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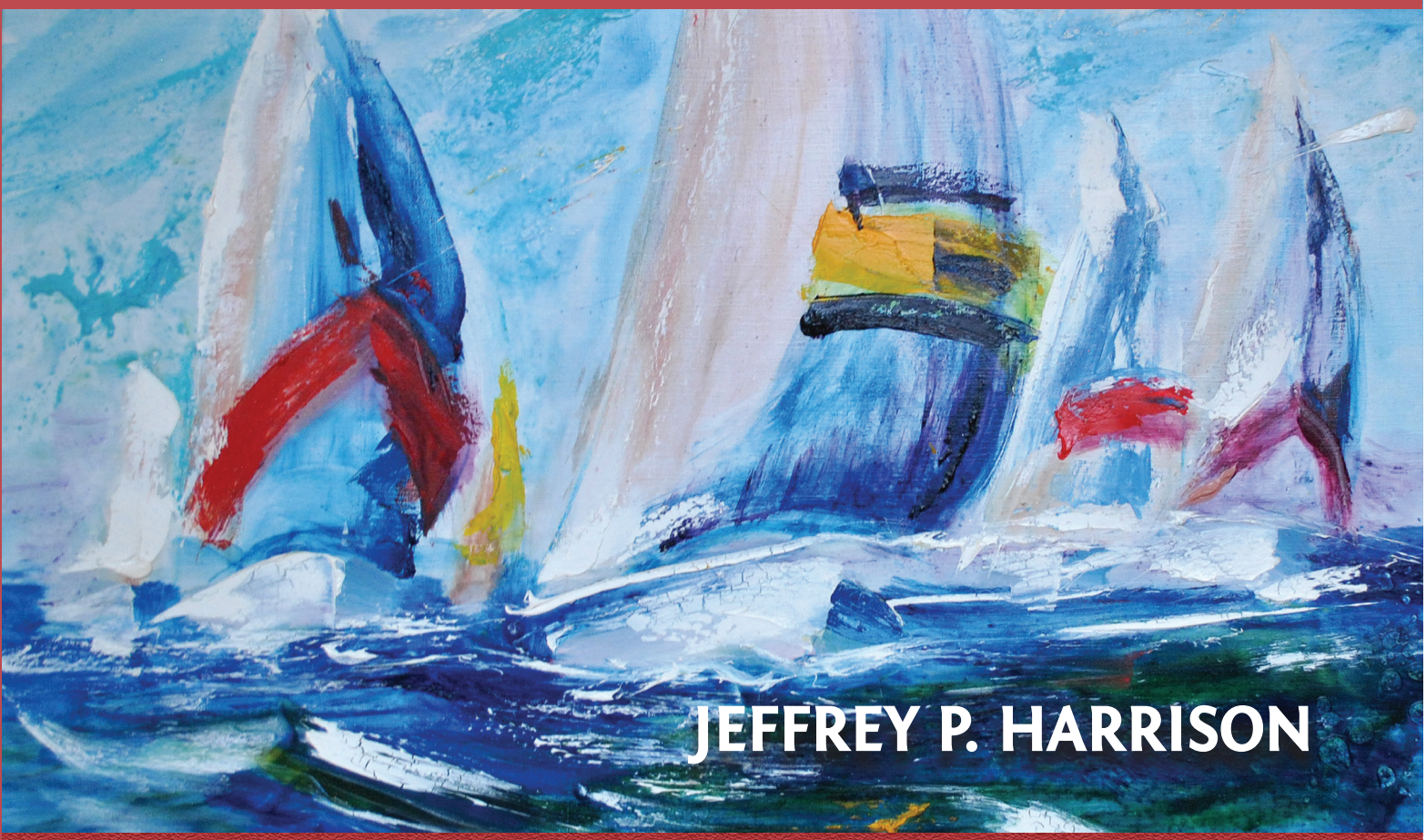

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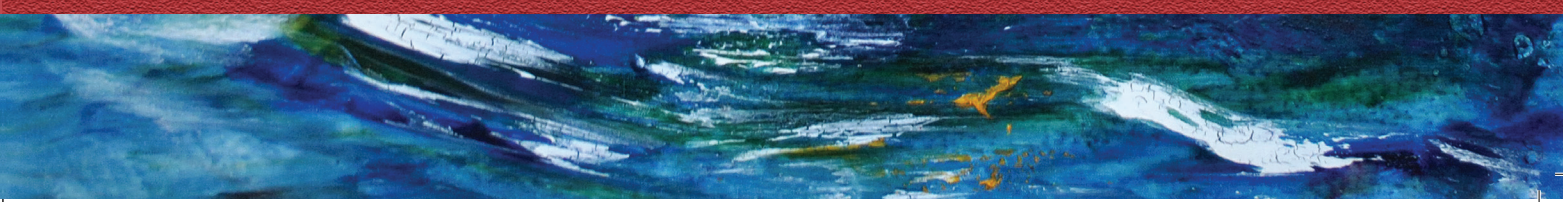
ESSENTIALS of STRATEGIC PLANNING in HEALTHCARE



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BRIEF CONTENTS

DETAILED CONTENTS

PREFACE

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

Healthcare research shows that the most successful organizations create a culture that fosters creativity, innovation, and transformational leadership. Effective strategic planning depends on leaders' commitment to creating an organizational culture that supports change. The first part of the book includes Chapter 1, "Leadership, Mission, Vision, and Culture: The Foundation for Strategic Planning," and Chapter 2, "Transformational Leadership Maximizes Strategic Planning." These chapters show leadership's important role in strategic planning and in creating an organizational culture that fosters successful strategic planning.

The second part of the book demonstrates essential strategic planning techniques for the healthcare field. It emphasizes the importance of positioning the healthcare organization relative to its environment to achieve its objectives and ensure its survival. Chapter 3, "Fundamentals of Strategic Planning," explains how to begin the strategic planning process with an analysis of the external environment and organizational factors critical to strategic planning. Chapter 4, "Strategic Planning and SWOT Analysis," focuses on the strengths, weaknesses, opportunities, and threats facing healthcare organizations and their importance in developing strategic plans. Chapter 5, "Healthcare Marketing," is new with this second edition because marketing is such an integral component of putting the strategic plan into action. In addition, with the growth of health systems, marketing is shifting from the local level to the regional or national level for some organizations.

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

The fourth part focuses on the development of strategic planning initiatives across the continuum of healthcare services. These developments include business initiatives in physician group management, long-term care, and other joint venture projects. Chapter 9, "Accountable Care Organizations and Physician Joint Ventures," stresses the impact of the Affordable Care Act of 2010 on kick-starting accountable care organizations and the strategic advantage hospitals can achieve through linking with physicians. Chapter 10, "Strategic Planning and Post-acute Care Services," explores strategic planning opportunities in inpatient rehabilitation, skilled nursing, hospice, and other post-acute care services.

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

Each chapter of the book includes definitions of key terms, and the reference list included at the end of the chapters can also serve as a list of recommended readings. Chapters 9 through 13 are modular, enabling the instructor to exclude chapters or change their order according to individual preference or classroom requirements.

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

Jeffrey P. Harrison
Jacksonville, Florida

Instructor Resources

This book's Instructor Resources include Power Point slides, HAP Course Lesson Plans, and other teaching tools.

For the most up-to-date information about this book and its Instructor Resources, go to ache.org/HAP and browse for the book's title or author name.

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

HAP Course Lesson Plans are designed to promote an active classroom. Use the lesson plans to set up a new course or adapt your current syllabus to this edition of the text. Activities have been designed to enhance critical-thinking and problem-solving skills, as well as information retention and retrieval capacity. Designed for either an online or on-ground environment.

ACKNOWLEDGMENTS

I gratefully acknowledge the help of those who assisted me in this endeavor. I thank my children—Christopher, Stacey, Shannon, and Craig—who have supported my research and always challenged me to present my findings in a clear and understandable manner.

I want to thank my coauthors in the textbook. One of these is Dr. Debra Harrison, who is the chief nursing officer at the Mayo Clinic in Florida and an assistant professor of nursing in the Mayo College of Medicine. In addition, I want to thank Art Layne, MHA, a former healthcare CEO, for his contributions on healthcare marketing.

I also acknowledge the behind-the-scenes work necessary to publishing a book. I thank my mother, Gloria Harrison, who helped edit the initial drafts of each chapter. Finally, I thank the staff at Health Administration Press. They were a pleasure to work with and were there every step of the way.

COASTAL MEDICAL CENTER COMPREHENSIVE CASE STUDY

Introduction

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

Coastal Medical Center (CMC) is a licensed, 450-bed regional referral hospital providing a full range of services. The primary service area is a coastal city and three counties, with a total population greater than 995,000, located in the Sunbelt. This tricounty area has had one of the fastest population growth rates in the country for the past five years. According to the local health planning council, the tricounty population is projected to increase by 15 percent from 2015 to 2020. Appendix A, at the end of this case study, provides detailed population statistics for the city and tricounty area.

The population growth rate for households (families) has been 1 to 2 percentage points higher than the overall population growth. The growth rate of the population under age 44 shows a young and growing community. Per capita (i.e., per person) income in the tricounty area is high and increasing. As the population of the tricounty area increases, the need for healthcare services is anticipated to increase. The area's economy is largely supported by manufacturing, with service companies and agriculture accounting for another 35 percent. Unemployment is typically 6 percent. The overall poverty rate is 12.4 percent. A recent study revealed that 40,000 city residents are below 125 percent of the established federal poverty level.

Healthcare Costs

Healthcare costs in the region are high in comparison to healthcare costs in most other areas in the state. In response to what they feel are excessively high healthcare costs, county

businesses recently formed a business coalition, hired a full-time executive, and publicly stated their intent to achieve reduction in healthcare costs. The local press has expressed its concern about the high cost of healthcare in the local community and consistently bashes the area's hospitals and physicians. The coalition refused to allow the three major medical centers in the area to join, despite the fact that each is a major employer.

The Competition

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

JMC is located less than two miles from CMC and is a 430-bed tertiary care facility. JMC owns four nursing homes, two assisted living facilities, a durable medical equipment company, a wellness center, an ambulance service, and an industrial medicine business. These facilities are located in the tricounty area and are within a 30-minute drive of the main CMC facility. JMC's parent company, Johnson Health System, also owns one small hospital in the region.

Full-time equivalent (FTE)
Total number of full-time and part-time employees, which is expressed as an equivalent number of full-time employees.

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

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

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

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

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

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

Highlights of Coastal Medical Center

As a referral center, CMC offers almost every level of care, including a number of tertiary care services, with the exception of neonatology and severe burn–unit services. Many of its patients require high-intensity services. For this reason, its costs are the second highest

in the entire state. The average length of stay of a patient at CMC is 9.2 days, compared to a statewide average of 6.4 days at hospitals of similar size and services. This difference is probably attributable to the intensity of services CMC offers. CMC's expenses per patient day are also the highest in the state, with the exception of two large university-affiliated teaching medical centers. Its FTEs per adjusted occupied bed (7.5), paid hours per adjusted patient day (35.2), and paid hours per patient discharge (238.5) all greatly exceed those of competitors and the norms of comparable facilities. CMC is currently authorized for 2,240 positions but actually employs 2,259 FTEs. Salary expenses per adjusted discharge and adjusted patient day are $2,760 and $491, respectively.

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

CMC has market advantage in substance abuse, psychiatrics, pediatrics, and obstetrics. JMC has market advantage in adult medical and surgical care. At a recent administrative meeting, the following CMC utilization figures for the year were reviewed:

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

A recent auditor's report included the following notes:

- A significant adjustment was required at year-end to correctly reflect contractual allowance expense (i.e., the amount of money spent in hiring

Exhibit Case.1
One-Year Market Share Analysis

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

outside contractors). The data used at the beginning of the year to estimate contractual allowance expense were grossly inaccurate.

- Insurers were not billed for services by certain hospital-based employed specialists ($7 million for the past year) as a result of neglect on the part of the hospital billing staff.
- A total of $1.7 million in Medicaid reimbursement was not authorized. No follow-ups were done, and no claims were resubmitted.

Historical Perspective

CMC was founded just after World War II using a Hill-Burton grant (see Highlight Case.1) and funds raised locally. From a modest beginning with 100 beds and a limited range of acute care service offerings, the medical center has grown to its present size of 450 beds and now offers a full range of services. Credit for the major growth and past success of CMC has been given to Don Wilson, who served as chief executive officer (CEO) from 1990 until his retirement in early 2012. Mr. Wilson was a visionary and successfully transformed the medical center to its present status as a tertiary care facility offering high-intensity care, including open-heart surgery and liver and kidney transplantation.

HIGHLIGHT CASE.1
Hill-Burton Act

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

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

Mr. Wilson's successor was Ron Henderson. For three years, Mr. Henderson practiced a loose, informal style of management. He seemed to sit back and enjoy himself while others ran the medical center. He was often characterized as a caretaker. The medical center made $52.5 million in 2012 following Mr. Wilson's retirement (the result of an excellent revenue stream and a strong balance sheet), so Mr. Henderson was not pressed to make major changes. He encouraged the board of trustees, the medical staff, and his administrative staff to submit new ideas for improving community healthcare services using CMC as the focal point for delivery. An avalanche of ideas was submitted during the first two years of Mr. Henderson's tenure. He moved quickly on these ideas and established himself as a person who made swift decisions on new ventures and kept things rolling. He simply let other executives "do their thing" and neither discouraged nor evaluated their work. His strategy was apparently rapid growth and diversity in new businesses. He made major fund commitments to new ideas but did little to evaluate the compatibility of those ideas with CMC's mission and its strategic direction, and he usually did not consider the financial implications of these ventures. His approach was simply "let's do it."

Before 2012, CMC was in excellent financial shape and faced few financial problems. By 2015, expenses began to skyrocket while utilization and revenues failed to keep pace. In addition, a hospital census indicated that, on average, 58 percent of CMC's patients were Medicare patients and 18 percent were Medicaid patients. As a result, the medical center suffered from reductions in reimbursement. Notable among CMC's excessive costs were labor, material, and purchased services. The chief financial officer (CFO) was convinced that a major part of this problem was the presence of three unions, including unionized employees in support services and unionized nursing services. Added to this cost burden was the more than $5 million being transferred to subsidize other CMC subsidiary companies.

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

In 2015, the medical center suffered a net loss of $16 million (see Appendix B). Surprised by this major loss, the board of trustees fired Mr. Henderson. They contended that he should have informed them of these serious problems. They felt that a better strategic planning process should have been in place for the selection of projects, on which millions of dollars had been spent. The board of trustees could not understand how overall corporate net income could drop to a loss of $16 million when $7.3 million in profit had been made the previous year.

Board of Trustees

CMC's governing board has 27 members. All of its trustees are prominent, influential, and generally wealthy members of the community. The board is self-perpetuating, meaning its members have continued their positions beyond the normal limits without any external intervention. The same chair has served for ten years. Average tenure on the board is 17 years. Committees of the board are detailed in Exhibit Case.2.

Exhibit Case.2
Committees of the Coastal Medical Center Board

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

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

Parent Corporation

The parent corporation of CMC is Coastal Healthcare Incorporated. A parent board was created through corporate restructuring several years ago, but its role has never been clear. This board is made up of friends of the most powerful trustees of the CMC board. In essence, when corporate restructuring was the "in" thing to do, this holding company was formed. By appointing a few CMC trustees to also sit on the parent board and by appointing friends of present CMC trustees, it was believed the two boards would function as one

happy family. However, there has been constant conflict from the beginning regarding the relative powers and roles of the two boards.

The parent board has 19 members, all of whom are white and male. The backgrounds of the parent board trustees mirror those of the CMC trustees in that they are prominent and mostly wealthy. Membership includes bankers, attorneys, business executives, business owners, developers, and prominent retired people.

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

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

- The parent board refused to approve the appointment of a new hospital CEO selected by the CMC board.
- In 2013, the two boards hired separate consultants to develop a long-range strategic plan. Two plans were produced but were never integrated and never really implemented.
- Committees from the parent board often request information about functions of the medical center, creating conflict because the parent board has a tendency to micromanage CMC's routine operations.
- Separate committees of both boards spent more than two years trying to revise CMC's mission statement.

Medical Staff

The medical staff at CMC has historically had difficulty cooperating with the board and administration. Patient length of stay is excessively high in most specialties, yet the physicians refuse to be educated on reimbursement and the need to reduce length of stay, excessive

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

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

tests, and so on. Approximately 90 percent of the medical staff also has privileges at one or more competing hospitals in town. Further, medical staff members have set up their own diagnostic services, especially the radiologists and neurologists, despite the fact that they were granted exclusive service contracts at CMC.

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

The medical staff also rated various aspects of medical center operations as unsatisfactory in a recent survey. The subjects of their complaints ran the gamut and included the following:

- Nursing services, and especially the nurses' attitudes, are not satisfactory. Nurses have formed themselves into shared governance councils and are taking issue with both physicians and administration regarding their autonomy.
- Excessive delays exist in every aspect of operations. Surgical procedures start late, supplies or equipment are lacking when needed, and processes for admitting patients take too long.
- CMC's recent Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores confirm doctors' perception, with satisfaction with nurses' communication rated only 74 percent (Appendix C). Patient satisfaction with physicians' communication was even lower at 72 percent.
- Medical staff members think they should have more voice in both financial and operational matters, especially in capital budgeting. They believe they are asked to provide free services too frequently (e.g., by committees), and many have refused to serve without compensation to offset the practice income they have lost.

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

Subsidiary Companies

Including CMC, Coastal Healthcare Inc. comprises 24 subsidiary corporations:

- **Medical Enterprises** is a for-profit joint venture with physicians. The company is developing computers that enhance imaging services. Thus far, CMC has invested $18 million in this company. No cash flow is expected for three to four years.
- **Three nursing homes**. These long-term care facilities are collectively losing almost $1 million annually. **Debt service** on two of them is very high. Only one is within patient transfer distance of CMC. The second is 70 miles away, and the third is 82 miles away. All three have unions. Almost all of the residents of the two facilities losing the greatest amount are Medicaid patients; there are only a few self-pay patients.

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

- **CMC Management Services** was formed to sell management and consulting services. The company lost $360,000 last year, which was its third year of operation.
- **Regional Neuroimaging** is a joint venture with physicians. The company lost $920,000 in its first year of operation. Capital invested by the hospital to date totals $9 million.
- **American Ambulance** is a local ambulance company. Financially, it just breaks even, but it does increase admissions to CMC, especially through trauma pickups.
- **Home Health Inc.** provides home health care services in an eight-county area. Its operating loss last year was $290,000. The company has considerable difficulty attracting and retaining professional personnel, especially nurses and physical therapists.
- **Industrial Services Inc.** provides health services to industrial companies throughout the state. Only one of the six operating locations is close enough to CMC to generate referrals. None of the operating sites is making a profit, though the company is five years old.
- **MRI Enterprises** is a successful mobile magnetic resonance imaging joint venture with a physician group. It has a consistently positive bottom line.
- **Textile Enterprises** is a large, high-tech laundry completed three years ago. It was intended to serve the medical center and many other companies in the region. Because of its debt service, union wages, and remote location, the

laundry has yet to break even. After three years, it still does not have its first non-CMC service contract.

- **Caroleen Hospital** (60 beds), **Grant Hospital** (74 beds), and **Ellenboro Hospital** (90 beds) are all small, rural hospitals purchased to feed patients to CMC. All are unprofitable. Collectively, the three require $2.5 million in subsidies annually.
- **HMO Care** is a health maintenance organization joint venture with 20,000 subscribers. After three years of operation, its costs are still rising. Last year, it required $2 million in subsidies.
- **Northeast Clinic** is a large multispecialty group of 11 physicians who were fed up with government red tape and sold out to CMC last year. CMC now employs these physicians and is responsible for all medical group operations. It is too early to determine whether this venture will succeed.
- **Imaging Venture** is a recently formed radiology joint venture. Until it becomes successful—if it does—it will cost just under $1 million in debt service annually.
- **North Rehabilitation**, a 60-bed inpatient rehabilitation facility, was just opened. It is expected to succeed because CMC will refer all of its rehabilitation patients here, and there is no other rehabilitation facility in the region.
- **Center for Pain** has been a successful outpatient facility and is expected to remain successful. Its space is leased, overhead is kept low, and the physicians are salaried.
- **Coastal Wellness**, a fitness and wellness center, was developed five years ago at a cost of $10 million. It is located in a coastal community and is intended to attract those from wealthy areas. A significant number of CMC employees and their family members use Coastal Wellness at a lower monthly rate, with the rest subsidized by CMC. Coastal Wellness is currently underutilized, so CMC subsidizes it with $220,000 annually.
- **Central Billing** was formed to attract patient billing contracts from health facilities and physician groups. It has been moderately successful and reached the break-even point this past year.
- **City Contractors**, a separate, small general contracting company, was just formed. It will require about $200,000 annually in subsidy.
- **Bay Enterprises** is a land acquisition and holding company.

Executives and Middle Management

CMC employs 20 executives (defined as positions above the administrative director level). Total annual executive compensation is $6.2 million. Each executive has an executive secretary whose average compensation is $35,000, which amounts to an executive-level support cost of $700,000.

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

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

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

The compensation and benefits policy of CMC deviates substantially from industry norms in terms of range. For example, the directors' annual salaries range from $85,000 to more than $170,000. Annual salaries for directors in the United States typically fall between $115,000 and $140,000.[1]

Corporate Staff

Coastal Healthcare Inc. consists of the following offices:

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

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

The parent company corporate staff comprises 26 total FTEs. The total costs of corporate overhead are $2.3 million annually. In addition, during the past year, the corporate officers purchased the consulting services listed in Exhibit Case.4.

Duplication of Functions

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

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

Service and Professional Contracts

CMC contracts with many service providers. Service contracts include housekeeping, food service, record transcription, biomedical maintenance, security, and many others. These contracts are renewed regularly with the same firms. CMC also contracts with countless health professionals. For example, CMC contracts with two physicians to cover CMC's pediatrics clinic at an annual cost of $380,000, and CMC furnishes the facilities as well as

Exhibit Case.4 Consulting Services Purchased by the Parent Corporation

Consultant Purpose	Cost
Conduct board retreat	$35,000
Prepare restructuring recommendations	$65,000
Write organization history	$60,000
Provide policy advice	$25,000
Lobby	$50,000
Undertake compensation (wage/salary) study	$72,000
Conduct labor negotiations	$120,000
Advise on management development	$90,000
Conduct managed care study	$47,000
Total	$564,000

professional and support personnel. Numerous physicians have negotiated arrangements through which they regularly receive checks for committee service, advice, and so on. Many of these negotiations are not documented in written contracts.

The hospital-based specialists' contracts are based on a percentage of gross earnings, with no provision for any type of adjustments to the gross amount. Several of these arrangements are long-standing but not documented in writing.

Materials Management

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

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

Special Projects

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

New CEO

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

- Compared to national personnel standards, many of the departments at CMC are grossly overstaffed. More than 100 new positions were added during the most recent fiscal year, despite the fact that utilization did not justify these positions. The overall administrative structure is top-heavy.
- CMC has 58 general contracts, many of which are standing contracts with consultants who appear to be receiving large monthly retainers but are not providing services. In addition, CMC has 121 contracts with physicians. Again, these physicians appear to be providing few services. The previous CEO apparently made numerous agreements to subsidize various physicians and pay them large sums for performing administrative services that are normally done on a voluntary basis by members of the medical staff.
- CMC has 53 major new service projects in the planning or construction phase. The analysis indicated they will require more than $100 million in future commitments, and Mr. Reynolds is not sure that CMC will be able to service the necessary debt. No project priorities exist and no feasibility studies have been done for most of the projects, so there is no way to forecast the financial impact of these "innovative ideas" on the organization.
- CMC has a large number of duplicate departments. Mr. Reynolds pinpointed many departments and services that could be consolidated.
- CMC has 66 "special" programs, collectively accounting for a $6 million outflow of cash. These programs are not directly related to CMC's tertiary care mission. CMC seems to have developed every type of program conceivable, from one end of the care continuum to the other, without considering whether the programs support its mission or generate a positive cash flow.
- In materials management, Mr. Reynolds found nearly $8 million in "unofficial" inventory stored throughout various facilities of the medical center and a declining inventory turnover rate of 42 percent. There is no centralized materials management system for the purchasing, storage, distribution, and accountability of materials.
- While the median operating margin for medical centers of similar size and service was about 2.5 percent during the past year, CMC experienced a multimillion-dollar loss and a –13.6 percent operating margin. In addition, the medical center's return on equity was a major problem. The number of **days accounts receivable** in other medical centers averaged 48 days during the past year; CMC's days accounts receivable were far greater at 58 days. Most alarming, CMC's cash on hand at any given time represented only 17.2 operating days. Finally, the hospital's major bond issue has been recently

Days accounts receivable
Average number of days an organization takes to collect payments on goods sold and services provided, calculated as follows: Average accounts payable (in dollars) × 365 (days per year) ÷ Sales revenue.

downgraded to the lowest credit rating, and the age of CMC's physical plant is 13 years, which is older than the average not-for-profit facility age of 11 years and the average for-profit facility of 7 years. (Days accounts receivable is the average number of days it takes to collect payments that clients owe to the organization The "normal" range is 40 to 50 days. A number significantly greater than 50 indicates the organization is having difficulty collecting payments from its clients; a number significantly lower than 40 indicates that the organization has overly strict credit policies that might be preventing it from taking in higher sales revenue.)

- Medicare has just notified the CFO that recovery of $4 million is forthcoming as a result of past errors in the Medicare cost report.
- The business coalition is becoming well established and intends to aggressively pursue discounted services through direct contracting.
- Coastal Healthcare Inc. is neither structured nor functions as a local healthcare system. Clinical services and administrative support are not integrated. For this reason, Coastal Healthcare Inc. does not meet the classic definition of a healthcare system provider.
- Nationally, capitation payment arrangements have not been successful for many hospitals. CMC is not in a favorable position to become an accountable care organization. To become an accountable health plan, CMC would have to partner with primary care and specialty physicians to meet the total healthcare needs of a defined patient population.
- No value-oriented efforts (e.g., continuous quality improvement, benchmarking) have been initiated at CMC.
- No leadership development is available for the board of trustees, medical staff, and administration.
- No formal strategic planning process is in place at either the CMC or the Coastal Healthcare Inc. level.
- No physician–hospital organizational arrangements exist.

General Conditions

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

Control systems are lacking, and CMC does not have a comprehensive information system. Moreover, the quality of care appears low, and a large number of legal cases against the medical center are pending. With respect to materials management, several suppliers have refused to deliver supplies because of delays in accounts payable.

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

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

Mr. Reynolds concluded that the prior CEO had followed the one-man rule concept and had failed to build necessary knowledge and management skills among the vice presidents. Thus, when difficulties occurred in the organization, inertia set in. The reactions of his executives and managers are characterized by indecisiveness and unwillingness to take risks for fear of compromising their job security. In addition, he found an excessive number of administrative positions.

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

From his discussion with the leadership team and other hospital staff, Mr. Reynolds believed CMC's leaders are considerably dissatisfied. To confirm his beliefs, he had the transition consultant administer a brief leadership survey, which included detailed questions about corporate culture and job satisfaction (Appendix F). Mr. Reynolds has decided to do a similar survey of all hospital staff within the next six months to obtain more baseline data on the organization's corporate culture and its ability to deal with the changes he knows are coming.

New Business Initiatives

To expand its physician staff, CMC has constructed a hospital-owned medical office building in a growing community five miles from the hospital. This effort has been successful and has attracted a prominent group of orthopedic physicians who now refer their surgical procedures to the hospital. As part of this expansion, and because the orthopedic workload has grown, CMC is exploring the financial feasibility of opening a physical therapy clinic at this new location. On the basis of current physician referral patterns, CMC anticipates $250,000 in outpatient physical therapy net income at the new location during the upcoming 12 months.

Value-Based Purchasing

Medicare value-based purchasing is a combined effect of efficiency and quality metrics. Value-based performance metrics have been identified at CMC in areas such as clinical processes; patient satisfaction; outcomes; readmission rates for heart attack, heart failure, pneumonia, chronic obstructive pulmonary disease, and hip or knee surgery; and hospital-acquired infections and conditions (Appendix G). The fact that CMC has a negative payment adjustment following each of these value-based purchasing metrics reflects the percentage reduction in Medicare reimbursement for the most current year.

Inpatient Data and Case-Mix Index

CMC had a case-mix index of 1.666 in 2015 (Appendix H). This index, which reflects the level of complexity for inpatient services, declined significantly since 2012, when it was 1.729. Given that the average case-mix index for an acute care hospital in the United States was 1.32 in 2015, CMC is more clinically complex than the average acute care hospital in the United States, but the level of complexity declined over the past four years. A major reason for this decline was the changing medical/surgical mix of the inpatients at CMC from 2012 to 2015 (Appendix H). Specifically, CMC's medical volume increased from 65 percent in 2012 to 66.26 percent in 2015. Conversely, CMC's surgical volume decreased from 35 percent in 2012 to 33.74 percent in 2015. This decline in surgical volume led to a reduction in volume in the overall case mix as well as an overall decline in profitability.

Conclusion

As Mr. Reynolds now ponders the many problems he has uncovered at CMC, he wonders what other problems lie beneath the surface. Every day he encounters additional major problems. At this point, Mr. Reynolds is so overwhelmed that he is unsure how to proceed. He does know, however, that priorities need to be set, the deteriorating situation needs to be turned around, and a strategic plan needs to be developed to chart the future of the organization.

Exercises

Assume you are Mr. Reynolds. Being new to the position, you are faced with major challenges. The questions and exercises at the end of each chapter in this book provide an opportunity to gain leadership experience in managing change in a healthcare organization. Most important, you will gain experience in developing a strategic plan.

Endnote

1. Annual salary statistics found at salary.com, 2015, "Critical Care Director Salaries," accessed August 2, www1.salary.com/Critical-Care-Director-Salary.html; salary.com, 2015, "Emergency Services Director Salaries," accessed August 2, www1.salary.com/Emergency-Services-Director-Salary.html.

Appendix A. Population and Household Data

	Riverside County	Metro City	Rural County	Ocean County
POPULATION AND HOUSEHOLD				
Square miles	609	775	601	485
Population density per square mile	214	1,028	245	111
Population 2010	83,829	672,971	105,986	28,701
Population 2015	129,832	794,569	146,739	53,506
Population 2020 (forecast)	148,289	842,179	163,082	63,543
% Population growth 2010–2015	54.88%	18.08%	38.45%	86.43%
% Population growth forecast 2015–2020	14.22%	5.10%	11.14%	18.76%
Households 2010	33,431	256,772	36,664	11,882
No. of households 2015	52,322	310,603	52,448	22,904
No. of households 2020 (forecast)	59,895	331,539	58,623	27,305
% Household growth 2010–2015	56.5%	20.97%	43.05%	92.76%
% Household growth forecast 2015–2020	14.5%	6.75%	11.77%	19.21%
Average household size	2.48	2.57	2.80	2.34
No. of families	35,793	205,123	40,907	16,766
% Urban population	56.5%	98.7%	59.6%	59.9%
% Rural population	43.5%	1.5%	40.4%	40.1%
% Female population	51.2%	51.5%	50.7%	51.5%
% Male population	48.8%	48.7%	49.3%	48.5%
% White population	91.1%	67.4%	88.6%	87.9%
% Black population	6.5%	28.5%	7.3%	9.5%
% Asian population	1.4%	3.8%	3.0%	1.6%
% Hispanic origin population	2.7%	4.3%	4.4%	5.2%
% Other population	1.4%	2.1%	3.1%	2.3%
% Population aged 0–5 years	6.5%	8.7%	8.0%	4.9%
% Population aged 6–11 years	8.1%	9.1%	9.6%	6.0%
% Population aged 12–17 years	8.2%	8.7%	10.2%	6.7%
% Population aged 18–24 years	6.4%	8.9%	7.2%	4.4%
% Population aged 25–34 years	9.7%	14.4%	11.6%	7.3%

% Population aged 35–44 years	17.8%	18.1%	18.7%	12.9%
% Population aged 45–54 years	17.0%	14.6%	15.9%	14.3%
% Population aged 55–64 years	10.2%	7.7%	8.9%	14.4%
% Population aged 65–74 years	8.8%	5.7%	5.6%	17.2%
% Population aged 75 years or older	7.3%	5.1%	4.3%	11.9%
Median age	41.3	35.5	36.8	50.5
INCOME AND EDUCATION				
Total household income	$5,145,536,895	$20,994,962,608	$3,656,788,183	$1,650,526,132
Median household income	$49,103	$41,410	$49,270	$42,975
Per capita income	$39,632	$26,423	$24,920	$30,847
Average income > $200,00	$474,930	$430,207	$348,177	$450,993
Education—% less than high school (age 25+)	11.2%	13.6%	11.5%	12.6%
Education—% high school graduate (age 25+)	31.6%	33.9%	35.4%	36.6%
Education—% some college (age 25+)	25.5%	26.9%	29.9%	27.1%
Education—% college graduate (age 25+)	22.1%	19.3%	16.8%	15.4%
Education—% graduate degree (age 25+)	9.6%	6.4%	6.5%	8.3%
EMPLOYMENT AND OCCUPATION				
Males employed (age 16+)	35,604	201,461	40,722	12,093
Females employed (age 16+)	29,337	169,863	30,949	9,654
Total employees (age 16+)	64,941	371,324	71,671	21,747
% White-collar occupations	62.9%	63.1%	61.8%	57.3%
% Blue-collar occupations	22.8%	23.6%	25.9%	27.5%
% Service occupations	14.3%	13.3%	12.4%	15.2%
% Local government workers	7.6%	7.0%	7.4%	7.7%
% State government workers	3.2%	2.4%	2.2%	1.6%
% Federal government workers	1.8%	3.5%	6.3%	0.9%
% Self-employed workers	9.0%	5.2%	6.3%	9.2%
CONSUMER EXPENDITURES				
Annual expenditures per capita ($US)	$18,211.60	$16,580.10	$16,226.00	$18,322.00
Healthcare expenditures per capita ($US)	$2,347.20	$2,183.90	$2,105.70	$2,390.30
Healthcare insurance expenditures per capita ($US)	$428.00	$385.00	$370.00	$482.20
COST OF LIVING				
Consumer Price Index	147.1	147.1	147.1	147.1
Medical care Consumer Price Index	211.3	211.3	211.3	211.3

Appendix B. Coastal Medical Center: Income Statement by Calendar Year (January 1–December 31)

	2015	2014	2013	2012
Inpatient revenue	719,329,916	755,618,849	784,412,051	827,231,608
Outpatient revenue	476,770,514	557,698,826	598,747,225	625,466,528
Total patient revenue	1,196,100,430	1,313,317,675	1,383,159,276	1,452,698,136
Contractual allowance (discounts)	809,575,220	912,970,880	970,156,446	1,062,616,080
Net patient revenues	386,525,210	400,346,795	413,002,830	390,082,056
Operating expense	416,531,087	421,383,586	411,066,597	356,255,182
Depreciation expense	22,616,659	17,701,123	21,479,371	21,412,330
Operating income	**–52,622,536**	**–38,737,914**	**–19,543,138**	**12,414,544**
Other income (contributions, bequests, other)	0	0	0	0
Income from investments	0	0	0	0
Governmental appropriations	0	0	0	0
Miscellaneous nonpatient revenue	36,527,105	47,063,315	37,025,334	40,113,376
Total nonpatient revenue	36,527,105	47,063,315	37,025,334	40,113,376
Total other expenses	0	944,991	0	0
Net income (loss)	**–16,095,431**	**7,380,410**	**17,482,196**	**52,527,920**

Note: Data are annualized for periods other than 12 months.

Appendix C. Coastal Medical Center: Hospital Consumer Assessment of Healthcare Providers and Systems Scores

	CMC	JMC	LMC	State Average	National Average
HCAHPS scores					
Patientswhoreportedthatnurses“Always”communicatedwell	74%	76%	83%	75%	79%
Patientswhoreportedthatdoctors“Always”communicatedwell	72%	76%	85%	78%	82%
Patients“Always”receivedhelpassoonastheywanted	55%	63%	71%	62%	68%
Patientswhoreportedthattheirpainwas“Always”wellcontrolled	66%	69%	75%	68%	71%
Staff“Always”explainedaboutmedicinebeforegivingittothem	56%	60%	67%	60%	64%
Patientsreportedtheirroomandbathroomwere“Always”clean	65%	72%	80%	70%	74%
Reportedareaaroundtheirroomwas“Always”quietatnight	57%	60%	70%	58%	61%
Giveninfoaboutwhattododuringtheirrecoveryathome	83%	85%	90%	83%	86%
“StronglyAgree”theyunderstoodtheircarewhentheyleftthehospital	43%	51%	65%	48%	51%
Gavetheirhospitalaratingof9or10(0[lowest]to10[highest])	62%	74%	90%	67%	71%
PatientsreportedYES,definitelyrecommendthehospital	63%	80%	92%	69%	71%

Appendix D. Coastal Medical Center: Balance Sheet

	2015	2014	2013	2012
Assets	339,055,010	347,278,187	384,551,932	403,459,670
Current assets	110,521,790	118,237,279	113,813,971	92,255,629
Fixed assets	143,848,624	132,031,268	141,037,047	130,904,980
Other assets	84,684,596	97,009,640	129,700,914	180,299,061
Liabilities and fund balances	339,055,010	347,278,187	384,551,932	403,459,670
Liabilities	289,863,632	268,244,657	296,496,775	295,606,794
Current liabilities	48,603,946	72,234,880	75,507,585	53,932,358
Long-term liabilities	241,259,686	196,009,777	220,989,190	241,674,436
Fund balances	49,191,378	79,033,530	88,055,157	107,852,876

Appendix E. Coastal Medical Center: Financial Ratios

	2015	2014	2013	2012
PROFITABILITY RATIOS				
EBITDAR (earnings before interest, taxes, depreciation, amortization, and rent)	$6,521,228	$30,150,947	$38,961,567	$73,940,250
Definition: Net income + Interest + Depreciation and amortization + Lease cost				
Net income (before taxes)	–$16,095,431.00	$7,380,410.00	$17,482,196.00	$52,527,920.00
Interest expense	$0.00	$5,069,414.00	$0.00	$0.00
Depreciation and amortization expense	$22,616,659.00	$17,701,123.00	$21,479,371.00	$21,412,330.00
Lease cost	$0.00	$0.00	$0.00	$0.00
Operating margin	–13.60%	–9.70%	–4.70%	3.20%
*Definition: (Total operating revenue – Total operating expense) / Total operating revenue * 100*				
Total operating revenue (net patient revenue)	$386,525,210.00	$400,346,795.00	$413,002,830.00	$390,082,056.00
Total operating expense	$439,147,746.00	$439,084,709.00	$432,545,968.00	$377,667,512.00
Excess margin	–3.80%	1.90%	3.90%	12.20%
*Definition: (Total operating revenue – Total operating expenses + Nonoperating revenue) / (Total operating revenue + Nonoperating revenue) * 100*				
Total operating revenue (net patient revenue)	$386,525,210.00	$400,346,795.00	$413,002,830.00	$390,082,056.00
Total operating expense	$439,147,746.00	$439,084,709.00	$432,545,968.00	$377,667,512.00
Nonoperating revenue (nonpatient revenue)	$36,527,105.00	$47,063,315.00	$37,025,334.00	$40,113,376.00
Return on equity	–32.70%	9.30%	19.90%	48.70%
*Definition: (Total assets – Total liabilities) * 100*				
Net income (before taxes)	–$16,095,431.00	$7,380,410.00	$17,482,196.00	$52,527,920.00

(continued)

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Total assets (general fund only)	$339,055,010.00	$347,278,187.00	$384,551,932.00	$403,459,670.00
Total liabilities (general fund only)	$289,863,632.00	$268,244,657.00	$296,496,775.00	$295,606,794.00
Return on assets (ROA)	–4.70%	2.10%	4.50%	13.00%
*Definition: Net income / Total assets * 100*				
Net income (before taxes)	–$16,095,431.00	$7,380,410.00	$17,482,196.00	$52,527,920.00
Total assets (general fund only)	$339,055,010.00	$347,278,187.00	$384,551,932.00	$403,459,670.00
LIQUIDITY RATIOS				
Current ratio	2.3	1.6	1.5	1.7
Definition: Total current assets / Total current liabilities				
Total current assets (general fund only)	$110,521,790.00	$118,237,279.00	$113,813,971.00	$92,255,629.00
Total current liabilities (general fund only)	$48,603,946.00	$72,234,880.00	$75,507,585.00	$53,932,358.00
Quick ratio	2.1	1.5	1.4	1.6
Definition: (Total current assets – Inventory) / Total current liabilities				
Total current assets (general fund only)	$110,521,790.00	$118,237,279.00	$113,813,971.00	$92,255,629.00
Inventory (general fund only)	$10,018,876.00	$6,729,591.00	$6,962,951.00	$7,474,424.00
Total current liabilities (general fund only)	$48,603,946.00	$72,234,880.00	$75,507,585.00	$53,932,358.00
Days cash on hand	17.2	27.9	15.6	7.1
Definition: (Cash on hand + Market securities) / (Total operating expenses – Depreciation) / 365				
Cash on hand (general fund only)	$19,681,648.00	$32,156,613.00	$17,610,303.00	$6,918,137.00
Market securities (temporary investments) (general fund only)	$0.00	$0.00	$0.00	$0.00
Total operating expense	$439,147,746.00	$439,084,709.00	$432,545,968.00	$377,667,512.00
Depreciation expense	$22,616,659.00	$17,701,123.00	$21,479,371.00	$21,412,330.00
Days cash on hand, all sources	63.4	81.3	101.7	160.0
Definition: (Cash on hand + Market securities + Investments) / (Total operating expenses – depreciation expenses) / 365				
Cash on hand (general fund only)	$19,681,648.00	$32,156,613.00	$17,610,303.00	$6,918,137.00
Market securities (temporary investments) (general fund only)	$0.00	$0.00	$0.00	$0.00
Investments (general fund only)	$52,629,288.00	$61,748,147.00	$96,899,834.00	$149,230,656.00
Total operating expense	$439,147,746.00	$439,084,709.00	$432,545,968.00	$377,667,512.00
Depreciation expense	$22,616,659.00	$17,701,123.00	$21,479,371.00	$21,412,330.00
Days in net patient accounts receivable	47.6	41.7	48.2	44.6
Definition: (Accounts receivable – Allowances for uncollectible) / (Total operating revenue / 365)				
Accounts receivable (general fund only)	$183,116,459.00	$208,154,053.00	$234,270,934.00	$221,427,548.00

Allowances for uncollectible (general fund only)	$132,664,535.00	$162,430,546.00	$179,696,832.00	$173,782,393.00
Total operating revenue (net patient revenue)	$386,525,210.00	$400,346,795.00	$413,002,830.00	$390,082,056.00
Days in net total receivable	58.8	51.4	57.1	50.2
Definition: (Accounts receivable + Notes receivable + Other receivables – Allowances for uncollectible) / (Total operating revenue / 365)				
Accounts receivable (general fund only)	$183,116,459.00	$208,154,053.00	$234,270,934.00	$221,427,548.00
Notes receivable (general fund only)	$0.00	$0.00	$0.00	$0.00
Other receivables (general fund only)	$11,846,498.00	$10,605,372.00	$10,022,079.00	$6,055,862.00
Allowances for uncollectible (general fund only)	$132,664,535.00	$162,430,546.00	$179,696,832.00	$173,782,393.00
Total operating revenue (net patient revenue)	$386,525,210.00	$400,346,795.00	$413,002,830.00	$390,082,056.00
Average payment period (days)	42.6	62.4	67.0	55.3
Definition: Total current liabilities / (Total operating expenses + Total other expenses – Depreciation) / 365				
Total current liabilities (general fund only)	$48,603,946.00	$72,234,880.00	$75,507,585.00	$53,932,358.00
Total operating expense	$439,147,746.00	$439,084,709.00	$432,545,968.00	$377,667,512.00
Total other expense	$0.00	$944,991.00	$0.00	$0.00
Depreciation expense	$22,616,659.00	$17,701,123.00	$21,479,371.00	$21,412,330.00
ACTIVITY RATIOS				
Inventory turnover	42.2	66.5	64.6	57.6
Definition: (Total operating revenue + Nonoperating revenue) / Inventory				
Total operating revenue (net patient revenue)	$386,525,210.00	$400,346,795.00	$413,002,830.00	$390,082,056.00
Nonoperating revenue (nonpatient revenue)	$36,527,105.00	$47,063,315.00	$37,025,334.00	$40,113,376.00
Inventory (general fund only)	$10,018,876.00	$6,729,591.00	$6,962,951.00	$7,474,424.00
Total asset turnover	1.2	1.3	1.2	1.1
Definition: (Total operating revenue + Nonoperating revenue) / Total assets				
Total operating revenue (net patient revenue)	$386,525,210.00	$400,346,795.00	$413,002,830.00	$390,082,056.00
Nonoperating revenue (nonpatient revenue)	$36,527,105.00	$47,063,315.00	$37,025,334.00	$40,113,376.00
Total assets (general fund only)	$339,055,010.00	$347,278,187.00	$384,551,932.00	$403,459,670.00
Average age of plant	13.8	18.3	15.5	6.6
Definition: Accumulated depreciation / Depreciation expense				
Accumulated depreciation	$312,510,684.00	$323,110,889.00	$333,323,022.00	$141,225,357.00

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Depreciation expense	$22,616,659.00	$17,701,123.00	$21,479,371.00	$21,412,330.00
Personnel expense as a percent of total operating revenue	41.90%	42.30%	39.90%	45.80%
*Definition: (Salary expense + Contract labor + Fringe benefits) / Total operating revenue * 100*				
Salary expense	$116,760,383.00	$117,450,538.00	$116,029,482.00	$114,008,926.00
Contract labor	$37,853,003.00	$42,326,811.00	$45,261,139.00	$56,208,185.00
Fringe benefits	$7,444,288.00	$9,742,577.00	$3,653,311.00	$8,620,180.00
Total operating revenue (net patient revenue)	$386,525,210.00	$400,346,795.00	$413,002,830.00	$390,082,056.00
CAPITAL RATIOS				
Long-term debt to net assets	4.90	2.48	2.51	2.24
Definition: Total long-term liabilities / (Total assets – Total liabilities)				
Total long-term liabilities (general fund only)	$241,259,686.00	$196,009,777.00	$220,989,190.00	$241,674,436.00
Total assets (general fund only)	$339,055,010.00	$347,278,187.00	$384,551,932.00	$403,459,670.00
Total liabilities (general fund only)	$289,863,632.00	$268,244,657.00	$296,496,775.00	$295,606,794.00
Total debt to net assets	5.89	3.39	3.37	2.74
Definition: Total liabilities / (Total assets – Total liabilities)				
Total assets (general fund only)	$339,055,010.00	$347,278,187.00	$384,551,932.00	$403,459,670.00
Total liabilities (general fund only)	$289,863,632.00	$268,244,657.00	$296,496,775.00	$295,606,794.00

Appendix F. Coastal Medical Center: Leadership Survey

Perceived Corporate Culture

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

Self-Evaluation of Position

Item	True %	Partly True %	Not True %
1. Sufficient decision-making authority	34	50	16
2. Clear understanding of role	43	30	27
3. Clear understanding of performance expectations	26	44	30
4. Fully use training and experience	27	33	40
5. Mix of management and routine is correct	33	30	37
6. Amount of work is reasonable	28	32	40
7. Work offers challenge, satisfaction, and growth	30	30	40
8. Performance is recognized	38	32	30
9. Compensation is satisfactory	45	35	20
10. Quality work is recognized and rewarded	29	41	30
11. Upward communication is effective	21	40	39
12. Downward communication is effective	17	50	33
13. Cross communication is effective	15	55	30
14. Operations problem solving is timely and thorough	17	43	40
15. Strategic decisions are timely and effective	26	30	44

Appendix G. Coastal Medical Center: Value-Based Purchasing

	CMC	JMC	LMC	State Average	National Average
Accreditation	Yes	Yes	Yes		
EmergencyService	Yes	Yes	Yes		
EmergencyVolume	High	Very high	Medium		
AverageTimePatientsSpentinEDBeforeAdmitted asInpatient	624 min.	338 min.	247 min.	282 min.	272 min.
AverageTimePatientsSpentinEDAfterAdmitOrder BeforeinaBed	277 min.	132 min.	92 min.	108 min.	97 min.
AverageTimePatientsSpentinEDBeforeBeingSent Home	226 min.	151 min.	145 min.	143 min.	133 min.
AverageTimePatientsSpentinEDBeforeSeenby HealthProfessional	55 min.	35 min.	33 min.	23 min.	24 min.
AverageTimePatientsSpentinEDWithBrokenBones BeforePainMed	84 min.	72 min.	57 min.	56 min.	55 min.
%ofPatientsLeftWithoutBeingSeen	8%	4%	1%	2%	2%
HeartAttackPatientsGivenAspirinatDischarge	99%	99%	100%	99%	99%
HeartAttackPatientsGivenStatinPrescriptionat Discharge	97%	99%	100%	99%	98%
HeartAttackPatientsGivenPCIWithin90Minutesof Arrival	88%	95%	95%	97%	96%
HeartFailurePatientsGivenACEInhibitororARBfor LeftVentric	95%	96%	98%	98%	97%
HeartFailurePatientsGivenanEvaluationofLVS Function	99%	100%	100%	100%	99%

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HeartFailurePatientsGivenDischargeInstructions	80%	92%	94%	96%	95%
PneumoniaPatientsGiventheMostAppropriateInitial Antibiotic	90%	95%	92%	98%	96%
SurgeryPatientsWhoReceivedPreventative AntibioticsOneHou	97%	99%	99%	99%	99%
SurgeryPatientsWhosePreventativeAntibioticsare StoppedWi	92%	98%	98%	99%	98%
SurgeryPatientsTakingBetaBlockersRemainon BetaBlockers	98%	98%	98%	99%	98%
SurgeryPatientsGiventheRightAntibioticAfter Surgery	96%	98%	99%	99%	99%
HeartSurgeryPatientsWhoseBloodSugarKeptin Control24H	90%	98%	100%	96%	94%
SurgeryPatientsWhoseUrinaryCathetersRemoved FirstorSecondDay	93%	95%	98%	98%	98%
PatientsHavingSurgeryWarmedinORorNormal TempatEndofSurg	99%	100%	100%	100%	100%
IschemicStrokePatientsWhoReceivedMedtoBreak UpClotsWi3Hrs	N/A	62%	89%	81%	73%
IschemicStrokePatientsWhoReceivedMedtoPrevent ComplicWi2Da	95%	98%	100%	98%	98%
StrokePatientsReceivingBloodThinnersWi2Days	95%	99%	99%	97%	95%

Healthcare-Associated Infections	**Comparison to National Benchmark**		
	CMC	JMC	LMC
Central line–associated bloodstream infections	No different	No different	Better
Catheter-associated urinary tract infections	Worse	Worse	No different
Surgical-site infections from colon surgery	No different	No different	Better
Surgical site infections from hysterectomy	Worse	No different	No different
Methicillin-resistant *Staph. aureus* (MRSA)	Worse	No different	No different
Clostridium difficile (*C.diff.*)	Worse	No different	Better

Appendix H. Coastal Medical Center: Inpatient Data

Trend Report

Inpatient Utilization Statistics	2015	2014	2013	2012
Case-mix index	1.666	1.692	1.713	1.729
Medical MS-DRGs	66.26%	65.57%	65.00%	65.38%
Surgical MS-DRGs	33.74%	34.43%	35.00%	34.62%
Routine discharges to home	5,729	5,343	5,110	5,092
Discharges to other acute care hospitals	85	94	94	81
Discharges to skilled nursing facilities	1,360	1,346	1,238	1,305
Deaths	404	289	330	314
Other discharges	2,120	2,171	1,962	1,661
Total discharges	9,698	9,243	8,734	8,453
Psychiatric discharges (DPU, included in total)	493	508	451	443
Rehabilitation discharges (DPU, included in total)	139	171	141	166
Medicare Advantage (HMO) discharges (not included in total)	942	1,872	2,308	2,518

2015 Statistics for the Top 20 Base MS-DRGs

Base MS-DRG Description	Base MS-DRG	IPPS Cases	ALOS	Average Charges ($)	Average Payment ($)	Average Cost ($)	Case-Mix Index	CC/MCC Rate (%)	MCC Rate (%)
Percutaneous cardiovascular proc with drug-eluting stent	247-246	625	2.5	74,651	15,101	18,173	2.181	16.3	16.3
Septicemia or severe sepsis without MV, 96+ hours	872-871	372	5.7	37,703	12,184	10,773	1.750	83.3	83.3
Circulatory disorders except AMI, with cardiac catheter	287-286	369	2.9	29,818	8,016	6,933	1.192	12.2	0.1
Psychoses	885	358	11.4	32,643	9,090	15,899	.954	0.0	0.0
Major joint replacement or reattachment of lower extremity	470-469	341	2.7	51,019	15,705	14,908	2.165	5.3	5.3
Heart failure and shock	293-292-291	321	4.9	22,240	8,064	7,189	1.161	84.7	40.5
Cardiac arrhythmia and conduction disorders	310-309-308	235	3.8	18,250	5,860	5,572	.846	66.8	28.9
Simple pneumonia and pleurisy	195-194-193	201	4.3	21,561	8,363	6,482	1.171	88.6	41.8
Renal failure	684-683-682	195	4.7	26,116	8,336	7,983	1.192	90.3	39.0
Chronic obstructive pulmonary disease	192-191-190	194	4.0	19,327	7,055	5,795	1.020	82.0	47.9
Intracranial hemorrhage or cerebral infarction	066-065-064	175	4.2	27,743	9,202	8,564	1.333	80.0	37.1
Rehabilitation	946-945	161	12.5	58,027	18,985	25,646	1.302	73.3	0.0
Chest pain	313	151	2.0	13,040	3,075	3,498	.562	0.0	0.0

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Esophagitis, gastroenterological, and miscellaneous digestive disorders	392-391	143	3.7	22,967	5,629	6,152	.839	22.4	22.4
Gastrointestinal hemorrhage	379-378-377	130	4.1	27,877	8,333	8,311	1.202	95.4	26.2
Extracranial procedures	039-038-037	127	2.1	37,900	9,886	8,455	1.315	29.1	7.9
Kidney and urinary tract infections	690-689	114	4.2	20,054	6,347	6,036	.945	41.2	41.2
Other vascular procedures	254-253-252	113	5.0	63,355	17,428	16,646	2.342	62.8	31.0
Permanent cardiac pacemaker implant	244-243-242	108	4.2	62,635	19,251	13,980	2.681	61.1	25.0
Acute myocardial infarction, discharged alive	282-281-280	105	4.8	37,112	10,517	10,275	1.422	84.8	53.3
All other base MS-DRGs		3,915	5.4	54,080	14,658	14,758	2.058		
TOTAL		8,453	5.0	45,557	12,506	12,827	1.729		

2015 Statistics by Medical Service

	Number Medicare Inpatients	Average Length of Stay	Average Charges ($)	Average Cost ($)	Medicare CMI	CMI-Adjusted Average Cost ($)
Cardiology	1,513	3.6	23,498	6,550	1.030	6,362
Cardiovascular surgery	1,123	3.9	86,224	21,103	2.909	7,255
Gynecology	38	2.1	36,756	8,613	1.084	7,944
Medicine	1,691	5.3	33,073	10,221	1.283	7,967
Neurology	502	4.3	27,248	8,378	1.200	6,982
Neurosurgery	42	9.5	114,058	30,272	3.492	8,669
Obstetrics	12	5.2	20,415	9,146	.687	13,324
Oncology	101	5.5	39,450	11,021	1.638	6,729
Orthopedic surgery	795	3.8	61,015	17,228	2.369	7,271
Orthopedics	145	4.1	23,034	7,127	1.060	6,725
Psychiatry	459	10.5	30,824	14,766	.924	15,989
Pulmonology	796	4.9	32,695	9,258	1.419	6,522
Surgery	513	8.8	100,849	27,114	3.858	7,027
Surgery for malignancy	37	6.9	89,678	22,285	2.138	10,425
Urology	420	4.5	27,637	8,082	1.199	6,742
Vascular surgery	265	3.7	52,825	13,205	1.886	7,002
TOTAL	8,453	4.98	45,557	12,827	1.729	7,421

CHAPTER 1

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

Leadership is the capacity to translate vision into reality.

—Warren Bennis

Innovation distinguishes between a leader and a follower.

—Steve Jobs

Learning Objectives

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

- develop an understanding of the healthcare system and its organizational complexity, including the role of healthcare leaders as they make decisions and formulate strategy;
- understand the importance of board and medical staff leadership;
- understand the role and importance of organizational structure and governance;
- discuss complex issues in the healthcare industry from the perspective of previous leadership literature;
- apply leadership and managerial principles to organizational and systemwide problems in healthcare;

- understand the importance of an organization's mission, vision, and values in healthcare strategic planning;
- discuss leadership's role in developing an organizational culture of ethics and professionalism; and
- compare systems and techniques to measure an organization's own performance and the performance of other organizations.

Key Terms and Concepts

- Board of directors
- Chief executive officer
- Chief financial officer
- Chief information officer
- Chief medical officer
- Chief nursing officer
- Credentialing
- Culture
- Fiduciary
- For-profit hospital
- Goals
- Health information technology
- Incentive
- Infrastructure
- Internal data
- Joint venture
- Leadership
- Magnet hospital designation
- Medical staff
- Mission
- Not-for-profit hospital
- Organizational culture
- Senior marketing executive
- Servant leadership
- Stakeholder
- Systems approach
- Values
- Vision

Introduction

Healthcare spending in the United States reached $2.9 trillion in 2013 (CMS 2014). This figure was up from $2.1 trillion in 2006—a 38 percent increase (Catlin et al. 2008). It represents an expenditure of $7,026 per person in 2006, climbing to $9,255 per person in 2013. As a percentage of the US economy, healthcare spending was 16 percent of the gross domestic product (GDP) in 2006 and 17.4 percent of the GDP in 2013. During 2013, the largest component of healthcare expenditures was hospital care, which increased 4.3 percent from the prior year, to $936.9 billion. The second largest component was

physician services, which in 2013 increased 3.8 percent to $586.7 billion. The third largest component was prescription drugs—$271.1 billion in 2013. Nursing care facilities ranked fourth at $155.8 billion.

Healthcare costs are increasing at a significant rate, and the industry needs leaders who can allocate resources more efficiently. Research shows that, taken as a group, hospitals are one of the largest employers in the country, and they are critical to attracting new business to a geographic area. Healthcare also contributes to the United States' economic and social well-being; 18.5 million Americans were employed in healthcare in 2015 (BLS 2015). The US hospital industry comprises a wide range of hospitals of varying size (see Exhibits 1.1 and 1.2).

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

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

Growth is important to an organization's future success. It helps the organization recruit physicians and provides greater economies of scale (see Highlight 1.1), which can result in increased profitability. To grow, organizations need effective **infrastructures**, high-performance work processes, and skilled personnel, and they must provide their employees with appropriate **incentives**. Most important to growth is good strategy development, which is a product of excellent leadership and diversity of individuals and expertise. Strategic planning is an effective way for organizations to improve their allocation of resources (see Highlight 1.2). Resources need to be allocated in a way that allows organizations to provide healthcare services as efficiently as possible. Research has shown that the efficient allocation of healthcare resources in the production process is linked to improved quality (Vigen, Duncan, and Coughlin 2013). The following section discusses the role of hospital leaders, particularly their function in strategic planning.

Infrastructure
Underlying foundation or basic framework.

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

EXHIBIT 1.1
US Hospitals by Category, 2005 to 2014

Type	2005	2014	Change (no.)	Change (%)
Government, federal	229	210	–19	–8
Government, nonfederal	1,435	1,294	–141	–9.8
Not-for-profit	3,204	3,118	–86	–2.7
For-profit	1,480	1,661	181	12.2
Total	6,348	6,283	–65	–1

Source: Data from AHA (2005, 2014).

Exhibit 1.2
US Hospitals by Bed Size, Category, and Year

	2005	2014	Change (no.)	Change (%)
Bed size 0–99				
Government, federal	100	94	–6	–6
Government, nonfederal	879	832	–47	–5
Not-for-profit	1,393	1,429	36	2.5
For-profit	948	1,040	92	9.7
Bed size 100–199				
Government, federal	45	45	0	0
Government, nonfederal	256	181	–75	–29
Not-for-profit	743	655	–88	–12
For-profit	340	335	–5	–1.5
Bed size 200–299				
Government, federal	31	33	2	6.4
Government, nonfederal	117	110	–7	–6
Not-for-profit	456	405	–51	–11
For-profit	119	120	1	0.8
Bed size 300–399				
Government, federal	20	17	–3	–15
Government, nonfederal	74	54	–20	–27
Not-for-profit	279	245	–34	–12
For-profit	45	56	11	24.4
Bed size 400+				
Government, federal	33	21	–12	–36
Government, nonfederal	109	117	8	7.3
Not-for-profit	333	384	51	15
For-profit	28	110	82	293
Total				
Government, federal	229	210	–19	–8
Government, nonfederal	1,435	1,294	–141	–9.8
Not-for-profit	3,204	3,118	–86	–2.7
For-profit	1,480	1,661	181	12.2
Overall total	6,328	6,283	45	–0.7

Source: Data from AHA (2005, 2014).

Definition of Leadership

Leadership
Ability to guide, influence, and inspire individuals to meet organizational goals.

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

HIGHLIGHT 1.1 Economies of Scale

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

HIGHLIGHT 1.2 Allocation of Resources

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

In the rapidly changing healthcare environment, strategic planning is becoming increasingly important to overall organizational success. Strategic planning involves the development of organizational objectives (i.e., what the organization wants to accomplish), the management of action plans, and the measurement of ongoing performance. An important part of strategic planning is the development of relationships with **stakeholders**, which include the board of directors, the leadership team, hospital staff, physicians, patients, local employers, insurers, community groups, and government agencies.

In healthcare organizations, the **board of directors** and the **chief executive officer (CEO)** are at the top of the leadership structure. The *board of directors* is the governing body appointed to hold **fiduciary** responsibility for the organization. (Piedmont Healthcare's board of directors is illustrated in Exhibit 1.3. Piedmont Healthcare is a large, not-for-profit health system based in Atlanta, Georgia.) As part of this responsibility, the board makes policy decisions, which guide the future of the organization. An essential area of

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

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

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

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

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

The HLA is a consortium of the nation's premier professional healthcare administration associations, representing more than 140,000 healthcare management professionals. The goal of the alliance is to pursue common interests and advance the healthcare management profession. It uses the combined knowledge and experience of its members to improve the field of healthcare management. These organizations are

- the American College of Healthcare Executives,
- the American Organization of Nurse Executives,
- the Healthcare Financial Management Association,
- the Healthcare Information and Management Systems Society, and
- the Medical Group Management Association.

The HLA (2013) categorizes key competencies under five domains: communication and relationship management, leadership, professionalism, knowledge of the healthcare environment, and business knowledge.

The NCHL is a nonprofit organization dedicated to ensuring high-quality, relevant, and accountable leadership for healthcare organizations in the twenty-first century. This is accomplished by using competency-based leadership models, benchmarking against best-in-class organizations, and establishing standards of best practice. It also supports evidence-based research, innovation, and quality improvement. The NCHL (2015) strives to improve the abilities of healthcare leaders to improve healthcare in the United States through research, publications, benchmarking, and formation of leadership networks.

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

the board of directors' responsibility is the development of a strategic plan consistent with the organization's mission and vision.

Many believe that an organizational culture that embraces continuous quality improvement (CQI; see Highlight 1.4) is necessary for long-term success and that the board of directors should focus on measuring performance to ensure healthcare quality. The Institute of Medicine (IOM; see Highlight 1.5) believes that improving healthcare will require changes to the structure and processes of the delivery system as well as a focus on coordination of care across all services. In addition, successful delivery of healthcare in the future will depend on the use of **health information technology**, such as electronic health records.

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

EXHIBIT 1.3 Sample Board of Directors (Piedmont Healthcare, Atlanta, Georgia)

The *CEO* is the highest-ranking executive in an organization and is responsible for strategic planning, hiring senior leadership, and managing operations. The CEO is often a member of the board of directors and is an important interface between the board and operations. The CEO also represents the organization to key stakeholders, including regulatory authorities and community groups. A competent CEO emphasizes organizational

HIGHLIGHT 1.4 Continuous Quality Improvement

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

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

HIGHLIGHT 1.5 Institute of Medicine

The IOM was founded in 1970 as a nongovernmental, nonprofit organization that would provide impartial information and advice about healthcare in the United States. It is part of the National Academies. The IOM's aim is to help those in government and the private sector make informed health decisions by providing reliable information. Many of the studies that the IOM undertakes begin as specific mandates from Congress; others are requested by federal agencies and independent organizations. The IOM (2015) also convenes a series of forums, roundtables, and standing committees, as well as other activities, to facilitate discussion, discovery, and critical thinking.

The IOM has published studies on the state of healthcare that have drawn a lot of attention; for example, in 2000 it disclosed the high number of medical errors occurring in hospitals in its report *To Err Is Human*, and in subsequent reports it continued to identify the health field's progress on quality. More recently, the IOM issued publications such as *Future Directions of Credentialing Research in Nursing*, *Research Priorities to Inform Public Health and Medical Practice for Ebola Virus Disease*, and *Investing in the Health and Well-Being of Young Adults*.

transformation by envisioning, energizing, and fostering change. Analytical and innovative thinking, a community orientation, and strategic planning are essential to this focus. At the execution level, CEOs must demonstrate an ability to communicate, manage change, influence staff, and measure performance. They also need to possess excellent people skills; they must build relationships, uphold professional ethics, develop talent, and lead teams. Most important, CEOs should focus on organizational values, direction, and performance expectations.

The Board of Directors' Role in Strategic Planning

Hospitals with a high-functioning board of directors perform better and are more profitable (Collum et al. 2014). In particular, outstanding hospital boards are composed of external members who are committed to the strategic planning process. Also important is the board's relationship to the community. A collaborative, community-oriented board stays in touch with the needs of the local population and develops new services to meet those needs. Such services can improve the health and well-being of the community as well as enhance the reputation of the healthcare organization.

Board participation in the strategic planning process helps build consensus among senior leadership and staff about the organization's future direction. Board members'