GETTING IT ALL TOGETHER

Systems Should Link Their Strategic And Financial Planning

BY ELLEN BARRON & DONALD A. WESTERMANN

Summary Foreseeing dramatic changes in healthcare delivery, the leaders of the Franciscan Health System (FHS) decided in the early 1990s to more closely link their strategic and financial planning. Though this cooperation was tentative at first, by 1993 both our planners and our chief financial officers shared certain assumptions about the future–above all, that the coming delivery model was managed care provided by integrated delivery systems (IDSs).

Having agreed on our assumptions, we translated them into a vision statement, from which we derived four strategic goals:

- Advance the healing mission of our sponsors
- Create a culture of continuous improvement in leadership, quality, innovation, cost-effectiveness, and measurable customer value
- Create an environment that values and empowers those with whom we work
- Develop, through partnering, an IDS that provides affordable care to our communities

Our goals established, we charted what we call a "crosswalk" between the strategic and financial aspects of our budgeting. We found that we had to think in a new way about capital. For example, we began investing as heavily in "soft" items like research, partnerships, and new services as in the traditional "bricks and mortar."

This process is new for us, and developing it has not always been comfortable. But we believe it has helped us to more wisely allocate FHS's resources and thus give our system greater stability.

Five years ago, the leaders of the Franciscan Health System (FHS), foreseeing the coming dramatic changes in healthcare delivery, decided to link much more closely the system's strategic and financial planning. This was, of course, easier said than done. It was perhaps symbolic that, at our very first meeting on the project, FHS's planners and chief financial officers (CFOs) sat on opposite sides of the room.

Despite this discomfort, the initial meeting helped begin to build understanding about the roles and values of planners and CFOs. Over time, trustees and other managers began to see value in developing this synergy. By 1993, we could talk about the key assumptions we shared about the future of healthcare. Those were:

- Large population groups will be aggregated for the purpose of purchasing comprehensive healthcare.
- Each population group will be represented by a large purchaser.
- Regional delivery systems will be organized to provide this care. The delivery model will be based on managed care and paid predominantly by capitation.
- Regional integrated delivery systems (IDSs) will provide comprehensive care, from preventive to long-term.
- Basic care will be provided by primary care physicians (who will be the gatekeepers) and other primary care practitioners.
- IDSs will be capable of bidding for large con-

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tracts and assuming the risks posed by them.

- Service will be characterized by convenience, quality, and value, and will be customized to meet the needs of the population.
- An IDS will partner with other IDSs, with similar values and complementary services, to cover large geographic areas.


Michael McGurl

Having agreed on these eight key assumptions, management throughout the system translated them into a vision statement for FHS: "We will be a healing influence in the communities we serve. We will improve health status, create easy access, and establish a cost-effective, quality health system." From the vision statement we derived a set of four strategic goals, which we elucidated as follows:

- **Shared vision goal** Advance the healing mission of our sponsors, the Sisters of St. Francis of Philadelphia
- **Total quality goal** Create a culture of continuous improvement in leadership, quality, and innovation that demonstrates cost-effectiveness and measurable customer value
- **Human resources goal** Create an organizational environment that values, empowers, enriches, and supports all those persons with whom we work
- **Integrated delivery goal** Develop, through partnering, an affordable integrated delivery system that provides a continuum of care in the communities we serve

Thus FHS's strategy for the future. What about the financial planning? In general, we believed that if we accomplished the above four goals, our financial needs would inevitably be addressed. But we realized that financial goals must of course be a key part of any planning; they keep us on a solid footing as we move into the future.

Let us now look at strategic/financial planning in a bit more detail.

We found that we had to develop a new way of thinking about capital.

The "Crosswalk"

We developed what we call a "crosswalk" between the strategic and financial aspects of our planning. The crosswalk identifies the three budget areas we wanted to emphasize in our strategic goals and resource allocation. The first—we call it the "breakthrough" area—represents those new core services, products, or processes (such as alternative therapy approaches or innovations in integrated delivery) in which FHS has decided to concentrate its future efforts and capital resources. Next in importance is the "platform" area, the services (information systems, for example) that must be in place to allow breakthroughs to occur. Last is the "derivatives and enhancements" area, representing services (communication and education, for example) that are necessary but also relatively undemanding in terms of time and capital.

We found that, to match up our strategy and resources, we had to develop a new way of thinking about capital. Traditionally, capital investment has usually meant investment in "bricks and mortar": the construction of new buildings and the purchase of new equipment. We decided that we would certainly not stop spending on new buildings and equipment, but we would *expand* the meaning of capital so that it included research, partnerships, and the development of nontraditional programs and services.

Trying to integrate strategic and financial planning is not an easy process. We needed, for one thing, to balance profit against FHS's strong commitment to charity care, access, and community benefit. At the same time, we needed to maintain a consistent debt rating, thus protecting our ability to borrow, and to honor our commitment to bondholders. And underlying everything was the ever-present question of resources: What were we able to reasonably afford?

In creating a capital budget that would be in line with the strategic plan, our first step was to hold a series of prebudget meetings. We asked managers throughout the system what they wanted, and then added it all up, getting a total of $136 million.

We decided that—given managed competition, health reform, and the volatility of the market—we could not afford to spend that much money. After looking at all factors (including bond rating, net income, prior capital investments, and others), we settled on the more realistic figure of $100 million. Where did we trim out the excess $36 million? In the past, the traditional bricks-and-mortar capital projects would probably have survived and we would have cut the "softer" items. This time, however, we said we wanted to do something different. We went back to our four strategic goals and, with them in mind, determined how much of the $100 million should be designated for each of the three budgetary areas. This, incidentally, is why our crosswalk chart was important. It reminded us that finances are to serve strategy, not the other way around.

When we were finished we found we had allocated roughly 50 percent of planned investment to the newer, breakthrough areas (managed care and primary care, for example) and 50 percent to the more traditional areas. This represented a real change in thinking for FHS. Just a few years before, the ratio would have been closer to 80 percent tradition, 20 percent innovation.

The new process allows us not only to match up strategy and resources, but also to broaden our focus. In the past, we had looked primarily at individual facility budgets, rather than viewing our system as a whole. Now, however, we are able to watch *across* the system how we are spending, say, the $25 million allocated for information systems or the $20 million allocated for primary care.

Here are some important lessons we have learned from our new planning process:

- Both the strategic and the financial plan must be future oriented.
- They also need to be market oriented. Planners must understand and respond to community needs, with the ultimate goal of improving health status.
- Both plans must have built-in flexibility so that they can be adapted to inevitable changes in community needs, medical practice, and financial constraints.

Finances should serve strategy, not the other way around.

- The planning process must be participatory. To develop positions regarding strategy and capital, we work very closely with the planners and CFOs of our member organizations, and they in turn work closely with their physicians, management teams, and boards of directors. The process is one of continual two-way communication and negotiation.

Sharing the Information

We found it helpful, in developing our strategic/financial planning process, to answer certain questions.

What Are the General Guidelines? We came up with these seven:

- Communicate throughout the organization so that everyone understands the market "envelope" in which they operate.
- Recognize that the process is "learn as you go."
- Recognize that there is no one right answer to any question.
- Be visionary. The things you do today will create your organization's future.
- Maintain a "can-do" attitude. Look for the ways you *can* do something, rather than why you cannot.
- See challenges as opportunities, not threats.
- Take a team approach.

Which Comes First, Strategy or Finance? As with the chicken and egg, there is no "first." Strategy and finance must be tightly interwoven. When they are, they will furnish you with the broad perspective necessary to balance short-range financial or competitive needs against longer-range goals and fiscal viability. It is also important to keep in mind the overall investment posture of your organization.

How Can the System Planner and CFO Best Serve the Board of Directors and Other Members of the Management Team? We outlined five ways:

- Identify early the issues and opportunities in the marketplace.
- Make budgeting an ongoing process. Begin next year's budget as soon as this year's is complete.
- Determine how much transition work you can bite off in a given year as you move forward with integration.
- The planner's role is to provide consistent, timely, comprehensive data on demographics, volumes, and service mix.
- The CFO's role is to translate these into

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cussions, the guidelines are shared with the potential partners. This communicates—up front—to potential partners the parameters within which DCNHS–East Central will operate. For both internal and external constituencies, the guidelines are proving to be helpful because they identify the overall expectations of the DCNHS–East Central Board of Directors, acting on behalf of the canonical sponsor, and outline a set of general steps to be followed when forming or joining a network.

As DCNHS–East Central institutions affiliate with CBNs and gain additional experience, the DCNHS–East Central Board of Directors will modify the guidelines from time to time to reflect the lessons our institutions have learned. In the year since the guidelines have been introduced, response has been positive. □

For more information about the DCNHS–East Central guidelines for planning and developing integrated networks, contact Lawrence Prybil or Ronald Mead, 812-963-3301.

NOTES

1. See, for example, Catholic Health Association, "Setting Relationships Right: A Proposal for Systemic Healthcare Reform," St. Louis, 1993, Chapter 3; and American Hospital Association, "National Health Care Reform: Refining and Advancing the Vision," Chicago, 1992.
2. Daughters of Charity National Health System, "Community-Based Networks," St. Louis, 1993; and "Community-Based Networks II," St. Louis, 1994.
3. For a useful source document, see Catholic Health Association, "How to Approach Catholic Identity in Changing Times," St. Louis, (a reprint from *Health Progress*, April 1994).
4. DCNHS–East Central Policy AF-1, "Formal Continuous Improvement Processes," 1992; and DCNHS–East Central Policy AR-2, "Principles and Key Components of Regional Evaluation," 1993.

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financial terms for the rest of the organization.

How Comfortable Are You that Your Strategic and Financial Plans Are in Sync? Each organization must answer this for itself. Our answer, in the early days, was: "Not too comfortable!" It took time for us to assure ourselves that if we had clearly inserted an item in our strategic plan, it would turn up in the financial plan as well.

How Comfortable Are You that You Are Making Strategic and Financial Plans Effectively Again, our answer at first was: "Not comfortable." We began to see some interesting differences between the two kinds of plan:

- Our traditional financial plan was about incremental changes, whereas the strategic plan was about *fundamental* change.
- The financial plan contained core business activities, whereas the strategic plan contained the vision, the "new frontier."
- Financial plan targets tended to be used to constrain, rather than complement, strategic initiatives.
- The financial plan was based on projected revenue increases, but the strategic plan forecast a drop in revenue.

Will Short-Term Trade-Offs in the Financial Plan *Impair Longer-Term Strategic Direction?* They certainly can; short-term trade-offs are very real. At FHS, we believe the solution lies in how you manage the trade-offs and how flexible you are in striking a balance. We have tried to move systematically from concept (the strategic plan) to reality (the financial plan).

Can Successful Strategic Plans and Successful Financial Plans Peacefully Coexist? Absolutely. They can flourish and become a force in moving your organization forward if:

- All parties involved understand the rapidly changing nature of the healthcare business.
- Planners stay focused on the market-based, economic reality of the organization, rather than looking at specific projects in isolation.
- Planners are willing to challenge their mental models of investment. (Making a 30-year investment in a business with a shelf life of fewer than five years does not make sense.)

TOWARD MORE CONTROL

FHS's development of its strategic/financial planning process has been a complex one. It has been complex not only because it has required balancing strategic and financial choices and constraints, but because it has also required balancing a mix of different roles and personalities. The new process forces us planners and CFOs to work together closely—and to do it continuously, not just twice a year.

Today there is a compelling need to have plans that support the most likely scenarios for the future. We discovered we could no longer afford to plan in the traditional manner, basing our budget on incremental volumes and adjusting after the first six months. If we had continued things in the old way, we might have found ourselves in serious trouble by the end of the *next* six months.

We believe we are creating a process that is ultimately going to give FHS leaders much firmer control of the system's future. It is true that, in today's healthcare market, payers strongly influence a system's income. If the system's leaders are wise, however, they can continue to determine the balance-sheet side. To the extent that they allocate their capital resources well, they wind up with more control, a greater sense of stability, and the knowledge that they are doing everything possible to increase the strategic value of their investments. And that will be a necessity for all healthcare providers as we move into a very demanding era. □