate the complex health care system removing jargon from informational materials as well as revamping signs in the hospital. Clinicians are also being encouraged to develop bilingual skills. Increasingly, research is showing a relationship between health literacy and an individual's health. Poor literacy skills are associated with difficulty taking medications and overuse of emergency departments.

Experts emphasize that communication is more than written and oral language. Skillful clinicians look beneath apparent issues and watch for non-verbal cues and unasked questions. Unfortunately, some literacy programs can be expensive, especially if they involve numerous signs and written materials. Despite of the potential costs, a number of health care organizations have developed programs to address the literacy problem. Some examples include:

- Twin Rivers Regional Medical Center in Missouri launched an initiative to assist patients in understanding medical instructions when they are sent home.
- At Coney Island Hospital in Brooklyn, New York clinicians are encouraged to wear "Ask Me 3" buttons, which is a program developed by the National Patient Safety Foundation. This program encourages patients to ask doctors and nurses three important questions. (1) What is my main problem? (2) What do I need to do? (3) Why is it important to do what you suggest?

Health care organizations cannot afford to ignore the potential cost of confused patients. In the future, Medicare's focus on readmissions may convince even more hospitals, medical practices, and long-term care organizations to devise ways to increase the literacy skills of their patients.

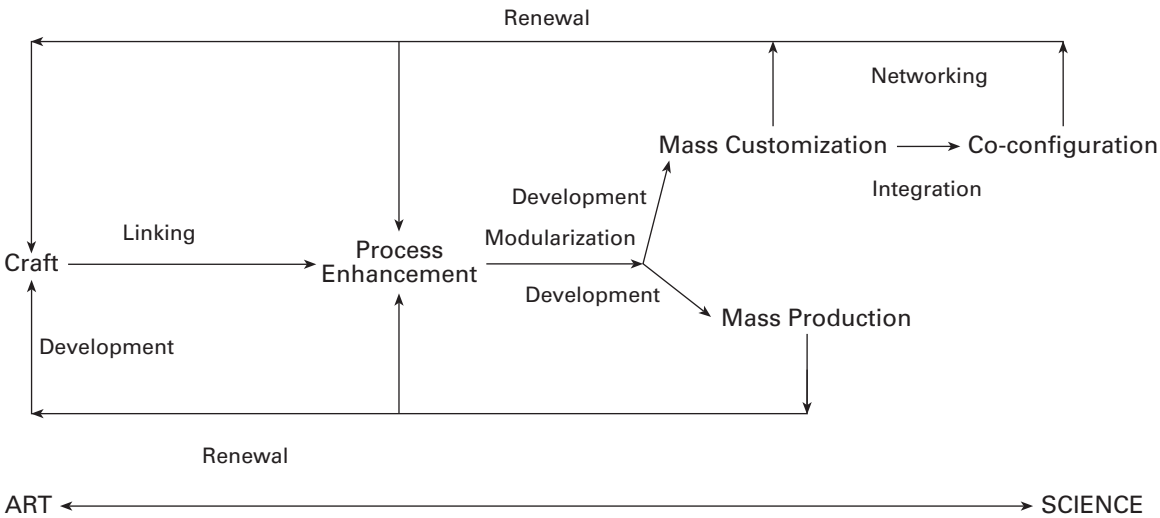
Source: Charlotte Huff, "Does Your Patient Really Understand?" *Hospitals & Health Networks* 85, no. 10 (2011), pp. 35–38.

Point-of-Service – Clinical Operations

The appropriate model of health care delivery is based to a great degree on the care required. If health care were divided into three sectors – acute illnesses with quick recovery, significant illnesses (chronic but manageable), and catastrophic illnesses (AIDS, cancer, and so on) – each accounts for approximately one-third of the health care dollar in America. However, the latter two represent 10 percent of the population. In other words, 90 percent of the population represents short-term treatable illnesses where the volume is high, but costs are low per episode and copayments and deductibles have a measurable impact. Technology can improve efficiencies in this sector. For significant and catastrophic illnesses, health care providers can increase efficiencies through understanding the choice of processes and selecting the one most suitable for patients' care (mass customization).[17]

Mass Customization Mass customization may be the way to capture the customer-friendly benefits of long-term physician–patient relationships plus the cost-careful benefits of capitation – for survival in today's health care market. *Mass customization* can be accomplished by a "series of modular approaches to prevention and care, highly articulated and well supported by information technology" (Exhibit 8–6). Clinical pathways represent an example of mass customization. Pathways represent the best known way to treat the patient; however, the path still has to be applied on the basis of the individual patient's background, medical history, health status, and so on.[18] Recognizing that people are different, this "synchronization of the implementation of the modules" or co-configuration, must be determined by the providers.[19]

EXHIBIT 8–6 **Increasing Quality through Mass Customization**



Source: Reprinted from C. P. McLaughlin and A. D. Kaluzny, *Defining Quality Improvement, Continuous Quality Improvement in Health Care*, 2nd edn (Sudbury, MA: Jones and Bartlett Publishers, 1999), p. 15. Reprinted with permission www.jbpub.com.

Mass customization requires that a sufficient number of people have the same disease or diagnosis. For example, Medco Health Solutions has effectively created mass customization through segmentation based on diagnosis. The mass customization "digs down" another level to differentiate clinical needs among people in a single disease category (diabetes) that is large enough to warrant separate contact but not too small to present an administrative burden. In these cases true customization is not cost justified, but "one-size" fits all programs standardized or mass programs are not effective either. Mass customization falls somewhere in between and prevents therapy gaps within categories, such as the gap between diabetics who have only a few health problems and diabetics who require frequent medical attention.[20]

Quality of Operations The trust in the health care system has diminished because of reports in the media over managed care's failures as well as the Institute of Medicine's study indicating that as many as 98,000 deaths per year are because of medical errors. The greatest opportunity a health care organization has is the day-to-day interaction between caregivers and patients.[21] Every person in a health care organization has some responsibility for its image.

Historically, hospitals have concentrated on meeting the expectations of physicians, and then more recently physicians and third-party payers. The structure of the health care industry has enabled it to circumvent a customer orientation that most other segments in the services industry have had to adopt.[22] Various environmental changes are creating the need for health care to be more responsive to the wants, needs, expectations, and requirements of patients for information, convenience, and personal control.[23] Recently, attempts have been made to rank health care organizations on the basis of clinical quality. However, as suggested in Perspective 8–4, rankings are difficult because there is a lack of agreement over the assumptions underlying the ranking attributes and some of the implications may be misleading.

PERSPECTIVE 8–4

To Err is Human – But in the Hospital!

Hospitals are great places to be when you are ill. Unfortunately, they are also plagued by daily errors and mistakes. For example, it is estimated that surgeons in the United States operate on the wrong person or body part 40 times a week. In 1999 the Institute of Medicine issued a report with the startling finding that each year as almost 100,000 Americans die in hospitals from preventable medical mistakes. And, there is no reason to expect that the situation has improved much over the past decade. A report released on Medicare patients found that hospital staff did not report 86 percent of the mistakes that adversely affected patients. Even more alarming

is a report by Health and Human Services stating that one in every seven Medicare patients suffered serious or long-term injury or died as a result of hospital care. Mistakes take many forms – surgeons cut healthy blood vessels, nurses mistakenly administer a toxic dose of medicine, or staff fail to disinfect a room. As a result, the number of patients who die each year from preventable hospital errors is equal to four full jumbo jets crashing each week!

Many of the problems arise from the complexity of modern medicine. Some experts suggest that medical practitioners could learn from the aviation industry's use of simple checklists.

This is not to suggest that no progress is being made. For years it was thought that bloodstream infections resulting from the insertion of a tube into a large vein near the heart to deliver medications were largely unavoidable. As a result, 30,000 deaths annually resulted from these infections. However, a program initiated in 2004 at more than 100 Michigan intensive care units managed to reduce these infections by two-thirds and save 1,500 lives in just 18 months. Major improvements were accomplished by using a short checklist for handling catheters and getting all staff on board.

Challenges remain. Only about half the hospital workers follow hand-washing guidelines despite of intensive training and generous availability of hand sanitizer dispensers. Other measures for reducing problems have been more effective.

For example, public reporting of hospital performance was unheard of a decade ago. Twenty-nine states now require public reporting of hospital infection rates and 28 require some information on medical errors. The Health and Human Services agency has added a key catheter infection rate reporting. The debate continues on what data should be reported. In 2008, Medicare began restricting payments to hospitals with extra costs associated with 10 hospital-acquired conditions and it will provide extra money to hospitals that score the highest on a set of standards linked to better patient outcomes.

It remains a difficult task to compare the safety records of hospitals. Existing data does not allow patients to be sure they selected the safest hospital. Even within hospitals it is difficult if not impossible to compare the safety record of one unit with another. Because one unit is excellent with regard to patient safety does not mean all units are equally safe.

Source: Katharine Greider, "The Worst Place to Be If You're Sick," *AARP Bulletin* 53, no. 2 (2011), pp. 10–14.

The National Committee for Quality Assurance (NCQA) developed by large employers provides the Healthplan Employer Data Information Set (HEDIS) to compare individual managed care health plans. The intent was to create a database that the participants (consumers or employers) could use to compare the performance of their health plans against other health plans on a consistently measured and reported set of criteria.

Neither the Joint Commission (JCAHO) nor the HEDIS data can be correlated with *Consumer Report* satisfaction studies. The fact that mammograms are done (a HEDIS measure) does not mean women are happy with the way they are done (a measure of patient satisfaction). Health care providers are more responsive to patients, at Lakeland Regional Medical Center, a large multiservice facility in Florida.

Lakeland Regional discovered during a planning retreat that the time allocated to coordination and scheduling of procedures was almost the same as the time spent in providing services. Red tape and increasingly specialized jobs made relatively simple procedures seem overly complex to the patients. In addition, customers had to repeat the same information to a variety of staff. A patient might come into contact with as many as 60 different employees.[24] The quality of clinical care received by patients was not perceived to be as good as it actually was because of the way care was delivered (see Exhibit 8–7).

Labor-intensive services are difficult to automate, but not impossible. Blood pressure checks have been automated. Additionally, a finger stick for routine blood work could be done by a machine; but would the public accept a machine instead of a nurse? In a different but important service industry, many bankers held on to their beliefs that consumers would want to talk to a real person when cashing checks or depositing money. Those banks that were the first to automate with teller machines have been very profitable. Similar results may be achieved in health care.

Clinical Process Innovation Clinical process innovation (or CPI) is defined as "the generation, acceptance, and implementation of new ideas, tools, and/or support systems aimed at improving clinical processes and, ultimately, patient care."[25] It differs from continuous quality improvement (CQI) in that CQI focuses on improving existing clinical processes for performance improvement. CPI is a contextual and critical appraisal of current clinical processes to identify opportunities for more effectively providing care. As Michael Hammer explains, "Operational innovation should not be confused with operational improvement or operational

EXHIBIT 8–7 Key Questions for Determining Patient- and Family-Oriented Care

Trustees, administrators, and medical and nursing leaders should ask themselves the following key questions to determine whether their organization's environment places patients and families first:

- Do the hospital's vision, mission, and philosophy of care statements reflect the principles of family-centered care?
- Are the vision, mission, and philosophy communicated clearly throughout the hospital, to patients and families, and others in the community?
- Do patients and families serve as advisers to the hospital? In what ways are the patients and families involved in the orientation and education of employees? In the design planning process?
- Are hospital policies, programs, and staff practices consistent with the view that families are allies and important to patient well-being? Are families considered visitors?
- What systems are in place to ensure that patients and families have access to complete, unbiased, and useful information?
- Does the hospital's human resources system support the practice of family-centered care?
- In academic medical centers, how do the education programs prepare students and professionals in training for family-centered practice?

Source: Institute for Family-Centered Care, Bethesda, Maryland.

excellence. Those terms refer to achieving high performance via existing modes of operation… Operational innovation means coming up with entirely new ways of filling orders, developing products, providing customer service, or doing any other activity that an enterprise performs."[26] In recent years a considerable amount of interest has developed in operational innovation in the clinical setting. Research has looked at the relationship between innovation and quality, improvements related to information technology innovations, and a variety of other areas.[27]

Through the first decade of the 21st century, providers need to realize that consumers who want more control over their health care will have it through consumer advocacy groups, increased competition, and unprecedented access to information. If customers do not receive the care they want, they will change to another provider. Physicians have to be willing to listen to patients talk about other treatments and how alternative therapies might blend with more traditional medicine to improve health.[28] Consumers who use alternative therapies are middle- to upper-class, well-educated people with good jobs and money to spend on whatever they believe to be important for their health care.[29]

Point-of-Service – Marketing

Physicians are an integral part of the health care system. As such, hospitals and health systems have tried a variety of models to incorporate physicians into the new systems. Thus far, none of the models (as depicted in Exhibit 8–8) has really worked. Perhaps that is because none of these models focuses on the physician–patient relationship. "A renewed patient focus is not only the best way to serve our customers and patients, it is also a business imperative for any organization that wishes to survive into the next era of health care."[30] Some strategies in which physicians and health systems can work together to achieve patient goals include redesigning service lines around enhancing the patient experience rather than around financial aspects of delivery of care, multispecialty physician care teams based on consumers' needs, physician outreach programs to determine ways that physicians believe patient care can better be delivered, increasing physician–patient communications since physicians are frustrated by the lack of time they can spend with patients, and agreeing on measurements for success.

Health care providers must understand their current situation in the market. How well are they satisfying the various customers they currently serve? Are competitors better meeting customer needs? What new needs will occur in the near future that should be in the planning stages today? Frequently, the necessary information is not available, and marketing research must be conducted to understand patient satisfaction, medical staff satisfaction, competitive offerings, and so on. Often it is important to collect data from patients and staff who do not use (or occasionally use) the facility as well as current users.

Matching Point-of-Service to the Strategy

Each strategic alternative selected by an organization may affect the point-of-service delivery strategy. However, as discussed previously, central to point-of-service delivery are issues such as quality, efficiency/speed, innovation, and flexibility (mass customization) of the service. Most organizations are constantly trying to improve point-of-service delivery – employing an adaptive/enhancement strategy.

EXHIBIT 8–8 A Partnership Model Scorecard

Model	Financial Performance	Strategic/Market Performance	Physician Satisfaction
Employed medical group	Health system suffers huge operating losses. Physician income is greater than production.	Market share does not increase substantially.	Health system control mentality is contrary to physician mindset.
Managed care organization/physician–hospital organization	Added market leverage is questionable. Capitation has proven difficult to manage.	Number of covered/served lives can increase.	Physicians often have multiple contracting vehicles and may question the value of this model.
Management services organization	Infrastructure can be expensive. Organization will break even at best.	Model typically has no impact.	Physicians are typically unhappy with the level of service.
Shared ownership	Physicians are reluctant to provide capital. Good investments can result in attractive returns.	Model has potential to increase market share.	Physician satisfaction is enhanced as physicians feel ownership in the organization.
Physician incentives to manage components of care delivery	Health system must be willing to share dollars.	Model is primarily a cost-reduction strategy.	Physicians receive financial rewards for improving quality and reducing cost.
Link with major health plan	Organizations must carefully develop appropriate financial incentives.	Model can secure a market leader position.	Physicians must take on the additional responsibility of controlling the delivery process.

Source: *The New Playbook: Transforming Health System–Physician Relationships.* © 1999 VHA/Tiber Group.

Maintaining Point-of-Service Activities When the requirements of the selected strategy match the characteristics of the current point-of-service delivery, the strategic managers should develop strategies to maintain the current strengths of the organization's resources, competencies, and capabilities. As with the pre-service activities, particular attention should be given to those point-of-service delivery areas that have created competitive advantage. In maintaining point-of-service delivery activities strategic managers should:

- Monitor service quality through asking customers (physicians, patients, payers, other) if there is a way the experience could be improved – as they are the ones receiving the service.
- Monitor clinical (patient) and organizational (financial) outcomes.
- Institute quality programs in key service areas.
- Benchmark other organizations' processes.

- Measure the organization's efficiency (personnel, assets, costs) against peer organizations and industry standards.
- Revise rules and regulations that limit process innovation.
- Continue to communicate and emphasize the individuality of customers.

Changing Point-of-Service Activities If the requirements of the strategy indicate that the present point-of-service delivery processes should be changed, then explicit strategies must be implemented. In addition, where internal environmental analysis indicates that the point-of-service delivery process is a weakness (resulting in competitive disadvantages) or the requirements of the strategy call for new standards of quality, efficiency, or innovation, change strategies should be initiated. Strategic managers who want to change clinical point-of-service activities should consider involving a team of appropriate leadership across disciplines to:

- Institute a quality improvement program for service delivery,
- Re-engineer critical service delivery activities,
- Provide quality enhancement training for service delivery personnel,
- Institute a cost-cutting program,
- Provide incentives for efficiency suggestions,
- Reduce dramatically rules and regulations that limit innovation, and
- Provide savings or revenue sharing with employees to encourage innovations.

To change marketing point-of-service activities, strategic managers should:

- Target unserved consumers,
- Increase market penetration activities,
- Serve new markets with existing products (market development),
- Offer new products for current consumers (product development), and
- Improve differentiation among services offered.

After-Service Activities

After-service includes follow-up (both clinical and marketing), billing, and follow-on activities. They are sometimes referred to as "back-office strategies" and are often the final impression (contact) that a customer has with the health care organization.

Follow-Up Activities

Follow-up – calling to inquire after the health of a child who was seen in the ER – would spotlight a pediatrician as "caring and concerned" and endear him or her to any mother. Calling after outpatient surgery to ask if everything is going as expected or whether additional prescriptions are needed is simply good clinical follow-up (and can save pain, complications, and an unscheduled office visit). Follow-up calls say to customers "we care" and may avoid unnecessary anxiety.

Marketing follow-up activities include patient satisfaction studies to determine from a patient's perspective how he or she was treated. All health care providers should be doing follow-up studies with their customers. The studies offer greater insight if they are conducted several days after the health care encounter as bias may occur with on-site collection of data.

With the assistance of Press Ganey, a health care consulting firm, *Hospitals & Health Networks* conducted a survey to determine the use of patient satisfaction studies. Of the 783 respondents, 95 percent said their organization measured patient satisfaction and over 99 percent said there were many opportunities to improve patient satisfaction. However, less than 40 percent said they were doing a better job of it than 10 years ago.[31]

Health care purchasing decisions are often made through a third-party payer with little or no consumer input eventually distancing the relationship between the provider and the consumer of health care. In 2012 consumers were spending more out-of-pocket for copays and a higher percentage of the cost of care, yet are not aware of how their money was being used. Pressed for time, they become frustrated if they feel their time is being wasted, as when they have an appointment and sit for an hour waiting for an X-ray or to see a physician. Today, consumers have the knowledge to take their business elsewhere.

Studies of patient satisfaction cannot be merely looked at, plotted as to movement up or down, and put on a shelf. They need to be analyzed to learn what customers expect, what the organization is able or willing to do to meet the expectations (its capabilities), and manage those they are not willing or able to meet.[32] For example, it may not be possible to shorten the time for test results because of the time it takes to do the test properly. However, patient expectations can be managed by explaining the length of time it takes to do the test and making the information available as soon as possible on a secure Internet website – if the patient wants the information this way – or an immediate call from the physician's office, or at a minimum providing a consumer hot line to call.

Although many health care organizations are undertaking customer satisfaction surveys, they may not be performing them in a rigorous enough manner. Despite all the studies that have been done, quality improvement has not lived up to expectations. To achieve satisfaction, customers must be satisfied throughout the value chain from pre-service activities to after-service activities. The problem has been that the studies were not designed with minimal standards of conceptual or methodological rigor; nor were they designed to facilitate quality improvement.[33] Regional coalitions are being used to more rigorously collect data. In Massachusetts, a partnership of health care, business, and government leaders recognized the need for better information and collected data from 24,200 patients discharged from over 50 hospitals. The participants agreed not to use the data for "best" and "worst" lists but to educate and inform hospitals and consumers and to focus and facilitate quality improvement efforts.

Billing Activities

There is more to the patient's determination of the value and quality of the total health care experience than the success or failure of the medical procedure or clinical service itself. Richard L. Clarke, HFMA (Health Financial Management Association) former CEO and president has stated: "The best care, and great

customer service provided during the patient's hospital encounter can be destroyed quickly by confusing, complicated, or incorrect billing afterwards."[34] Hospital bill features that irritate customers most include:

1. Confusion about what the patient's insurance company has paid.
2. Confusion about the balance the patient owes the hospital once the insurance company pays its share.
3. Use of medical terminology that the patient does not understand.
4. Sending a bill to the patient before the insurance company has processed the patient's claims.
5. Inability to determine exactly what services the hospital has provided and what the patient is being charged for a service.[35]

Greenwich Hospital's convoluted billing statement was reported in the *New York Times* when a freelance writer tried to figure out what he owed the hospital. His very public discussion of the problems with billing began a major change for the hospital. Having undergone the process, Greenwich recommends that when a health care organization realizes that its billing statement needs revision, the task should not be delegated to staff. Rather, a task force of actual customers, physicians, information systems personnel, clinical employees, and billing personnel should be charged with making the bill understandable. Greenwich followed this format and the redesigned billing process reduced consumer complaints from about 30 per week to 5 per week and, interestingly, there was a reduction in accounts receivable and bad debt because people understood their bill and paid it.[36]

When customers call in with questions about their bill, how are the calls handled? More than likely someone has to stop with data entry or analysis of data input to answer a patient's question. See Perspective 8–5. If answering customers' questions is not a priority, customers will know; moreover costs are associated with doing things incorrectly. Consider a hospital or nursing home billing statement that contains errors. Not only is there the cost of finding the error, addressing the complaint, and redoing the statement, but there is an additional cost of losing a positive consumer attitude – and, perhaps, a patient who decides to go elsewhere.

Follow-On Activities

It is almost always preferable to have services recovery occur during services delivery rather than waiting to institute services recovery at a later time. However, health care managers are not always aware of the failure until *follow-on* activities are undertaken.

After a patient has been seen by a physician or is leaving the hospital after surgery, there is a likely need for further services: a child with an ear infection has to return in 10 days for another check-up to make sure the infection is no longer present; after hip surgery a patient may need to be relocated to a rehabilitation facility to learn to walk again. These additional services are called follow-on value-adding service activities. A new mother with a child's first ear infection has no idea about returning. An unexpected broken hip, surgery, and then the need for additional care is not something most families research until it happens. If the health care provider has thought through the follow-on care

PERSPECTIVE 8–5

Consistent Care Really Works

In one year a patient with uncontrolled diabetes visited 52 different emergency departments including 42 visits to the emergency department (ED) at Providence St. Peter Hospital in Olympia, Washington. After being placed in the "Consistent Care" program at the hospital and assigned a primary care provider, the patient's ED visits dropped from 42 to eight after two years and zero the following year.

Providence St. Peter Hospital initiated Consistent Care in 2003 to address a problem that all EDs have – patients with chronic or severe health problems or substance abuse issues over using the ED. Consistent Care is designed to guide treatment decisions for repeat ED patients. It involves community health clinics, mental health providers, private physicians, and other partners in an effort to reduce inappropriate use of the ED, improve patient health, and enhance the capacity and integration of the community's limited health care resources.

Consistent Care is an interdisciplinary approach that provides members of the community with resources to assist in addressing health care needs of those who over use the ED. In 2011, the program received a NOVA award from the American Hospital Association in recognition of its hospital-led partnership to improve community health.

The program identifies patients who visit the ED at least twice in one month or four times in six months and then examines their cases for narcotic dependency, mental health issues, and other factors. A team of ED staff, primary care physicians, mental health professionals, and case managers meet to identify appropriate patients and develop individual care plans. The care team attempts to coordinate the medical needs and improve communication between the different professionals caring for the patient.

Consistent Care has already served more than 600 people. About 90 percent of the patients have mental health illness or substance abuse problems. The hospital has seen ED visits for the group cut in half. A study of the program indicated that Consistent Care saves the hospital more than $9,000 per patient, with the overall savings amounting to about $5.4 million in ED-related charges. Further, the program has reduced waiting time in the ED for other patients.

Consistent Choice has been expanded to four other hospitals. Soon a new web-based repository will be introduced to allow the immediate identification of frequent users of ED services at participating hospitals. This information can be shared by appropriate individuals and ensure better-coordinated care.

Source: Pete Davis, "Consistent Care Curbs Inappropriate ED Use," *AHA News* 47, no. 17 (2011), p. 5.

and provides literature, assistance with placement in another facility, and so on, consumers will leave with a more favorable attitude about the experience.

After a doctor's visit, can the patient easily find the appointment desk? Is the employee that handles follow-on appointments knowledgeable concerning the length of time it will take for a patient's next visit? Do these employees know that they represent the entire organization to the patient? Customer capital is the value of customer relationships and the contribution this value makes to future

growth prospects. Customer capital includes an organization's customer base, customer relationships, customer potential, and brand recognition. Although the specifics vary by industry, it has long been understood that it costs more to gain a new customer than it takes to retain a customer. Given that this is true, it is logical to assume that the customer franchise is an asset of real worth. Establishing lifetime relationships with customers is the focus of the smart 21st-century organization because it leads to competitive advantage.[37] Follow-on activities can cement or destroy a good customer relationship.

To achieve high levels of patient satisfaction, Baptist Hospital in Pensacola, Florida felt that it needed to become the employer of choice.[38] It monitors employee satisfaction as well as customer satisfaction. Managers' performance is measured in five areas – customer service, quality (length of stay), expense management, employee turnover, and growth – and compensation is linked to accomplishing objectives.

Matching After-Service to the Strategy

As with pre-service and point-of-service activities, after-service activities must contribute to the accomplishment of the selected strategy. These operations and marketing activities may be quite important in an effective strategy. Follow-up, billing, and follow-on activities humanize the services, reduce hassles and frustration, and provide for continued care. Such activities often make the difference between a positive and negative health care experience and can differentiate the service and create competitive advantage. Effective after-service activities are typically of high value, often rare, fairly easy to develop, and are sustainable. These activities can be the source of at least short-term competitive advantage. However, these areas are often ignored by many health care organizations and thus those organizations that do them well may create a long-term advantage.[39] Therefore, careful attention should be given to understanding the after-service requirements of the selected strategy. Strategic managers must decide if the activities should be maintained or changed.

Maintaining After-Service Activities When the requirements of the selected strategy match the characteristics of the current after-service activities, the manager should develop strategies to maintain the current after-service strengths of the organization through its resources, competencies, and capabilities. Likewise, those after-service activities that have resulted in a competitive advantage should be protected and maintained. In maintaining after-service activities, strategic managers should continue to:

- Emphasize and train employees on telephone and email communication and etiquette.
- Emphasize patient satisfaction.
- Improve the "readability" of billing statements.
- Stress the importance of correct billing statements and ensure their accuracy.
- Develop relationships in the referral network to facilitate follow-on activities.

Changing After-Service Activities If the requirements of the strategy indicate that the present after-service activities should be changed, then explicit strategies must be implemented. In addition, where internal environmental analysis has indicated that follow-up, billing, or follow-on is a weakness resulting in competitive disadvantage, change strategies should be developed. Strategic managers who want to change after-service activities should:

- Make follow-up an explicit part of patient (customer) care.
- Keep a log of patient follow-up as a part of the patient/customer record.
- Train employees on telephone and email communication and etiquette.
- Emphasize customer satisfaction at staff meetings.
- Redesign the billing statement with the assistance of a variety of stakeholders, including patients and define complicated medical terms.
- Inform customers about billing procedures.
- Clear any confusion about billing charges and which charges are to be paid by insurance.
- Continue to improve relationships with payers.
- Develop more and better relationships with referral organizations.
- Develop a list of options for patients who need follow-on referral, explaining the characteristics and pricing of each.

Extending the Strategic Thinking Map

Value-adding service delivery strategies translate the directional, adaptive, market entry, and competitive strategies into action. As a critical component of the value chain, value-adding service delivery strategies, coupled with value-adding support strategies, set the stage for maintaining strategic momentum through the action plans and control of the strategies.

No position of leadership lasts forever. Every health care organization that succeeds at differentiation serves as a model for new competitors.[40] The dynamic health care market and ever-changing technology mean that no competitive advantage can be sustained in the long run without a great deal of thought and effort. To further complicate the strategic process, the long run itself is becoming shorter as the rate of change becomes increasingly rapid.

In conjunction with external environmental analysis, service area competitor analysis, and internal analysis, value-adding service delivery strategies attempt to reposition the health care organization in its environment to create new competitive advantages. Although there are maps for developing value-adding service delivery strategies (see Exhibit 8–9 for an example), using a compass to creatively develop new strategies for pre-service, point-of-service, and after-service delivery can rejuvenate competitive advantage.

EXHIBIT 8–9 Strategic Thinking Map for Value-Adding Support Strategies for a Long-Term Care Organization

Adaptive strategy: Vertical integration – enter into a system of care.
Market entry strategy: Enter into an alliance with a hospital to assure a referral network.
Strategic posture: Move from defender posture to analyzer posture.
Positioning strategy: Differentiation based on quality, upscale image.

	Characteristics/Attributes		Evaluation			Support Strategy
Value-Adding Service Delivery Strategies	**Results of Internal Analysis**	**Requirements of Selected Strategies**	**Comparison: Strategy Requirements – Internal Analysis Results**	**Maintain**	**Change**	**Guidance For Organizational Units (Basis For Unit Action Plan Development)**
Pre-service • Market/marketing research • Target market • Services offered/ branding • Pricing • Promotion • Distribution/logistics	Target market: upscale families, private pay. Prestige pricing in this step-down facility that offers long-term care and skilled nursing. Word-of-mouth is relied on as well as the publicity about the CEO's mother residing there. Excellent location – upscale neighborhood with excellent shopping and recreation nearby.	Become Medicare and Medicaid qualified to meet hospital's needs. Intensify branding efforts to combat new competition. Maintain upscale appearance, caring staff. Add new services to be "full-service."	Fairly good match. Expansion of the target market may impact upscale image. Word-of-mouth promotion not sufficient to develop brand awareness. Maintaining the current competitive advantage will be challenging with an expanded target market.	**X**		**Marketing** – enhancement: develop a promotional campaign to enhance brand awareness, redesign the logo and new signage, consider comparative advertising with other local upscale facilities. **Operations** – enhancement: modify procedures to be consistent with Medicare and Medicaid regulations, ensure facilities are clean/neat to reflect upscale image, make facilities modifications to meet Medicare and Medicaid requirements, ensure recruitment of caring professionals.

Point-of-service ● Service delivery	Patients/families indicate care delivery is outstanding. Facility is clean, does not smell like a nursing home. Food is tasty and nutritious – like home cooked. Families do not want to move the loved one if other problems associated with aging occur.	Expand services: Alzheimer's care, senior day care, rehabilitation.	Fairly good match. Services differentiation strategy requires improved information system to track care. Enhancement strategy requires process innovation while maintaining caring environment, cleanliness, great food. Product development appears attractive.	**X**		**Clinical** – status quo: maintain service delivery at its current high level of quality and caring, continue quality food service/dining. **Marketing** – product development analysis: Alzheimer's care and senior day care units. **Operations** – enhancement: work with IT to enhance tracking of care, improve activities and social opportunities for residents, develop procedures for operating Alzheimer's and day care units. Work with Facilities Management on the facilities requirement for Alzheimer's and day care units.
After-service ● Follow-up activities ● Billing ● Follow-on activities	"No need" for patient/family satisfaction studies. Billing process: give an accumulated bill to a family member when they stop in for a visit. If the patient needs care from a specialist, referrals are prompt, transportation arranged.	Satisfaction studies to track improvements. Billing procedure to provide consistent revenue stream.	Not a good match. Information systems upgrade needed to match the hospital's system for timely, accurate billing to increase customer satisfaction. Expanded target market requires careful tracking to maintain image.		**X**	**Marketing** – initiate patient/family satisfaction studies, make recommendations to leadership based on results of the study, track brand awareness and image in an expanded target market. **Operations** – work with Information systems to change billing system, coordinate with alliance hospital for consistency in billing procedures.

Managing Strategic Momentum – Service Delivery Strategies

Just as the success of the directional, adaptive, market entry, and competitive strategies of the organization must be evaluated as an ongoing part of managing the strategy, the service delivery strategies often must be adjusted as managers learn by doing. This type of change represents an evolutionary alteration or a strategic adjustment. Lorange, Morton, and Ghoshal referred to this as managing the strategic momentum and explained, "The basic continuity of the business is still credible, and one can hence speak of an extrapolation of the given strategy, even though a lot of operational changes may be taking place. The challenge here is to manage the buffeting of the given strategy and to maintain the strategy on course."[41]

In the end it is implementation that has to be effective and efficient. Changes in the "way we do things" represent evolutionary change. Each of the value-adding strategies – service delivery and support – should be examined separately to determine whether management has correctly defined the role of these strategies in supporting the organization's overall strategy. Strategic managers must determine whether the service delivery, support strategies, and action plans are well integrated and support one another. The questions presented in Exhibit 8–10 provide an evaluation of the effectiveness of the service delivery strategies.

EXHIBIT 8–10 **Strategic Thinking Map for Evaluating Service Delivery Strategies**

1. Have the pre-service activities provided customers with need-satisfying services?
2. Have the pre-service activities provided at the right price, the appropriate information to current and potential customers, and convenient locations?
3. Are the pre-service logistics appropriate to the service?
4. Are the point-of-service activities sensitive to changing customer needs?
5. Are the point-of-service activities efficient? Effective?
6. Has the quality of the services changed?
7. Has the organization innovated delivery of its services?
8. Is the delivery of services flexible (can accommodate special customer needs)?
9. Is there proper follow-up with customers?
10. Is the billing system timely, accurate, and user-friendly?
11. Are the follow-on strategies appropriate?

The logic underlying these questions is that the organization's strategy is fundamentally sound but the organization's performance in carrying out service delivery may not be as effective or efficient as it could be. Adding value is an ongoing process and requires the value-adding support strategies to be in concert with the value-adding service delivery strategies. The value-adding support strategies are discussed in Chapter 9.

Lessons for Health Care Managers

Because of the competition and complexity in the market, health care providers must add value to survive. The value chain consists of value-adding service delivery strategies that are primarily operations (clinical) and marketing oriented as well as value-adding support strategies that include organizational culture, organizational structure, and strategic resources.

The directional, adaptive, market entry, and positioning strategies are implemented through value-adding service delivery, including pre-service, point-of-service, and after-service strategies. Pre-service activities include market research to understand the customer and marketing research to understand the customer's reactions to the organization's marketing efforts. A variety of health care customers – including physicians, patients, third-party payers, volunteers, employees, and so on must be considered. Patients have to be admitted to a hospital by a physician; third-party payers influence physician choice, length of stay, and so on; volunteers and employees may also be patients; government entities interpret the need for additional health care subsidies from the public. In addition, pre-service includes segmentation to select the target market and determination of the services that will satisfy the target market. Further, decisions have to be made concerning branding as well as pricing, promotion, and distribution/logistics.

Point-of-service delivery is oriented around patient care and delivery – clinical and marketing activities. Marketers study the customer and market to suggest the manner of care delivery, while clinical personnel deliver care. Properly implemented mass customization is a way to deliver efficient and effective care.

After-service activities include both clinical (next appointments, further services) and marketing (determining how to satisfy customers through new products/services that are needed) follow-up activities. Staff could make clinical calls to inquire how the patient is doing and whether additional medication is needed. Marketing follow-up is generally in the form of patient satisfaction studies. Billing is another important after-service activity, as it is the time when the consumer decides if value has been received. Follow-on activities include nursing home care arrangements after hospitalization, arranging home care, and other similar activities. Chapter 9 examines implementation strategies for the lower half of the value chain – the value-adding support strategies.

Health Care Manager's Bookshelf

James C. Collins, *Good to Great: Why Some Companies Make the Leap . . . and Others Don't* (New York: Harper Collins, 2001)

Good to Great is an innovative study of 1,435 companies, 11 of which were deemed to be great by the author. The 11 great companies produced cumulative stock returns at or below the general stock market for 15 years, then punctuated by a transition point, had cumulative returns of at least three times the market over the next 15 years. Actually, the companies averaged cumulative stock returns of 6.9 times that of the general stock market.[1] An important aspect of Collins' research is that he did not "study success" but rather the contrast between highly successful and less highly successful organizations. The organizations that failed to achieve greatness were studied as well as those that did achieve phenomenal outcomes.[2] Collins' study provided a new and unique angle to much of strategy research.

There were several factors behind the transformations from good to great, however a "Level 5" leader was often the key. This individual has a paradoxical mix of traits – extreme personal humility and intense professional will. Level 5 leaders do not begin with vision and strategy but with an attention to people. They confront the darkest situation with the absolute faith that they can prevail in the end. This strategy is called the Stockdale Paradox, named after Vietnam prisoner of war Admiral James Stockdale.

Other factors involved in the transformation were getting the right people on the bus (in the right jobs) and the wrong people off, and creating a culture of discipline. In addition, good-to-great transformations take time. They begin slow and gain momentum, and require an understanding of three related concepts – what the organization can be best at in the world, how its economics work, and what ignites the passions of its people. At the same time, the book offers a challenging caution. Most people can do remarkable things, but almost no one can do all things remarkably.[3]

Good-to-great research was initiated in health care organizations ranging in size from 15 to 854 beds.[4] In addition, 226 health-related organizations were analyzed relative to their cost per case mix-adjusted discharge. Organizations in the 75th percentile or higher were labeled quantum improvers. Quantum improvers consistently set non-negotiable goals, focused on their key businesses, and used a "tight–loose–tight" approach. Finally, quantum improvers maintained a culture of accountability but were not driven by threats.

Other executives have asked whether it is possible to go from good to great in health care. Collins is clear in his answer – YES. The distinction is not between business and health care but rather between great and good.[5] However, the standards are different for business and health care. In business, greatness is about returns to investors where as in health care, greatness is about delivering on the mission and making a distinct impact in view of organizational resources. Collins believes there are probably more Level 5 leaders in health care than in business because in health care there are many people passionate about the "cause" of the organization and for the improvement of patient lives.

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KEY TERMS AND CONCEPTS IN STRATEGIC MANAGEMENT

After-Service Strategy
Follow-On
Follow-Up
Market/Marketing Research
Marketing Research
Mass Customization
Point-of-Service Strategy
Pre-Service Strategy
Target Market
Value-Adding Service Delivery Strategies

Questions for Class Discussion

1. Explain the linkage between internal environmental analysis and the value-adding service delivery and support strategies. How are the value-adding strategies linked with action plans?
2. Explain the difference between pre-service, point-of-service, and after-service activities. What elements are central to each? Provide an example of how an organization might create a competitive advantage in each of these areas.
3. For a health care organization, explain why pre-service, point-of-service, and after-service activities are fundamentally marketing and clinical in nature.
4. Pre-service, point-of-service, and after-service are different for health care than for producing and distributing a tangible product. Explain some of these differences.
5. Discuss the various ways that health care providers can define the market they want to serve.
6. What role does marketing play in the implementation of adaptive strategies for expansion? Is marketing ever involved in contraction?
7. Does marketing have a role to play in the market entry strategies? Explain your answer.
8. What is mass customization? In what circumstance does mass customization become useful?
9. What is "evolutionary" strategic change?

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9 Value-Adding Support Strategies

"On the surface VCE (value chain evolution) theory is breathtakingly simple. The theory suggests that companies ought to control any activity or combination of activities within the value chain that drive performance along dimensions that matter most to customers."

—CLAYTON M. CHRISTENSEN, SCOTT D. ANTHONY, AND ERIK A. ROTH

Introductory Incident

Increasing Payer Influence Over the Delivery of Health Care

Large insurers are expanding, diversifying, and strategically acquiring different businesses. One of the more significant diversifications involves insurers acquiring medical practices. A few examples include:

- Humana acquired Concentra, a company that provides occupational medicine, urgent care, and physical therapy at more than 300 medical centers in 42 states.
- WellPoint, although insisting the transaction should not be called an acquisition, struck a deal with CareMore, a company that owns an insurance plan and operates 26 clinics specializing in elder care. WellPoint prefers to refer to the transaction as "a unique care model."

- Optum-Health purchased Monarch HealthCare's management unit (California prohibits insurers from employing physicians directly). Monarch is a 2,300 physician group that closely follows two other Optum purchases. These include AppleCare Medical Group and Memorial Healthcare IPA (independent physician association).
- Highmark announced its intent to purchase West Penn Allegheny Health System, a physician-led health care organization.

The aim of these new relationships centers on "controlling the utilization of health services, rooting out excesses, and preventing wasteful spending via the coordination of care" according to an executive at Gorman Health Group. These acquisitions are strategies for creating efficient physician networks that will receive performance-based payments and pre-empt hospitals from gaining control of doctors. Many hospitals are, in fact, purchasing medical practices. From the perspective of physicians, acquisition by an insurer provides advantages because there is a belief that the future is linked to access to covered lives and that a specific plan can bring in the needed volume.

Several years ago, the reduction in the number of primary care physicians caused Peoples Health (a Medicare Advantage plan with 47,000 members) to consider buying its own clinics. When Stanocola Clinic filed for bankruptcy, Peoples Health bought the clinic out of bankruptcy for $1 million and invested an additional $2 million to fund an electronic health record with a new management system. Peoples Health plans to add clinics in an effort to overcome the shortage in primary care. In addition, it added mid-level providers, social workers, and registered nurses to Stanocola and contracted with hospitalists to foster a patient-centered medical home model.

The prospect of health care reform has encouraged payers to acquire providers as part of the larger strategy to remain competitive in the future. Owning providers can allow the umbrella company to influence efficiency upgrades such as electronic medical records and other operational measures that individual providers may not be able to afford. To remain profitable, insurers have to lower administrative costs by investing in technologies and possibly by purchasing and managing medical practices.

Source: Mari Edlin, "What the Doctor Ordered: How Payer Acquisition of Practices and their Increasing Influence over the Delivery of Health Care Will Affect Your Practice," *Medical Economics* 88, no. 24 (2011), pp. 76–78.

Learning Objectives

After completing the chapter you will be able to:

1. Understand that the value-adding support strategies are important elements in the implementation of strategy.
2. Appreciate the importance of aligning the value-adding support strategies to ensure they point the organization toward achieving its mission, vision, and goals.

3. Link the results of internal environmental analysis of the support activities to the implementation of value-adding support strategies.
4. Understand how the culture, structure, and strategic resources of an organization must be explicitly linked to directional, adaptive, market entry, and competitive strategies, as well as the value-adding service delivery strategies.
5. Understand that through the value-adding support strategies the organization itself is changed, creating or solidifying competitive advantages and strengthening weaknesses to overcome competitive disadvantages.
6. Understand that the value-adding support strategies provide guidance for the development of organizational objectives and action plans.
7. Create value-adding support strategies that help to accomplish directional, adaptive, market entry, and competitive strategies, as well as value-adding service delivery strategies.

Implementing Support Strategies

As indicated in Chapter 8, implementation strategies take a decidedly internal focus. Effective and efficient operations make strategies work. Along with the pre-service, point-of-service, and after-service strategies, the value-adding support strategies should be developed and specified. Similar to the service delivery strategies, the value-adding support strategies are implementation strategies directed toward accomplishment of all the other strategies including the directional, adaptive, market entry, competitive, and service delivery strategies. As introduced in the strategic thinking map of the value chain shown in Exhibit 8–1, the value-adding support strategies are based on the elements of the lower portion of the value chain and are the means for accomplishing the decisions made in strategy formulation. Once the support strategies are determined, more specific action plans may be developed (see Chapter 10).

Value-Adding Support Strategies

The lower portion of the value chain contains the *value-adding support activities* and includes the organization's culture, structure, and strategic resources. More specifically, the support strategies concern areas such as the behavioral norms, organization structure and flexibility, human resources, finance, information systems, and technology, and will play a major role in the implementation of the organization's overall strategy. Each area adds value in the organization. Thus, strategies are required to maintain or enhance the organization's competitive advantages and to strengthen areas where the organization has competitive disadvantages.

As with the service delivery strategies, value-adding support strategies must be consciously aligned. Strategic managers should take care to ensure that the support strategies are consistent and compatible with each other as well as contribute to the accomplishment of the organization's overall strategy. Therefore, the support strategies for each area cannot be developed or evaluated in isolation. It is the strategic manager's responsibility not only to make decisions concerning each support strategy but also to ensure that these elements are aligned and coordinated to help achieve the overall strategy of the organization. Strategic thinking, strategic planning, and managing strategic momentum are central to this process.

Decision Logic for the Value-Adding Support Strategies

Once the service delivery strategies (the primary value-adding activities) are formulated, support strategies that provide the appropriate organizational context and resources to carry out the organization's strategy may be developed. As with the value-adding service delivery strategies, the results of the internal environmental analysis identify the competitively relevant strengths and weaknesses for the support activities. Each of these value chain support areas was evaluated in situational analysis (Chapter 4) and the conclusions used in strategy formulation. Similarly, the appropriate directional, adaptive, market entry, and competitive strategies have been discussed in Chapters 5 through 7. Depending on the results of this comparison, the support areas may need to be maintained or changed to carry out the selected strategy. A strategic thinking map depicting this rationale in the form of a table is shown in Exhibit 9–1. In this chapter each of the value-adding support strategies will be examined and key decision areas identified to suggest support strategies.

Organizational Culture as a Value-Adding Support Strategy

Culture permeates the organization and successful strategic managers understand its importance. Studies have demonstrated that in addition to strategy,

EXHIBIT 9–1 Strategic Thinking Map for Developing Value-Adding Support Strategies

Value-Adding Support Strategies	Results of Internal Analysis	Requirements of Selected Strategies	Comparison of Strategy Requirements and Internal Analysis	Maintain or Change
Organizational culture				
Organizational structure				
Strategic resources				

execution, and structure, the proper culture was imperative for organizations that outperformed their industry peers.[1] After careful study, organizational culture has been recognized as much more complex than originally thought. In the case of health care delivery, cultural factors such as excellence in health care delivery, ethical values, involvement, professionalism, value for money, cost of care, commitment to quality, and strategic thinking have been shown to be important determinants of the quality of care.[2] To successfully implement strategy, strategic managers must know how to maintain as well as change organizational culture. Organizational culture may be supportive of strategic efforts and, thus, there is no requirement to change the culture. In this case, a policy of maintaining the culture is necessary. On the other hand, the current culture may inhibit changes that alter the accepted ways of doing things. If this situation occurs, the implementation process will require modification of the culture. Although culture change is difficult, it is often an important factor in moving the organization toward realizing its vision.

A Definition of Organizational Culture

Organizational *culture* is defined as the "implicit, invisible, intrinsic, and informal consciousness of the organization that guides the behavior of individuals and shapes itself out of their behavior."[3] Therefore, organizational culture may be thought of as:

- shared assumptions,
- shared values, and
- behavioral norms.

Assumptions and values are the basis for an informal consciousness of the organization and persist over time even when the membership of the organization changes. *Shared assumptions* include a common understanding of "who we are" (mission) and "what we are trying to accomplish" (vision and strategic goals) and the belief in the values of the organization. *Shared values* represent the understanding of "the way we do things" and may or may not reflect the organization's "stated" values – it is the actual members' values that create the organization's culture. The behavioral expectations or *behavioral norms* that are common among the members of a group are the visible consequences resulting from the informal consciousness.

Culture and the Bottom Line

Some organizational cultures have the potential to inspire aggressive and calculated managerial action, whereas other cultures do little more than encourage managers to be mere caretakers. Cultures build group cohesiveness and when members of the group insist on high levels of performance, each individual is encouraged to do his or her best.[4] A surgical team performing complex operations is a good example of how the culture of the group demands that each individual performs at the highest possible level if membership is to be maintained.

Unfortunately, cohesive cultures can discourage change. When organizations become too committed to "how we do things around here" and "what we

believe in," it may be difficult, at least in the short run, to change the culture. Opportunities can be missed and competitive advantages can be lost simply because the culture is so strong that it will not tolerate new ideas and directions. However, organizational cultures, when they encourage mission-critical factors such as patient-centered care, can be positive contributors to the overall success of an organization. As pointed out in Perspective 9–1, standardized processes, such as clinical pathways, may be a powerful force in shaping health care organizational cultures over the next several years where the emphasis often has been on unilateral decision making.

PERSPECTIVE 9–1

Enhancement of Health Care Quality Using Clinical Pathways

Health care organizations are increasingly being asked (sometimes required) to reduce costs and simultaneously increase quality. For almost two decades, clinical pathways have been used as a tool for optimizing health care resources and enhancing quality of care. Clinical pathway analysis applies critical-path methods used in industrial process control to clinical processes. These methods can lead to optimal interdisciplinary patient care. Clinical pathways involve all health care professionals – physicians, nurses, social workers, pharmacists, and so on. A clinical pathway can be thought of as a visualization of the patient's health care process and a multifaceted, resource-intensive process involving all concerned parties. Because health care is a knowledge-intensive industry, any attempt to reduce costs and increase quality will require effective knowledge management across a diversity of disciplines, interdisciplinary teamwork, and management of the culture.

The sharing and integrating of the knowledge of diverse professionals are important to the implementation of a successful health care process using clinical pathways. Knowledge management is a business concept that can facilitate the application of clinical pathways because it relates to an organization's ability to acquire and disseminate new and existing knowledge. One theory of knowledge management that relates well to health care is the "community of practice." Communities of practice galvanize knowledge sharing and adaptation to change. Communities of practice are defined as groups of people bound together by shared experience and a passion for joint enterprise. It is a cross-functional group brought together to capture and spread ideas and know-how. The disadvantage of communities of practice is that the knowledge shared is often informal in nature. Clinical pathways are developed informally through the cooperative efforts of physicians, nurses, and other professionals to improve the quality and value of patient, yet formally captured pathways are designed using clinical guidelines based on evidence-based management and visualized knowledge.

Additionally, pathways benefit from effective interdisciplinary teamwork or they may suffer from poor teamwork. Interdisciplinary teamwork can bring different professional points of view to bear on a patient's problem(s); however, teamwork may not be sufficient to ensure integrative knowledge. Integrative knowledge

sharing among knowledge workers is critical for the application of new knowledge to health care phenomena.

One of the major barriers to effective teamwork in health care is poor communication among diverse health care professionals. Poor communication occurs because of inherent differences in cultures and experiences. Miscommunication is especially likely to arise in emergency situations where events are unpredictable and a high level of cooperation among professionals is mandatory.

For effective clinical pathways, health care professionals have to understand and appreciate differences in cultures and the results these differences have on the attitudes of colleagues. Most culture is based on context-specific knowledge unique to each profession. Sharing of different knowledge is important for the continuous implementation of knowledge management in health care organizations. Clinical pathways have the effect of promoting communication among health care professionals because they express clearly that tacit knowledge is a part of all health care processes

Source: Tomoyoshi Yamazaki, Mitsuru Ikeda, and Katsuhiro Umemoto, "Enhancement of Healthcare Quality Using Clinical-Pathways Activities," *VINE* 41, no. 1 (2011), pp. 63–71.

Matching Culture and Strategy

Mission, vision, values, and strategic goals (discussed in Chapter 5) provide the linkage between strategy and culture. Just as these directional strategies were a major input to the selection of the adaptive, market entry, and competitive strategies, they play a major role in shaping the appropriate organizational culture. How the organization defines itself, what it wants to be, how it accomplishes its tasks, and what it wants to achieve, shape the culture of the organization. The directional strategies can be powerful forces in maintaining or changing the culture.

Strategic mangers must decide if the organizational culture can help to achieve the strategy. Therefore, they must assess what assumptions, values, and behavioral norms are necessary to most effectively carry out the strategy. Attributes of the current assumptions, values, and behavioral norms must be compared with the assumptions, values, and behavioral norms required by the strategy. For example, if a market development strategy is being pursued, strategic managers may have to maintain the current culture; for new entrepreneurial ventures or product development, however, the culture may have to change. As discussed in Chapter 6, strategies that involve acquisitions, mergers, and alliances usually have organizational culture implications. Incompatible cultures may contribute to failure of the strategy.

During the situational analysis of the strategic management process, the mission, vision, values, and strategic goals (the directional strategies) were evaluated. The leader must assess whether these directional strategies are still appropriate and are actually reflected in the culture of the organization. Results of this assessment will determine whether the leader needs to create implementation strategies to maintain or change organizational culture.

In addition to the comparison of the requirements of the overall strategy to current culture, results of the internal analysis itself may suggest action. The

internal analysis specifies whether the organization's culture is a strength or weakness and whether it might create a competitive advantage or disadvantage. Therefore, the results of the internal analysis must also be considered in the decision to maintain or change the culture. The culture of an organization will greatly influence the extent to which individuals are willing to share decision making, how open individuals are to ideas from patients, and the quality of cooperation among diverse organizational units.[5]

Maintaining Organizational Culture Despite a good match between the attributes of the current culture and requirements of the strategy, the work of management is not complete. Maintaining culture often requires a great deal of hard work. In internal environmental analysis, if aspects of culture are evaluated as strengths having high value (H), being rare (Y), easy or difficult to develop (E or D), and sustainable (Y) – resulting in HYEY or HYDY – maintaining culture is particularly important because culture can be a source of short-term or long-term competitive advantage. Culture can be a powerful weapon in recruiting, efficiency, and innovation. Allowing this strength to deteriorate will lead to competitive disadvantage, particularly when it is common (not rare) among competitors.

Therefore, in maintaining culture, managers should:

- Communicate often the mission, vision, values, and goals – verbally and in writing.
- Behave in ways that are consistent with the values and vision – first through their personal behavior, and then through who they hire, who they promote, and what they reward.
- Review and discuss the values and behavioral norms periodically.

Changing Organizational Culture Changing organizational culture can be difficult and requires a great deal of planning, time, and energy. Michael Beer and Russell Eisenstat noted that, "We've become convinced that the most powerful way for leaders to realign their organization is to publicly confront the unvarnished truth about the barriers blocking strategy implementation. Typically this involves looking closely at the roles and decision rights of various parts of the business, as well as changing the behavior of people at all levels."[6]

When culture is viewed as a weakness (from internal environmental analysis) or the requirements of the strategy call for a different culture, culture-change strategies should be initiated. In cases where ineffective culture is assessed as a common weakness but easy to correct (HYEY or HYEN), competitors may be moving to build their own organizational culture to create competitive advantage; therefore, culture-change actions are warranted. When effective culture is a weakness, the weakness is not common among competitors and is difficult to develop (HNDY and HNDN), change strategies should be initiated, particularly where competitors may act and achieve a significant competitive advantage. The most serious situation, of course, is where an organization has a weak culture and other organizations have effective cultures (weak culture is not common), and it is difficult to develop a new culture (HNDY and HNDN)

resulting in a significant competitive disadvantage. Strategic managers who want to create culture change should focus their energies on a few critical activities:

- Clarify the mission and vision and discuss the types of values and behaviors that would best achieve the vision.
- Discuss and codify the values and behavioral norms.
- Live by the values from the very beginning.
- Review and discuss the values and behavioral norms periodically.
- Create an atmosphere of perceived "crisis" in the organization. Without dissatisfaction with the current state, there is little incentive for managers to change familiar patterns of behavior.
- Clarify the vision and indicate what changes are necessary to achieve the vision. People need a clear sense of where the organization is going and where they should be headed.
- Communicate the mission, vision, values, and goals widely and repeatedly. Strategic managers should use simple, powerful, and consistent language.
- Model the kinds of behaviors and practices that management wants infused into the organization through actions. "Walking the talk" gives credibility to the words and provides examples to others in the organization of what behavior is expected.
- Empower other people to start acting in ways that are consistent with the desired values, and to implement new behaviors and practices. Part of empowering others is removing barriers within the organization that are in the way of the desired behavior.
- Look for some quick but sustainable successes. Short-term successes are critical to provide the change effort with some credibility, keep people motivated, and demonstrate positive results to the organization.
- Demonstrate patience and persistence. Major culture change takes a long time – years not months – and the willingness to persist in the face of obstacles and setbacks is critical.[7]

Organizational Structure as a Value-Adding Support Strategy

Similar to culture, the organizational structure must facilitate rather than impede the implementation of the overall strategy. As Alfred Chandler observed, "Matching organization structure to the strategy is a fundamental task of the strategist."[8] A long-standing, although not universally accepted, tradition in strategy research is known as configuration theory. This theory argues that in specific cases (e.g., industries, locations, and so on) certain organizational structures are more effective in accomplishing the mission than others.[9] This view has been confirmed in a number of settings and reinforces Chandler's argument.[10]

Once the directional, market entry, competitive, and service delivery strategies have been developed, management must determine what organizational structure will best facilitate the strategy. This strategic thinking activity matches the requirements of strategy with the advantages and disadvantages of various organizational structural options. In addition, it should be acknowledged that an organization's current organizational structure might limit the strategic options or at least their initiation in the short run. Over time, the structure can be changed to meet the needs of the proposed strategy. At some point, the strategist must decide if the present structure should be maintained or changed.

Organizational Structure Building Blocks

Organizational hierarchy remains the basic structure of most, if not all, large organizations. As Harold Leavitt has written, ". . . just about every large organization remains hierarchical."[11] Organizations, whether loosely coupled, networked, or divisionalized, seem to be no more than modifications of the same basic design. Leavitt concludes that, ". . . hierarchies remain the best available mechanism for doing complex work."[12] There are three fundamental organizational hierarchical designs that form the basic building blocks for organizations:

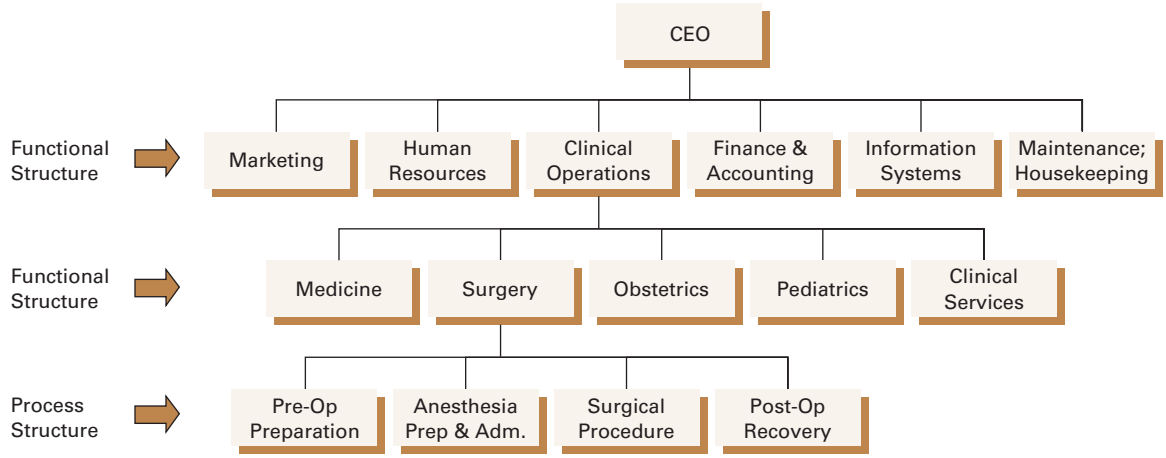
- functional structure,
- divisional structure (strategic business or service units), and
- matrix structure.

Functional Structure

Functional structures organize activities around the mission-critical activities or processes of the organization and are the most prevalent structures for single product/service and narrowly focused organizations. A functional structure might include departments such as clinical operations, marketing, finance, information systems, and so on. However, activities will vary from one organization to another. Often parts of an organization are structured around processes. For example, in health care organizations, clinical operations are mission critical and the clinical function may be at the center of a functional structure. The clinic may then be organized around separate clinical processes such as registration, testing, examination, lab, and so on.

A functional structure builds a high degree of specialization and expertise within the functions or processes and can foster efficiency, particularly when tasks are routine and repetitive (such as in clinics). Moreover, in this type of organizational structure, control of strategic decisions is highly centralized. However, functional structures sometimes foster "silo thinking," slowing down decision making and inhibiting horizontal communication. As a result, it becomes a major task of strategic management to keep functional managers focused on the broader mission and the organization's vision (beyond their own functions) and to ensure coordination and communication across the functions. Exhibit 9–2 illustrates a functional organizational structure for clinical operations (organized around processes) and summarizes the advantages and disadvantages of functional structures.

EXHIBIT 9–2 Functional Structure Combined with Process Structure



Functional Structure Strategic Advantages

- Builds a high degree of specialization
- Fosters efficiency
- Centralizes control and decision making
- Develops functional expertise

Functional Structure Strategic Disadvantages

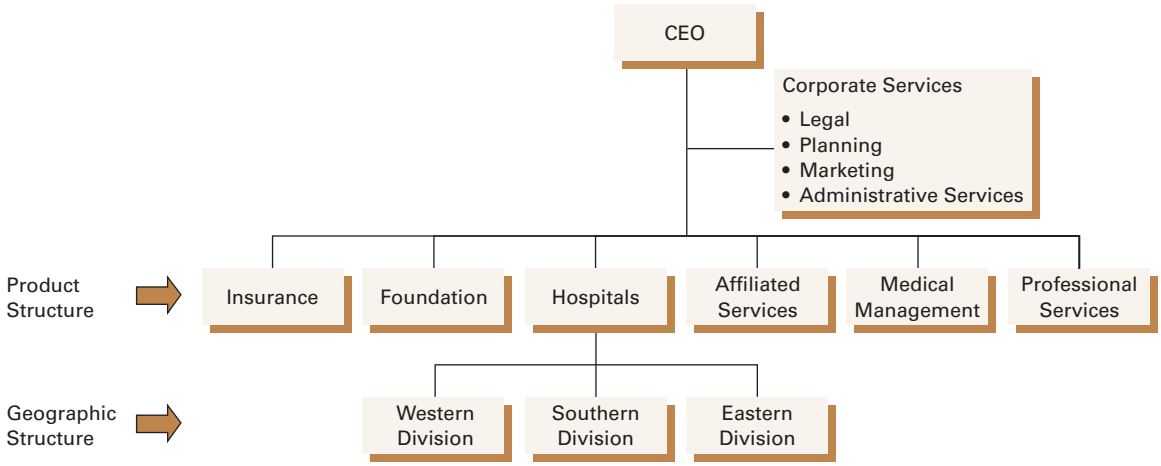
- Fosters "silo thinking" – narrow specialization
- Slows down decision making
- Makes horizontal communication difficult
- Makes coordination difficult
- Limits the development of general managers

Divisional Structure *Divisional structures* are common in organizations that have grown through diversification, vertical integration, and aggressive market or product development. As organizations grow and become more diverse, divisional organizational structures are used to break the organization down into more manageable and focused parts. Therefore, a divisional structure creates several smaller, more focused, semi-autonomous strategic business/service units (SBUs/SSUs). Typical divisions might be based on geography (markets), products/services, or customers.

Structures with geographic divisions allow each division to tailor strategy and differentiate products/services based on the unique needs or characteristics of the geographic area or market. Local responsiveness will usually result in enhanced performance because communication and coordination with a target market will be improved. When organizations have multiple unique products/services, a divisional structure that places organizational emphasis on these products/services may be most appropriate. This structure gives the product division managers authority and responsibility to formulate and implement a product/service strategy. In addition, the structure allows functional areas to specialize around each product/service, thus increasing the coordination and communication. Divisions based on products/services increase the focus on products, markets, and quick response to change.

Divisional structures are not without problems. Divisional structures make it difficult to maintain a consistent image or reputation, add layers of management because of duplicate services and functions, and require carefully developed policy guidelines for the SBU/SSU. In addition, divisional structures may create

EXHIBIT 9–3 Divisional Structure – Product with Geographic Divisions



Divisional Structure Strategic Advantages

- Forces decision making down the organization
- Allows different strategies among divisions
- Fosters improved local responsiveness
- Places emphasis on the geographic region or product/service
- Improves functional coordination within the division
- Identifies responsibility and accountability
- Develops general managers

Divisional Structure Strategic Disadvantages

- Makes it difficult to maintain a consistent image/reputation
- Adds layers of management
- Duplicates services and functions
- Requires carefully developed policies and decision-making guidelines
- Creates competition for resources

competition for resources among the divisions. Exhibit 9–3 illustrates an organizational structure with product divisions (organized geographically) and summarizes the advantages and disadvantages of divisional structures.

Matrix Structures A *matrix structure* may be most appropriate when organizations have numerous products or projects that draw on common functional expertise. The fundamental rationale underlying a matrix structure is to organize around problems to be solved rather than functions or products or geography. Matrix organizations develop expertise and allow product areas or projects to use that expertise as needed. Therefore, in this structure, functional specialists may work on a number of different projects and with a number of project managers over time. Matrix structures foster creativity and innovation in the organization and, therefore, the structure is particularly effective for rapid product development and can accommodate a wide variety of product or project activities.

As illustrated in Perspective 9–2, matrix structures are difficult to manage – no one disputes that fact. The structure violates the "unity of command" (people report to only one boss) principle and, as a result, employees are often confused on priorities and "who is the boss." Therefore, this type of structure requires a great deal of coordination and communication and some degree of negotiation

PERSPECTIVE 9–2

Challenges of Matrix Management

Managing a matrix organization is not an easy task. A survey of almost 300 top and mid-level managers in six industries identified five challenges of the matrix form of organization: (1) misaligned goals; (2) unclear roles and responsibilities; (3) ambiguous authority; (4) lack of a matrix guardian; and (5) silo-focused employees.

Misaligned goals. Often there are competing or conflicting goals between the dimensions (functions, regions, services, customers) of the matrix. A project working toward a specific deadline date may have goals that are different from the functional units supporting the project. Usually inadequate processes to align goals or detect possible misalignments exist. Moreover, communication between projects and functional areas is frequently strained and fragmented. Some managers suggest that misalignment can be reduced by constantly communicating and reinforcing the organization's mission and vision.

Unclear roles and responsibilities. Confusion over roles and responsibilities is a challenge for virtually all matrix organizations. The lack of clarity results from unclear job descriptions, confusion over who is boss, and lack of a sense of direction or determining who to contact for information. Ambiguous goals and responsibilities create tension and can become dysfunctional. Four basic requirements are necessary to minimize the lack of clarity: (1) clear guidelines and descriptions of roles and responsibilities; (2) specific assignments for the accomplishment of business goals; (3) a single point of contact for information or approval for areas of responsibility; and (4) a set plan for communication and information sharing.

Ambiguous authority. In the matrix structure, decision makers sometimes have responsibility without authority. In a hospital, the human resources (HR) department, for example, might be charged with the responsibility of developing a policy but the department might not have the authority to implement the policy. The head of medicine may be able to ignore or violate the HR policy with few adverse consequences. In the matrix structure, confusion over final authority is common and there is a lack of clarity in areas of accountability, which may lead to delays in decision making.

Organizational culture plays an important role in resolving authority problems in matrix organizations. In organizations with collaborative cultures, managers are more focused on problem solving and are able to resolve authority issues through informal negotiation. When the culture is more political, managers tend to focus more on maintaining their status and power than on resolving issues.

Matrix guardian. In most organizations "what gets measured, gets done." For this reason, performance measures for functional, geographical, and related units are well established. It is less likely that organizations carefully measure the performance of projects. Top-level executives, especially, may be unaware of project performance. A matrix guardian responsible for matrix performance can correct many of the apparent problems. Research has shown that: (1) lack of consequences and rewards for matrix performance fails to motivate employees to make the matrix work; (2) establishing a monitoring process to detect and identify matrix performance problems overcomes employees' reluctance to divulge problems associated with their units;

(3) the matrix guardian must have senior-level support and authority to make decisions and act; and (4) the objectivity of the guardian must be preserved and protected from political pressure.

Silo-focused employees. Most people in most organizations tend to be silo-focused. Organizational membership and loyalty is often directed toward the functional unit (e.g., nursing, nutrition, administration, etc.) rather than a project to which they are assigned. There are two primary reasons for silo-focused behavior. First, most people spend the majority of their careers in a particular function. They tend to interact with other professionals like themselves and over time develop allegiances to the group. Second, matrix organizations require high degrees of cooperation when compared with single hierarchies. Most employees have not developed the interpersonal and negotiating skills necessary to make matrix organizations work efficiently and effectively. Research suggests that people need different types of training targeted at specific matrix challenges and programs rarely focus on the development of this type of skill.

Source: Thomas Sy and Laura Sue D'Annunzio, "Challenge and Strategies of Matrix Organizations: Top-Level and Mid-Level Managers' Perspectives," *Human Resource Planning* 28, no. 1 (2005), pp. 39–48.

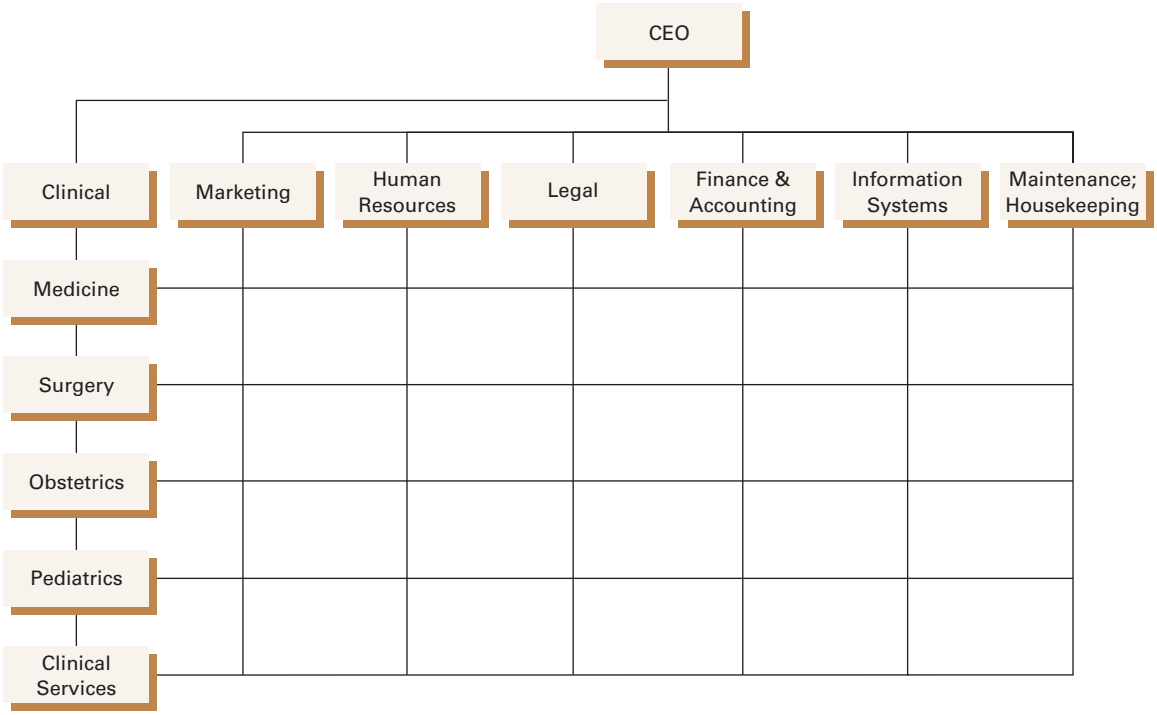
and shared responsibility between project managers and functional managers. Exhibit 9–4 illustrates a matrix structure and summarizes the advantages and disadvantages.

Combination Structures Determining the most effective basic structure that will carry out the strategy is critical for all organizations, however, most health care organizations are rarely organized using just a single structural building block. Rather, health care organizations find it necessary to mix and often supplement the basic design. These designs are *combination structures*. For example, functional organizations are often supplemented with cross-functional teams to improve coordination and communication. Geographic divisions may be organized around functions or products. Product divisions may have geographic divisions as well as functional components. Organizational structure should enable the strategy; managers should select the most appropriate set of organizational structure building blocks.

Although the organizational structure building blocks set the basic design of the organization, seldom is it adequate alone for carrying out the strategy and work of the organization. Therefore, most organizations modify their basic structure with some type of coordinating structures. These coordinating structures are sometimes referred to as the *collateral organization* – a system of task forces, committees, and ad hoc groups used to bring different perspectives on issues to the table for discussion and resolution. No organization can function for long without an effective collateral organization.[13] Collateral structures include:

- **Project and product teams** – created to undertake well-focused projects (typically short term) or to develop new products.

EXHIBIT 9–4 Matrix Structure



Matrix Structure Strategic Advantages

- Develops functional expertise
- Allows for a variety of product/project developments
- Allows for the efficient use of functional expertise
- Encourages rapid product development
- Fosters creativity and innovation

Matrix Structure Strategic Disadvantages

- Causes difficulties in management
- Violates the unity of command principle
- Creates coordination and communications problems
- Requires negotiation and shared responsibility
- Allows for confusion on priorities

- **Cross-functional task forces** – created to bring together specialists from several functional areas and address threats or opportunities. Typically, task forces take on a major project such as reorganization or the building of new facilities.
- **Venture teams** – created outside the normal organizational structure, they are not bound by the normal "rules" of the organization. Because they develop new products or processes, the creation of venture teams is sometimes called "intrapreneuring."
- **Re-engineering teams** – created to evaluate and reconfigure an organizational process (such as service delivery). Such teams are asked to disregard the current way of doing things and to redesign a process from scratch.
- **Executive and standing committees** – created to make organization-wide decisions. Executive and standing committees provide wide representation for key decisions and facilitate communication of the organization's direction and strategy implementation.

Matching Structure and Strategy

Strategic managers should strive to keep their structures (and processes) as simple as possible and trim every vestige of unnecessary bureaucracy – for example, extra layers of management.[14] Fundamentally, the structural decision is one of prioritizing standardization versus flexibility and selecting the basic structure that best achieves the required priority. Therefore, strategic managers must evaluate the advantages and disadvantages of each of the structural building blocks and match them with the requirements of the strategy. For example, a different structure may be required to carry out a defender/cost leadership competitive strategy than that for a prospector/differentiation strategy. Defender strategies require a high degree of structural standardization to create cost efficiencies while prospector strategies require a great deal of structural flexibility to develop new technologies and innovative products and services. The strategic thinking map shown in Exhibit 9–5 provides guidance concerning the most appropriate organizational structure based on the strategy requirements of standardization or flexibility.

Maintaining the Structure If there is a good match between the characteristics of the current organizational structure and the requirements of the strategy, then the present basic structure should be maintained; although additional coordinating mechanisms may be required. It is not often that organizational structure alone will create long-term competitive advantage; however, structure is a key implementation area (especially when coupled with an effective culture). When it is viewed as a competitively relevant strength, efforts should be made to keep it effective – whether it is or is not rare among competitors. In maintaining the present structure, management should:

- Evaluate the present level of communication and coordination and discuss needed additional communication channels and coordinating mechanisms.
- Evaluate the present structure to ensure that there are opportunities for innovation where appropriate.
- Evaluate the management team to ensure that the leadership skills match their positions.
- Inventory the present skills to ensure that they are matched to the structure and strategy.

Changing the Structure If the comparison of the present structure and requirements of the strategy suggest a need to change the basic organizational structure, then management must develop a plan and move very carefully. Ineffective or inappropriate organizational structure can debilitate the organization's strategy – such as might be the case with too many organizational layers, thus delaying decision making – but by itself structure is not generally seen as a significant long-term competitive disadvantage. However, where the organizational structure is viewed as a competitive disadvantage, action must be taken. Reorganization represents a significant change for employees and is often viewed as threatening. To help managers think through reorganization, a re-engineering approach may be taken. Re-engineering reconsiders and changes how tasks connect to each other to produce more efficient overall systems of work.[15] Therefore, when changing the structure, management should:

EXHIBIT 9–5 Strategy Requirements and Organizational Structure

Strategy Requirements	Functional High Standardization	Divisional	Matrix High Flexibility
High level of coordination	X		
High level of standardization	X		
Area/functional expertise	X		
Main goal of efficiency	X		
High level of control	X		
Develop general managers		X	X
High degree of operating autonomy		X	
Decentralized decision making geared to market		X	
High need to customize product or services to market	X		
Consistent image		X	
Need local coordination		X	
Many projects using similar technologies			X
Need high level of creativity and innovation		X	X
Need high level of stability	X		
Need to develop new technologies			X
Need to be a cost leader	X		
Need to have service diversity		X	
Large organization		X	

- Develop a flow chart of the total process, including its interfaces with other value chain activities.
- Simplify first, eliminating tasks and steps where possible and analyzing how to streamline the performance of what remains.
- Determine which parts can be automated (usually those that are repetitive, time consuming, and require little thought or decision).
- Introduce advanced technologies that can be upgraded to achieve next-generation capability and provide a basis for further productivity gains in the future.
- Evaluate each activity to determine whether it is strategy critical (strategy-critical activities are candidates for benchmarking to achieve best-in-industry performance status).

- Weigh the pros and cons of outsourcing activities that are non-critical or that contribute little to the organizational capabilities and core competencies.
- Compare the advantages and disadvantages of the organizational building blocks regarding standardization and flexibility.
- Design a structure for performing the activities that remain, then reorganize the personnel and groups who perform these activities into the new structure.[16]

Changing the organizational structure can be a difficult task and may require some new thinking and new approaches to old problems. Re-engineering efforts that have been undertaken by health care organizations indicate that the use of integrating mechanisms, such as codifying the process, and the use of internal teams and committees during implementation appear to be most effective.[17] In addition, as they undertake restructuring, strategic managers need to evaluate what competitive benefits are actually accruing to ensure that managers are not just reorganizing to be like everyone else, but for improved outcomes – they must understand how re-engineering affects their competitive position.[18]

Strategic Resources as Value-Adding Support Strategies

Effective development and use of key organizational resources are critical in carrying out the selected strategies. Key *strategic resources* (resources, competencies, and capabilities) include financial, human, information systems, and technology.

Financial Resources

The financial resources of the organization are evaluated during internal environmental analysis and contribute to strategy formulation. Therefore, to this point the financial resources have provided a framework for developing a realistic strategy. Once the strategy has been selected, finance becomes a way to implement the strategy. All organizational strategies have financial implications and most likely will require an assessment of needed capital and a method to access capital. In addition, strategies require an understanding of the relationship between the organization's business model, reimbursement methods, and the mission.[19] Expansion, contraction, or maintenance of scope-adaptive strategies will require a financial implementation strategy.

Expansion and maintenance of scope strategies frequently make it necessary for health care organizations to enter the capital market or make arrangements to borrow money from one or more financial institutions. Expansion of scope, such as market development, may be realized through acquisition of a competitor (horizontal integration) and involve hundreds of millions of dollars. Expansion carried out through cooperation strategies similarly may require additional financial resources. For example, joint ventures are often financed by attracting other

individuals, such as physicians, to invest in promising ideas or equipment along with the hospital. Organizations with sufficient financial resources may even act as venture capitalists for new ideas. Similarly, maintenance of scope strategies directed toward enhancement of facilities, equipment, quality of services, and so on will often require new capital and operating funds. For example, an organization may have to acquire new property and relocate in its efforts to change the image held by physicians who might join its staff and the patients who might use its facilities. New technology may be demanded as well for this change in image or for significant improvement of services.

Contraction of scope strategies require equally challenging financial decision making. Divestiture, liquidation, harvesting, and, in some cases, retrenchment all convert financial resources, at least temporarily, into cash or near cash assets. An inflow of cash forces strategic managers to consider alternatives for the funds to ensure that they are appropriately invested until they are needed for other uses. Contraction requires careful re-evaluation and possible redirection of the use of financial resources. For example, a hospital experiencing financial distress, after careful analysis, might decide that its emergency room is too expensive to continue to operate in view of limited demand by the community. The high level of specialized staffing for around-the-clock operations is a financial burden that cannot be justified economically. The decision to close the emergency room would temporarily free financial resources that could be allocated to more profitable areas and relieve some of the cost pressure on the hospital.

In developing financial strategies to carry out the organization's overall strategy, two issues typically predominate – increasing financial resources (equity and debt capital acquisition and fund raising) and better management of the organization's current financial resources including cash flow management, budgeting, and financial planning. Analysis of these issues as well as other balance sheet and income statement issues is reviewed in Appendix B – Financial Analysis for Health Care Organizations.

Human Resources

It is clear that a successfully implemented strategy is inextricably connected with having committed, high-performing employees.[20] It takes strong leadership and a positive organizational culture to keep employees motivated and productive. Motivated employees are the key to any strategy; however, human resource requirements of the selected strategies will vary considerably depending on whether the organization is expanding, contracting, or maintaining scope. For example, expansion strategies, such as related diversification, will make it necessary to recruit new personnel with skills and talents similar to those already in the organization. On the other hand, unrelated diversification and backward and forward vertical integration will create the need for human resources with skills and talents quite different from those presently employed. The necessity of recruiting, hiring, and leading individuals with different skills and talents is a major reason that these strategies are "riskier" than related diversification. Any one of these strategies requires the merger of similar or dissimilar organizational cultures, presenting yet another human resources challenge.

Diversification and integration are two very different strategic choices, but they require similar types of organizational and human resources management responses. When diversification or integration is selected as a strategic alternative, the potential exists that organizational size and diversity will increase, as will the demand for more specialized human resources management services.

Although the problems are difficult and demanding, expansion is always more fun to manage than maturity and decline. During maturity, the emphasis is on efficiency. Human resources management practices must be constantly refined and improved to ensure that things are done in the best way at the least cost. However, organizations do not always successfully manage maturity, and markets erode and even disappear. Therefore, it is important for the strategic health care manager to understand how to manage the organizational and human resources aspects during market contraction.

Contraction involves different human resources management skills. Incentives must be devised to encourage employees to find other jobs or to retire earlier than anticipated. For some, layoffs may be necessary, and the organization will be forced to determine its responsibility in assisting displaced employees to find alternative employment opportunities. At times, health care organizations may assist employees by retraining them for different tasks that will be needed as contraction takes place.

In Chapter 6, several contraction strategies, such as divestiture and liquidation, were discussed. Although terms such as "divestiture" and "liquidation" imply financial actions, they have important human resources implications in the form of restructuring and reorganizing, early retirements, layoffs, and so on.

The benefits of systematically managing the human resources dimension under expansion and contraction strategies are somewhat obvious. The need for carefully managing maintenance of scope strategies is equally important, if not as obvious. Maintenance strategies almost always require training and development activities. Enhancement strategies through total quality management programs involve significant commitments to continuous learning on the part of the individual and the organization. Status quo requires the challenging task of keeping people motivated in the face of career plateaus.

When an organization reaches a point in its life cycle where it is no longer growing, it must work extremely hard to keep from contracting. Strategic decision makers may adopt a conservative strategy, such as managing the steady state or status quo. As was noted in Chapter 6, the assumption underlying this strategy is that the expansion phase of the organization's evolution is over, maturity has been achieved, and acceptable market shares have been attained. The organization attempts to replace personnel with employees of similar skills and training, and works to keep existing personnel up-to-date and technologically prepared to perform their jobs at high levels of effectiveness.

Maintaining scope can present an opportunity to enhance current levels of operation. This stage of organizational development can be thought of as a temporary "breather," allowing preparation to commence for the next period of growth. Or, decision makers may simply think of maintaining scope in a dynamic sense and recognize that they must work hard just to hold their current position. In this case, they may choose to enhance their facilities, improve the quality of their services, increase the speed with which they respond to patients and make

decisions, and create new and better ways of doing things. Human resources strategies are important to support any attempt at enhancement because ultimately it is the employees that must improve quality, innovate, and work faster if things are to improve.[21] As pointed out in Perspective 9–3, a key component of a human resources enhancement strategy is to use evidence-based approaches that are known to be successful.

PERSPECTIVE 9–3

Building People Stewardship

There are many things organizations cannot control, such as economic conditions. There is, however, one proven way for decision makers to achieve better financial outcomes – by using evidence-based approaches effectively to manage the workforce.

About 60 percent of hospital and health system budgets are allocated to human capital. This makes "people stewardship" very important. People stewardship involves playing to an organization's strengths in human capital, planning to better control costs, and investing most intelligently. Human capital planning should be approached similar to other strategic planning and budgeting processes. Decision makers should set goals and priorities and maintain standards for excellent performance.

Health care finance executives have skills to help lead the effort toward people stewardship. They have the analytical skills needed to help determine rates of turnover, variations in performance, and dips in employee satisfaction. In evaluating their organization's workforce hiring and promotion patterns, decision makers should consider several questions. These are:

1. Does our organization have an appropriate mix of internal promotions and external hires? It is important to get the right person in the right job at the right time.
2. If the organization is searching outside to fill a leadership position, is the external candidate clearly stronger than internal candidates? Too often we assume that outsiders will come in and be perfect fits. Then reality sets in.
3. How well does the organization track its average length of service? The longer the average length of service, the harder it will be for outsiders to penetrate the organization.
4. What is the organization's tolerance for risk? Some believe the safest action is to always select the internal candidate even if an outsider appears more qualified.

Consistent hiring and promotion successes are difficult to obtain because naturally the "best" indication we have of future performance is an individual's past performance. Sometimes, however, the highest performers of specific tasks do not make the best managers because of a tendency to continue to do what is comfortable. Effective management requires delegation skills. Good managers learn to assign tasks to others, motivate and coach them, and measure their performance instead of handling operational tasks themselves.

Effectively utilizing existing talent depends on four critical components. First, there must be objective performance expectations for each

position. Health care executives should have precise ideas about the activities and competencies required for each job – not only for today but for the future as well. Second, organizations need a robust performance appraisal system. This involves having accurate and in-depth evaluations for each person, a framework for identifying leadership talent, and the creation of a leadership pipeline that successfully feeds the succession plan. Third, performance appraisal is not enough; organizations need individualized development plans as well. Finally, a fluid succession planning process is needed to accommodate the variable business needs of the organization over time.

To most effectively leverage their workforce, health care executives should employ the following strategies:

- Commit to creating and implementing a formal program. When any type of human capital strategy is too informal and unplanned, job incumbents tend to identify and groom successors remarkably similar to themselves.
- Incorporate values in the appraisal of staff work requirements and competencies. Without this, individuals may be equipped with the competencies and skills but lack the ethical dimension needed for leadership in the future.
- Appraise individual performance. It takes courage and emotional fortitude for those doing appraisals to be forthright.
- Assess future requirements. Evaluation systems should not only look backward, focusing on what people have accomplished today, but look forward as well to consider the individual's potential.
- Assess future individual potential. Organizations should consider developing their own set of critical success factors to include things such as past experiences or personal characteristics that are linked to and correlated with successful advancement.
- Close the developmental gap. Keep people engaged and build the appropriate conditions so that the hospital or health system has "just in time people" who are prepared to move into a role rather than a mass of stagnated people.
- Evaluate the success of your workforce planning program. Make an effort to evaluate how well your program is working in terms of patient satisfaction, effective placements, and organizational results.

Source: Kenneth R. Cohen, "The Case for Evidence-Based Human Capital Management," *Healthcare Financial Management* 65, no. 8 (2011), pp. 102–107.

Information Resources

Information systems (IS) are an essential competitive resource for health care organizations and are critical in supporting strategic decision making, administrative operations, and patient care in an increasingly information-intensive industry. Information systems in health care may be divided into four general categories: clinical, management, strategic decision support, and electronic networking and e-health applications.[22] Competitive advantage may be created in each of these areas, and strategic managers should therefore play a key decision-making role in defining and shaping these systems, as illustrated in the Introductory Incident. Such systems draw on both internal data from clinical and

administrative systems in the organization as well as external data on community health, market demography, and activities of competitors.[23] To meet strategic objectives and develop high-priority applications, the health care organization must make decisions about hardware configurations (architecture), network communications, degree of centralization or decentralization of computing facilities, and types of computer software required to support the network.[24] The strategic information system may be used effectively to consider and help implement adaptive, market entry, and competitive strategies. See Perspective 9–4.

PERSPECTIVE 9–4

Information Technology and Health Care Organizational Performance

Health care information technology (HIT) – such as computerized physician order entry systems, electronic health records, and electronic prescriptions – is believed to be instrumental in reducing medical errors, enhancing staff productivity, and lowering health care costs. This belief arises from the resource-based view that suggests organizations compete on the basis of unique organizational resources that are valuable, rare, non-substitutable, and difficult to imitate. Information technology is an important resource that has the potential to deliver long-term operational and strategic benefits to an organization. IT can become an important tool for improving decisions, lowering costs, improving quality, and increasing efficiency.

In other industries where there has been a long and established history of investments in IT (e.g., banking, airlines), IT may not be a source of competitive advantage, rather a requirement to compete because most firms have certain basic IT capabilities. Because IT adoption in health care organizations lags behind other major industries, robust HIT capabilities can lead to a short-term competitive edge. Recognizing the lag in IT adoption in health care, the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 allocated billions of dollars to incentivize widespread adoption and use of electronic medical records among doctors and hospitals.

Much research has been conducted that has linked the use of HIT to improved patient and organizational outcomes; however, prior to the incentives embedded in the HITECH Act, there was misalignment of incentives. Traditionally, providers would incur the full cost of HIT implementation even though much of the financial benefits would accrue to third-party payers in the form of reduced redundant test orders, reduced lengths of stay, and improved error rates and quality. Although the HITECH Act is expected to greatly influence the adoption of HIT among hospitals and medical practices, it is still unclear to what extent it will successfully overcome the traditional misalignment of incentives.

Another challenge is that to fully appreciate the financial benefits of HIT investments, expanded models of analyses are needed because many of the benefits expected are not easy to quantify in dollars (e.g., lives saved, errors averted, etc.). Many of the traditional

methods for evaluating financial performance do not work well in not-for-profit settings and, of course, many hospitals are non-profit. Moreover, these institutions ordinarily provide large amounts of charitable care to the uninsured, underinsured, and indigent populations. Thus, measures such as revenue per patient per day are not as meaningful as in the for-profit environment. In addition, financial performance depends on many extraneous factors such as geography (rural versus urban), payer mix (Medicare, Medicaid, etc.), and other factors beyond the control of hospital decision makers. At the same time, the objective of HIT in health care is to improve operations and service delivery by focusing on operational performance rather than maximizing profits and revenues. In this light, it should be emphasized that not all investments in HIT have similar effects on performance.

Source: Nir Menachemi, PhD, Professor of Health Care Organization and Policy, University of Alabama at Birmingham.

A *strategic information system* (SIS), sometimes referred to as a *decision support system*, attempts to take vast quantities of unorganized data and turn them into useful information to enable managers to make better decisions. Such information systems involve organizing the data, selecting the models that will be used to analyze the data, and interpreting the output; nevertheless it is not sufficient simply to provide the reports to the strategist. Sometimes there is a need to interpret and clarify the data relative to the assumptions that were used. Because decision support systems attempt to investigate future activities, the assumptions are critical. The organization that can design a strategic IS that is pertinent, relatively accurate, and timely will have developed a competitive advantage. "Inappropriate use and interpretation of decision support models can be dangerous, but appropriate use of these models can be a powerful tool in the hands of an informed decision maker."[25] For example, as explained in Perspective 9–5, a geographic information system (GIS) is increasingly being used in health care to provide decision support.

Administrative information systems support areas other than direct patient care and include financial information systems, human resources systems, payroll, billing, purchasing, materials and facilities management, outpatient clinic scheduling, office automation, and so on. Clinical information systems support patient care and include computerized patient records systems, automated medical instrumentation, patient monitoring systems, nursing information systems, laboratory information systems, pharmacy information systems, clinical decision support systems, and information systems that support clinical research and education. Most information systems in the health care industry focus on the financial and administrative aspects of the practice of medicine and much less on the clinical decision making.[26] However, clinical information systems are growing in importance, creating significant competitive advantage through increased efficiency and effectiveness in patient care. Basic clinical information systems provide a "dictionary" of health problems for clinicians or display background information on specific patients. More sophisticated systems, often referred to as

PERSPECTIVE 9–5

Strategic Decision Making Using a Geographic Information System

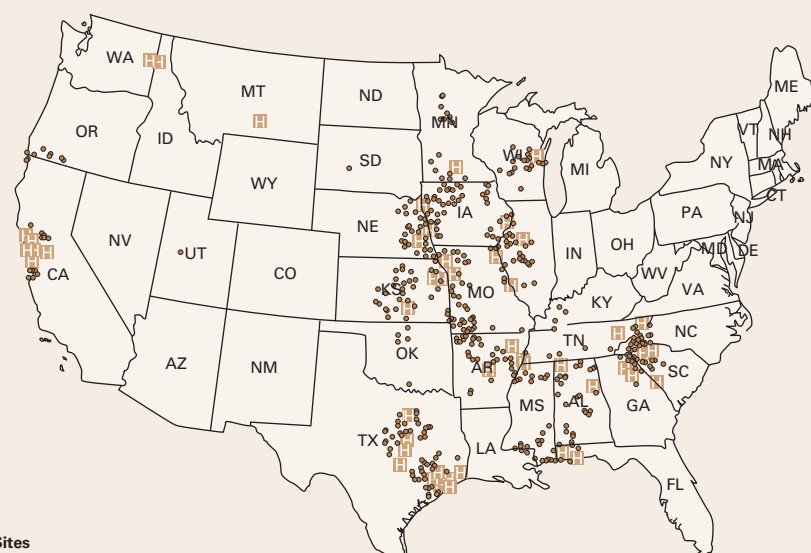
Poor geographical distribution of health services is an important reason for inadequate access to care and disparities in health outcomes. Using geographical information system (GIS) technology, spatial analysis can be used to examine the relationships between access, community resources, and disease burden in order to tailor strategic plans that improve the quality of health service delivery in a particular region. In addition, a GIS functions as a strategic tool for planning, implementing, and evaluating market availability, viability, and penetration.

GIS is an automated system for the capture, storage, retrieval, analysis, and display of spatial data. The integration of data with spatial information allows for more complex data processing, analysis, and modeling. Layered information, displayed as maps, can assist in the understanding of complicated strategic, spatial, and informational relationships. For example, GIS can be used to:

- determine geographic distribution of diseases,
- analyze spatial and temporal demographic trends,
- map populations at risk,
- stratify risk factors,
- assess resource allocation,
- plan and target interventions,
- inform the selection of clinical trial sites
- evaluate and prepare areas at risk for disasters,
- analyze referral patterns,
- monitor diseases and interventions over time, and
- evaluate marketing campaigns.

GIS technology was used to analyze spatial data to inform the selection of clinical trial sites for a biopharmaceutical company (see the map). Traditionally, clinical trial sites have been selected based on past experience of the company,

Selection of Clinical Trial Sites using GIS



Hospital Sites

= 1 hospital (n = 65)

Area of High Clustering

= Statistically significant clustered area

Source: Medical Marketing Services, Inc. American Hospital Association, Annual Survey Database, 2007.

relationships with top faculty, or through networks set up by clinical research organizations. Based on these and other factors, sites are then validated for resources and experience to implement the necessary trial protocol. However, many of these methods are inefficient and can often lead to longer trial times and lower than expected recruitment rates. These challenges were overcome using GIS as a novel approach to select trial sites for a biopharmaceutical company. Using multiple sources of data including prescribing data, hospital location, past clinical trial experience, and hospital characteristics, 65 locations were selected from 2,400. The selected locations represented a potential of over 1,000 investigators, much more than their traditional methods yielded. Based on the GIS analysis, the biopharmaceutical company was able to efficiently validate the sites and train the sites on the study protocol, thereby increasing patient recruitment and reducing the length of the trial, which in the pharmaceutical business translates to greater market potential.

Historically, spatial information has been used in the health care arena for epidemiological research, such as determining cancer mortality or food illness outbreaks by zip code, county, or census tract. However, given the power of GIS and the massive amounts of collected data in health care organizations, spatial analysis can provide valuable insight and become an effective tool for decision makers. The challenges of planning, implementing, and evaluating strategies can be greatly enhanced by applying GIS technology to prepare for disasters and terrorism events, increase health care access, and improve market positioning.

Source: Maziar Abdolrasulnia, PhD, CE Outcomes LLC.

expert or knowledge-based systems, can actively assist clinicians in the decision-making process.[27] Such functions include:

- assistance with diagnosing a patient's condition;
- assistance in determining proper drug dosage;
- reminders to administer preventive services to patients at specific times; and
- assistance in carrying out diagnostic or therapeutic procedures, such as recommending specific treatments, reminders to perform procedures, alerts regarding potential adverse events, feedback based on previous orders, and prompts for testing or treatment options.[28]

In today's information-intense environment, seamless integration and information sharing are becoming increasingly important. Most health care organizations interchange electronic data within their own organizations as well as with other organizations for insurance billing and claims processing, accessing clinical information from regional and national databases, online purchasing, and communications between affiliated providers.[29] Telemedicine is a part of such systems and has the potential to create competitive advantage for health care organizations.

Strategic Technologies

The technologies selected by the organization are dictated by the chosen strategies. Broadly, *strategic technologies* concern the type of facilities, type and sophistication of equipment, and management of technology employed within

the organization. Each of these activities is critical to the successful implementation of the organization's strategy.

Facilities *Facilities* is the broad term used to delineate the physical environment of the health care organization. It is the "shell" in which health care is delivered. It generally includes such diverse areas as design and construction of new facilities and renovation of older facilities, key equipment, clinical engineering, environmental services, safety and security, materials management, and food service. Each component affects the health care organization's ability to implement its strategy.

Facilities management is an area of increasing concern to strategic managers of health care organizations for a variety of reasons. One of the most important is changing technology that has fostered tremendous growth in the number and kind of alternative delivery systems requiring different strategies for success. Free-standing outpatient clinics, ambulatory (same-day) surgery centers, diagnostic and imaging centers, and others, are challenging traditional inpatient health care delivery. To survive, hospitals have altered their strategies to expand vertically and horizontally or to diversify into these new delivery systems; however, each type is subject to different regulatory guidelines as well as entirely different design needs for buildings – a challenge for the facilities manager.

A variety of components should be considered in the design of a health care facility: medical technology, the full range of medical procedures from routine exams to complicated life-saving activities, medical staff, sanitation, prevention of injury, economics, patients, and visitors. From the patients' perspective, the facility includes "curb appeal," ease of access to the main entrance, ease of parking, ease of wayfinding (finding the department, room, diagnostic area, or other area where the patient is expected), comfort, and convenience. Designing the facility with the human experience in mind recognizes that people's perceptions of health care are multidimensional; the facility helps them to define the care they receive. Sending a "we care" message cannot stop with the staff but must be designed into the facility itself.[30]

When the health care organization decides on a high-tech, high-touch, or some other strategy, the facility provides the first impression. The design, layout, color scheme, and so on should reflect the desired image to improve the implementation of the strategy. "Unlike the quality of medical care, health facility design is something that can readily be understood and judged, for better or worse, by the public."[31]

Equipment Closely associated with facilities is the choice of the type and sophistication of equipment and effective management of technology; integral parts of strategic management and should be approached in a systematic way. Because health care technology changes rapidly, is costly, and often requires changes in the facility, it must be assessed and planned for carefully to operate the facility to its greatest potential. Physicians generally want the latest technology – using the "latest" equipment or newest procedure provides prestige with colleagues and patients and may save more lives or provide less discomfort to patients. The decision concerning the use of the latest technology must fit with the strategy (differentiation based on high-technology image).

Technology decisions involve technology assessment, planning, acquisition, and management.[32] Strategists advocate that a committee assess requests for

new and emerging technology alongside the capital budget requests for new and replacement technology. The committee should report to senior management and should set mission-based, strategic priorities for new, emerging, and replacement technologies. Many hospitals do not incorporate into the budget the costs of redesign and "space" for new technology; nor do they investigate ways to reduce maintenance, insurance, and outside service contract costs. The planning process has to take into account what the competition is planning to acquire in terms of new and emerging technology as well as assessing the services offered by competitors.

Clinical engineering (sometimes called biomedical engineering) is a relatively new area in most health care organizations. Its responsibilities include: applying engineering technology to diagnostic and treatment devices used by health care facilities through testing, maintaining, and repairing equipment; training; consultation with clinical staff concerning the capabilities, efficiencies, and accuracy of the equipment; environmental testing; and incident and recall investigations that involve diagnostic or treatment equipment. The number and sophistication of technologies within health care institutions has increased significantly in the past decade. Because of the expertise required for such a large variety of equipment, some health care organizations use outside service contracts for some or all of their technological equipment.

Maintaining Strategic Resources

If there is a match between the present level of strategic resources and the requirements of the strategy, then efforts should be made to maintain the financial, human, information, and technology resources. These areas may represent key competitive advantages or disadvantages for an organization. Care should be taken to maintain those areas that are valued by customers and are a strength of the organization. In maintaining strategic resources the leader should do the following:

Financial

- Evaluate whether current financial resources are being used efficiently.
- Determine whether the liquidity is appropriate for meeting ongoing expenses.
- Seek ways to increase profitability without sacrificing other mission-critical factors.
- Assess the current level of leverage to determine if there is an appropriate level of risk.
- Determine whether asset activity can be improved.
- Assess cash-flow management.
- Consider investment opportunities for idle cash.

Human Resources

- Develop training programs to maintain the current human expertise and capabilities.

- Develop a management succession plan.
- Develop a job market network.

Information Systems

- Assess information systems growth needs.
- Develop information systems plans for operations and upgrades.

Technologies

- Make sure there is a plan for facilities and equipment maintenance.
- Develop a facilities and equipment replacement schedule.
- Periodically review the operating procedures, policies, and rules to keep them "lean."
- Review environmental services activities and procedures.
- Evaluate current security procedures.
- Evaluate food service activities.
- Evaluate operation and maintenance procedures.

Changing Strategic Resources

If there is a poor match between the present level of strategic resources and the requirements of the strategy, the goal should be to change the financial and human resources, information systems, and strategic technologies to meet the needs of the strategy. As with the service delivery strategies and other support strategies, the organization must be particularly sensitive to situations where it is easy to build a strength (its own or the competition's) because the competition may create a short-term competitive advantage. For example, evidence suggests that the early adoption of technology is often driven by technological competition where competitive rivalry is high (thus the need to eliminate competitive disadvantage). On the other hand, late adoption of technology may be more a result of revenue considerations (the threat of losing revenue).[33]

Changing the type or nature of the financial and human resources, information systems, or facilities and equipment can be a difficult and long-term project. To change these strategic resources, the leader should do the following:

Financial

- Assess whether the current revenue can finance the change.
- Investigate the opportunities to finance the change through the issuance of stock and the infusion of additional equity.
- Investigate the opportunities to finance the change through bonds, mortgages, bank loans, fund raising, or philanthropy.

Human Resources

- Assess job markets to determine the availability of individuals possessing the new required skills.
- Begin recruiting for new skills.
- Develop training programs to retrain individuals with skills no longer needed.

Information Systems

- Consider outsourcing needed changes in information systems.
- Assess the impact of needed changes on the current information systems.
- Assess needs of information systems in pre-service, point-of-service, and after-service activities.

Technologies

- Identify the exact specifications of the need for facilities, equipment, or processes, including space needs.
- Perform cost analysis on the required changes.
- Develop timelines for changing the technologies.
- Investigate the financing alternatives for the required changes.
- Investigate any new required skills or experience to operate or maintain the new facilities or equipment.
- Specify any new required processes or ways of doing things.
- Initiate the facilities, equipment, and technology management renewal.

Extending the Strategic Thinking Map

There are many ways to add value in organizations. The value-adding support strategies provide a powerful means to change the organization and create competitive advantage, especially because some of the value-adding support activities are less visible to those outside the organization, making the competitive advantage much more difficult to imitate or duplicate. Decisions concerning the organization's culture, structure, and resources are strategic in nature and should be made by strategic thinkers. The effectiveness of the organization's overall strategy may be influenced or even determined by the effectiveness of these implementation strategies. Exhibit 9–6 shows a completed strategic thinking map that compares the results of an internal environmental analysis and the selected strategy requirements and proposed value-adding support strategies for a long-term care organization. This map extends and further articulates the strategic thinking maps developed in strategy formulation and the development of the value-adding service delivery strategy. In addition, as with the service delivery strategies, guidance for managing the strategic momentum is provided so that unit managers may develop effective action plans that are tied directly to the organization's strategy.

EXHIBIT 9–6 Strategic Thinking Map for Value-Adding Support Strategies for a Long-Term Care Organization: An Example

Adaptive strategy: Vertical integration – enter into a system of care.
Market entry strategy: Enter into an alliance with hospital to assure referral network.
Strategic posture: Move from defender posture to analyzer posture.
Positioning strategy: Differentiation based on quality, upscale image.

	Characteristics/Attributes		Evaluation			Support Strategy
Value-Adding Support Strategies	**Results of Internal Analysis**	**Requirements of Selected Strategies**	**Comparison of Strategy Requirements and Results of Internal Analysis**	**Maintain**	**Change**	**Guidance for Organizational Units (Basis for Unit Action Plan Development)**
Organizational culture • Assumptions • Values • Behavior • Norms	Strong, positive culture based on religious affiliation, caring environment with appropriate behavioral norms (seen as competitive advantage: valuable, rare, difficult to imitate, and sustainable).	Culture reflects upscale differentiation positioning strategy.	Good match. However, culture (values and behavior norms) will need to be transferred to alliance partner (requires major organization effort to maintain competitive advantage).	X		**HR** – Emphasize importance of the organization's culture and image, review and discuss the values/behavior norms, discuss mission, vision, values, and strategic goals with new alliance partner.
Organizational structure • Function • Division • Matrix	Strong functional structure (some communication problems across functions, seen as short-term competitive disadvantage: valuable but fairly easy to fix).	Strategy requires specialization, vertical integration through alliance moves organization toward more decentralization.	Fairly good match. However, need to increase coordination and communication, improve communications and coordination through executive and standing committees. Cross-functional task force needed to plan and facilitate alliance.	X		**All units** – more discussion at executive and departmental meetings, create cross-functional task force to plan and implement alliance with appropriate hospital, initiate training program on communication and coordination.

(Continued)

EXHIBIT 9–6 *(Continued)*

Adaptive strategy: Vertical integration – enter into a system of care.
Market entry strategy: Enter into an alliance with hospital to assure referral network.
Strategic posture: Move from defender posture to analyzer posture.
Positioning strategy: Differentiation based on quality, upscale image.

	Characteristics/Attributes		Evaluation			Support Strategy
Value-Adding Support Strategies	**Results of Internal Analysis**	**Requirements of Selected Strategies**	**Comparison of Strategy Requirements and Results of Internal Analysis**	**Maintain**	**Change**	**Guidance for Organizational Units (Basis for Unit Action Plan Development)**
Strategic resources ● Human resources ● Information systems ● Strategic technologies ● Financial resources	Shortages of clinical personnel, reward system not tied to performance (not seen as competitive disadvantage because the problems are common in the industry). Little management depth, information system weak, many billing problems (competitive disadvantages). Excellent facilities, recently remodeled, equipment is state of-the-art, effective management facilities and technology (competitive advantage: valuable, rare, difficult to imitate, and sustainable). Strong financially.	Strong staff to provide long-term continuity of care and maintain image. Superior IS to support differentiation strategy. Positioning strategies (upscale differentiation) requires quality facilities and technology.	Poor match in the areas of HR and IS. Need to be improved to implement strategy. Most problems in HR concern personnel shortages, lack of management depth, and the reward system. Need major emphasis on recruitment of management and technical staff. Information system outdated. Need development of patient record and billing system. IS critical to the selected positioning strategy. Good match: facilities and technology, continual upgrade and maintenance needed. Finances available to support the strategy.		X X X X	**HR** – create recruitment package to attract and retain key management personnel and technical personnel, develop performance/reward proposal tied to behavior norms identified in internal analysis. **IS** – purchase new billing system, create overall information systems strategy. **Technologies** – install maintenance and upgrade schedule, ensure state-of-the-art facilities and equipment, ensure housekeeping keeps appearances up to high standards, state-of-the-art facilities and equipment in promotional materials, continue image promotions that emphasize differentiation strategy. **Finance** – budget for facilities and equipment upgrades utilizing current revenues.

EXHIBIT 9–7 Strategic Thinking Map for Evaluation – Support Strategies

1. Is the organization's culture appropriate for the overall strategy?
2. Are the organization's values reflected in the service delivery?
3. Are the behavioral norms appropriate for the strategy?
4. Are the management processes (the way we do things) appropriate for the strategy?
5. Does the organizational structure help to facilitate the overall strategy?
6. Is there a balance between standardization and flexibility?
7. Are additional coordinating or collateral structures required?
8. Does the organization have the financial resources to carry out the strategy?
9. Does the organization have the appropriate human resources, skills, policies, and procedures for the strategy?
10. Is the management talent appropriate?
11. Do the information systems help to facilitate the strategy?
12. Are the facilities and equipment up to date and appropriate to carry out the overall strategy?

Managing Strategic Momentum – Support Strategies

The actual management of the support strategies includes the managerial processes, procedures, style, and technologies of the organization and is an inherent part of the organization and the way it operates. Strategic thinking and strategy evaluation should be regarded as normal and necessary parts of what the organization and its managers do. Through the setting of objectives, the performance appraisal process, the compensation program, and so on, managers' actions are coordinated toward agreed-upon organizational objectives. Strategic thinking and strategic evaluation become part of the operating procedures and culture (shared values) of the organization. Additional questions to aid strategic managers in managing the support strategies and evaluating their progress and appropriateness are presented in Exhibit 9–7.

Lessons for Health Care Managers

The value chain activities provide the basis for strategy implementation. After the value-adding service delivery strategies have been developed, the value-adding support strategies should be formulated. The value-adding support strategies are important in implementing the overall strategy and include organizational culture, organizational structure, and strategic resources. These strategies work together with the service delivery strategies to effectively implement the organization's strategy.

As with the service delivery strategies, the results of the internal environmental analysis for each of the support activities in the value chain must be compared with the requirements of the strategies selected in the strategy formulation stage of the strategic management process. Results of that comparison indicate whether there needs to be a strategy that maintains the current status of the support activity or a strategy that changes the support area. Value-adding support strategies typically maintain current strengths or build new ones, or correct weaknesses in the support activities. For each of the value-adding support areas, actions for maintaining or changing the area are recommended as a way to initiate strategic thinking.

The organizational culture permeates the organization and is defined in terms of the shared assumptions, shared values, and accepted behavioral norms. Strategic managers must decide if the organization's culture will contribute to the accomplishment of the strategy or must change over time. Therefore, the current assumptions, values and norms must be compared with the requirement of the selected strategy.

The organizational structure should help to implement the strategy. The fundamental building blocks of organizational structure are functional, divisional, and matrix designs as well. Each structure has its advantages and disadvantages, and the decision concerning which structure is best to carry out the strategy is based on the need for standardization versus flexibility. Where a high degree of standardization is required, functional structures are desirable. Where a high level of flexibility is required because of diversity of product or markets, or where markets are rapidly changing, divisional or matrix structures may work best. Most organizations use a combination of designs supplemented with coordinating structures such as project teams and cross-functional task forces.

An organization's strategic resources are critical for most strategies – directional, adaptive, market entry, and competitive. Adequate resources allow for a number of strategic alternatives, whereas having few strategic resources inhibits strategy implementation. Strategic resources include financial, human, information, and technological resources. People are always key and different strategies require different human talents. Responsibility for recruiting and developing the right human resources for the strategy falls to leadership. Strategic information systems and decision support systems can create competitive advantage for organizations through improved customer service and more efficient and effective service delivery. The selection of the strategic technologies is a decision of the strategic leader and is central to strategy implementation. Strategic technologies include the type of facilities and the type and sophistication of equipment. The strategic technologies decisions set the physical context and level of sophistication for service delivery and affect everything from the organization's image to patient satisfaction.

An example of value-adding support strategies developed through a comparison of the results of an internal analysis and the requirements of the selected strategies for each are presented to extend strategic thinking. Chapter 10 demonstrates how individual organizational units must set objectives and develop action plans based on the value-adding service delivery strategies and support strategies selected to achieve directional and adaptive strategies.

Health Care Manager's Bookshelf

Thomas H. Davenport and Jeanne G. Harris, *Competing on Analytics: The New Science of Winning* (Boston, MA: Harvard Business School Press, 2007)

Many of the historical bases for competitive advantage are no longer significant advantages. For example, geographical or location advantage is less important in today's global society, proprietary technologies are rapidly duplicated, and breakthrough innovations are increasingly difficult to achieve. Today, competitive advantage lies more in operating efficiently and effectively and making consistently smart business decisions. Analytics can inform these decisions.

Analytics is defined as the extensive use of data, statistical and quantitative analysis, exploratory and predictive models, and fact-based management to drive decisions and actions (p. 9). Analytics can be useful in supporting almost any business process; however, to take advantage of analytics and ultimately achieve a competitive advantage, organizations must have an attribute at which they are better than other organizations in their strategic group – they must have a distinctive resource, competence, or capability. Analytical competitors are organizations that have identified and selected a few distinctive resources, competencies, or capabilities on which to base their strategies and then applied extensive data, statistical and quantitative analysis, and fact-based decision making to support their decisions. Analytics are not strategies but rather aids in achieving the strategy.

Much of the research on operations in health care concerns finding better evidence-based medicine and treatment strategies for specific diseases. Despite the scientific nature of medicine, studies reveal that only one-quarter to one-third of medical decisions are based on science (p. 76). Increasingly, health care organizations are using analytics to predict the likelihood that members of a health plan will develop a higher risk for diseases over time. Healthways uses data for predictions and to identify ways to improve health outcomes, thereby reducing the cost to insurers. Healthways collects data on members' demographics, claims, prescriptions, and so on. For the companies that employ Healthways, the information provided represents analytical capabilities that are hard to duplicate, unique, adaptable, renewable, and better than what competitors have for decision making.[1] Businesses have pioneered the application of analytics to predict who will be at highest risk for higher medical bills in the future (p. 77). Partners HealthCare in Boston has several initiatives to improve health care outcomes through clinical support systems to aid physicians and other health care providers.

Analytical competitors are organizations that use analytics extensively and systematically to out-think and out-execute competitors. These organizations possess the following four characteristics: (1) analytics is used to support a distinctive resource, competence, or capability; (2) the approach to and management of analytics is enterprise wide; (3) senior leaders are committed to the

use of analytics; and (4) the organization has made a significant strategic bet on analytics-based competition (p. 23).

Organizations that compete on the basis of analytics pass through five stages. In Stage 1 they are analytically impaired. These organizations usually have negligible distinctive resources, competencies, or capabilities and virtually no metrics or measurements. Stage 2 organizations use localized analytics. The analytics are opportunistic and may not significantly support the organization's distinctive attributes. Familiar metrics include conventions that might include return on investment, for example. Stage 3 organizations have analytical aspirations. These organizations begin efforts for more integrated information and analytics. Future performance and market value are frequently used metrics. Stage 4 organizations are analytical organizations with an enterprise-wide perspective and are able to use analytics to successfully compete. Analytics are important drivers of performance and value. Finally, Stage 5 organizations are analytical competitors. These organizations gain significant results and achieve a sustainable competitive advantage. Analytics are the primary drivers of performance and value in these organizations.

Winning by competing with analytics is not easy; organizations that compete successfully must have decision making. Health care, however, has many opportunities to learn from what business has accomplished using analytics for new and important areas in service industries.

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KEY TERMS AND CONCEPTS IN STRATEGIC MANAGEMENT

Behavioral Norms
Collateral Organization
Combination Structure
Culture
Decision Support System (DSS)
Divisional Structure
Facilities
Functional Structure
Matrix Structure
Shared Assumptions
Shared Values
Strategic Information System (SIS)
Strategic Resources
Strategic Technologies
Value-Adding Support Strategies

Questions for Class Discussion

1. What part does internal environmental analysis play in the development of value-adding support strategies? What part does strategy formulation play?
2. How do the value-adding support strategies create the "context" for strategy implementation?

3. What is organizational culture? How does it implement strategy?
4. What are the basic building blocks of structure? What are the advantages and disadvantages of each?
5. In what circumstances might a high level of standardization be required? A high level of flexibility?
6. Which do you think changes first, strategy or structure? After formulating your answer and making your case, argue the opposite position.
7. What are the primary differences in the financial strategies needed for expansion, contraction, and maintenance of scope?
8. What are the primary differences in the human resources strategies needed for expansion, contraction, and maintenance of scope? Which type of adaptive strategy is most difficult to implement from a human resources perspective? Why?
9. How can information systems be used to develop competitive advantage?
10. What changes are information systems bringing to health care?
11. Why is facilities management an increasing concern for strategic management?
12. How do facilities affect a health care organization's strategy?
13. How can the equipment–technology decision create competitive advantage?
14. How might future internal analyses be affected by the value-adding support strategies?

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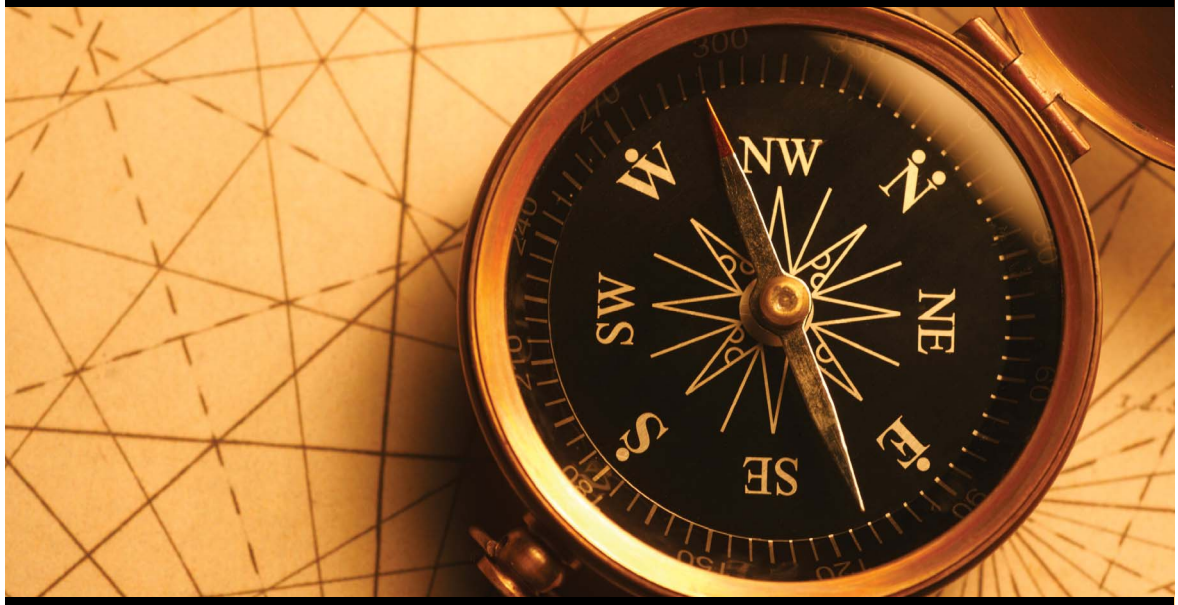
10 Communicating the Strategy and Developing Action Plans



"So when a good idea comes, part of my job is to move it around, just see what different people think, get people talking about it, argue with people about it, get ideas moving among a group of people . . ."

—STEVE JOBS

Introductory Incident

Pay for Performance and Patient Outcomes

As with many programs in many industries, data on the effectiveness of pay for performance, or P4P as it is sometimes called, has been limited.

A four-year study by Continuum Health Partners, a consortium of New York City hospitals, looked at data from the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) and the Society of Thoracic Surgeons and included gastric bypass,

colorectal operations, removal of the appendix and gall bladder, bypass of occluded arteries, carotid artery endarterectomy, and complete and partial removal of the lung surgeries performed in three New York City hospitals from 2007 to 2010. A total of 1,768 patients were included. Data were collected for two years before the implementation of P4P and two years after program implementation. The study found that P4P can help reduce costs without adversely affecting patient outcomes when quality variables are implemented simultaneously. Moreover, the study suggested that P4P did not result in "cherry picking" patients.

The researchers suggested that "quality care outcomes should be the essential framework of pay for performance programs." The ACS NSQIP collects clinical data, including risk factors before surgery, variables during surgery, and survival and morbidity outcomes up to 30 days after surgery. Complications included pneumonia, pulmonary embolism, unplanned breathing tube insertions, acute renal failure, bleeding requiring transfusion, cardiac arrest, coma, stroke, superficial surgical site infection, and wound disruption. Cases were normalized by severity index and by comorbidity to ensure the cases were similar before and after the P4P program was implemented. The researchers concluded "we found no significant differences before and after implementation of pay for performance in studying the overall outcomes of these procedures."

Some have argued that with P4P programs doctors will avoid sicker, frailer patients to make their outcomes look better. This study found no evidence of such avoidance. Although not part of the original study, a peripheral finding was that with the P4P program the approximately $18 million of total savings resulted without negatively affecting patient care. In this particular study, the P4P program involved gainsharing, where physicians share in the cost savings along with a host of quality measures that doctors must meet before they can participate.

As one would expect, P4P programs come in a variety of forms. At the Hospital of Central Connecticut, for example, all emergency department physicians receive the same base pay and the same opportunity to increase that by about 30 percent based on performance. The amount of variable compensation they receive is based on productivity (75 percent) and patient satisfaction (25 percent). Before the implementation of the program, the compensation plan rewarded physicians by their tenure with no objective criteria. Patient satisfaction was below the 70th percentile.

Two somewhat unique "twists" to the Central Connecticut program are: (1) if a doctor fails to meet certain ED quality standards in a given quarter she/he receives a formal performance improvement plan and if the standards are not met in two consecutive quarters he/she is asked to leave; and (2) no physician receives the patient satisfaction component of the variable pay unless all doctors in the group score at least in the 70th percentile on the quarterly patient satisfaction survey. Since the compensation plan was changed five years ago, patient satisfaction has never fallen below the 80th percentile and hit the 99th percentile in two quarters. According to the chief of emergency medicine, "one physician went from my lowest performer to one of the top three performers consistently for three years. And, he was totally motivated by the change in compensation."

Not all P4P outcomes have been positive. At Kelowna General Hospital in Kelowna, British Colombia the Interior Health Authority implemented a program that rewarded the hospital (not the individual) for performance improvements. The initiative resulted in a total of $1.3 million

increase in patient-focused funding between November 2010 and June 2011. Most of the revenue resulted from increases in the volume of patients admitted to an inpatient bed within 10 hours of arrival, which improved from 47 percent to 57 percent. However, it was noted that to assist with inpatient admissions the flow nurse began to focus more on patient admissions and the rapid treatment unit, which resulted in less contact time with non-admitted patients. Obviously, challenges exist with the implementation of P4P programs but the results to date look promising.

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Learning Objectives

After completing the chapter you will be able to:

1. Describe the interrelationship among situation analysis, strategy formulation, value-adding service delivery and support strategies, and action plans.
2. Understand the manner in which strategies are translated into action plans.
3. List the components of an action plan and explain the function of each component.
4. Cite some reasons that cause strategies to be difficult to implement in health care organizations.
5. Suggest some effective ways to overcome barriers to the implementation of strategies.
6. Understand the need for contingency planning and know when contingency plans should be undertaken.
7. Relate the map and compass metaphor to strategic thinking, strategic planning, and managing the strategic momentum.

Implementation through Action Plans

The situational analysis discussed in Chapters 2 through 5 culminates with a series of strategic goals that, along with the mission, vision, and values, are directional strategies that provide focus for the organization. Adaptive, market entry, and competitive strategies are designed to accomplish the strategic goals and move the organization in the desired direction. Value-adding service delivery and support strategies further shape the strategy and provide guidance and direction to managers who are responsible for implementing action plans.

The desired direction and organizational momentum have been discussed and consensus reached during the strategic planning process, yet no movement has occurred. For real movement to take place, action plans will have to be developed throughout the organization. As Peter Drucker stated, "[strategic] insights are 'bled off' and converted into tasks and work assignments."[1]

Implementation strategies have been referred to by various terms. Some organizations refer to implementation strategies as "tactical plans," although others may use "business plans," and still others, many in health care, have adopted the term "action plans." Action plan is the most descriptive term as it connotes the steps required to carry out strategies and meet objectives. In addition, the term "action plan" may be applied to the several different levels within organizations that must develop implementation strategies, and thus lessens confusion.

The Level and Orientation of the Strategy

This chapter concerns communicating the overall strategy (to those who must develop specific action plans to accomplish the strategy) and providing managers with a consistent format for implementation. However, it is important to note that strategy is crafted, step by step, as managers at all levels commit resources to policies, programs, people, and facilities.[2] A large integrated health care system may develop strategy at a number of levels – a corporate level, divisional level, organizational level, and functional level. If the strategy has been developed at the corporate level, action plans will be for entire divisions. If the strategy has been developed at the divisional level, action plans will be for individual institutions or organizations comprising the division, such as a hospital (within the hospital division) or a long-term care facility (within the long-term care division). If the strategy has been developed for an individual organization, such as a hospital, the action plans will be developed by functional units within the hospital (such as surgery or pharmacy). Because, strategies may be developed for large, complex organizations or small well-focused units, action plans to implement the strategies will be developed at different levels as well. Trinity Health, introduced in Chapter 1 and illustrated in Exhibit 1–2, portrays the organizational levels and the different orientations.

An effective *action plan*, regardless of level, consists of objectives that specify how the unit (division, hospital, pharmacy) is going to contribute to the strategy, what actions will be required to achieve the objectives and within what time period, who is responsible for the actions, the resources required to achieve the objectives, and how results will be measured. These elements are required whether the action plan is for entire divisions as part of a complex corporate-level strategic plan or for functional units contributing to the strategic plan of a small organization. Identifying objectives, determining who is responsible for accomplishing them, the resources required, and how results will be measured is an approach that keeps the strategic plan straightforward and comprehendible. A simple understandable action plan is always preferable to a complex incomprehensible plan (see Perspective 10–1).

PERSPECTIVE 10–1

Action Planning in Action

Situation analysis allows the organization to understand the external environment, recognize internal strengths and weaknesses and clarify its directional strategies – essentially it involves data gathering and analysis and is directed toward the development of strategic goals and priorities. Once the information gathered in situation analysis is examined and the strategy of the organization is formulated, developing specific organizational priorities, objectives and activities to accomplish the strategy are required. Creating real organizational momentum is the role of action planning.

To illustrate, a county health department participated in an extensive strategic planning process that engaged a number of task forces in situation analysis. After examination of the results of the analyses and the development of mission, vision, and values, the department involved key staff members in a strategic planning retreat designed to identify a series of strategic priorities and action plans for accomplishing them. Four strategic priorities were developed:

- Protect and improve the quality of life for the citizens of the local community.
- Ensure and improve organizational excellence.
- Ensure community preparedness for natural and manmade emergencies.
- Maintain financial stability.

Participants were divided into four groups and assigned the task of developing a series of objectives under each priority as well as a list of activities required for the accomplishment of each objective.

To illustrate the logic of action planning, only one part of the second strategic priority will be examined. Under the second strategic priority participants identified: Objective 1: "To obtain accreditation by the Public Health Accreditation Board (PHAB) by the end of fiscal year 2014." The attendees at the retreat agreed that one of the most tangible ways to ensure organizational excellence was to engage in and successfully accomplish PHAB accreditation.

Participants determined that four primary activities had to be accomplished during the forthcoming year if the department was to have a chance at accreditation. These activities were:

- Completion of the self-study protocol and meeting the accreditation standards designed to measure the overall operational capacity of the agency.
- Completion of a community health assessment to use as the basis for a community health improvement plan as required for accreditation.
- Development of a community health improvement plan based on the outcomes of the community health assessment.
- Integration of the accreditation document, the community health improvement plan, and a quality improvement plan aimed specifically at the internal operations of the department.

At the conclusion of the strategic planning retreat, the health officer assigned the responsibility for ensuring the implementation of the overall strategic plan as well as the accreditation documentation to the assistant health officer. The assistant health officer examined each of the strategic priorities, the objective statements for each one, and enlisted a group of informed individuals to develop timelines for each activity. The group agreed that the community health assessment was the first priority to be accomplished and that it should be completed within six months. The director of health statistics and information systems was assigned responsibility for the coordination of this activity. Further, it was agreed that the quality improvement planning process

should be initiated immediately and completed within four months, under the direction of the head of quality improvement.

The community health assessment group under the direction of the director of community services was tasked with completing a community health improvement plan within two months after the completion of the needs assessment. Finally, the assistant health officer was assigned the responsibility for leading the development of the accreditation document which was to be completed by December 31, 2013.

A similar process was completed for each activity relative to the objectives for each strategic priority. The resulting unit action plans provided the basis for "managing" the strategic plan to ensure that the strategic planning process would not be an exercise in futility; rather a living document that had specified milestones that could be used to ensure progress was being made on the overall plan.

Action Plan Development Responsibilities

Not everyone can realistically be involved in the strategic planning process. Rather, it involves a number of key participants working together to develop a strategy. A few key players – senior staff, top management, or a leadership team – are needed to provide balanced and informed points of view. Therefore, the development of the initial plan is usually the product of a relatively small number of strategic thinkers. Margaret Meade challenged us to "never doubt that a small group of thoughtful, committed people can change the world; indeed, it's the only thing that ever has!"[3] A small group of thoughtful, committed people can reshape even the most rigid organization.

Because of its involvement in developing strategy, the strategic planning team determines the "broad strokes" of strategy. The team should shape the organization through: a review or revision of the organization's mission, vision, values, and goals; development of strategy through service delivery and support strategies; and providing guidance for what needs to be accomplished. However, action plans should be left to the organizational units. Senior managers shape strategic direction less by deciding the specific strategic content than by framing the context – creating "a sense of purpose that not only provides an integrating framework for bottom-up strategic initiatives but also injects meaning into individual effort."[4] Others in the organization should use their ingenuity to develop action plans and carry out the strategy. As George Patton once said, "Never tell people how to do things. Tell them what to do and they will surprise you with their ingenuity."

Communicating Strategy to Initiate Action Planning

Because everyone cannot be directly involved, many employees within the organization do not know the underlying issues and assumptions that were used to develop the strategy, nor do they know the goals for which they will

develop objectives. Therefore, successive layers of management must communicate the overall strategy and provide "maintain or change" *guidance* for the various units that will need to be engaged if the strategy is to be achieved. For example, if management has determined that an expansion strategy is required, guidance is needed as to which parts of the organization have been identified for the expansion. Managers in the identified part or parts then determine the objectives to accomplish the expansion in that area. When different units have overlapping or integrated activities, multiple groups have to coordinate planning. Communication from the top down and the bottom up – as well as across – is required to engage everyone to do his or her part.

Specific milestones in the strategic planning process should include updates for all employees, telling them that the process is ongoing, and explaining expected timelines for the strategy to be handed over to those who will be responsible for carrying it out. In addition, successes can be shared and celebrated, and challenges can be identified and monitored. For example, some organizations hold weekly, monthly, or quarterly staff meetings to provide open communications with all employees there by maintaining their engagement in carrying out the organization's strategy. Other organizations have team meetings. Typically it is challenging in health care to have a meeting of all employees because of the patient care requirements. However, it is also challenging to implement strategy if the employees are not engaged. If top management determines that it is impossible to hold a meeting for all employees, the question should be asked: "Why isn't it possible?" Then, much thought should be given to the question of how management expects to accomplish any strategy if the first decision is: "We can't do that."

Developing Action Plans

Although implementation strategies may be carried out at various organizational levels, implementation plans should have common characteristics. These plans concern translating directional, adaptive, market entry, and competitive strategies into tasks and work assignments (specific actions that accomplish the mission, vision, values, goals, strategies, and value-adding service delivery and support strategies). In addition, these actions must be the responsibility of individuals within the organization and made an integral part of their jobs. Each job should be structured to show how it contributes to the strategic plan. In general, action plans address the following questions:

- What objectives should units establish?
- What actions are required to accomplish unit objectives? In what sequence should the actions be accomplished?
- Who will be responsible for accomplishing each action by the designated time?
- What organizational resources will be required to accomplish each action in a timely manner?
- How will results be measured?

The answers to these questions form the basis for action plans. Action plans initiate the strategy – start the work – and serve as a blueprint for managing the strategy. As indicated in previous chapters, managers must be ready to think strategically and learn as they carry out their implementation plans. Learning by doing may modify the implementation, the strategy itself, or assumptions underlying the strategy.

Action Planning

As Peter Drucker indicated, "The statement, 'This is what we are here for,' must eventually become the statement, 'This is how we do it. This is the time span in which we do it. This is who is accountable.' This is, in other words, the work for which we are responsible."[5] A critically important responsibility of the health care organization's leadership is to carefully articulate its strategy to the unit managers. Unit managers should be provided guidance or strategy statements regarding their responsibility to change or maintain the scope of their respective areas. These managers, in turn, are obligated to continue the communication by articulating the manner in which each unit is expected to contribute to service delivery or support services as well as adaptive, market entry, and competitive strategies. Unit manager action plans, in aggregate, represent the implementation plan for the organization.

Action Planning Example – Community Hospital Pharmacy

The middle section of the strategic management model (see Exhibit 1–1) provides a step-by-step strategic thinking map to illustrate that strategic planning links situational analysis through strategy formulation and planning the implementation. Action plans provide unit managers with a more detailed blueprint that links unit planning activities to the strategy.

To illustrate, consider the implementation responsibility of the head of pharmacy in a community hospital. Strategic leaders determined through a comprehensive strategic thinking effort that the hospital should become more of a health resource to the community at large – an enhancement strategy. Leaders provided value chain guidance statements regarding the hospital's commitment to become more community focused to all managers of service delivery and support activities. These managers, in turn, discussed the community focus with the members of the functional units under their respective area or areas of responsibility. The head of clinical operations, for example, held discussions with pharmacy, laboratories, and other ancillary service areas and challenged them to develop plans for expanding the role of the hospital as a community health resource.

The pharmacy might propose that one way the hospital could increase its positive impact on the community would be in the area of outpatient pharmacy services. Community access to health services could be enhanced and hospital revenues could be increased if outpatient pharmacy operations were expanded – the value-adding service delivery strategy of point-of-service clinical operations needed to change (expand its services) to better serve the community.

Setting Objectives

The first task of the pharmacy unit is to establish objectives that would accomplish the enhancement strategy. More specific than strategic goals, unit *objectives* should possess the following characteristics:

- Objectives should reinforce organizational strategic goals. Strategic goals relate to mission-critical activities. Reinforcing objectives ensures that the various units contribute to the accomplishment of the organization's mission.
- Objectives should be measurable. The objectives of the individual units are tools for the determination of unit effectiveness, and ultimately resource allocation, so the ability to measure and evaluate unit performance is essential.
- Objectives should identify the timeframe for accomplishment.
- Objectives should be challenging but attainable. Objectives that are easy to accomplish do not require stretch. Objectives that are impossible to attain are not motivational.
- Objectives should be easy to understand. Individual group members must accomplish the tasks that result in objective attainment. People work harder to achieve objectives they understand and believe are important.
- Objectives should be formulated with the assistance of the individuals who will be responsible for accomplishing the work. Just as strategic leaders should allow managers discretion in determining how strategies will be achieved, unit managers should allow employee input into the development of unit objectives.

In the action planning process, the head of pharmacy scheduled a meeting of pharmacy employees and encouraged them to suggest ways the pharmacy could aid the hospital in becoming a more valuable community health resource. Although several objectives were actually developed by the pharmacy group, only one objective and its associated action plan is illustrated here. A pharmacy objective that fulfills the criteria for a good objective and contributes to the organization's goal is:

> Pharmacy Objective – Revenue Increase. To increase the number of patients served such that the volume of outpatient pharmacy revenues increase by 25 percent by the end of the first year of expanded outpatient operations.

A 25 percent increase in revenue from outpatients in the first year was attainable. This increase in service would contribute significantly to the value-adding point-of-service strategy of clinical operations. In addition, accomplishing the objective would be a challenge for the pharmacy. The objective's outcome is measurable and easy to understand by those who will be responsible for making things happen in the unit.

Action Plans and Budget Requests

When unit objectives have been formulated and agreed on, the next step is to identify the actions or activities necessary to accomplish each objective. The expected revenues as well as costs and other resources associated with achieving each activity must be determined to estimate any additional resources needed so they can be incorporated into the unit's budget request.[6] In addition, a timeline should be established for achieving each action to ensure that activities remain on schedule. Finally, a specific individual or group of individuals should be assigned the responsibility for ensuring that each activity is accomplished.

Beginning and ending dates should be established for each action. This process firstly forces participants to think sequentially regarding the ordering of actions or activities and secondly forces a commitment for completion of the individual activities as well as the overall goal. Thinking sequentially about the required activities essentially develops a process for achieving the goal, as often some activities must be completed before others can begin. A process is defined as ". . . a collection of activities that takes one or more kinds of inputs and creates an output that is of value . . . "[7] Therefore, it is often useful to ask participants to develop a flow chart or to diagram the required activities. A process orientation helps participants to sequence activities and establish timing. In addition, through this process, reasonable timelines can be established. Further, establishing beginning and completion dates provides personal, unit, and organizational commitment.

In the pharmacy example, an action plan for accomplishing the increase in outpatient pharmacy revenue is presented in Exhibit 10–1. The plan begins with an estimate of the revenue that will be generated from the increase in outpatient pharmacy services. Then, the activities required to accomplish the objective are listed along with the timelines and responsibility assignments. The cost associated with accomplishing each activity is identified. A final column is provided for comments, should clarification be needed regarding an activity, timeline, or responsibility assignment.

This action plan projects a net operating loss of $43,650 for the outpatient pharmacy during the first year. However, after the first year, additional staff will have been hired and no further hiring is planned; the facilities remodeling will be complete; and the introductory promotion expenditures will be reduced significantly to a maintenance level. Therefore, in year two, revenues are expected to exceed costs. The positive impact on the community, however, will begin immediately as access to pharmacy services is expanded. Moreover, as the community discovers that the hospital is providing greater pharmacy service, revenues are expected to increase significantly. This action plan provides the head of pharmacy with the information necessary to develop the budget request and communicate to the manager of clinical services how the pharmacy intends to use the extra resources needed to launch the outpatient pharmacy.

Focusing on Strategy through Strategy Implementation – Another Approach

The action plan is one of several widely used approaches to assist in the implementation of strategies. Another tool for focusing on implementation as strategy is the *Balanced Scorecard* developed by Robert S. Kaplan of the Harvard Business

EXHIBIT 10–1 Example of Pharmacy Action Plan

Value adding strategy – Clinical services. Change. Increase role of hospital as community health resource.

***Pharmacy objective* – Revenue increase. To increase the volume of outpatient pharmacy revenues by 25 percent by the end of the first year of expanded outpatient operations.**

Activity	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Revenues	Costs	Responsible person/group	Comments
New revenues													$114,750			
Costs																
1. Remodel storage space for waiting area.	———													$12,750	Hospital Facilities Management	Waiting area is the only additional space needed in first year of expanded operations.
2. Expand curbside parking near hospital entrance.		—												$4,500	Hospital Grounds and Landscaping	Additional parking spaces will be necessary for customer drop-off and pick-up.
3.Add additional telephone line and expand hospital website.	———													$3,150	Telecommunication Services	Additional telephone line required for anticipated increase in volume. Website needed for outpatient pharmacy.
4. Contract with marketing firm to promote outpatient pharmacy initiative.	———	———	———	———	———	———	———	———	———	———	———			$36,000	Head of Pharmacy	Assistance of marketing firm needed to inform physicians and potential customers of new outpatient initiative.
5. Recruit and hire up to two additional FTE pharmacy technicians.		——— 1st FTE Hire									——— 2nd FTE Hire			$49,500	Hospital Human Resources	Increase in volume initially handled by technician. Second may be needed in June depending on volume.
6. Recruit and hire one additional 0.5 FTE pharmacist.						——— 0.5 FTE Hire								$52,500	Head of Pharmacy	Anticipated volume will require new pharmacist by end of December.
Total revenue/cost													$114,750	$158,400		
Net revenue/cost														($43,650)		

School and David P. Norton, Founder and Director of Palladium Group. As suggested in Perspective 10-2 illustrated in Exhibit 10–2, the Balanced Scorecard is compatible with, and complementary to, the value chain approach discussed in this text.

The primary benefit of the Balanced Scorecard approach is to focus the health care organization on those aspects of its operations that most directly impact the accomplishment of its strategies. By identifying those factors that most

PERSPECTIVE 10–2

The Balanced Scorecard

Robert S. Kaplan of the Harvard Business School and David P. Norton, Founder and Director of Palladium Group, Inc., observed that the traditional view of corporate performance was developed by, and for, industrial-age companies – a view that is no longer appropriate in an age of information and service. Manufacturers create value by managing tangible assets, whereas modern knowledge-based organizations create value by deploying intangible assets such as customer relations, innovative services, high-quality and responsive operations, information technology, databases, and employee competencies. Originally the Balanced Scorecard was concerned with measurement and control. Kaplan and Norton now believe it is a tool for implementing strategy – for dealing with the numerous cases where strategies fail because they are not implemented.

The Balanced Scorecard approach links the organization's strategy to short-term actions. As the concept evolved, four processes were identified for transforming the Balanced Scorecard into a strategic management implementation system: the financial perspective, the customer perspective, the internal perspective, and the learning/growth perspective. The usefulness of the Balanced Scorecard in health care has been evaluated in a number of provider sectors and numerous international settings.

First, if the Balanced Scorecard is to be an effective strategic management system it should be useful in translating the vision into an integrated set of objectives that, when accomplished, contribute to long-term success. Second, successful implementation relies on effective communication with, and linking to, the units that comprise the larger organization. Third, action plans allow the integration of strategic and financial plans. And finally, feedback and learning are developed and nurtured such that consistent decisions are made throughout the organization and resources are allocated in a logical and comprehendible manner.

Additionally, understanding the cause-and-effect relationships among all the performance indicators is important. Performance indicators can generally be divided into two major categories. These are "performance drivers/leading indicators" and "outcome measures/lagging indicators." The former are drivers of future financial performance whereas the latter are the result of earlier actions.

Depending on the type of organization, performance excellence may be defined in different ways. In the for-profit sector, for example, earnings and financial achievements are central to success. In a public mental health setting, excellence is more likely to be defined in non-financial terms. In this sector excellence might be "fully meeting the needs of those who

require the services most, at the lowest cost to the organization, within the limits and directives set by higher authorities."

Regardless of the sector, health care or business, for-profit or not-for-profit, the vision and goals of an organization must be translated into tangible strategic objectives that relate to critical success factors. Specific action plans describe the specifications and steps to be taken to achieve the targets or goals. These plans drive actions strategically to attain the vision and deliver excellence at all levels of the organization. Actions have to be linked to each Balanced Scorecard indicator.

Balanced Scorecards are one way to define what is important in an organization, develop ways to measure important goals, and thereby assist in focusing the organization on its strategic direction. Other tools are available; however, the Balanced Scorecard has become an increasingly important element in the strategic manager's toolbox.

Sources: Robert S. Kaplan and David P. Norton, "The Balanced Scorecard – Measures that Drive Performance," *Harvard Business Review* 72, no. 1 (1993), pp. 71–79; Robert S. Kaplan and David P. Norton, "Using the Balanced Scorecard as a Strategic Management System," *Harvard Business Review* 85, no. 7/8 (2007), pp. 150–161; Stefan Schmidt, Ian Bateman, Jochen Breinlinger-O'Reilly, and Peter Smith, "A Management Approach that Drives Actions Strategically: Balanced Scorecard in a Mental Health Trust Case Study," *International Journal of Health Care Quality Assurance* 19, no. 2 (2006), pp. 119–126; Lars-Göran Aidemark, "Cooperation and Competition: Balanced Scorecard and Hospital Privatization," *International Journal of Health Care Quality Assurance* 23, no. 8 (2010), pp. 730–737.

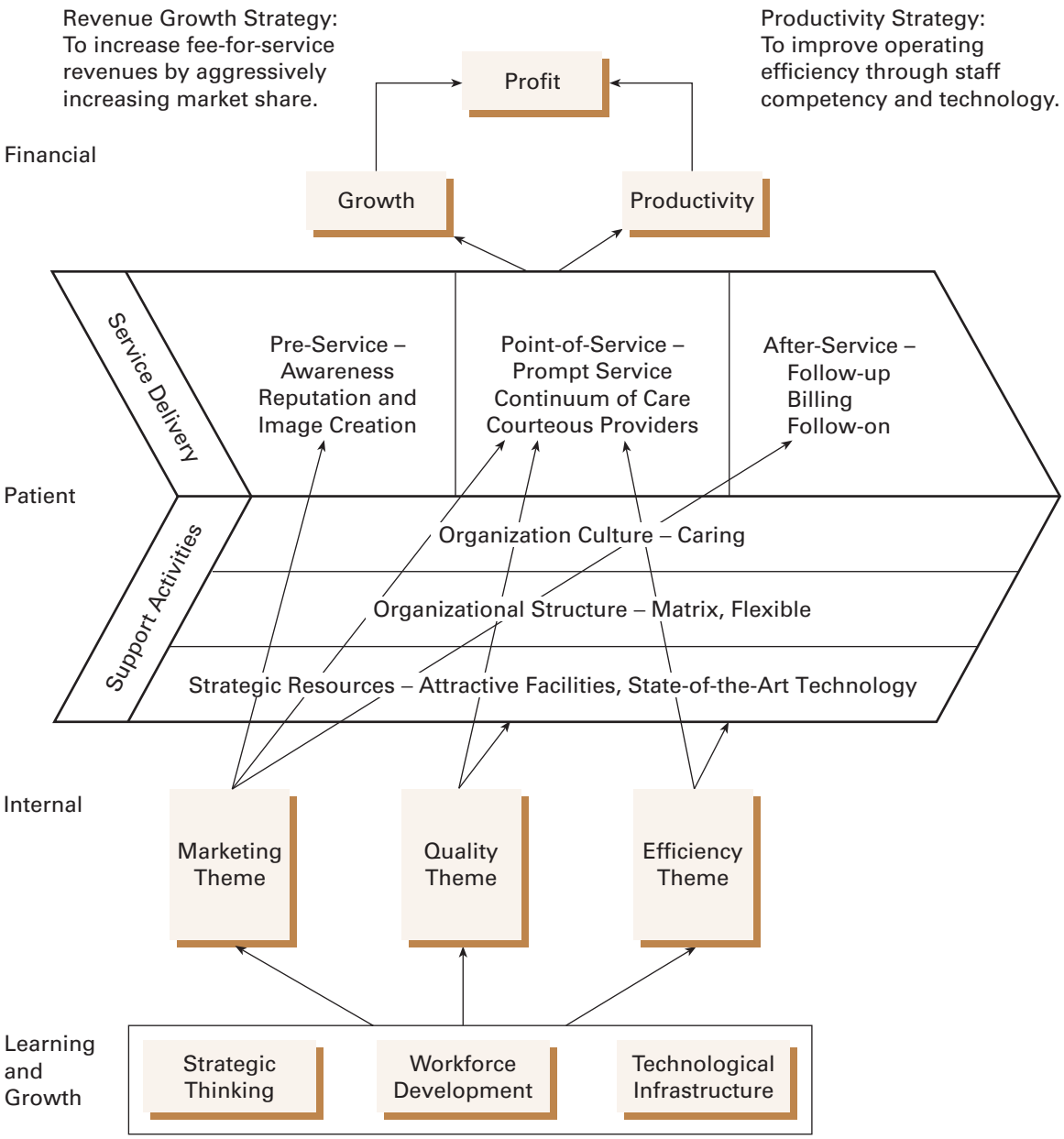
directly influence successful outcomes and concentrating on accomplishing and improving them, resources of the organization can be used most effectively and efficiently.

The Mayo Clinic used a modified version of the Balanced Scorecard to strategically think about implementation. The leadership of outpatient operations at the Mayo Clinic in Rochester, Minnesota recognized that the competitive environment was changing. Even for the Mayo Clinic it was important to operate in an economically efficient manner while maintaining world-class medical services. Leadership believed that those things that are measured are the things that are managed. Therefore, an effort was made to discover an appropriate measurement system that would contribute to strategy implementation.

Since various perspectives were important, the Balanced Scorecard immediately came to the mind of leaders. This system along with others was analyzed, modified, and ultimately a customized system was developed that was considered to be consistent with the Mayo Clinic's mission, vision, and core values. The leadership of outpatient operations believed that to be competitive, several competencies were essential. These were: (1) clinical quality to maintain and enhance market share; (2) organizational agility in creating and responding to market forces; (3) organizational focus on critical performance metrics; and (4) timely, accurate management information to improve and predict performance.

In the process of customizing the system, managers at the Mayo Clinic learned that performance measurement takes time and continuous commitment; new measurements require new information systems; multiple audiences must

EXHIBIT 10–2 Health Care Provider Balanced Scorecard Strategy Map



Source: Adapted from Robert S. Kaplan and David P. Norton, "Having Trouble with Your Strategy? Then Map It," *Harvard Business Review* 78, no. 5 (2000), pp. 168–169.

understand the performance measures; and performance measurement is an evolving process. In addition, it was noted that strategy implementation cannot be separated altogether from strategy control. The leadership of the Mayo Clinic focused on the Balanced Scorecard, as its developers did early in its evolution, as a performance measurement tool; however, its value as a linkage between

strategy implementation and control has become more evident as it has become more widely used.[8] More recently, research on the Balanced Scorecard has focused on its application to various sectors (e.g., not-for-profit, governmental, educational, and so on) as well as potential improvements in the metrics employed in evaluating performance.[9]

Managing Strategic Momentum – Evaluating Action Plans

Generally, managing action plans involves agreeing upon objectives, measuring performance, evaluating performance against the objectives, and taking corrective action, if necessary. All of the units act in concert to ensure that the level of actual performance comes as close as possible to a set of desired performance specifications. Managing the strategy provides strategic managers with a means of determining whether the organization is performing satisfactorily; it is an explicit process for refining or completely altering the strategy. Therefore, strategic managers must monitor, evaluate, and adjust the action plans. Exhibit 10–3 provides some questions to initiate strategic thinking for assessing the appropriateness and effectiveness of the action plans. These questions may generate information for changing the strategies or action plans.

Implementation Challenges

Although many organizational resources are devoted to strategy formulation, research indicates that strategies are often not implemented. Furthermore, one study found that more than 40 percent of senior executives and 90 percent of employees did not think they had a clear understanding of their organization's strategy. Ninety percent of these individuals believed that a better understanding of the strategy would improve the likelihood of successful implementation.[10] Understanding the many *paradoxes of strategic management* is a good

EXHIBIT 10–3 Strategic Thinking Map for Evaluating the Action Plans

1. Has the organization's overall strategy been well communicated to all members of the organizational units?
2. Do the organizational units have the resources required for successful implementation of the strategy?
3. Is there a high level of commitment to the strategy within the organizational unit?
4. Has the organizational unit developed action plans, including realistic objectives, timelines, responsibilities, and budgets?
5. Are the unit objectives consistent and compatible with the strategy?
6. Do the organizational units have the managerial and employee capabilities required for successfully implementing the organization's strategy?
7. Do the combined action plans accomplish the overall strategies of the organization?

start toward better understanding strategy and implementation difficulties. See Perspective 10–3.

Typically, more attention has been given to strategy formulation and its link to organizational performance than to the intervening process of strategy implementation. In addition, the organization's culture and hierarchical structure may

PERSPECTIVE 10–3

Strategic Management Paradoxes

- The more chaotic (unpredictable) the external environment, the more is strategic planning is needed. Placid environments do not require a great deal of planning; however, where there is a great deal of change, anticipating, recognizing the signals of change, and repositioning the organization are important.
- Strategic management is a top-down, bottom-up process. Top management must initiate and support strategic management – however, organizations must learn by doing. Strategic planning is generally less effective when it does not involve the line managers who must implement the strategy.
- Strategic management is a democratic process where the boss (CEO) is in control. Although everyone has something to offer and should be involved in the process, final responsibility for the viability of the organization rests with the CEO.
- Strategic management is an organized-messy process. There are clear steps in the process of strategic management, but each step raises many questions, controversies, and disagreements. Often, it is an inefficient process of consensus building and decision making.
- Strategic management is about defining the "big picture" and emphasizing the details. The strategic management process defines the organization's relationship with its environment and sets direction; however, implementation involves coordinating numerous details.
- Strategic management concerns destruction and renewal. Sometimes in the process of reinventing an organization, parts of the old organization must first be dismantled to put new processes in place.
- The rules for success are written outside the organization (in the environment), but competitive advantage is created inside the organization. Opportunities and threats are external to the organization; however, management must find the appropriate internal resources, competencies, and capabilities to build sustainable competitive advantage.
- People cannot perform strategic management until they "get it" (understand the process and its implications); and people cannot "get it" until they perform strategic management. Sometimes the full implications of strategic management as a way (philosophy) of managing cannot be fully appreciated until people have experienced it. (You cannot really learn to swim until you have been in the pool.)
- Everybody wants a strategic plan but it is the process that is important. Often managers think the plan (the document) is the objective of strategic management; however, the real objective is to set direction through the

processes of communicating, reaching consensus, and decision making.

- Strategic management is easy, but difficult. The processes are not complicated but it is often difficult to get people to overcome their fear of change.
- Strategic management is a philosophy composed of techniques. It is management by a compass, but there are many maps to use as a start.
- Strategic management concerns effectiveness and efficiency. Strategic management concerns doing the right thing as well as doing things right.
- Managers seek quantifiable data, but strategic management is fundamentally a qualitative art. Strategic management uses quantifiable data, but basically involves judgment. There are no such things as cold, hard, objective facts – only opinions about those facts. Strategic management is a matter of interpretation and opinion.
- Strategic management controls and empowers. Strategic management focuses organizational efforts toward a vision and well-defined goals; however, the process allows for individual decision making, innovation, and self-expression. If organizations are to successfully renew themselves, freedom for employees to question assumptions, strategic decisions, and the way things are done must be encouraged.

have been ignored such that those responsible for implementation may know little about the thinking that provided the basis for the strategy. Research in hospitals has confirmed that consensus around strategic decisions builds commitment to the strategy and commitment leads to successful implementation, although it sometimes progresses at a slow pace.[11]

Seven deadly sins have been identified that doom effective strategy implementation:

1. The strategy is lacking in terms of rigor, insight, vision, ambition, or practicality. If the strategy is simply more of the same, comfortable, and incremental, it will not create the excitement needed for successful implementation.
2. People are not sure how the strategy is to be implemented. Leaders are too impatient to make the strategy happen so communicating details about how implementation is to proceed is thought of as time-consuming indecisiveness.
3. The strategy is communicated on a "need-to-know" basis rather than freely throughout the organization.
4. No one is responsible for every aspect of strategy implementation. Failure to carefully see to all aspects of implementation results in oversights and confusion.
5. Leaders send mixed signals by dropping out of sight when implementation begins. The absence of leadership implies that implementation is not worthy of their attention and, therefore, unimportant.

6. Unforeseen obstacles to implementation will inevitably occur. The responsible people should therefore be prepared for these barriers and be encouraged to overcome them in creative and innovative ways.
7. Strategy becomes all-consuming and details of day-to-day operations are lost or neglected. Strategy is important, but so are operations.[12]

Barriers to Implementation

Effective strategy implementation requires the same determination and effort that is devoted to situational analysis and strategy formulation. If the barriers to effective implementation are to be eliminated or overcome, a number of actions will be required.[13] Everyone in the organization has to be a partner in implementation. Strategies are organization-wide and require inter-unit and cross-functional cooperation. Successful strategies require a willingness to seek the good of the entire organization over any single part. Unit managers have to broaden their view and the organization's leadership has to evaluate success based on contribution to the whole rather than to a single unit.

Strategic managers are responsible for turning vision into a compelling strategy for the future. This compelling vision elevates unclear strategies and conflicting priorities into a consistent pathway to success and makes it "something worth doing." The message from visible and engaged leadership is clear – strategy implementation is important.

If strategy is important, it should be a part of the budgeting, performance evaluation, and reward system of the health care organization. A primary reason why strategies are not implemented is because, in many health care organizations, effective or ineffective implementation makes little or no difference in resource allocation and reward distribution. People, therefore, concentrate on what they perceive as the important things – those things that actually affect their budgets and their paychecks.[14]

Contingency Planning

Contingency planning may be incorporated into the normal strategic management process at any level and is a part of managing the strategic momentum. Contingency planning is really about resourcefulness. Strategic thinkers ready themselves for alternative routes.[15] Thus, contingency plans are alternative plans that are put into effect if the strategic assumptions change quickly or dramatically, or if organizational performance is lagging. Therefore, alternative plans are the result of strategic thinking and provide leadership with a different course of action until further analysis can be undertaken and a different strategy – more appropriate for the changed environment – adopted. The more turbulent, discontinuous, and unpredictable the external environment, the more likely it is that unexpected or dramatic shifts will occur and the greater the need for contingency planning. In these environments the better developed the contingency plans are, the more likely the organization will achieve its strategic goals.[16] Incorporating contingency planning requires top management to have some very specific contingency plan triggers that are understood by everyone and significant enough to require a change.

Strategic plans are based on the events and trends that management views to be the most likely (the strategic assumptions). However, these events may not occur, or trends may weaken, or they may accelerate far faster than strategic managers anticipated. Therefore, contingency plans are normally tied to key issues or events occurring or not occurring. For instance, if strategic thinkers have based the strategy on an expanding economy but are presented with clear evidence that the economy is slipping into a recession, contingency plans may be activated. Similarly, the announcement that a major competitor is leaving the market may present an opportunity that initiates contingency plans for market development. Such contingency planning forces strategic managers to think in terms of possible outcomes of the strategy.

As illustrated in Perspective 10–4, one type of contingency planning that has gained importance in recent years is continuity of operations planning (COOP).

PERSPECTIVE 10–4

Continuity of Operations Planning

Survival is the most basic instinct of all living things and the fundamental goal of organizations. Today's world is a dangerous place as man-made and natural disasters have become increasingly prevalent making organizational survival more challenging and disrupting the lives and functioning of employees, suppliers, customers, and organizational infrastructure. In 2011, the Federal Emergency Management Agency (FEMA) issued 99 major disaster declarations, which was almost twice the number for 2009. A total of 81 disasters were declared in 2010 and 75 in 2008, which along with 1996 were the worst years for disasters in the United States since 1953 (FEMA, 2012). Increasingly, one of the most important contingency plans is the continuity of operations plan or COOP.

FEMA (2009) states that continuity of operations is an effort within organizations to "ensure primary essential functions continue to be performed during a wide range of emergencies, including localized acts of nature, accidents, technological or attack-related emergencies" (p. 1). FEMA believes that "continuity planning is a particularly good business practice that the execution of essential functions under any circumstances and is a fundamental responsibility of all public and private entities" (p. 4).

There are a number of reasons why health care organizations do not have continuity of operations plans. Some of the more important include the temptation to deny the possibility of low-probability events, the up-front cost of planning, the possibility of little or no payback, and the pressing nature of current problems. Moreover, guidance for what should be a relatively simple process is typically so complex that many organizations choose to take their chances rather than devote the time and resources necessary to preparing a comprehensive and complicated plan for a low-probability event.

Continuity of operations planning does not have to be complicated and bureaucratic. In fact, the major benefits of this type of planning may be obtained by going through a relatively simple process. This process requires carefully answering four important questions and establishing

a method for ensuring the plan is practiced and perfected. The four critical questions are:

1. *What are the Business's Essential Functions?* Essential functions are defined as those organizational functions and activities that must be continued under any and all circumstances (FEMA, 2004). It should be noted that COOP is greatly facilitated by the existence of a carefully formulated strategic plan. If the organization has a well-understood mission statement, the essential functions should flow logically from this statement. Critical success factors are a familiar concept in the business literature. Critical success factors in a particular industry are those activities that a firm must accomplish in order to compete successfully. Essential functions is a similar concept although critical success factors apply to all firms in a particular industry or industry segment, essential functions apply to a single organization.

Identification of essential functions is more difficult than it appears. Essential functions are those things that cannot be interrupted for an extended period of time under any circumstance if the organization is to continue to accomplish its purpose. Thus, a list of these functions must result from serious examination by the individuals who best understand the business. Moreover, the individuals involved in identifying essential functions must be able to "step outside their silos" and think about the organization as a whole.

2. *What is the Order of Leadership Succession?* Survival of disasters requires leadership. Once the list of essential functions is generated and agreed on, individuals must be identified who will be held accountable for ensuring each essential function is accomplished.
3. *Who Will Be in Charge?* An incident command structure (ICS) must be established and communicated in advance of any disastrous event. An effective ICS begins with a continuity coordinator. Every organization that is seriously considering the development of a COOP should designate a continuity coordinator. This individual should have a thorough knowledge of the business, the industry, and the human and non-human resources of the organization. This individual will activate the event response on orders from the CEO and will assume operational responsibility for the implementation of the plan. The ICS should be closely aligned with the order of succession and clear decision-making authority should be defined.
4. *What Resources Will Be Required by Designated Leaders*? Leaders accountable for accomplishing essential functions cannot succeed without resources. Five types of resource are essential for ensuring continuity of operations – facilities, communication, records and databases, supplies, and human resources. Finally, COOP requires testing. Developing a plan is not enough.

For a plan to be effective it has to be exercised and tested. Exercising the plan forces everyone to continually think about survival, risks, and making the plan a living document that is regularly updated. Testing and re-testing the plan means trying it out under simulated conditions. Testing and re-testing is the only way to be sure that when the emergency occurs your plan will swing into action. Activation will occur only if everyone is familiar with the plan, committed to his/her role in making the plan a reality, and aware of their responsibilities and how their responsibilities relate to plan effectiveness.

Sources: W. J. Duncan, V. A. Yeager, A. C. Rucks, and P. M. Ginter, "Surviving Organizational Disasters," *Business Horizons* 54, no. 2 (2011), pp. 135–142; Federal Emergency Management Agency, *Annual Major Disaster Declaration Totals* (2011), http://fema.gov/news/disaster_totals_annual.fema. See also Richard E. Deichmann, *Code Blue: A Katrina Physician's Memoir* (Bloomington, IN: Rooftop Publishing, 2007).

These plans are designed to ensure the essential functions of organizations are continued in the event of the most unpredictable disasters – hurricanes, tornados, floods, pandemics, and so on.

Replace this para with the following (this is basically the same text just sentences are in a different order):

Another example of contingency planning relates to specialty hospitals. Cardiac and orthopedic hospitals were aggressively pursuing market development expansion strategies – building free-standing new specialty hospitals in different markets, especially in those states without certificate of need requirements. The strategic assumptions of specialty hospitals changed dramatically when Congress placed a moratorium that prohibited the construction of any additional specialty hospitals until it was determined whether the impact was too great on traditional community hospitals. New plans were required immediately; contingency plans became important. What strategies could be pursued to maintain profitability and growth? What should the organizations do if the moratorium changed into law prohibiting the construction of specialty hospitals? If the expansion strategy of market development was no longer an option for increasing profitability, contingency plans might incorporate a change in strategy to an enhancement strategy (service improvement of current operations or cost reduction and efficiency of current operations) or product development (new services such as outsourcing for cardiac or orthopedic units), or one of the contraction strategies (divestiture, liquidation, and so on).

To provide strategic control for organizations, effective contingency planning involves a seven-step process:

1. Identify both favorable and unfavorable events that could possibly derail the strategy or strategies.
2. Specify trigger points. Calculate a likely timetable for contingent events to occur.
3. Assess the impact of each contingent event by estimating the potential benefit or harm.
4. Develop contingency plans. Be sure that contingency plans are compatible with current strategies and are economically feasible.
5. Assess the counter-impact of each contingency plan. Estimate how much each contingency plan will capitalize on or cancel out its associated contingent event. Doing so will quantify the potential value of each contingency plan.
6. Determine early warning signals for key contingent events. Monitor the early warning signals.
7. For contingent events with reliable early warning signals, develop advance-action plans to take advantage of the available lead time.[17]

Managing Strategic Momentum – A New Beginning

The model of strategic management introduced in Chapter 1 presented managing strategic momentum as the last stage of the model. However, managing the strategic momentum is an inherent part of all the strategic management

processes. Strategic managers are managing the strategic momentum as they consider the reasons for strategic change. Managing the strategic momentum addresses making changes in what the organization is currently doing. Perhaps the best explanation is that strategic management is circular and all of its processes are continuous. For instance, strategic thinking and situational analysis are not halted so that strategy formulation may begin. All are continuous and affect one another.

Nevertheless, the act of managing provides the momentum for change, and change is a fundamental part of survival. As health care leaders manage momentum and change their organizations, they chart new courses into the future. In effect, they create new beginnings, new chances for success, new challenges for employees, and new hopes for patients. Therefore, it is imperative that health care managers understand the changes taking place in their environment; they should not simply be responsive to them, but strive to create the future. Health care leaders must see into the future and create new visions for success.

The Map and Compass

Chapter 1 introduced the concept of the map and the compass. Recall that maps provide explicit directions and start the organization on its journey. Sometimes as organizations progress, however, the landscape or landmarks have changed, or in other cases the organization is not really sure exactly where it should be headed. In these instances the compass is more valuable to chart the course. Through strategic planning, organizations create plans (maps) for the future but must be willing to abandon the plan as the situation changes, new opportunities emerge, or managers find out what really works. This requires strategic thinking and leadership – leaders who recognize discontinuities and the need for change before others and commit to managing for the new realities.

Each chapter in this text has presented a strategic thinking map (rational model) for accomplishing strategic management. These maps provide guidelines for strategic management, including general environmental analysis, service area competitor analysis, internal analysis, and so on. The maps keep leaders from being overwhelmed and provide some perspective to chart where they are going and what they want to accomplish. In addition, the maps initiate action toward renewing the organization. Without a map it is difficult to start the journey. However, similar to an organization's plans, these rational models cannot anticipate everything; nor can they be universally applied. They will not be a perfect fit for every organization, yet they can provide the initial logical direction for exploring and learning. They may be used to initiate thinking. Therefore, the organization must reinvent the processes and learn as it goes. True creativity – the kind that is responsible for breakthrough innovations in our society – always changes the rules.

Do not work for the map; allow the map to work for you. When the strategic thinking map no longer provides direction and insight, management must dare to innovate and recreate the process – use a compass. The vision for the organization and its future should be used to determine what to do today to make it happen. To summarize, Perspective 10–5 presents some general dos and don'ts for successful strategic management.

PERSPECTIVE 10–5

The Dos and Don'ts of Strategic Management

Do

- Understand that strategic management is a philosophy or way of managing, not simply a technique. Strategic management transcends techniques.
- Remember that in strategic management, the process (strategic thinking) is more important than the product (a plan).
- Involve everyone possible in the process. Those who participate will better understand the benefits and will be more willing to buy into the process.
- Ensure that people within the organization take ownership of the process and its results.
- Realize that because the "rules for success" are written outside the organization, understanding the external environment is an essential task of strategic management.
- Expect that strategic management is really hard work and that it may take years before people really manage (and think) strategically.
- Remember that strategic management is about organizational renewal. Be ready to learn and reinvent the process (and the organization).
- Expect things to get worse before they get better (people are typically confused at first and resistant to change).
- Remember that you will never get it quite right. Strategic management is about constant organizational rethinking, reinvention, recreation, and renewal.
- Expect the process to be exciting and challenging.

Don't

- Expect strategic management to be the "magic bullet" that will fix everything.
- Start strategic management without full commitment from top management – its support, time, and resources.
- Expect perfection. Strategic management is a "messy" and sometimes inefficient process.
- Rely too much on consultants, outsiders, or a small staff group. It should not be "their" plan, but rather "our" plan.
- Follow the process (map) of strategic management blindly. A compass is necessary to go where the organization has not gone before.
- Expect someone to provide a strategic management "template" that will overlay perfectly with your organization.
- Expect strategic management to be easy or take only a few months or a year.
- Expect that everyone will understand the full implications of strategic management ("get it") at first. People learn by doing.
- Expect immediate results. Strategic management may be a fundamental change in doing business.
- Expect the future to be an extension of the past. The only thing we know for certain is that the future will be different.
- Expect that your organization will survive without change. Organizations that fail to change, fail.

Finally, strategic management requires concentrated effort and takes practice. Lasting change will be made only through a lifelong commitment to a continuing discipline. Lasting organizational change (renewal) comes from thinking strategically and adopting sound management principles that are practiced on a continuing basis. There are no quick fixes. Using strategic thinking, strategic planning, and managing the strategic momentum to go forward enables the organization to change itself, and the world.

Lessons for Health Care Managers

Successful implementation relies on communicating the strategic plan and developing action plans – the translation of organizational strategies into actions. Otherwise, strategy remains little more than wishful thinking. Action plans make strategy happen, yet strategy cannot happen if people do not understand their roles in accomplishing the strategies of the organization.

It is important that the interrelationships among situational analysis, strategy formulation, and action plans are understood by managers and employees. Such understanding is critical because, unless it is achieved, action plans are unlikely to reflect organizational priorities.

Action plans should contain clear objectives that, when accomplished, will achieve the strategies of the organization. These objectives should be measurable, easy to understand, contain timeframes, and involve the individuals responsible for accomplishing them in their formulation. If they are to be effective guides to behavior, unit objectives – whether the unit is a division, a single entity, or a department – must be understood and agreed on by the members of that unit who are responsible for accomplishing the tasks necessary to achieve the objectives.

Action plans are important aids to accomplish the strategies of health care organizations. They outline the activities required for the accomplishment of each unit objective along with an estimate of resources generated and expended in the accomplishment of each unit objective. In addition, action plans specify the time requirements for the accomplishment of each action and the individual or group responsible for ensuring the action is accomplished. Action planning is an effective aid in the formulation of unit budget requests and when rewards are based on action plan accomplishments, everyone recognizes their importance. Finally, the Balanced Scorecard is discussed as a tool for effectively managing strategy implementation as it has evolved from a comprehensive performance measurement tool to a strategy implementation tool.

The strategic management planning process often “falls apart” at implementation. Less attention is given to implementation in most strategic management texts because it is so difficult to provide the specifics (there is no generic implementation strategy but, rather, a series of requirements: objectives, timelines, responsibilities, and measures of success). Implementation is specific to an organization, a strategy, a service area, and a culture.

Because strategic assumptions may change, contingency planning is essential to enable an organization to quickly change direction in a fast-paced environment. The map is a useful guide for known destinations whereas the compass aids in times of greater uncertainty.

Health Care Manager's Bookshelf

Robert S. Kaplan and David P. Norton, The *Strategy-Focused Organization: How Balanced Scorecard Companies Thrive in the New Business Environment* (Boston, MA: Harvard Business School Press, 2001)

Studies of managers consistently demonstrate that the ability to execute or implement a strategy may be more important than the strategy itself – at least according to a group of portfolio managers cited in *The Strategy-Focused Organization* (p. 1). Studies found that fewer than 10 percent of effectively formulated strategies are successfully implemented. Sometimes the failures of implementation are traced to CEOs who entertain the mistaken belief that the emphasis placed on strategy and vision is all that is needed for success.[1] The statistics are disturbing: (1) only 5 percent of the workforce understand their company strategy; (2) only 25 percent of managers have incentives linked to strategies; (3) 60 percent of all organizations do not link budgets to strategies; and (4) 85 percent of executive teams spend less than one hour per month discussing strategy.[2]

More and more it seems that opportunities to create value are shifting from managing tangible assets to managing knowledge-based strategies, deploying intangible assets, innovative products and services, high-quality and responsive operating processes, and so on (p. 2). In an age of knowledge workers, strategy must be implemented at all levels of the enterprise.[3] The Balanced Scorecard brings together four primary perspectives – financial, customer, internal processes, and learning and growth. These are represented on a strategic map that highlights the relationship among the four perspectives and key elements of strategy.[4]

Montefiore Hospital in the Bronx, New York is the teaching hospital for the Albert Einstein College of Medicine. In 2001 it consisted of two hospitals, a network of 26 primary care satellites, a large specialty-focused faculty practice, and performed 400,000 home care visits. Its annual budget was over $1 billion. The hospital was described as made up of functional silos with no real authority. New leadership developed a strategy around four major areas:

1. **Growth.** Volume and market share.
2. **Rebalance.** Academic and clinical staff.
3. **Infrastructure.** Information systems, state-of-the-art technology.
4. **Performance.** Setting targets and achieving them.

A Balanced Scorecard was adapted to the needs of Montefiore Hospital using the following perspectives. The customer perspective was first and the scorecard metrics for customers included satisfaction scores, point-of-service surveys, complaints and compliments, and time to first appointment. The second perspective was operations and the metrics included length of stay, appropriate bed usage, readmit rate, aggregate patient outcome, and so on. The third area was innovation and growth was measured by market share, associate surveys, referring MDs, and

patients per referring MDs. Finally, the fourth perspective was financial with revenue per unit of service, cost per unit of service, and units of service as the appropriate metrics (p. 158).

Kaplan and Norton conclude with five steps that enable the Balanced Scorecard to create the strategy-focused organization. These are: (1) translate strategy into operational terms; (2) align the organization to the strategy; (3) make strategy everyone's everyday job; (4) make strategy a continual process; and (5) mobilize change through executive leadership (p. 367). Kaplan believes that the popularity of the Balanced Scorecard relates to its ability to bridge two important initiatives – strategy and employee empowerment for continuous improvement.[5]

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KEY TERMS AND CONCEPTS IN STRATEGIC MANAGEMENT

Action Plan
Balanced Scorecard
Contingency Planning
Objectives
Paradoxes of Strategic Management

Questions for Class Discussion

1. Explain the relationship between situational analysis and action plans.
2. List the important components of action plans. Which component do you think is the most important? The least important? Explain your response.
3. How are the action plans for a division (for example, hospital division) similar to action plans for a department (such as housekeeping)? How are they different?
4. How do action plans assist in the allocation of organizational resources in line with strategies?

5. Are the costs associated with accomplishing the unit objectives the only ones that should be included in budget requests? Why or why not?
6. What are the primary characteristics of unit objectives? Are these characteristics descriptive of good organizational strategic goals? Why or why not?
7. What is a Balanced Scorecard? In what ways is it a means of focusing attention on strategy implementation?
8. What are some of the primary barriers to the effective implementation of strategies in health care organizations? How can each be overcome or removed?
9. Should every organization formulate contingency plans? Why or why not?
10. Explain why strategic momentum may be a new beginning.
11. Explain whether a map or a compass is better for your career path in health care.

Notes

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A Analyzing Strategic Health Care Cases

How do students of management gain experience in strategic thinking and making strategic decisions in health care organizations? One way is to work their way up the organization, holding a variety of positions, experimenting as they develop their decision-making skills, and observing other leaders as they deal with issues and develop strategies. Then, when the opportunity presents itself, they combine what they have learned from others and their own management philosophy, and do the best they can. Unfortunately, learning by experimenting and observing others may be risky in rapidly changing environments and in the often unique situations that health care managers and leaders face.

Hospitals, HMOs, long-term care facilities, public health and other health services organizations prefer to trust important decision making to experienced managers and leaders. Case studies have been used successfully as a surrogate method to provide aspiring managers and leaders with experience in strategic thinking, strategic planning, and making decisions without undue risk. The best case studies contain real situations actually faced by managers and leaders in health care organizations and are documented in a way that makes them useful in providing experience for future strategic decision makers. Because many instructors in strategic management classes use case studies to provide future health care decision makers experience in making strategic decisions, this appendix has been included, not to prescribe how cases should always be solved, but to offer some initial direction on how to surface and address the real issues.

An Overview of Case Analysis

Case analysis provides health care students an exciting opportunity to act in the role of a key decision maker. From hospitals to community blood centers to physicians' offices, students have the chance to learn about a variety of health and medical organizations and to practice decision-making skills through analyzing cases.

The decisions required to "solve" cases represent a wide range of complexity, so that no two cases are addressed in exactly the same manner. However, the strategic thinking maps presented in this text provide frameworks to aid in strategically thinking about case issues. The fundamental task of the case analyst is to make decisions that will serve as a map to guide the organization into the future. Therefore, most case instructors will expect a comprehensive plan for the organization that addresses relevant current issues and provides a viable and reasonably complete strategy for the future. In order to achieve this goal, the case analyst typically should:

- surface and summarize the key issues,
- analyze the situation,
- develop an organizational strategy,
- develop an implementation plan, and
- set some benchmarks to measure success.

These categories represent the major elements of strategy development and make appropriate section headings for a case analysis written report or presentation. First, using the strategic thinking map presented in Chapter 1 (Exhibit 1–1), it is important to do some serious strategic thinking about the external environment of the organization – the political/legal, economic, social/cultural, technological, and competitive situations faced by the case characters. After gaining knowledge of the issues in the general and industry environments, the service area competitors should be assessed. Next, it is important to relate the resources, competencies, and capabilities of the organization to the external environment, which will require a thorough and objective analysis of the competitively relevant strengths and weaknesses. The value chain provides a useful tool for uncovering these strengths and weaknesses. These strengths and weaknesses must be evaluated as to their potential to create competitive advantages or disadvantages for the organization. External issues and the organization's competitive advantages and disadvantages provide the basis for strategy formulation. In addition, to create the strategy for a health care organization it is necessary to understand its unique mission, vision, values, and strategic goals (directional strategies).

Once the situational analysis is complete, strategic alternatives can be generated as possible solutions to the issues identified in the case. Consideration must be given to the possible adaptive strategies, market entry strategies, and competitive strategies that provide the means for achieving the organization's mission and goals and lead to the accomplishment of its vision. The effectiveness of the chosen alternative for each type of strategy must be evaluated. In

addition, at least some thought must be given to the likely outcomes resulting from the different choices. After the evaluation, a recommendation needs to be made from among the alternatives.

Nothing will happen, of course, unless the strategy can be implemented. Therefore, the case analyst must address how the strategy will be carried out. The development of a feasible implementation plan should include specific service delivery and support strategies and, where possible, action plans. These areas are important because they create value for the organization and translate strategy into organizational and individual actions – the work to be done.

Finally, the case analyst should consider how the success of the proposed strategy should be measured. Returning to the mission, vision, values, and goals will provide an initial measure of success. Other measures will include fit with the changing environment, internal changes (development of competitive advantages and lessening of competitive disadvantages), and other more specific measures such as financial measures, market share, growth, and so on.

Although the approach outlined here is logical, it is important to remember that a case should be approached and appreciated as a unique opportunity for problem solving. Cases that everyone agrees have only one solution are not good decision-making aids. Moreover, managers in health care organizations rarely face problems where the solution is obvious to everyone. This does not mean that there are no good and bad answers or solutions in case analysis; some are better than others on the basis of the logic presented. Sometimes the issues presented in a case are not even problems (defined as a negative occurrence that needs to be addressed). Often the greatest challenge facing an organization is recognizing and acting on an opportunity rather than solving a problem. The evaluation of a case analysis is often based more on the approach and logic employed than the precise recommendation offered.

Cases, Strategic Management, and Health Care Organizations

Cases add realism that is impossible to achieve in traditional lecture classes. Realism results from the essential nature of cases, although students may complain that cases fail to provide all the information necessary for decision making. The complaint is valid because cases rarely provide everything that is needed. However, decision makers in health care organizations rarely have all the information they want or need when they face decisions. Risks must be taken in case analysis just as in actual decision making.

Risk Taking in Case Analysis

Any decision about the future involves uncertainty. Decision making under conditions of uncertainty requires that means be devised for dealing with the risks faced by leaders. Cases are valuable aids in this area because they allow the analysts to practice making decisions in low-risk environments. Decisions in a poor case analysis may be embarrassing, but at least they will not result in the closure

of a hospital or medical practice. At the same time, the lessons learned by solving cases and participating in discussions will begin to build problem-solving skills.

Solving Case Problems

Solving a case is much like solving any problem. First, information is gathered and issues are defined; the competitive situation is analyzed; alternatives are generated, evaluated, selected, and implemented. Although the person solving the case seldom has the chance to implement a decision, he or she should always keep in mind that recommendations must be tempered by the limitations imposed on the organization in terms of its resources, competencies, and capabilities (although strategies to improve these areas may be required). As the success or failure of the recommendation is analyzed, lessons are learned that can be applied to future decision making.

Alternative Perspectives: Passion or Objectivity

Different hypothetical roles can be assumed when analyzing cases. Some prefer to think of themselves as the chief executive officer or leader to impose a perspective on the problems presented in the case, providing the case analyst with the liberty to become a passionate advocate for a particular course of action. Others prefer to observe the case from the detached objectivity of a consultant who has been employed by the organization to solve a problem.

Either the leader or the consultant perspective may be assumed, but the first offers some unique advantages. To answer the questions from the leader's perspective, it is important to get inside the decision maker's head – to feel the excitement and fear of doing new and innovative things in the dynamic and complex health care environment. However, the passion and frustration of the leader suggest why some case analysts prefer to assume the objective posture of a consultant. Not being in the front line can sometimes suggest alternatives that cannot be seen by those directly involved in making the payroll and paying the bills. The consultant can more easily play the devil's advocate and point out how actions are at odds with current theory. Although the fun and excitement of case analysis is enhanced by assuming the decision maker's role, the options might be expanded through a more objective and detached outlook of an outsider. There are no absolutely correct or incorrect answers to complex cases. The most important lesson is to learn problem-solving and strategic management skills.

Reading the Case

Effective case analysis begins with data collection. This means carefully reading the case, re-reading it, and sometimes reading it yet again. Rarely can anyone absorb enough information from the initial reading of a comprehensive case to adequately solve it. From the very first reading of the case, the analyst should start to list the external issues and the organization's internal strengths and

weaknesses. For example, when a significant issue is discovered it should be marked for more detailed examination. "Is the issue financial? Do the primary issues appear to be those of human resources, capital investment, or marketing?" Perhaps there are few, if any, apparent issues with negative consequences. The strategic issue facing the organization may be one to be exploited or it may have both positive and negative aspects. For example, health insurance reform has created some interesting positive and negative consequences for many health care organizations.

Listing the possible strengths and weaknesses in the initial reading provides some perspective concerning the organization's resources, competencies, and capabilities. This list will provide a basis for further investigation and provide a guide for additional information gathering. Once the situation has been reviewed, a better evaluation of the issues facing the organization can be made. An effective way of summarizing the results is through the use of an internal/external strategy matrix (refer to Exhibit 7–1 on page 263) showing the long- and short-term competitive advantages and disadvantages as well as external issues.

Gathering Information

The information required to successfully analyze a case comes in two forms. The first type of information is given as part of the case and customarily includes history of the hospital, long-term care facility, or home-health care agency; its organizational structure; its management; and its financial condition. Gathering this information is relatively easy because the author of the case has typically done the work.

A second type of information is "obtainable." This information is not provided in the case or by the instructor but is available from secondary sources in the library, familiar magazines and related publications, or through an Internet site. Obtainable secondary information helps with understanding the nature of the service category, the competition, and even some managers, past and present, who have made an impact on the service category.

If the case does not include service category information or competitor information, the instructor may expect the class to do some detective work before proceeding. Students should investigate to find out what is happening in the service category and learn enough about trends to position the problems discussed in the case in a broader health care context. The culture of the organization or the style of the chief executive officer may constitute relevant information. Some instructors do not want students to investigate beyond the date of the case or to gather additional service category data. Therefore, students must ask the instructor's preference.

Case Analysis Using the Strategic Thinking Maps

The strategic thinking maps presented in this text provide a means of thinking through strategic management issues and serve as road maps to case analysis. They are useful for analyzing cases and succinctly presenting strategic management decisions in written reports and presentations. The following discussion

provides some tips for using the strategic thinking maps in each of the major elements of case analysis – surfacing the issues, situational analysis, development of the strategy, and development of the implementation plan.

Tips on Surfacing the Issues

The discussion and questions presented in the "Managing Strategic Momentum" section of each chapter are designed to surface present and potential issues. In case analysis, issues include not only problems but also situations where things may be working well but improvements are possible. The problem may actually be an opportunity that can be capitalized on by the organization if it acts consciously and decisively. With careful analysis, patterns can be detected and discrepancies between what actually is and what ought to be become more apparent. In other words, fundamental issues, not mere symptoms, begin to emerge.

Problems vs. Symptoms It is important to realize that the things observed in an organization and reported in a case may not be the real or essential issues. Often what analysts observe are the symptoms of more serious core problems. For example, increasing interest rates and cash-flow discrepancies appear to be problems in many case analyses. In reality, the issue is the fundamental absence of adequate financial planning. The lack of planning is simply manifest as a cash-flow problem, and rising interest rates certainly complicate cash flow.

Frequently, hospitals conclude that they have operational problems in the area of marketing when bed occupancy rates decline. Someone may suggest that the marketing department is not doing a good job of convincing physicians to use the hospital. Sometimes people will complain that the hospital is not spending enough on advertising. The real issue, however, might be fundamental changes in the demographics of the market area or an outdated services mix that no amount of advertising will overcome. In organizations as complex as health care, problems may have more than a single cause, so the analyst must not be overly confident when a single, simple reason is isolated. In fact, the suggestion of a simple solution should increase rather than decrease skepticism.

Using Tools Identifying key issues requires that information be carefully examined and analyzed. Often, quantitative tools are helpful. Financial ratio analysis of the exhibits included in the case will sometimes be helpful in the identification of the real problems. In arriving at the final determination of core problems, the analyst should try not to slip into "paralysis by analysis" and waste more time than is necessary on identifying problems. At the same time, premature judgments must be avoided because then real issues may be missed. One general guideline is that when research and analysis cease to generate surprises, the analyst can feel relatively, though not absolutely, sure that adequate research has been conducted and the key issues have been identified.

Check Facts The issue discovery process should not become myopic. There may be a tendency on the part of individuals interested and experienced in accounting and finance to see all problems in terms of accounting and finance. A physician approaching the same case will likely focus on the medical

implications. This approach is too limited a view for effective strategic decision makers. Strategic analysis effectively transcends a single function. Insistence on approaching case analysis exclusively from the viewpoint of the analyst's expertise and training is not likely to produce an accurate overall picture of the situation facing the organization; nor is this approach likely to improve the organization's performance.

Information, either given or obtained, must never be accepted at face value. If a CEO states that the hospital delivers outstanding quality care, it should not be accepted as a statement of fact without some thought. For example, a character in the case may voice an opinion that is not grounded in fact. The ratios on a long-term care facility's financial statements may look strange, but are they? Before jumping to such a conclusion, analysts should look at the financial ratios in a historical perspective. Even better, they should look at the history (as well as similar ratios) of other long-term care facilities of the same size during the same time period.

Relevant Issues Once the issues are identified, they must be precisely stated and their selection defended. The best defense for the selection of the key issues is the data set used to guide the issue discovery process. The reasons for selection of the issues should be briefly and specifically summarized along with the supportive information on which judgments have been based. The issue statement stage is not the time for solutions. Focusing on solutions at this point will reduce the impact of the issue statement. If the role of consultant has been assumed, the issue statement must be convincing, precise, and logical to the client organization, or credibility will be reduced. If the role of the strategic decision maker has been selected, the student must be equally convincing and precise. The strategic decision maker should be as certain as possible that the correct issues have been identified to pursue the appropriate alternatives.

The statement of the issues should relate only to those areas of strategy and operations where actions have a chance of producing results. The results may be either increasing gains or cutting potential losses. Long- and short-range aspects of issues should be identified and stated. In strategic analysis the emphasis is on long-range issues rather than merely handling emergencies and holding things together. However, in some situations, immediate problems have to be solved and then a strategy developed to avoid similar situations in the future (combination strategy).

It is important for students to keep in mind that most strategic decision makers can deal with only a limited number of issues at a single time. Therefore, identify key result areas that will have the greatest positive impact on organizational performance.

Tips on Analyzing the Situation

Situational analysis is one of the most important steps in analyzing a case. In most instances instructors will expect comprehensive external and internal environmental analyses. For external environmental analysis, the case analyst may want to use and present a variety of tools including a trend analysis, stakeholder analysis, the development of a scenario, and service area competitive analysis. Whatever method is used, a clear picture and assessment of the external

environment should be presented. Chapters 2 and 3 provide strategic thinking maps for assessing the external environment.

For the internal environment, it is important that the case analyst understands the strengths and weaknesses of the organization in terms of its resources, competencies, and capabilities. Therefore, the case analyst may want to use the value chain, as discussed in Chapter 4, to map resources, competencies, and capabilities and assess their strategic relevance using the criteria of value, rareness, imitability, and sustainability.

Understanding the mission is a good starting point to assess the directional strategies. If a mission statement is included in the case, the analyst should ask "Does it serve the purpose of communicating to the public why the organization exists? Does it provide employees with a genuine statement of what the organization is all about?" In addition, the other directional strategies (vision, values, and strategic goals) should be evaluated as to their appropriateness to the organization and its environment. The vision and goals provide a profile of the future and targets to focus organizational actions. Sometimes the case will indicate what the health care organization plans to achieve in the next year and where it hopes to be in three years, or even in five years. As with mission statements, if the vision and goals are not explicitly stated, there is a need to speculate about them because they will be the standards against which the success or failure of a particular strategy will be evaluated. Moreover, because strategic planning is futuristic and no one can predict the future with complete accuracy, vision and goals should always be adaptable to the changing conditions taking place in the organization and in the service category. Sometimes an organization will have to face a major strategic problem simply because it was unwilling to alter its vision and goals in light of changing conditions.

Tips on Formulating the Strategy

After the situational analysis, a recommended course of action – the strategy – must be developed. Thus, adaptive, market entry, and competitive strategies for the organization must be recommended and defended. Exhibit 6–4 (p. 212) provides a strategic thinking map depicting the various alternatives for each of the types of strategy in the strategy formulation process.

Effective Alternatives If obtaining and organizing information have been done well, the generation of strategic alternatives will be a challenging yet attainable task. Good alternatives possess specific characteristics:

1. They should be practical or no one will seriously consider them. Alternative courses of action that are too theoretical or abstract to be understood by those who have to accomplish them are not useful.
2. Alternatives should be specific.
3. Alternatives should be related to the key issue they are intended to address. If the strategic alternatives generated do not directly address key issues, the analyst should ask how important the issues are to the case analysis; rethinking the issues may be required. Exhibit 6–1 (p. 210) is helpful in demonstrating how the strategic alternatives relate to external and internal issues.

4. Alternatives should be usable. A usable alternative is one that can be reasonably accomplished within the constraints of the financial and human resources available to the organization.
5. Alternatives should be ones that can be placed into action in a relatively short period of time. If it takes too long to implement a proposed solution, it is likely that the momentum of the recommended action will be lost.

Alternative Evaluation Alternatives should be evaluated according to both quantitative and qualitative criteria. Financial analysis provides one basis for examining the impact of different courses of action. However, a good alternative course of action is more than merely the one with the highest payoff. It may be that the culture of the organization cannot accommodate some of the more financially promising alternative courses of action. For the adaptive strategies, one or more of the decision-making tools discussed in Chapter 7 should be used – external/internal strategy matrix, PLC analysis, BCG portfolio analysis, extended portfolio matrix analysis, SPACE analysis, or program evaluation. For the market entry and competitive strategies, matching the external conditions appropriate for the strategies with the internal requirements of the strategies as discussed in the text with internal strengths and weaknesses and external conditions described in the case provide a basis for selecting and defending these strategies (Chapter 7).

The case analyst should be able to map the strategies selected in the strategy formulation process. Strategy maps similar to the one presented in Exhibit 7–22 (p. 297) show the ends–means decision logic for each strategic initiative and provide an excellent overview of the strategy of the organization.

Tips on Developing Implementation Strategies

Once a strategic alternative has been selected, an action plan is required. Action planning moves the decision maker from the realm of strategy to operations. Now the question becomes, "How does the group accomplish the work in the most effective and efficient way possible?"

The task of case analysis does not require that the analyst actually implement a decision; however, because the strategies must be implementable, it is necessary that thought be given to how each strategy would be put into action. Therefore, value-adding service delivery and support strategies must be developed as well as action plans. This process is a continuation of the ends–means linkage started in strategy formulation – the implementation strategies are the means to achieve the overall organizational strategies.

Each element of the value chain should be addressed, comparing the results of the internal analysis with the requirements of the selected strategy. Matching the present situation with the requirements of the strategy provides a basis to maintain the value chain element or change it to meet the needs of the strategy. Exhibits 8–9 (p. 336) and 9–6 (p. 375) provide examples of what instructors might expect for presenting the value-adding strategies.

Next, action plans for the major organizational units affected by the strategy should be developed. Objectives, action plans, and budgets should be addressed if enough detail is provided in the case. Finally, the responsibility for accomplishing the different groups of tasks must be clearly assigned to the appropriate

individuals in the organization. Although this is not always possible in case analysis, it is important that consideration be given to how, in a real organization, the recommendations would be accomplished. If, in the process of thinking about getting the different activities completed, it becomes apparent that the organization lacks the resources or the structure to accomplish a recommendation, another approach should be proposed.

The process of developing action plans for important organizational units – whether a highly focused unit, such as a pharmacy, or a broadly focused unit, such as a hospital division for a health system – should not be neglected. Organizations sometimes spend large amounts of money and resources developing strategic plans only to discover that they are not prepared to implement them in an effective manner.

Making Recommendations

Making good recommendations is a critical aspect of successful case analysis. If recommendations are theoretically sound and justifiable, people will pay attention to them. If they are not, little is likely to result from all the work done to this point.

One effective method for presenting recommendations is to relate each one to organizational strengths. Or, if necessary, a recommendation may be related to addressing a weakness. If the organization has sufficient financial strength, the recommendations should highlight how each alternative will capitalize on the strong financial condition. If, on the other hand, the resources are limited, it will be important to avoid recommendations that rely on resources that are not available or there should be a combination strategy to gain new resources.

It will be particularly useful to ask the following questions when making recommendations:

- Does the health care organization have the financial resources needed to make the recommendation work?
- Does the organization have the personnel with the right skills to accomplish what will be required by each recommendation?
- Does the organization have methods to monitor whether or not the recommendations are being accomplished?
- Is the timing right to implement each recommendation? If not, when will the timing be right? Can the organization afford to wait?

Finalizing the Report

Preparation and presentation is the final activity in most case analyses. The report can be either written or oral depending on the preference of the instructor. Although the form is slightly different, the goal is the same – to summarize and communicate in an effective manner what the analysis has uncovered and what the organization should do.

Decision making is the intended result of the report. The analysis must be complete; but the emphasis should be on making the entire report brief enough to encourage people to read it and comprehensive enough to ensure that no major factors are overlooked – especially those that might adversely affect the decision. Therefore, charts and flow diagrams can be effective. In brief outline, the important sections of a case analysis report include:

- Executive summary – usually one page, and rarely more than two pages, it functions as an abstract. Its purpose is to force the writer to carefully evaluate what is really important in all the accumulated facts and data. It is not an introduction.
- Body of the case report
  - *Key Issues*: with the rationale for focusing on them.
  - *Situational Analysis*: results of the external environmental analysis, service area competitor analysis, and internal environmental analysis, as well as analysis of the directional strategies.
  - *Strategy Formulation*: feasible alternatives for directional, adaptive, market entry, and competitive strategies.
  - *Recommendation*: analysis of the feasible alternatives, and which one or ones is/are recommended.
  - *Implementation Strategies*: service delivery and support strategies with linkage to the directional, adaptive, market entry, and competitive strategies.
  - *Benchmarks for Success and Contingency Plans*: measures of success for the strategy and alternative plans if a major opportunity or threat is subject to change in the short run (contingency plan).

Conclusions

Case analysis is an art. There is no one precise way to accomplish the task, and the analysis has to be adapted to the case problem under review. The analyst must keep in mind that case analysis is a logical process that involves: (1) clearly defining strategic issues; (2) understanding the situation – the organization, service area/service category, and environment; (3) developing a strategy to enable the organization to accomplish its mission and vision; and (4) formulating an implementation plan.

The work of case analysis is not over until all these stages are completed. Often a formal written report or oral presentation of the recommendations is required. Case problems provide a unique opportunity to integrate all that students have learned about decision making and direct it toward issues faced by real organizations. It is an exciting way to gain experience with decision making. Students should take it seriously and develop their own, systematic, and defensible ways of solving management problems.

B Health Care Organization Accounting, Finance, and Performance Analysis

—BY ANDREW C. RUCKS

The purpose of this appendix is to provide an overview and explain financial and accounting concepts as they relate to health care organizations. From Chapters 1 through 10 of this text, students have learned that many strategic decisions are influenced by the financial position of the organization. Similarly, the financial position of an organization is shaped through the implementation of its strategic plan. The ability to trace cause and effect relationships between managerial decisions and the resulting financial position of the organization is a fundamental management skill. This appendix is intended to provide a framework for understanding and managing the key elements of a health care organization's financial position.

The financial position of an organization is summarized through the organization's accounting. Accounting is the process of recording, summarizing, reporting, and analyzing the economic activity of an organization. To maintain comparability of reports of economic activity of different organizations, the accounting process is governed by Generally Accepted Accounting Principles (GAAP). In the United States GAAP is developed by the Financial Accounting Standards Board (FASB), the authority for establishing the "standards of financial accounting that governs the preparation of financial reports by nongovernmental organizations"[1] and the Governmental Accounting Standards Board (GASB) is "the independent

organization that establishes and improves standards of accounting and financial reporting for U.S., state, and local governments."[2] Internationally, GAAP is developed by the International Financial Reporting Standards Foundation (IFRSF) and its standard-setting body, the International Accounting Standards Board (IASB).

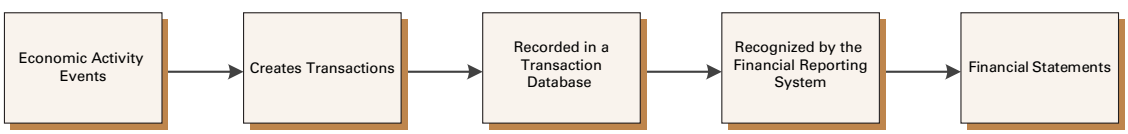
The purpose of accounting is to provide information to decision makers. *Financial accounting* focuses on the specific needs of external decision makers such as investors and regulators, whereas *managerial accounting* focuses on the specific needs of internal decision makers – the leaders and managers of the organization. Therefore, managerial accounting is the primary focus of this appendix. The discussion presented in this appendix addresses for-profit and not-for-profit health care organizations and incorporates GAAP guidelines.

Accounting Basis

Exhibit B–1 demonstrates the relationship among an organization's economic activity, transactions, recording of those transactions, and financial reporting through financial statements. Economic activity occurs when a health care organization has an economic exchange with an individual or another organization. For example, when a physician enters an order for a medical test, an economic exchange is initiated as the service (medical test) is exchanged for a charge to the patient's account for that service. Similarly, the purchasing department of an assisted-living facility placing an order for janitorial supplies is an economic exchange. The supply order generates a purchase order for the assisted living facility and a sales transaction for the supplier. Transactions are recorded through the accounting system and, based on GAAP, the cumulative results of these transactions are ultimately summarized in the organization's financial statements.

Organizations have a choice between a "cash" or "accrual" basis of recognizing and recording transactions for financial reporting. The difference between a cash basis and an accrual basis is simply the point at which the transaction is recognized and recorded. In cash-basis accounting, a transaction is recognized when it is converted to cash – when there is an inflow or outflow of cash. Accrual-basis accounting transactions are recognized when they occur – when the transaction decision is made (when the order is placed). Using the order of janitorial supplies as an example, if the assisted living facility uses cash-basis accounting, the value of the order will not be recognized, that is, made available to the financial reporting system, until a check is written to the supplier for the supplies. On the other hand, if the assisted living facility uses accrual-basis accounting, the order transaction will be reported to the accounting system at the time the order is

EXHIBIT B–1 Economic Activity, Transactions, Recording, and Financial Reporting



entered into the purchasing system. As one may imagine, the simultaneous use of cash-basis and accrual-basis accounting would create considerable confusion; therefore, GAAP does not allow the mixing of cash and accrual methods.

Financial Reporting

Accounting systems are designed to capture the economic activities of an organization. A summary of the financial position of an organization is provided through its financial statements and is based on the accounting equation shown in Exhibit B–2. The accounting equation states an equivalency – what an organization owns equals how these assets were financed. Another way of viewing the accounting equation is that things of value owned by the organization (its assets) are equal to the source of funds used to purchase the assets – by debt (termed liabilities) or through its own resources (equity investment or retained earnings). As presented in Exhibit B–2, the terminology for owned assets differs in for-profit and not-for-profit organizations; however, the meanings of the equations are the same – uses of funds equal the sources of funds. The term for owned resources in for-profit organizations is *equity* and the term used by not-for-profit organizations is *net assets*. Based on the accounting equation, there are three primary financial statements: (1) the balance sheet (for-profit organizations) and statement of financial position or statement of financial condition (not-for-profit organizations);[3] (2) the income statement (for-profit organizations) and statement of activity (not-for-profit organizations); and (3) the statement of cash flows (for-profit and not-for-profit organizations) as shown in Exhibit B–3.

Another difference between for-profit and not-for-profit organizations is the concept of ownership. For-profit organizations have stockholders that invest in the organization through the purchase of shares of stock, resulting in the stockholders having an *equity interest* in the organization. The sum of equity investments in a for-profit organization is part of what is referred to as *stockholders' equity*. Stockholders' equity may also be called *capital* or *net worth*. If the value of an organization's assets exceeds its debt, stockholders' equity represents the funds that would be left in the event the organization liquidated all of its assets (sold the assets) and paid off all its debts (liabilities). Stockholders' equity may also include earnings or profits that the management of an organization has decided to retain or reinvest in itself. For-profit organizations may pay out earnings, also termed *net income*, to stockholders as dividends or distributions or may retain the earnings for purposes of providing resources for the organization. Earnings not distributed to stockholders are referred to as *retained earnings*.

Not-for-profit organizations do not have owners per se, and therefore do not have stockholders; however, they have parties that are interested in the mission

EXHIBIT B–2 The Accounting Equation

For-profit organization

Assets = Liabilities + Equity

Not-for-profit organization

Assets = Liabilities + Net Assets

EXHIBIT B–3 The Three Primary Financial Statements

What the Financial Statement Shows	Titles Used with For-Profit Organizations	Titles Used with Not-For-Profit Organizations
Reports as of a specific date: the assets owned, liabilities owed, and equity (for-profit organizations) or net assets (not-for-profit organizations).	Balance sheet	Statement of financial position Statement of financial condition Balance sheet
Reports for a period of time, usually 12 consecutive months (a fiscal year): the revenues received, and the expenses incurred by an organization. The difference between revenue and expenses is profit or loss (for-profit organizations) or a surplus or deficit (not-for-profit).	Income statement	Statement of activity Statement of operations
Reports for a period of time, usually a fiscal year: the exchange of money between the organization and outside parties thus reporting the sources of cash received (e.g., the sale of services) and the uses of cash for operations plus any financial arrangements such as investing.	Statement of cash flows	Statement of cash flows

of the organization. Interested parties may make monetary contributions to a not-for-profit organization, in which case they are termed *stakeholders*. Not-for-profit organizations do not pay dividends or distributions to stakeholders. However, not-for-profit organizations may have funds left over after paying all expenses, termed *surplus*, which may, at the discretion of management, be paid as wages to employees or retained or reinvested in the organization.

It should be noted that, from a managerial perspective, decisions to reinvest in an organization are for the same purposes in both for-profit and not-for-profit organizations. Reinvested funds may be used to purchase new assets such as technologies, remodel/expand facilities, acquire other organizations, invest in financial instruments (stocks, bonds, mutual funds), and so on.

The Balance Sheet/Statement of Financial Position

The structure of the balance sheet and the statement of financial position reflects the accounting equation: assets = liabilities + equity. The general form of the balance sheet and statement of financial position is shown in Exhibit B–4. As illustrated in Exhibit B–4, assets, liabilities, and equities are presented in separate

EXHIBIT B–4 The Structure of the Balance Sheet and Statement of Financial Position

For-Profit Organizations	Not-For-Profit Organizations
Balance Sheet	**Statement of Financial Position**
Assets	Assets
Current Assets	Current Assets
Long-term Assets	Long-term Assets
Total Assets	Total Assets
Liabilities and Equity	Liabilities and Net Assets
Current Liabilities	Current Liabilities
Long-term Liabilities	Long-term Liabilities
Equity	Net Assets
Total Liabilities and Equity	Total Liabilities and Net Assets

accounts. Assets generally are listed in order of their degree of liquidity (the ease with which assets are convertible into cash) from current assets to long-term assets. *Current* applied to assets means convertible into cash within one year; when applied to liabilities, current means a debt due and must be paid within one year. Liabilities are listed in order of the degree of their maturity – current liabilities followed by longer-term liabilities. Equities consist of contributed capital and retained earnings or retained surplus.

The financial statements of Frederick Memorial Hospital are presented throughout this appendix as an example of the financial statements produced by a health care organization. Frederick Memorial Hospital is a private, not-for-profit, 315-bed hospital offering health services, education in healthy lifestyle choices, and disease prevention. The hospital is the centerpiece of the Frederick Regional Health System, which extends services throughout Frederick County (Maryland) and the surrounding four-state region. Annually, the health system records more than two million outpatient encounters as well as 75,000 visits to its Emergency Department and more than 22,000 hospital admissions.[4]

Exhibit B–5 presents Frederick Memorial's balance sheet. Several line items in the Frederick Regional Health System balance sheet demonstrate common practices in the reporting of financial position or condition.[5]

Assets

- **Cash and cash equivalents** – funds deposited in commercial banks or in highly liquid and secure investments such as short-term US Treasury Bills.[6]
- **Assets limited as to use** – the value of current assets on which donors have imposed restrictions that limit the use of the assets.
- **Patient receivables, net** – funds due either from patients directly or from third-party payers such as a health insurance company,

Medicare, or Medicaid. The term *net* simply means that the hospital expects that some of the amount due will not be paid and, therefore, it has deducted the expected amount that will not be paid from the total amount due. It is typical of health care organizations to have a policy of *writing off* (deducting) receivables that are deemed to be uncollectable.

- **Inventory** – the *fair value* of supplies and materials that will be consumed in the process of providing patient services. An organization selects a method of determining the fair value of assets. For inventory, a typical valuation policy will use the method of "the lower of cost or market." This valuation methodology means that at the time an inventory is taken (items in inventory counted), the value of each item will be based on either what was paid for it at its time of purchase (also known as *historical cost*) or its value in the marketplace at the time

EXHIBIT B–5 **Frederick Memorial Hospital, Inc. and Subsidiaries**
Consolidated Balance Sheets *(in thousands)*

	June 30	
	2011	2010
Assets		
Current assets:		
Cash and cash equivalents	$27,295	$34,805
Patient receivables, net	45,977	43,158
Other receivables	1,155	2,391
Inventory	4,356	4,156
Prepaid expenses	2,446	2,291
Assets limited as to use	3,702	2,841
Promises to give, net	613	711
Total current assets	85,544	90,353
Net property and equipment	180,833	181,666
Other assets:		
Assets limited as to use	14,003	11,091
Investments – donor restricted	2,896	2,552
Promises to give, net	2,665	2,402
Long-term investments	105,795	67,837
Other investments	3,423	4,190
Debt issuance costs, net	1,694	1,799
Other assets	177	320
Total other assets	130,653	90,191
Total assets	$397,030	$362,210

EXHIBIT B–5 *(Continued)*

	June 30	
	2011	2010
Liabilities and net assets		
Current liabilities:		
Current maturities of long-term debt and capital lease obligations	$3,732	$1,568
Accounts payable	14,500	15,869
Accrued expenses	21,553	18,364
Advances from third-party payers	8,178	8,048
Other current liabilities	2,987	3,047
Total current liabilities	50,950	46,896
Long-term liabilities, net of current portion:		
Long-term debt and capital lease obligations	142,567	140,211
Interest rate swap contract	9,715	11,265
Accrued pension expense	16,476	22,416
Other long-term liabilities	9,481	6,605
Total long-term liabilities, net of current portion	178,239	180,497
Total liabilities	$229,189	$227,393
Net assets:		
Unrestricted	161,667	129,158
Temporarily restricted	5,198	4,683
Permanently restricted	976	976
Total net assets	167,841	134,817
Total liabilities and net assets	$397,030	$362,210

of the inventory, whichever is lower. In addition, the organization will adopt an inventory consumption policy – either FIFO (first-in, first-out) consuming the oldest items first or LIFO (last-in, first-out) consuming the newest items first. Determining the fair value of assets as well as liabilities is sometimes a complex task.[7]

- **Prepaid expenses** – the value of current assets for which payment has been made, but the use for which the asset is intended has not yet occurred. The concept of prepayment is generally associated with expenses that are incurred as lump-sum payments and will be used or consumed over a period of time. Insurance premiums paid for coverage in the areas of property and casualty, product liability, officer errors and omissions, and vehicle coverage are examples of expenditures that are paid as a lump sum, either annually or semi-annually. Other examples

include subscriptions to publications, accrued employee vacation days, and accrued employee sick leave. Any expense item for which the provider of goods/services is willing to accept payment for the delivery of goods/services in the future would be classified as a prepaid expense.

- **Assets limited as to use** (a classification used in both the current assets and other assets sections of the balance sheet) – the fair value of assets for which donors have imposed restrictions or conditions as to use. For example, if a donor made a gift to the hospital, but restricted the use of the gift or its earnings to the Neonatology Department, then the fair value of the investment will be included in this balance sheet account.
- **Promises to give, net** (a classification used in both the current assets and other assets sections of the balance sheet) – the value of gifts promised to be delivered within one year (current assets) or to be delivered at a time that is beyond one year (other assets). The term *net* conveys the same connotation described earlier – the hospital does not expect to receive all gifts that have been promised and thus has reduced the total value of promises by an amount consistent with this expectation.
- **Net property and equipment** (this account may also be labeled *Property, plant, and equipment*) – the sum of the book value of land and the net book value of long-lived physical or fixed assets. *Book value* is the historical cost of an item; net book value is historical cost less accumulated depreciation. The accounting for fixed assets is intended to allocate the cost of the asset over its useful life. Therefore, a fixed asset is reduced in value (expensed) each year by an amount that is a function of its overall life expectancy. This reduction is reported on the income statement as depreciation expense – a non-cash expense that is the annual allocation of the historical cost of the fixed asset. Property and equipment (long-term assets) are valued at their historical value rather than fair market value or replacement value because, in general, they are not intended for sale. This account includes the value of capital leases (also known as financial leases). A capital lease refers to a situation where a health care organization leases an asset for its entire useful life. The value of the asset is reduced annually by the year's lease payments and the lease payments are recorded as a cash expense on the statement of activities or income statement.[8]
- **Long-term investment** – the value of unrestricted investments in stocks, bonds, and mutual funds. The valuation placed on these investments is the fair-market value on the date of the publication of the financial statement. For tax accounting purposes, the value of long-term investments may be either fair market value, historical cost, or the lower of either fair market value or historical cost. Long-term investments are usually the last item in the assets section of the balance sheet.

Liabilities and equity/net assets

Liabilities are listed in the order of maturity from current liabilities (maturing in less than one year) to long-term liabilities (maturing in more than one year).

- **Accounts payable** – the amounts owed to vendors and creditors for goods and services rendered, or in other words, unpaid bills.
- **Long-term liabilities** – the fair market value of liabilities with maturities exceeding one year. Common long-term liabilities include mortgages, notes payable, and bonds. The term *note* is a generic term used for formal written obligations (contracts) to banks or other creditors. Notes may or may not involve collateral. *Collateral* is an asset that is pledged by the borrower in the event of *default* (inability of the borrower to pay a note at a time when a payment is due). Should there be a default, the lender may take possession of the collateral or cause it to be sold to satisfy the obligation of the borrower to the lender.
- **Accrued expenses** – the value of certain expenses such as utilities that have been expensed (recorded on the statement of activities or income statement), but have not yet been remitted to a vendor.
- **Net assets – unrestricted** – the value of net assets that is not restricted by stipulations imposed by donors.
- **Net assets – temporarily restricted** – the value of net assets with uses limited by donor stipulations for which the restrictions will either expire with time or through the actions of the hospital.
- **Net assets – permanently restricted** – the value of net assets with donor-specified restrictions of use for which the donor stipulations will not expire either with time or action of the hospital.
- **Total liabilities and net assets** – the sum of total liabilities and total net assets must be equal to the value of total assets. The balance sheet must balance – total assets must equal total liabilities plus net assets.

The Income Statement/Statement of Activities

Similar to the balance sheet, the structure of the income statement and the statement of activities (or statement of operations) is based on a simple equation. For the income statement and statement of activities: earnings = revenues – expenses. The general form of the income statement and statement of activities is shown in Exhibit B–6. The time frame covered by the information in an income statement or statement of activities is usually one year, specifically, the fiscal year of the organization preparing the report. Nevertheless, these financial reports may be prepared for any period such as a month or year-to-date; however, when used as reports to stockholders, stakeholders, and regulators, the time frame of the report is the fiscal year.

Generally, revenue and expenses associated with operations of the organization are separated from non-operating income and expenses. The difference between the two is that operations revenues and expenses are the result of directly fulfilling the organization's mission while non-operating revenues and expenses are ancillary to, although supportive of, the mission of the organization.

EXHIBIT B–6 The Structure of the Income Statement and Statement of Activities

For-Profit Organizations	Not-For-Profit Organizations
Income Statement	**Statement of Activities**
Revenue	Unrestricted revenue
Sales	Patient service revenue, net
Less discounts	Other operating revenue
Net sales	Gifts
Total sales	Total unrestricted revenue
Operating expenses	Operating expenses
Cost of goods sold	Cost of goods sold
Employee expenses	Employee expenses
Utilities	Utilities
Insurance	Insurance
Depreciation	Depreciation
Total operating expenses	Total operating expenses
Operating income	Operating income
Other income and expenses	Other income and expenses
Gain (loss) on sale of assets	Gain (loss) on sale of assets
Investment gain (loss)	Investment gain (loss)
Non-operating expenses	Non-operating expenses
Total other income, net	Total other income, net
Profit (loss)	Surplus (deficit)

Exhibit B–7 presents the statement of operations of Frederick Memorial Hospital. A number of important line items in the Frederick Regional Health System statement of operations demonstrate common practices in the reporting of financial position or condition.

- **Unrestricted revenue and other support** – funds from four sources: (1) patient services; (2) other operating revenue such as food services, pharmacy, and gift shop; (3) contributions from donors that are given without donor restrictions; and (4) funds made available by the expiration of donor restrictions.
- **Operating expenses** – funds expended on activities that are integral to the mission of the hospital. Within the set of accounts reported is one labeled "Cost of goods sold." It should be noted that the value of the cost of goods sold (COGS) is derived through the consumption of items from the inventory account that is found on the hospital's balance sheet.

EXHIBIT B–7 Frederick Memorial Hospital, Inc. and Subsidiaries

Consolidated Statement of Operations (*in thousands*)

	Year Ended June 30	
	2011	2010
Unrestricted revenue and other support:		
Net patient service revenue	$341,584	$304,786
Other operating revenues	9,831	6,719
Gifts, bequests, and contributions	2,294	1,965
Net assets released from restriction used for operations	368	2,368
Total unrestricted revenue and other support	354,077	315,838
Operating expenses:		
Salaries and wages	140,080	128,402
Employee benefits	35,401	32,228
Professional fees	11,768	11,465
Cost of goods sold	49,869	45,060
Supplies	10,740	9,295
Contract services	32,708	28,928
Other	11,996	10,711
Utilities	4,541	4,390
Insurance	4,737	2,707
Depreciation and amortization	19,304	18,301
Interest	4,665	4,357
Provision for uncollectible accounts	13,801	12,821
Total operating expenses	339,610	308,665
Operating income	14,467	7,173
Other income (loss), net:		
Gain on sale of assets	5	14
Investment gain (loss), net	3,893	(1,802)
Change in unrealized gains on trading securities, net	8,391	8,414
Realized and unrealized losses on interest rate swap contract, net	(1,068)	(5,836)
Other non-operating income, net	61	291
Total other income, net	11,282	1,081
Excess of unrestricted revenue and other support over expenses	25,749	8,254
Other changes in unrestricted net assets:		
Pension adjustment	6,504	(7,037)
Released from restriction	256	640
Increase in unrestricted net assets	$32,509	$1,857

- **Realized and unrealized losses on interest rate swap contract, net** – interest rate swap contracts are financial instruments used by organizations to mitigate the financial risk (uncertainty of the amount of interest due in any period) associated with variable-rate bond debt. A variable-rate bond is one for which the interest due is associated with or "tied to" some widely accepted rate such as the London Interbank Offer Rate (LIBOR) and as such may change periodically as the associated benchmark rate changes. A fixed-rate bond is one for which the rate of interest will not change from the time of issuance until its maturity. In this case, Frederick Memorial Hospital entered into an interest rate swap agreement associated with the issuance of variable-rate bonds to fund some of its capital needs. A *realized loss* represents an amount of money that the hospital actually lost through the execution of part of the rate swap contract and any part of the total loss that is unrealized is an amount that has not been converted to funds that exchanged hands, but represents a potential loss when it is converted to funds or realized. The accounting is reflective of the application of GAAP to the interest rate swap contract.[9]
- **Increase in unrestricted net assets** – the value of the surplus reported by Frederick Memorial Hospital. The value of the increase in unrestricted net assets is included in the line item *total net assets* in the balance sheet shown in Exhibit B–5. The reporting of the surplus is identical to the manner in which profit is reported by for-profit organizations. In for-profit organizations, the value of profit would be included in the line item *retained earnings* in the balance sheet.

The Statement of Cash Flows

As with the balance sheet and income statement, the structure of the statement of cash flows is based on a simple equation: change in cash = cash from operations + cash from investing activities + cash from financing activities. Operations are activities in pursuit of the mission of the organization, investing activities add or remove fixed assets, and financing activities are associated with issuing and repaying debt, and issuing and purchasing stock (applicable to for-profit organizations). The general form of the statement of cash flows is shown in Exhibit B–8. The time frame covered by the information in a statement of cash flows is usually one year; specifically, the fiscal year of the organization. However, these financial reports may be prepared for any period such as a month or year-to-date; however, when used as reports to stockholders, stakeholders, and regulators, the time frame of the report is the fiscal year.

The statement of cash flows at first glance appears to be almost identical for both for-profit and not-for-profit organizations. However, a significant difference is found in the *financing activities* portion of the statement of cash flows. Both for-profit and not-for-profit organizations may borrow funds; however, only for-profit organizations may pay dividends or issue stock, and only not-for-profit organizations may engage in fundraising activities and solicit contributions and gifts that are tax-deductible for the donors.

EXHIBIT B–8 The Structure of the Statement of Cash Flows

Statement of Cash Flows (for-profit organization)
Cash flows from operations
Profit (loss)
Depreciation
Changes in assets and liabilities
Net cash provided by operations
Cash flows from investing activities
Additions of fixed assets
Acquisitions
Other
Net cash used by investing activities
Cash flows from financing activities
Net change in borrowings
Cash dividends paid
Other
Net cash provided by financing activities
Net increase (decrease) in cash
Cash at beginning of year
Cash at end of year

Statement of Cash Flows (not-for-profit organization)
Cash flows provided by operating activities
Surplus (deficit)
Depreciation
Changes in assets and liabilities
Net cash provided by operating activities
Cash flows from investing activities
Additions of fixed assets
Acquisitions
Other
Net cash used by investing activities
Cash flows from fundraising and financing
Proceeds from contributions
Net cash provided by fundraising and financing activities
Net increase (decrease) in cash
Cash at beginning of year
Cash at end of year

Exhibit B–9 presents the statement of cash flows for Frederick Memorial Hospital. Major sections of the statement include:

- **Cash flows provided by operating activities** – cash inflows and outflows from activities associated with fulfilling the organization's mission.
- **Change in net assets** – the value of earnings from the statement of operations. This entry also links the statement of operations to the statement of cash flows. From this point forward in the statement of cash flows, all adjustments reflect changes in accounts reported on the statement of financial position or balance sheet.
- **Depreciation and amortization** (refer to the discussion of depreciation on page 430) – depreciation is a non-cash expense reported on income statements (statement of operations). As an expense, it reduces earnings; however, a non-cash expenditure does not cause any change in any of the cash asset categories, therefore, a change in net assets or operating income or loss must be adjusted by the value of depreciation in order to reconcile the apparent removal of cash by including depreciation in the expense section of the income statement. In other words, depreciation

EXHIBIT B–9 Frederick Memorial Hospital, Inc. and Subsidiaries

Consolidated Statements of Cash Flows (*in thousands*)

	Year Ended June 30	
	2011	2010
Cash flows provided by operating activities		
Change in net assets	$33,024	$392
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	19,304	18,301
Amortization of original issue discount and bond issue costs	204	194
Equity in (gains) losses of joint ventures	384	(362)
Change in other assets	143	–
Gain on sale of property and equipment	(5)	(14)
Gain on sale of joint venture	(3,300)	–
Investment in subsidiaries	(620)	–
Change in unrealized gains on trading securities, net	(8,391)	(8,414)
Proceeds from realized (gains) losses on investments – trading	(1,338)	4,039
Increase in investments – trading	(28,573)	(5,940)
Increase in assets limited as to use – trading, net	(2,716)	(140)
Proceeds from restricted contributions	(624)	(1,543)
Change in pledges receivable	(165)	1,582
Realized and unrealized losses on interest rate swap contract, net	1,068	5,836
Change in operating assets and liabilities:		
Receivables, patient and other	(1,583)	(3,698)
Inventories and other assets	(355)	717
Accounts payable	(1,369)	2,604
Accrued expenses	3,189	88
Accrued pension expense	(5,940)	9,109
Advances from third-party payors	130	843
Other short-term liabilities	(60)	(707)
Other long-term liabilities	2,876	1,836
Net cash provided by operating activities	5,283	24,723
Cash flows used in investing activities		
(Increase) decrease in assets limited as to use-non-trading, net	(1,057)	14
Realized losses on interest rate swap contract	(2,620)	(2,618)
Purchases of property and equipment	(14,322)	(20,726)
Proceeds from sale of assets	2,445	523
Proceeds from sale of joint venture	4,000	–
Other investing activities	300	1,102
Net cash used in investing activities	(11,254)	(21,705)

EXHIBIT B–9 *(Continued)*

Cash flows from fundraising and financing activities		
Proceeds from restricted contributions	624	1,543
Repayments of long-term debt	(2,163)	(2,308)
Net cash used in fundraising and financing activities	(1,539)	(765)
Net (decrease) increase in cash and cash equivalents	–(7,510)	2,253
Cash and cash equivalents at beginning of year	34,805	32,552
Cash and cash equivalents at end of year	$27,295	$34,805
Supplemental disclosures:		
New capital lease obligations	$6,584	$ –
Cash paid for interest	$4,655	$4,387

must be added to earnings or loss in order to obtain the true cash value of earnings or loss.

- **Changes in operating assets and liabilities** – the amount of cash is reduced by increases in the value of assets, decreases in liabilities. Further, the amount of cash is increased by decreases in the value of assets or increases in the value of liabilities.
- **Cash flows used in investing activities** – the inflow and outflow of funds associated with the sale and purchase of long-lived assets and investment instruments.
- **Cash flows from fundraising and financing activities** – the inflow and outflow of cash through transactions with donors and creditors.
- **Cash and cash equivalents at end of year** – the value of cash reported in the asset section of the statement of financial position or balance sheet.

Financial Performance Analysis

Financial reports are important in themselves, but require analysis to provide useful investor and managerial decision-making information. Ratio analysis is a common method for assessing the financial performance of an organization. Typical financial performance measures are shown in Exhibit B–10 for for-profit and not-for-profit organizations. These analytical measures address the following financial performance concepts:

- Liquidity – measures the ability of an organization to pay its bills and more importantly, to determine if an organization is financing assets with similar liabilities. In general, current assets should be fully financed by current liabilities (1:1 ratio).[10]

- Profitability and return on investment – measures the efficiency with which an organization employs capital contributed or invested in the organization and reinvested through the retention of earnings.
- Asset turnover – measures the relationship between revenue generation (sales) and investment in assets; low values indicate asset-intense businesses whereas high values indicate lower asset intensity, meaning lower investments are required to generate each dollar of revenue; and financial leverage measures the extent to which the organization depends on debt to finance its operations, and thereby its exposure to financial risk.[11]

EXHIBIT B–10 Formulas for Measuring Financial Performance

Measures of liquidity

For-profit organization

current ratio = current assets ÷ current liabilities

liquid ratio = (cash + accounts receivable) ÷ current liabilities

Not-for-profit organization

current ratio = unrestricted current assets ÷ unrestricted current liabilities

available funds ratio = (cash + accounts receivable) ÷ unrestricted current liabilities

Measures of profitability and return on investment

For-profit organization

return on equity = net income ÷ shareholders equity

operating ratio = operating income ÷ total sales

Not-for-profit organization

return on net assets = change in net assets ÷ total net assets

operating income ratio = operating income ÷ total unrestricted revenue

Measures of asset turnover

For-profit organization

total asset turnover = total sales ÷ total assets

current asset turnover = total sales ÷ current assets

fixed asset turnover = total sales ÷ long-term assets

Not-for-profit organization

total asset turnover = total unrestricted revenue ÷ total assets

current asset turnover = total unrestricted revenue ÷ current assets

fixed asset turnover = total sales ÷ net property and equipment

Measures of Financial Leverage

For-Profit Organization

debt-to-assets ratio = (current liabilities + long-term liabilities) ÷ total assets

debt-to-equity ratio = (current liabilities + long-term liabilities) ÷ equity

Not-for-Profit Organization

debt-to-assets ratio = (current liabilities + long-term liabilities) ÷ total assets

debt-to-equity ratio = (current liabilities + long-term liabilities) ÷ total net assets

The application of the financial performance analysis measures to Frederick Memorial Hospital (FMH) is presented in Exhibit B–11. The dollar values shown in Exhibit B–11 are derived from the financial statements found in Exhibits B–5, B–7, and B–9. The two measures of liquidity, the current ratio and the available funds ratio, indicate that although 2011 demonstrates some deterioration in the liquidity position of FMH from 2010, FMH is highly liquid with at least 50 percent more liquid assets than current liabilities. As a general rule of thumb, liquidity ratios exceeding 1.25 are considered to be excellent, and those below 1.0 indicate an organization with a deficiency in liquid assets; however, comparing liquidity to other similar-sized hospitals with a similar patient base for the same time period would provide a better indicator of FMH's liquidity.

The two profitability and return on investment measures – return on net assets and operating income ratio – show improvement from 2010 to 2011. For example, in 2010, Frederick Memorial Hospital achieved a return of less than 30 cents for each dollar of net assets invested; however, in 2011, it achieved a return of almost $20 per dollar of net assets invested. The operating income

EXHIBIT B–11 Financial Performance of Frederick Memorial Hospital 2010–2011

Frederick Memorial Hospital (*dollars in thousands*)

			2011	2010
Liquidity	current ratio	=	85,544 / 50,950	90,353 / 46,896
	current ratio	=	1.68	1.93
	available funds ratio	=	(27,295 + 45,977 + 1,155) / 50,950	(34,805 + 43,158 + 2,391) / 46,896
	available funds ratio	=	74,427 / 50,950	80,354 / 46,896
	available funds ratio	=	1.46	1.71

			2011	2010
Profitability and return on investment	return on net assets	=	33,024 / 167,841	392 / 134,817
	return on net assets	=	19.68%	0.29%
	operating income ratio	=	14,467 / 354,077	7,173 / 315,838
	operating income ratio	=	0.041	0.023

(*Continued*)

EXHIBIT B–11 *(Continued)*

			2011	2010
Asset turnover	total asset turnover	=	354,077 / 397,030	315,838 / 362,210
	total asset turnover	=	0.89 times	0.87 times
	current asset turnover	=	354,077 / 85,544	315,838 / 90,353
	current asset turnover	=	4.14 times	3.50 times
	fixed asset turnover	=	354,077 / 180,833	315,838 / 181,666
	fixed asset turnover	=	1.96 times	1.74 times

			2011	2010
Financial leverage			50,950	46,896
	debt-to-assets ratio	=	+178,239 / 397,030	+180,497 / 362,210
	debt-to-assets ratio	=	0.577	0.628
			50,950	46,896
	debt-to-equity ratio	=	+178,239 / 167,841	+180,497 / 134,817
	debt-to-equity ratio	=	1.366	1.687

ratio improved from 2010 to 2011 as well, almost doubling from 2.3 percent to 4.1 percent. The operating income ratio may also be interpreted as the *operating margin*, indicating the relationship between revenue and operating costs. The operating margin for Frederick Memorial Hospital may be characterized as thin, but positive; again comparing with other similar hospitals for the same time span is warranted.

The total asset turnover rate for Fredrick Memorial Hospital, 0.89 times in 2011 and 0.87 times in 2010, indicates that the hospital is an asset-intensive organization – meaning that large amounts of total assets are required for revenue generation. By examining the fixed asset turnover and current asset turnover rates, it is revealed that fixed assets (property, plant, and equipment) contribute more to asset intensity for the hospital than current assets, as one would expect.

In terms of financial leverage, Frederick Memorial Hospital finances just over one-half of its assets with debt (debt-to-asset ratio of 0.63 in 2010 and 0.58 in 2011). The proportion of equity supporting the hospital's assets improved from 2010 to 2011 (debt-to-equity ratio of 1.69 in 2010 and 1.37 in 2011). The leverage ratios are a reflection of managerial decisions concerning the sources of long-term funds for the hospital, indicating that management is comfortable with more debt financing than equity financing.

Financial Forecasting

The development of pro forma financial statements is an integral part of developing budgets for a health care organization. The financial statements provide an excellent template for developing budgets. Each line item should be carefully modeled in terms of developing data and assumptions about the drivers of each line item. For example, the identification of capital projects (buildings, expensive equipment, clinics, etc.) and their timing plus developing assumptions about interest rates are integral to developing not only a capital budget, but also a pro forma statement of cash flows and balance sheet. Examining data on patient mix, third-party payer payment trends, Medicare and Medicaid reimbursement rates, and the impact of the Affordable Care Act are essential in developing a detailed operating budget. A detailed operating budget will produce expected revenue and expense data that should be used to produce a pro forma statement of activities (or income statement), which in turn will inform a pro forma balance sheet and statement of cash flows.

Notes

1. "About the FASB." Available at: http://www.fasb.org/jsp/FASB/Page/SectionPage&cid=1176154526495
2. "FactsaboutGASB."Availableat:http://www.gasb.org/cs/BlobServer?blobcol=urldata&blobtable=MungoBlobs&blobkey=id&blobwhere=1175824006278&blobheader=application%2Fpdf
3. In the health care industry, it has become common for not-for-profit hospitals to establish or acquire for-profit subsidiaries and enter into for-profit joint ventures (e.g., the joint venture between Ascension Health and Oak Hill Capital Partners described in Joe Carlson, "Offering salvation: Ascension, equity firm forge deal they say could save Catholic hospitals," *Modern Healthcare* (February 21, 2011)). Not-for-profit hospitals with for-profit subsidiaries prepare financial statements that combine the reports of the not-for-profit components with the for-profit ones and may use the financial statement titles of for-profit organizations; however, the contents of the reports use not-for-profit nomenclature. The combining of financial statements of subsidiaries is termed consolidation, and these financial statements generally include the term "consolidated" in their title.
4. Financial statements for Frederick Memorial Hospital are available at: http://www.fmh.org/workfiles/FMH2011Statements.pdf. The notes that accompany the financial statements are an integral part of the financial statements. The financial statements of Fredrick Memorial Hospital are used with permission.
5. Frederick Memorial's financial statements "include the accounts and transactions of the Hospital, its for-profit, wholly-owned subsidiary, Frederick Health Services Corporation (FHSC); Emmitsburg Properties, LLC; Hospice of Frederick County, Inc.; and Frederick Memorial Hospital Self-Insurance Trust." From "Frederick Memorial Hospital, Inc. and Subsidiaries, Notes to Consolidated Financial Statements." Available at: http://www.fmh.org/workfiles/FMH2011Statements.pdf
6. US Treasury bills are short-term securities with maturities of one year or less. Typical maturity terms are 4, 13, 26, and 52 weeks. More information is available at: http://www.treasurydirect.gov/instit/marketables/tbills/tbills.htm
7. Aswath Damodaran, *Investment Valuation: Tools and Techniques for Determining the Value of Any Asset* (Hoboken, NJ: John Wiley & Sons, 2012).
8. The accounting for leases is explained in detail in FASB statement number 13, found at: http://www.fasb.org/cs/BlobServer?blobcol=urldata&blobtable=MungoBlobs&blobkey=id&blobwhere=1175820908834&blobheader=application%2Fpdf
9. A thorough treatment of the nature and mathematics associated with interest rate swaps is beyond the scope of this appendix; however, a brief explanation of interest rate swaps is appropriate. An interest rate swap is an agreement between a borrower (in this case of Frederick Memorial Hospital, the issuer of bonds) and another party to exchange interest payments on debts without exchanging the underlying debt. The purpose of such a transaction is to permit the payer of variable interest rates to hedge against or stabilize the potential volatility of interest rates during a period of perceived economic instability and for a fixed-rate borrower to obtain what it perceives to be a better or lower interest rate. By way of example, organization

A issues variable-rate debt in the amount of $1M that adjusts monthly at a rate of "Treasury 30 + 2%" (meaning the monthly interest rate paid by the US Treasury on 30-year notes plus 2 percent; thus, if the 30-year Treasury rate is 3%, organization A will pay a rate of 5%, if the 30-year Treasury rate is 6%, organization A will pay 8%, etc.) and organization B issues $1M of debt at a fixed rate, say 8%. Organization A is concerned that interest rates will vary significantly over the next few years and wants to stabilize its cash outflows and organization B feels uncomfortable with its interest rate. Organization A and organization B decide to "swap" interest rates. They enter into a contract on a "notional" debt between the two (notional means that the money does not change hands) in which organization A agrees to pay organization B a fixed rate on the notional debt, say 7%, and organization B agrees to pay a variable rate, say 30-year Treasury + 0.5%. In this manner, organization A pays a fixed amount of funds each month for its debt and organization B pays a variable rate, achieving a comparative advantage for both parties.

A good overview of interest rate swaps may be found in James Bickler and Andrew H. Chen, "An Economic Analysis of Interest Rate Swaps," *Journal of Finance* 41, no. 3 (July 1986), pp. 645–655.

The mechanics of interest rate swaps may be understood by viewing two lessons from the Kahn Academy – "Interest Rate Swap 1: The basic dynamic of an interest rate swap" available at: http://www.khanacademy.org/finance-economics/core-finance/v/interest-rate-swap-1and "Interest Rate Swap 2" available at: http://www.khanacademy.org/finance-economics/core-finance /v/interest-rate-swap-2

10. The liquid ratio is also known as the quick ratio and the acid test ratio. For organizations with significant inventory values, there are alternate formulations of the liquid ratio. The quick ratio for for-profit organizations is:

    quick ratio = (current assets − inventory) ÷ current liabilities

    The quick ratio for not-for-profit organizations is:

    quick ratio = (unrestricted current assets − inventory) ÷ unrestricted current liabilities

11. The reader is directed to two significant works for a more detailed discussion and presentation on financial performance measures and techniques: Robert C. Higgins, *Analysis for Financial Management*, 10th edn (New York: McGraw Hill, 2011) and Helisse Levine and Anne G. Zahradnik, "Online Media, Market Orientation, and Financial Performance in Nonprofits," *Journal of Nonprofit & Public Sector Marketing* 24, no. 1 (2012), pp. 26–42.

C Health Care Acronyms

Legislative/political, economic, social/demographic, technological, and competitive changes over the past three decades have shaped the health care industry and contributed to the creation of a new language to describe it. This appendix examines the growing list of health care acronyms and abbreviations that characterize the nature of industry change.

ACA (Affordable Care Act) See PPACA.

ACC (ambulatory care center): walk-in and outpatient services provided.

ACO (accountable care organizations): groups of doctors, hospitals, and other health care providers, who willingly come together to take responsibility for providing coordinated high-quality care to improve health status, and care.

AHC (academic health center) or AMC (academic medical center): a group of related institutions including a teaching hospital, a medical school and its affiliated faculty practice plan, as well as other health professional schools.

ALOS (average length of stay): a measure that hospitals use to determine whether treatment is within an appropriate range (often tied to reimbursement rates).

APC (ambulatory payment codes or classification): used in reimbursements, greater detail incorporated into ICD-10; method for payment of outpatient care for Medicare patients and some Medicaid patients (depending on the state).

APG (ambulatory payment group): a prospective payment system in managed care, similar to inpatient DRGs, used for free-standing diagnostic and treatment centers, hospital-based outpatient treatments, ambulatory surgery, and emergency departments. APGs group together procedures and medical visits that share similar characteristics and resource utilization patterns for payment purposes. This new methodology allows for greater payment homogeneity for comparable services across all ambulatory care settings (i.e., outpatient department, ambulatory surgery, emergency department, and diagnostic and treatment centers) making Medicaid reimbursement more transparent and reimbursing based on patients' conditions and severity.

ASC (ambulatory surgery center): outpatient surgery procedures performed within these centers that are sometimes totally independent or closely tied to and near hospitals

CBO (community-based organizations): under ACA, CBOs are funded to work with discharged Medicare patients to avoid social problems – no transportation for follow-up MD visits, not filling prescriptions or taking medications, dialing 911 when they are anxious, lonely, or have an adverse drug reaction – thoughtfully and inexpensively. The goal is to help patients self-manage their post-hospital care through home visits, counseling, financial assistance, meals and nutrition, legal aid, and follow-up phone calls for 30 days to avoid readmissions.

CHIP (Children's Health Insurance Plan): formerly the State Children's Health Insurance Program (SCHIP) was created by the Balanced Budget Act of 1997 to help states insure low-income children who are ineligible for Medicaid but cannot afford private insurance.

CLASS (Community Living Assistance and Support Act): payroll deduction to program designed to help seniors and the disabled pay for long-term care programs such as in-home caretaker or adult day care services; begins 2016.

CMS (Center for Medicare and Medicaid Services): part of the US Department of Health and Human Services, the contracting agency for health maintenance organizations (HMOs) that seek direct contractor/provider status for provision of Medicare and Medicaid benefits.

CON (certificate of need): laws in some states require a CON to determine whether the state will permit a hospital or a physician's practice to open or add beds, operating rooms, or expensive pieces of technology (see Perspective 3–3).

COURAGE (clinical outcomes utilizing revascularization and aggressive drug evaluation): studied stents vs. medical therapy and they were about the same in terms of results, but medical therapy costs less and requires no surgery.

C-suite (chief officers of the health care organization): CEO, chief executive officer; CFO, chief financial officer; CIO, chief information officer; CMO, chief marketing officer and chief medical officer; COO, chief operations officer; CNO, chief nursing officer.

DRG (diagnosis-related group): a classification system using 383 major diagnostic categories that assign patients into case types. It is used to facilitate utilization review, analyze patient case mix, and determine hospital reimbursement. For example, the classification DRG 320 indicates a kidney and urinary tract infection.

DSH (disproportionate share hospital): programs that provide for additional payments to hospitals that serve a large number of low-income inpatients.

EHR (electronic health record): also electronic patient record or electronic medical record, but meant to focus on prevention of health rather than medical problems.

EMR (electronic medical record): a medical document stored in a machine-readable format. Data are entered into the record via many different sources, including computerized entry and various document imaging systems. Also called an electronic patient record.

EPO (exclusive provider organization): although structurally similar to a preferred provider organization (PPO), an EPO can simply be a network of health care providers; the plan beneficiaries cannot go out of the network or they must pay the entire cost of services. EPO physicians are reimbursed only for services actually provided to plan beneficiaries (rather than a capitated rate).

FDA (Food and Drug Administration): the most comprehensive consumer protection agency in the US, its origins can be traced back to the Patent Office in 1848. FDA's modern regulatory functions began with the 1906 Pure Food and Drugs Act, a law that prohibited interstate commerce in adulterated and misbranded food and drugs. The FDA approval process for patented drugs is noteworthy. See www.fda.gov.

FEHBP (Federal Employee Health Benefit Plan): still kept separate from other health plans; used as a benchmark for comparables of plans to be developed under ACA.

FFS (fee for service): refers to a provider that charges the patient according to a fee schedule set for each service or procedure performed; the patient's total bill will vary by the number of services or procedures actually performed.

FSA (flexible spending account): a federal program that allows for an account where an employee contributes money from his/her salary BEFORE taxes are withheld and then can be reimbursed for out-of-pocket health care and dependent care expenses.

HEDIS (healthplan employer data and information set): a set of standardized measures of health plan performance that allows comparisons of quality, access, satisfaction, membership, utilization, financial information, and management.

HIE (health insurance exchange): an organized regional network that enables hospitals, physicians, and other care providers to upload and access patient health information – from affiliates to competitors – to share clinical data that can improve a patient's overall care.

HIPAA (Health Insurance Portability and Accountability Act): enacted in 1996, it includes five primary sections or "titles." Title 1: Health Care Access, Portability, and Renewability. Title 2: Preventing Health Care Fraud and Abuse; Administrative Simplification. Title 3: Tax-Related Health Provisions. Title 4: Application and Enforcement of Group Health Plan Requirement. Title 5: Revenue Offsets.

HMO (health maintenance organization): an organization interposed between providers and payers that attempts to "manage the care" on behalf of the health service consumer and payer. HMOs are responsible for both the financing and delivery of comprehensive health services to an enrolled group of patients.

HPID (unique health plan identifier): an attempt to simplify the claims process by standardizing the identifier format. All insurers will have a unique code, structured in a common format.

HRA (health reimbursement accounts): similar to HSAs; however, only the employer contributes to the fund (employees may not use salary deductions to the account). The employer sets the restrictions and unused dollars are retained by the employer and can be rolled over to the next year, but do not move with the employee if he/she changes employers.

HSA, MSA (healthcare savings account or medical savings account): healthcare or medical savings accounts are tax-deferred programs coupled with high deductible health plans (HDHP). Designed primarily for the self-employed, contributions to the savings account are limited ($3,100 in 2012); with a cost of $1,200 for the HDHP; out-of-pocket expenses are limited to $6,050 (annually 2012) when the insurance kicks in to cover the cost of extended or catastrophic care. MSAs can be used to pay for most forms of health care, including disability, dental care, vision care, and long-term care; however, withdrawals not used for medical expenses are charged 20 percent of the amount of the distribution (2012) and over-the-counter drugs only qualify when they have been prescribed by a physician. Leftover funds can be rolled over to the next year or withdrawn as taxable income.

ICD-9 and ICD-10 (International Classification of Diseases, 9th Revision diagnosis coding standard and International Classification of Diseases, 10th edition diagnosis and procedure codes): ICD-9, in place for 30 years using 13,000 different codes, is to be replaced with ICD-10 offering 68,000 codes to provide more accurate information to chart, measure, and bill patient encounters. Under ICD-10, instead of coding "fracture of forearm," health care providers will be able to provide details: "torus fracture of lower end of right radius, subsequent encounter for closed fracture with routine healing" by using ICD-10's alphanumeric language. Additional coding covers ambulatory services and inpatient discharges. Implementation to begin October 1, 2013 has been delayed one year to October 1, 2014.

IDS (integrated delivery system): IDSs combine and own, or closely coordinate, multiple stages of health care delivery. The integration usually includes many steps in the full spectrum of health services delivery, including physicians, hospitals, and long-term care facilities.

IPA, IPO (independent practice association, independent practice organization): a legal entity composed of physicians who have organized for the purpose of negotiating contracts to provide medical services. Typically, physicians maintain their independent businesses but come together as a group to negotiate with payers. A super-IPA has many IPAs rolled into one to contract with payers.

JC (Joint Commission, formerly Joint Commission on the Accreditation of Healthcare Organizations): the major accrediting body for many health care organizations. Hospitals must be JC-accredited to receive Medicare and Medicaid funds; thus, the organization has great importance in the health care delivery system.

LOS (length of stay): length of stay is also known as the average length of stay (ALOS) or the arithmetic mean length of stay (AMLOS). It is the average number of days patients stay in the hospital for a specific DRG (diagnosis-related group).

MCO (managed care organization): any organization whose goal is to eliminate excessive and unnecessary service, thereby keeping health care costs manageable.

MLR (medical loss ratio): PPACA requires that no more than 20 percent of insurers' premium payments from individual and small group plans may be spent on administrative expenses. The remaining 80 percent of premiums is to be spent on direct patient care and improvements in quality of care. If the 20 percent is exceeded, the insurer must pay financial rebates to the members. In 2011, $1.1 billion was rebated to 12.8 million members. A state may apply for an exception to waive the penalties (or delay implementation) if it believes that the 80/20 standard would "destabilize a state's individual and small group market." Seventeen requests have been made to CMS, seven have been granted and ten denied.

MMA (Medicare Prescription Drug, Improvement, and Modernization Act of 2003): made prescription drug costs more manageable for Medicare patients.

MSA (medical savings account): see healthcare savings account (HSA).

MSO (management service organization): a legal corporation formed to provide practice management services to physicians. At one extreme, an MSO could own one practice or several hundred practices. At the other extreme, an MSO may not own any physician practices or provide management services. In that case, the MSO would be strictly an entity that signs managed care contracts for an affiliated provider group. Typically, an MSO will require a commitment of 10 to 40 years from the physician or group practice contracting for its services.

NCQA (National Committee for Quality Assurance): a private, not-for-profit organization. NCQA is governed by a board of directors that includes employers, labor representatives, consumers, health planners, quality experts, policy makers, and representatives from organized medicine.

NIH (National Institutes of Health): one of the agencies of the Public Health Service, which is a part of the Department of Health and Human Services

of the US federal government. The NIH is responsible for medical and behavioral research for the United States.

NP (nurse practitioner): a nurse who serves as the initial contact into the health care system and coordinates community-based services necessary for health promotion, health maintenance, rehabilitation, or prevention of disease and disability. Nurse practitioners work interdependently with other health professionals to provide primary health care in many communities.

OON (out of network): describes health care services received from providers who do not participate in a managed care program's contracted network of providers. Typically, patients pay all costs out of pocket (no reimbursement).

OTC (over the counter): drugs sold without the requirement of a prescription.

OSHA (Occupational Safety and Health Act): a comprehensive plan for regulating workplace safety.

PA (physician assistant): an allied health professional who, by virtue of having completed an educational program in the medical sciences and a structured clinical experience in surgical services, is qualified to assist the physician in patient care activities. Physician assistants may be involved with patients in any medical setting for which the physician is responsible, including the operating room, recovery room, intensive care unit, emergency department, hospital outpatient clinic, and the physician's office.

PCMH (patient-centered medical home): established by the ACA; efficiency, and experience for a defined population of patients such as Medicare patients.

PCP (primary care physician): a physician responsible for coordinating and managing the health care needs of members. PCPs may be trained in primary care, pediatrics, obstetrics/gynecology, internal medicine, or family medicine. They determine hospitalization and referral to specialists for their patients.

PHO (physician–hospital organization): an organization designed to integrate a hospital and its medical staff to contract with payers as a single entity. Physicians retain their independence. A super-PHO has many PHOs rolled into one to contract with payers.

PMPM (per member per month): under capitation, the amount paid to care for each member per month, regardless of the number and extent of services used by the member.

POS (point-of-service): combines a health maintenance organization insurance plan with traditional insurance. "Point-of-service" refers to members deciding whether to go in or out of the network. The employee belongs to a managed care plan but can opt for the traditional plan anytime. POS members usually pay less when they stay within the HMO network but can avoid restrictions. When they choose the traditional insurance plan, typical coverage requires them to meet a deductible and 70 to 80 percent of health care costs are paid. Sometimes POS is called an "HMO with an escape hatch."

PPACA (Patient Protection Affordable Care Act, often shortened to "Affordable Care Act"): sometimes called "Obama-care." Enacted in 2010, only a few parts of the legislation went into effect immediately (required insurance companies to cover children to age 26), others were to be phased in (adoption of ICD-10 in 2013, extended to 2014). Most sweeping change for health care since Medicare and Medicaid in the 1960s.

PPO (preferred provider organization): an entity through which various health plans or carriers contract to purchase health care services for patients from a selected group of providers, typically at a better per-patient cost.

PPS (prospective payment system): a system designed to control costs for Medicare and Medicaid patients. Rather than reimbursing on a retrospective cost-plus system, PPS legislation in 1983 reimbursed hospitals on a prospective (predetermined) basis. For example, a hospital would know that it would receive a set amount to treat a broken hip. If the patient could be treated at a cost lower than the reimbursed amount, the hospital could keep the "profit." On the other hand, if the hospital spent more than the reimbursable amount, for whatever reason, it had to absorb the loss.

PSO (provider-sponsored organization): integrated groups of doctors and hospitals that assume managed care (often Medicare) risk contracts.

RBRVS (resource-based relative value scale): a national fee system for Medicare payments to physicians. The fee schedule is designed to shift payment patterns from a number of more costly specialties (such as those in surgery) to primary care.

SCHIP (State Children's Health Insurance Plan) See CHIP.

SNF (skilled nursing facility): an institution that provides inpatient skilled nursing care and rehabilitative services and has transfer agreements with one or more hospitals.

TPA (third-party administrator): a firm that performs administrative functions such as claims processing and membership for a self-funded health care insurance plan or a start-up managed care plan.

UR (utilization review): the review of services delivered by a health care provider to evaluate the appropriateness, necessity, and quality of the prescribed services.

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