Strategic Planning for a Financial Turnaround

Not Just for Successful Hospitals, Strategic Thinking Can Also Help One Trapped in a Downward Spiral

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Articles about health care frequently tout the theoretical benefits of strategic planning, or, on the other hand, describe process improvements that could make strategic planning more effective. Although strategic planning is a common management practice in today's health care organizations, its practical application often diverges from its theoretical benefits. Strategic planning in not-for-profit organizations should improve financial performance and mission effectiveness. But it often doesn't, which leads to disagreement among health care professionals about its value.

Most health care strategic planning appears to take place in organizations that are already successful and in which the impetus behind such planning is to manage and focus future growth. It is sometimes hard to measure the contribution strategic planning makes to future organizational success in these situations.

Far less common is strategic planning in an organization caught in a downward spiral, perhaps already in financial difficulty. The management challenge in these organizations is quite acute and short-term in nature: It is to reverse the losses before they are fatal to the organization, stabilize a shaky situation, or sell the organization or merge it with another organization. Managers facing these choices rarely have the time or inclination to think critically about anything other than the immediate problems. In such situations, strategic planning is largely impractical.

However, there are instances when financially troubled health care organizations should consider using strategic planning along with operations improvement to stabilize their situations. Organizations that exhibit the following characteristics may be viable candidates for this approach:

- The organization is firmly entrenched in the community, with strong ownership/governance, community support and recognition, and significant position in the market.
- The organization has a sizable patient base (even if it is diminishing).
- The organization has a new CEO and leadership team.

In such cases, strategic planning and operations improvement should be carried out concurrently and continuously. In contrast to the situation common in health care organizations today, neither strategic planning nor operations improvement is a one-time event with a start date and finish date. Rather, both are instituted as ongoing management processes, so that the disciplines of strategic management (rather than strategic planning) and continuous improvement of operations and financial management (rather than periodic cost cutting and crisis management) replace the less effective traditional approaches.

Also in contrast to the usual and customary practices in health care today, strategic planning or strategic management must include a strong orientation to near-term operations and financial improvement, so that the processes overlap, interrelate, and are synergistic for optimal organizational benefit. The continuous nature of these processes should be incorporated into the workflow of regular management routines, although

some unpredictable peaks and valleys in time and effort will occur.

A Case Study

Let's hypothesize that an organization we will call the Christian Healthcare System (CHS) is an integrated delivery system operating in a mid-sized metropolitan area. CHS's experiences are quite similar to those of an actual health system. Our fictional system belongs to a larger system that has members in three states. CHS is the largest member of this overall system, and its fortunes therefore have a disproportionate effect on the system as a whole.

CHS consists of five hospitals, a multispecialty medical group, and a continuing care division. It has a broad scope of services, including nearly all tertiary services. Four of CHS's hospitals are located in the city itself, which means that the system is somewhat underrepresented in the growing suburban areas to the north, west, and south of the city. CHS's total operating revenue in FY2004 was approximately $800 million.

There are 20 hospitals in the four-county metropolitan area, and the local health care market is highly competitive. Over the past decade, it has experienced a shrinking acute-care patient base similar to that found in other aging, declining northern cities. As a result, 17 of the 20 hospitals now belong to one of five different systems. CHS's primary competitor—which also has five hospitals in the market—owns facilities in a number of other locations in the state.

Lagging Behind the Competition

CHS was outperformed competitively throughout the late 1990s and saw its market share decline precipitously. In a five-year period ending in 2002, CHS's inpatient share dropped from 30 percent to 24 percent. Each of the other four competing systems implemented successful strategies that negatively affected CHS. CHS's financial position also deteriorated, culminating in a $15 million loss on operations in 2001. To compound matters, CHS had underinvested in its physical plants and faced enormous capital expenditures to upgrade its facilities to increase its competitiveness.

Launching an Organizational Turnaround

In early 2001, a change of leadership occurred at CHS. A new CEO was in place by late spring. After a brief evaluation period, he began rebuilding and upgrading the system's management team so that it would be in a position to attack the operational, financial, and strategic problems CHS faced.

Concurrent interdependent strategic, operational, and financial improvement processes were begun. Although the strategic process was largely oriented toward reversing the market-share losses that the system was experiencing, and the operational and financial processes were focused on near-term financial improvements, there was considerable overlap and interrelationships among the three processes.

The major near-term initiatives carried out in the operational/financial planning process included:

- *Revenue Cycle Management* CHS's new leaders instituted a series of changes to both the "front end" (e.g., coding, collection of co-pays) and the "back end" (e.g., management of significantly overdue accounts, managed care contracts, compliance) of revenue capture.
- *Rate Recalibration* CHS's new leaders revised the rate structure considerably, so that rates comparable to those of the system's competitors were charged and inconsistencies in the rate structure were eliminated.
- *Managed Care Contract Modifications* CHS's new leaders scrutinized each contract, and as contracts came up for renewal, renegotiated their terms and rates; one capitation arrangement was eliminated.
- *Medical Group Losses* CHS's new leaders implemented many changes to trim the substantial losses incurred by the medical group, including a myriad of expense-reduction measures; by far, the most substantial changes were revisions in incentive contracts with physicians.
- *Agency Staffing* CHS's new leaders launched ongoing efforts to replace agency staff with employed staff, with significant reductions in agency use to date.
- *Program Divestiture and Reduction* CHS's new leaders reduced some programs in scope and restructured or eliminated others. For example, they outsourced dialysis, eliminated pain-management services, and downsized behavioral health programs.

> CHS's experiences, though fictional, are similar to those of an actual system.

These short-term initiatives aimed at operational and financial improvement have been supplemented by a broad range of longer-term initiatives, the most significant of which involve:

- Instituting a comprehensive fund-raising program
- Implementing quality improvement in major clinical areas and in each operating unit
- Launching efforts to heighten employee sensitivity to patient and customer concerns, thereby increasing patient satisfaction with both the care provided and the CHS experience overall
- Introducing a new human resources and organizational development program
- Improving the appearance of CHS facilities in the context of campus-specific master plans

CHS's leaders launched a multiyear, multifaceted effort to address deficiencies.

All these operational and financial changes are occurring within the framework of a total CHS-wide strategy for improvement and are being managed on a continuous basis both at the system level and within each operating unit.

Incorporating Strategic Planning

CHS's new leaders also carried out strategic planning with short-term and longer-term emphases. Deficiencies in emergency services, medical/surgical services, obstetrics, and ambulatory care made it difficult to stop CHS's market share slide. In each case, these deficiencies were reflected in an unusually weak market position in the "backyard"—the surrounding zip codes—of the hospital involved. CHS's leaders focused their near-term efforts on recapturing share in those "backyards," putting particular emphasis on strengthening core business areas. They:

- Made operational improvements that increased the efficiency of the system's emergency services
- Persuaded physicians who split their time between hospitals to provide more care at CHS facilities, and began to adopt a physician-friendly culture and set of behaviors to support this effort
- Developed a network of easy-to-access, off-site ambulatory care centers that complemented operational improvements in hospital-based ambulatory care

In their strategic planning, CHS's new leaders identified a number of areas in which sustained, longer-term effort would be needed to improve competitive position. They launched major strategic initiatives in the following areas.

Medical Staff Development CHS's new leaders launched a multiyear, multifaceted effort to address primary care shortages, inadequate business from physicians who split their practices among multiple hospitals, and numerous specialty needs. In particular, they began to recruit physicians new to the market, including graduates from the system's own residency programs, and instituted a comprehensive medical staff-relations program to improve satisfaction and increase utilization by affiliated physicians.

Program Development CHS's new leaders launched a campaign to build strong programs in the important areas of cardiovascular disease, oncology, and women's health.

Ambulatory Care CHS's new leaders discussed plans to develop a significant presence in the high-growth, suburban markets in the region.

Post-Acute Care CHS's new leaders recognized that the system's home care and care management programs were well-known in the local market and thus represented strengths that could be built on and capitalized on.

Identity/Branding CHS's new leaders, determining that the system's market image was confused, mandated the development of a clear, consistent image in its public relations and advertising.

Interdependence of Strategic and Operational Improvement

The area of capital allocation is one where the interdependence of CHS's strategic and operational improvement processes can easily be illustrated. Strategically, CHS required capital for a multitude of program investments. It also needed capital for operational reasons: the upgrading and improvement of aging physical plants. Unfortunately, when the system's new leadership team assumed control in 2001, the capital requests from the five CHS entities far exceeded the available funds.

During the initial capital budgeting process, CHS's new leaders instituted a fair and rational system for evaluating and assigning a priority to each capital project request. As a result, they were able to fund the highest-priority needs, including some projects that had a primary strategic thrust, others that had a primary operational-improvement thrust, and still others whose contributions

were mainly financial improvement.

Most funded projects made important contributions in two or all three of the improvement areas. Typical of the funded projects were those at the flagship hospital, which focused on program development in the critical areas of women's services, cancer, and cardiovascular care; significant expansion of a subsidiary facility in an affluent, rapidly growing suburb; and development of six freestanding ambulatory care centers in highly strategic locations. The capital budgeting process, which was subsequently refined and improved in 2002 (with continued improvement annually since then), has made clear contributions to CHS's recovery.

CHS's new leaders have geared strategic, operational, and financial improvement toward achieving measurable progress in a number of key areas. Although market-share targets and volume growth in selected areas constitute the main measures of market success, improvement in patient satisfaction, designated quality/outcome indicators, and progress toward the main components of an "A" bond rating profile provide a series of important indicators against which operational and financial improvement may be measured. And regular measurement, evaluation, and redirection are part of the continuous nature of the processes implemented.

Keeping Sight of Mission

Although CHS's new leaders have obviously emphasized critical strategic, operational, and financial improvements, they have also insisted that mission integration remain an important and active goal of the system. They have, along with the strategic and operational initiatives, developed and implemented important changes in the system's ethics and spiritual service policies. They have also launched an enhanced and expanded mission and value integration initiative, involving employees at all levels of the organization. Since the system had languished for a number of years prior to the arrival of the new CEO, employee morale and connectedness to the organization were key issues. The spiritual dimensions of care, which had been deemphasized during the system's downward spiral, needed to be revitalized.

Tallying the Results

Many of CHS's impressive accomplishments are worthy of mention. Most notably, significant financial improvement has occurred. The operating margin increased from -2.5 percent in 2001 to 3.1 percent in 2002, and then to more than 5 percent in 2003, and was maintained at the 2003 level through 2004. The cash flow turned positive in 2002, at the same time as the catch-up on capital spending began. Capital improvements are currently—and visibly—in progress throughout the system; these improvements, which will result in major upgrades in capacities, have already generated significant physician and employee interest and approval. Inpatient market share appeared to stabilize in mid-2003 and modest gains were recorded in the second half of the year; these continued through 2004. Outpatient visits in 2003 ran ahead of budget, and the increases suggest market-share gains in several areas of outpatient service as well; these have continued, too.

The leaders have also implemented important changes in CHS's ethics and spiritual service policies.

The CHS case study is illuminating in many ways, but is especially noteworthy for its illustration of the ability of leadership to rapidly bring an organization from financial distress to financial health while, at the same time, refusing to be so shortsighted as to neglect the need to develop a sustainable strategic plan of action.

And unlike many other organizations that have demonstrated significant near-term improvements, CHS has put the processes in place to continue to reap the benefits of ongoing strategic management interrelated with operational and financial improvements. These regular, continuous, interdependent processes will allow CHS to progress on all fronts in the future, creating, developing, and implementing the improvements necessary for it to remain a vital and progressive health care provider in the region. ■

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