

STRATEGIC MANAGEMENT *OF* HEALTH CARE ORGANIZATIONS

EIGHTH EDITION



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



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Cover Design: Wiley

Cover Image: © Jamie Grill/Getty Images

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Published by John Wiley & Sons, Inc., Hoboken, New Jersey.

Previous editions published under the Jossey-Bass imprint by John Wiley & Sons, Ltd. Seventh edition published 2013.

Published simultaneously in Canada.

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Library of Congress Cataloging-in-Publication Data:

Names: Ginter, Peter M., author. | Duncan, W. Jack (Walter Jack), author. | Swayne, Linda E., author.

Title: Strategic management of health care organizations / by Peter M. Ginter, University of Alabama at Birmingham, W. Jack Duncan, University of Alabama at Birmingham, Linda E. Swayne, University of North Carolina at Charlotte.

Description: Eighth edition. | Hoboken, New Jersey : Wiley, [2018] | Includes bibliographical references and index. |

Identifiers: LCCN 2017051205 (print) | ISBN 9781119349709 (hbk)

Subjects: LCSH: Health facilities—Administration. | Strategic planning. |

Mission statements. | BISAC: MEDICAL / Nursing / Management & Leadership. | HEALTH & FITNESS / Health Care Issues.

Classification: LCC RA971 .D78 2018 (print) | DDC 362.1068—dc23

LC record available at <https://lcn.loc.gov/2017051205>

ISBN 978-1-119-34970-9 (hbk)

ISBN 978-1-119-34969-3 (ebk)

ISBN 978-1-119-34971-6 (ebk)

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CASES

For book adopters, the following cases from the health care sector are available on the book's website, www.wiley.com/go/ginter8e.

Case 1 Cottage Senior Living

Andrew C. Rucks, PhD

School of Public Health, University of Alabama Birmingham

Cottage Senior Living (CSL) was a family owned assisted-living company headquartered in Huntsville, Alabama. CSL had developed or acquired nine continuing care retirement communities (CCRCs) in seven locations in Alabama and one each in Mississippi and Tennessee. CSL operated in a highly-controlled environment with regulations stipulating staffing and building requirements. The leadership team of CSL assembled at a strategic planning retreat to move the business “to the next level.” The purpose of the retreat was to answer three questions: (1) How to grow? (2) Where to grow? and (3) Do we have the organizational capacity to grow?

Case 2 Asian Health Services: Rediscovering a Blue Ocean

Ken Chung, PhD and Wendell N. Chin, MBA
California State University at Eastbay

Asian Health Services (AHS) is a not-for-profit community health care provider that focuses on serving ethnic Asians in Oakland, California. With the advent of the Affordable Care Act (ACA or “Obamacare”), AHS had been preparing vigorously for significant changes. Now that the initial operational systems were in place, AHS’s CEO Sherry Hirota must decide what proposals to include in a coherent blue ocean strategy presentation at the upcoming board meeting that balanced AHS’s dual mission of social benefit against generating more revenues than costs. Looming threats included payments moving from pay-for-service to pay-per-patient or even pay-for-value. As the original founders had identified a blue ocean (i.e. uncontested markets) in the health care environment 40 years ago, now Hirota must find another blue ocean.

Case 3 Community Blood Center of the Carolinas: Building for a Better Community

Linda E. Swayne, PhD

Belk College of Business, The University of North Carolina at Charlotte

In early 2010, Martin Grable, President of the Community Blood Center of the Carolinas (CBCC), was ready to move the first community blood center in North Carolina to a new level. In a strategic planning retreat, he asked the Board of Directors to evaluate seven strategic options for CBCC. Although all of the alternatives were needed by the community, CBCC did not have unlimited resources. Further, health care reform loomed on the horizon. Clearly, to serve the community, CBCC needed not only to survive, but to thrive in the near term. Which of the alternatives would allow achievement of that goal for the newest FDA-licensed community blood center?

Case 4 Navigating Change at Alaska's Southcentral Foundation

Erin E. Sullivan, PhD, and Jessica L. Alpert
Center for Primary Care, Harvard Medical School

Long-time president and CEO Katherine Gottlieb reflected on a recent meeting of Southcentral Foundation's (SCF) board of directors where CEO succession planning was discussed as she contemplated retirement. The case provides background information about Alaska, the American Indian and Alaska Native (AIAN) health care system, and reviews SCF's mission, vision, and key tenets of the organization's culture: customer-ownership, core concepts, and continuous improvement. SCF's approach to hiring and developing its workforce and its governance structure are highlighted as background for Gottlieb's concerns in choosing the next CEO: maintaining SCF's culture, choosing an internal or external CEO, and identifying the top three qualities that SCF's next leader must embody.

Case 5 LINET Americas: This Bed Is Just Right!

Linda E. Swayne, PhD

*Belk College of Business, The University of North Carolina at Charlotte and
Colin Bain, President and CEO, LINET Americas*

LINET was the leading manufacturer of ICU (intensive care unit) beds in Europe. In 2010 LINET Americas began competing with the two largest U.S. bed manufacturers, Hill-Rom and Stryker, by marketing to smaller hospitals based on lower prices and better safety features for caregivers. Hill-Rom and Stryker noticed and head-to-head competition began. Hill-Rom lowered its prices and extended its warranty to match two of LINET Americas' competitive advantages; however, the innovative design was much harder to match. President and CEO Colin Bain needed to determine how he could continue to grow LINET Americas, especially when the company was blocked out of the largest group purchasing organization (GPO) that was offering Hill-Rom or Stryker ICU beds.

Case 6 West Kendall Baptist Hospital: Meeting the Demand of Community-Based Health Care in the New (and Stormy) Regulatory Environment

Miriam Weismann, PhD, and students Javier Hernandez Lichtl, Heather Pierce, Denise Harris, Lourdes Boue, and Cathy Campbell
Florida International University

The first three years of operation of the West Kendall Baptist Hospital in Miami provided a “poster child” for efficient and cost-effective health care delivery to the West Kendall community. The 133-bed facility’s mission was to promote the preservation of life by improving the health and well-being of its constituents. WKBH exceeded every budget prediction and showed a profit in year 3; however, with the passage of the Affordable Care Act, the situation changed almost overnight. By the first quarter 2016, WKBH started to lose money in excess of budget predictions, despite its increased patient admissions, careful financial planning, expense reductions, quality service, and excellence in patient care delivery. A serious financial crisis loomed with little relief in sight; the management team was searching for solutions.

Case 7 Humana's Bold Goal: 20 Percent Healthier by 2020

Nancy M. Kane, DBA with the assistance of Deborah Milstein
Harvard T.H. Chan School of Public Health

Humana, Inc., headquartered in Louisville, Kentucky, was the fourth largest U.S. health insurance firm with annual revenues of \$54.3 billion, membership of 14.2 million, and 50,100 employees in 2015. The company served members in 17 states plus the military. Under the leadership of CEO Bruce Broussard, Humana was attempting to shift its focus from paying claims to improving the health of beneficiaries. Humana set an “aspirational Bold Goal of improving the health of the communities we serve by 20 percent by 2020 because we make it easy for people to achieve their best health.” Dr. Andrew Renda, hired as Director, Bold Goal Measurement, knew that senior leaders understood that it would take time to change population health, yet they wanted to see some results quickly.

Case 8 Pricing the EpiPen: This Is Going to Sting

Thomas J. Steenburgh, PhD

The Darden School of Business, University of Virginia

Mylan Inc., a generic drug manufacturer, bought the EpiPen product line from Merck, invested in marketing, and dramatically increased the price from \$100 to \$600 per two-pack, igniting consumer anger and provoking a media firestorm. Congress was compelled to step in, demanding to know how Heather Bresch, CEO of the company, could justify the high price of EpiPens. Such health care companies face a tension between doing good in the world and making a profit. Is it fair for drug prices to vary so dramatically across countries (as the EpiPen is priced at \$85 in France)? How should such a public controversy be resolved?

Case 9 Cavalier Hospital

Kenan W. Yount, MD MBA under the supervision of Michael J. Schill, PhD
The Darden School of Business, University of Virginia

A midsize (650-bed) community not-for-profit hospital, located in south central Virginia, chose an expansion strategy in 2008 by bringing all its cardiology under one roof in a new comprehensive care center. Impressive results drew the attention of several insurers who approached Cavalier Hospital, each hoping to include the hospital in its network of physician providers. In preparation for his first board meeting, the physician director wanted to assess the hospital's overall financial condition to determine which strategies should be pursued next: focusing on acquiring patient volume, expanding investment into integrated care, setting the reimbursement structure for revenue collection, or moving to a capitation-based payment system. The evaluation of revenue models would help him understand which alternatives could best be supported for the business strategy.

Case 10 Pleasant Bluffs: Launching a Home-Based Hospital Program

Laura Erskine, PhD

Ivey Business School, University of Western Ontario

Pleasant Bluffs Health System was a Level I Trauma Center with 400+ licensed beds that provided outpatient care, acute and subacute care, biomedical research, and graduate and undergraduate education. Pleasant Bluffs wanted to create a pilot program for home-based hospital care. Graft Salot, as the director of the hospital's Performance Improvement (PI) department, was asked to recommend the pilot program's location, duration, eligible population, and possible changes to the intake process. Salot must consider issues related to an educational program about home-based care and an implementation strategy for it as well as a cost/profit comparison for providing care in the hospital versus home-based care.

Case 11 Kaiser Permanente: Creating a No-Wait Emergency Department

Edward D. Arnheiter, PhD
Ivey Business School, University of Western Ontario

Kaiser Permanente, based in California, was a vertically integrated health care system comprised of 38 hospitals, 619 medical offices, and 10.1 million members in eight western U.S. states. In 2007, the emergency department at South Sacramento was experiencing long patient wait times; it became clear that a better way was needed. Changes were made from 2007 until 2015 by Dr. Karen Murrell, leader of the LEAN program, and her flow group, to significantly improve many key performance measures of the emergency department. In 2016, she was wondering whether there were any additional ways to create capacity in the ED.

Case 12 ExAblate Neuro

Matthew Thames, MBA/MD under the supervision of Robert E. Spekman, PhD
The Darden School of Business, University of Virginia

InSightec, a privately-held Israeli company, developed a new medical device, ExAblate. Focused ultrasound provided precise concentration of sound waves to act on a particular part of the body; the guidance of magnetic resonance imaging (MRI) technology allowed for non-invasive, targeted destruction of diseased tissue. The company required a marketing strategy, navigating a number of barriers that could impinge on its ability to successfully introduce the new technology. The FDA approved its use for removing uterine fibroids and bone metastases. Yet the holy grail of this technology was the application to the brain. InSightec needed to develop a go-to-market strategy for ExAblate Neuro, which was intended to treat essential tremor (ET) and other diseases, such as Parkinson's, for which there was no cure at present.

Case 13 Huntington Hospital

Davina Drabkin and Sarah Soule, PhD

Stanford Business Graduate School, Stanford University

Located in Pasadena, California, Huntington Hospital (HH) was a 625-bed not-for-profit organization named among the top-performing hospitals in 2012 by *U.S. News & World Report*. To further HH's focus on high-quality, patient-centered care, Jim Noble, Executive VP-COO/CFO, was looking for a change in direction, particularly in the Business Services Office. Accounts Receivable (AR), a key billing metric, could be lower; Noble hired Kim Markey with the mandate to improve performance. Markey's long-term vision involved re-examining the revenue cycle and the hospital's processes to ensure that HH would become a stronger performer. She needed to get her metrics under control as a first step before transforming the departments she oversaw into truly patient-focused business centers.

Case 14 Valley Health

S. Hughes Melton, MBA under the supervision of Alexander B. Horniman, PhD
The Darden School of Business, University of Virginia

Felton Wayne, MD, began his career in private practice with a friend. After ten years of developing the practice, he sold his share and Dr. Wayne joined the much larger practice of Valley Health (VH) that had recently merged with Franklin Memorial Hospital (FMH). He was appointed Chief Medical Officer (CMO) and was responsible for the North Carolina organization. The medical staff was unhappy and many physicians left; two CMOs left before Dr. Wayne took up the position. During a feedback session with John Richmond, from the South Carolina division of VH, Dr. Wayne was stunned to discover that Richmond considered him a “cowboy!” Dr. Wayne personally thought he was doing a good job of developing a better working environment.

PREFACE

Almost three decades ago, the three of us agreed that health care was experiencing evolutionary, and in some segments, revolutionary change. At that time, we wrote in the Preface for the first edition of this text (1992) that health care organizations have “had difficulty in dealing with a dynamic environment, holding down costs, diversifying wisely, and balancing capacity and demand.” Our conclusion was that only health care organizations with a structured strategic management approach that recognized the value of emergent thinking could make sense of such a rapidly changing environment.

Our only surprise has been that the rate of change in the health care system has been far greater than we imagined and now certainly exceeds the magnitude of changes initiated with the passage of Medicare and Medicaid in the 1960s and later in 1983 with the implementation of Medicare’s prospective payment system. Significant change in health care continues as evidenced, first, by the passage of the Patient Protection and Affordable Care Act (ACA) in 2010 and more recently by the election of a new administration focusing once again on changing the health insurance landscape and subsequently the “rules for success” for health care organizations. Such regulatory changes, as well as significant economic, technological, social, political, and competitive changes in health care are likely to continue.

To cope with such alterations, by the late 1990s health care organizations had universally embraced strategic management as the primary leadership philosophy and process for understanding and addressing change. The widespread adoption of strategic management continues today as health care leaders have found that strategic thinking, planning, and managing strategic momentum are essential for coping with the dynamics of the health care system. We believe that strategic management has become the single clearest manifestation of effective leadership in health care organizations.

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

Specifically, our approach depicts strategic management as the processes of strategic thinking, consensus building and documentation of that thinking into a strategic plan, and maintaining strategic momentum. Through the management of the strategic plan, new insights and perspectives emerge and strategic thinking, planning, and managing are reinitiated. Therefore, strategic managers must become strategic thinkers with the ability to evaluate a changing industry, analyze data, question assumptions, and develop new ideas. Additionally, through strategic planning, strategic managers must be able to create and document a

plan of action. Once a strategic plan is developed, managers maintain the strategic momentum of the organization. As strategic managers attempt to carry out the strategic plan, they evaluate its success, learn more about what works, and incorporate new strategic thinking.

It is our view that strategic control is integral to strategic momentum and cannot be thought of or taught as a separate process. Therefore, traditional strategic control concepts are integrated into the strategy development chapters under the heading of “Strategic Momentum.” We believe that this approach better reflects how strategic control actually works in organizations – as a part of managing the strategy, not as an afterthought.

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

Features of the Text

We have incorporated some new features into this 8th edition of *Strategic Management of Health Care Organizations* as well as retained features that users of previous editions have said were informative, interesting, and a pedagogically sound foundation for understanding and embracing strategic management of health care organizations.

Retained Features

- Retained from the 7th edition, *Learning Objectives* direct attention to the important points or specific chapter elements that students should know and be able to describe, explain, discuss, clarify, and justify.
- We continue to emphasize analytical models, illustrative examples, and informative exhibits to aid in learning chapter material.
- As in the 7th edition, the *Map* and *Compass* provide a useful metaphor for conveying the view that strategic leaders must both plan as best they are able, but also learn, adjust, and establish new direction (develop a new plan) as they progress.
- Retained from the 7th edition, *The Language of Strategic Management – Key Terms and Concepts*, presents a list of the essential vocabulary and terminology relative to the chapter's material.
- The *Questions for Class Discussion* focus on key chapter concepts and assist the reader in reviewing the material and thinking about the implications of the ideas presented.
- We have retained our extensive end of chapter *Notes*, which contain the references used in development of the chapter materials.
- An even more extensive and easy to access *Web-based Instructor's Support* site is available to verified course instructors using the text. The support material includes PowerPoint slides for each chapter, chapter lecture notes that include suggestions for effective teaching, answers to the end of chapter questions, example assignments and quizzes, the strategic management case studies, and the instructor's manual (teaching notes) for the case studies. In addition, the *Instructor's Support* contains a true/false, multiple choice, and discussion question test bank and can be found at www.wiley.com/go/ginter8e.

New Features

- Each chapter now begins with *Why this Chapter Is Important*, a brief chapter introduction – a call to action, providing a clear and compelling reason for continuing to read and understand the concepts discussed in the chapter.
- In addition to *Learning Objectives*, this edition identifies a *Strategic*

Management Competency that describes the overall applied skill that students of strategic management should be able to demonstrate after completing the chapter.

- Each chapter now has a step-by-step process for accomplishing the elements of strategic management discussed in the chapter. Thus, readers are guided through a series of detailed steps for performing external analysis, service area analysis, internal analysis, and so on through strategy implementation.
- Newly introduced in the 8th edition, *Essentials for a Strategic Thinker* are one-page sidebars that provide summaries of contextual concepts important to understanding health care and the health care system. These “Essentials” do not concern core strategic management concepts per se, but rather provide concise descriptions of terms, institutions, or concepts in the changing health care landscape that every strategic thinker should know.
- New to this edition, *Practical Lessons for Health Care Strategic Thinkers* provides bullet points (derived from the chapter content) containing practical advice for those undertaking strategic thinking, strategic planning, and managing strategic momentum.
- For this edition we have eliminated the *Introductory Incidents*, which provided a practical example of the concepts addressed in the chapter, and instead included additional in-text examples more specific to the concepts being discussed.
- For this edition, four *Resources for Strategic Thinkers* are included at the end of the text to assist readers:

Resource 1. *Analyzing Strategic Health Care Cases*

Resource 2. *Health Care Organization Accounting, Finance, and Performance Analysis*

Resource 3. *Health Care Acronyms*

Resource 4. *Glossary of Strategic Management Terms*

- The new *Glossary of Strategic Management Terms* (presented in alphabetic order with the chapter noted) defines all the terms and concepts presented in *The Language of Strategic Management – Key Terms and Concepts* section at the end of each chapter as well other terms referenced in the text that students of strategic management should know.
- *Strategic Management Case Studies* are returning to this edition in response to user requests. These case studies, listed in the Table of Contents, are unique to this edition and are available for download to verified course instructors on the Web-based Instructor’s Support site (see www.wiley.com/go/ginter8e). In addition, favorite case studies from the sixth edition of this text as well as other selected cases written by the authors are available for download from the support site.

Through our own teaching, research, and consulting in the health care field, we have applied the process outlined in this text to physician practices, hospitals, local and state public health departments, long-term care facilities, social

service organizations, and physical therapy practices. In addition, we have students who report back to us saying that they lead strategic planning in their organizations using the process with great success. The process works.

Organization of the Text

The text contains ten chapters, four resources for strategic thinkers addressing the philosophy and activities of strategic management, and 14 online case studies. Chapter 1 introduces definitions for strategic management and its activities – strategic thinking, strategic planning, and strategic momentum. The chapter discusses the need and rationale for strategic management in today's turbulent health care system and briefly traces its historical foundations. In addition, Chapter 1 presents a conceptual model or map that guides strategic thinking, focuses on important areas for strategic planning, and provides the constructs for managing strategic momentum.

Chapter 2 contains strategic thinking and planning maps for investigating the general environment, health care system, and service area. Chapter 3 narrows the external focus by providing strategic thinking maps for conducting service area competitor analysis for a specific health care organization. Next in Chapter 4, an assessment of the organization's internal situation is accomplished using the health care value chain and an analysis of resources, capabilities, and competencies.

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

Strategy formulation is concerned with making strategic decisions using the information gathered during situational analysis. Chapter 6 provides the decision logic for strategy formulation and identifies an organization's strategic alternatives. The broadest decisions are made first and subsequent decisions more explicitly define the strategy and must be consistent with previous decisions. Chapter 7 discusses how to evaluate the strategic alternatives within each strategy type. These evaluation methods do not make the strategy decision; rather, the constructs or maps help strategists think about the organization and its relative situation, thus enabling them to understand the potential risks and rewards of different strategic choices.

Managing strategic momentum entails putting strategies to work (managerial actions that accomplish the strategy), incorporating strategy evaluation and control, and building strategic awareness. Implementation requires that strategic managers shape and coordinate the value chain components and ensure that the organization's action plans are directly tied to selected strategies. Chapter 8 addresses the development of implementation plans through either maintaining or changing the pre-service, point-of-service, and after-service strategies. Strategic managers should determine the essential characteristics of service delivery to ensure they best contribute to

accomplishment of the strategy. Chapter 9 examines the role of organizational culture, organizational structure, and strategic resources in implementing strategy. These value chain components determine the organizational context and are vital in effective strategy implementation. Chapter 10 demonstrates how strategy may be translated into organizational unit objectives, timelines, and action plans. It is the organizational units that must carry out strategy and strategic managers must review objectives and action plans to ensure that they are coordinated and make best use of human, physical, and financial resources. Each of these chapters reinforces the need to manage strategic momentum by thinking, planning, and doing, and then rethinking, new planning, and re-doing.

Finally there are four Resources for Strategic Thinkers as a reference for users of the text. The first resource, Analyzing Strategic Health Care Cases, presents a methodology for case analysis for those using case studies to “practice” strategic thinking and planning. The second resource, Health Care Organization Accounting, Finance, and Performance Analysis, serves as an accounting and finance refresher and reference. The third resource, Health Care Acronyms, is a quick source for definitions of the “short-hand” language of health care. Finally, the fourth resource is a Glossary of Strategic Management Terms as used in this text.

To the Students: Why This Book About Strategic Management Is Important

Students often wonder about the relevance of various topics or courses they take. They ask, “How am I ever going to use this stuff?” Well, if you are a part of a health care organization, plan to join a health care organization, or even start your own health care business, you almost certainly will be involved in strategic management and particularly the strategic planning process in your organization – you simply cannot avoid it. Virtually all health care organizations, indeed, nearly all organizations, engage in some form of strategic planning. You may be asked to participate in the strategic planning process by providing input, gathering data, or analyzing and summarizing information. You may be asked to brainstorm changes in the industry that will affect the organization. You may serve as team leader to produce a critical part of the plan or you may even be asked to lead the process. Strategic thinking, strategic planning, and managing strategic momentum are skills you simply have to have if you are to be successful. Understanding strategic management and its processes will give you a competitive advantage and possibly play a role in your advancement in the organization. Additionally, strategic management and the concepts offered here can help you think about and plan for your personal life – they work equally well at a corporate, business, unit, or personal level.

Furthermore, effective leadership and management are inherently tied to strategic management. After all, leadership is about setting direction and strategic goals for an organization and management is about the effective and efficient use of resources to pursue that direction and achieve those goals. When you understand strategic management you will have a better understanding of how to lead and manage organizations. This textbook will provide you with the necessary foundation for participating in and leading a strategic planning process. In addition, you will understand why organizations simply have to engage in strategic thinking, strategic planning, and managing strategic momentum to develop and carry out effective plans. In doing so, you will see why strategic management is so crucial in today’s changing world.

We believe this textbook is essential for your long-term professional success in a health care organization and will help you think about setting and achieving your professional and personal goals.

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Acknowledgments

A number of people have provided inspiration, ideas, and considerable effort to produce the eighth edition. We are indebted to many individuals for their assistance and encouragement. A special note of thanks to Sunil Erevelles, Chair of the Department of Marketing in the Belk College of Business at The University of North Carolina at Charlotte, and to Dean Max Michael, MD of the School of Public Health at the University of Alabama at Birmingham, who have continuously been supportive of our efforts.

A special thanks to Andrew C. (Andy) Rucks for his Health Care Organization Accounting, Finance, and Performance Analysis Resource; case study; and Essentials for Strategic Thinkers as well as for his reviews of our draft chapters and suggestions. In addition, we thank the case authors who crafted actual organizational experiences into case studies for students to practice their strategic management skills as well as a thanks to their subject organizations for their willingness to allow these case authors to document their experiences. Thanks to all the Essentials for Strategic Thinkers authors and other contributors whose expertise greatly enriched the text and will further enhance the education of health care strategic management students. Thank you to Lauren Wallace, our graduate teaching and research assistant at UAB, who tirelessly worked with us on this text and instructor's materials, and supported our in-class and online teaching.

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

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

“Without a map, one cannot begin the journey toward a dream, without a compass one may not be able to find it.”

PMG
WJD
LES

Chapter 1

The Nature of Strategic Management

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

—CHARLES DARWIN, BRITISH NATURALIST

Why the Nature of Strategic Management Is Important

Charles Darwin's quote speaks to a core concept of strategic management – responsiveness to change. For organizations in a world where there is no change, strategic management is unnecessary; however, for organizations in an ever-changing world, strategic management is essential. Similar to biology, the organization that best adapts to the demands of its environment prospers and those organizations that do not adapt become less and less relevant. Staying relevant is the key to success. The rate of technological, social, economic, competitive, and political change impacting organizations continues to accelerate. Although change affects all industries, nowhere has greater change occurred than in the health care sector. Strategic management enables leaders to make sense of change and develop strategies to position organizations for success in the continuously evolving health care environment.

More than simply being responsive to change, strategic management attempts to create the future by envisioning what could be and charting a course toward that dream. In addition to the processes underlying the pursuit of the dream, strategic management provides the organization with structured thinking and practices for translating dreams into effective visions, missions, strategies, and plans that will move organizations toward their aspirations. Dreams, without the enabling strategic management processes and direction, are just fantasies; with the structure provided by strategic management, dreams can become reality.

Strategic management is leadership – responding to change, setting direction, and focusing the organization's momentum. Strategic management is the clearest manifestation of leadership in organizations. As a result, virtually all successful health care organizations have embraced strategic management to cope with change and translate their visions, missions, and strategic goals into actuality. Learning about strategic management also means learning about leadership – the ability to utilize strategic thinking, strategic planning, and strategic momentum in organizations.

Use concepts in this chapter to remain relevant!

Learning Objectives

After completing the chapter you will be able to:

1. Describe why strategic management is crucial in today's dynamic health care environment.
2. Trace the evolution of strategic management.
3. Discuss the rationale and usefulness of strategic thinking maps.
4. Define and differentiate between strategic management, strategic thinking, strategic planning, and strategic momentum.

5. Articulate the necessity for both the analytic and emergent models of strategic management.
6. Clarify whether an organization may realize a strategy that it never intended.
7. Discuss the benefits of strategic management for health care organizations.
8. Explain the links between the different levels of strategy within an organization.
9. Describe the various leadership roles of strategic managers.

Strategic Management Competency

After completing this chapter you will be able to create a process for developing a strategic plan for a health care organization.

Managing in a Dynamic Industry

A major aspect of strategic management concerns responsiveness to change to remain relevant. Significant change in the health care system comes from many sources, including: legislative and policy initiatives; international as well as domestic economic and market forces; demographic shifts and lifestyle changes; technological advances; and fundamental health care delivery changes. Furthermore, a multitude of interests are directly or indirectly involved in the delivery of health care. For instance, the for-profit provider segment has grown dramatically; private-sector businesses are largely responsible for the development and delivery of drugs, medical supplies, and many technical innovations, and government agencies regulate much of the actual delivery of and payment for health care services. Certainly, health care systems, as well as other domestic and international health care organizations, have had to continuously adapt to these and other changes. As suggested in the introductory quote, health care organizations must be responsive to change and effectively manage that change in this dynamic industry.

The Nature of Health Care Change

The health care system has experienced considerable change and will undoubtedly contend with even more intensive transformations in the future. Interviews with health care professionals and a review of the health care literature suggest that the types and magnitude of change for which health care organizations will have to be responsive include some or all of the following areas: legislative/political, economic, social/demographic, technological, and competitive.¹ A few illustrations are provided below.

Economic Changes

- Continued growth in the industry – health care by most measures is the largest U.S. industry and non-government employer.²
- Procedure costs may be falling while total spending is rising.³
- Employers will become increasingly unwilling to shoulder the burden of the costs of health care for their employees and retirees.
- Over 27.3 million Americans were without health insurance in 2016. However, the uninsured rate dropped to 8.6 percent, which is the first time in recent history the rate has dropped below 9 percent.

Social/Demographic Changes

- Without a truly radical reduction in health care spending, which there is no reason to expect, demographics alone will drive health care's share of GDP (gross domestic product) as high as 25 percent.⁴

- The 2010 Affordable Care Act (ACA) resulted in 20 million people gaining health insurance coverage – continuing evolution of health care legislation will no doubt further affect the number of people with health insurance.
- An aging population and increased average life span will place capacity burdens on some health care organizations while a lessening of demand threatens the survival of others. By 2020, the U.S. population over the age of 65 is expected to increase from 47.5 million to 53.7 million or approximately 20 percent of the U.S. population.
- The U.S. population will become increasingly diverse.
- The Hispanic population will continue to grow; some experience difficulty with health literacy. Hispanics have become the largest minority group, representing about 18 percent of the U.S. population. By 2050, it is estimated that as many as one out of every four Americans will be Hispanic.

Legislative/Political Changes

- Legislative changes in health care regulation will become the “new normal” in conjunction with changes in government administrations as policy makers try to balance costs and issues related to health care access.
- The most significant external factor affecting health care may be how it is financed. See Essentials for a Strategic Thinker 1–1, “What Is Private Health Insurance?” and Essentials for a Strategic Thinker 2–1, “What Is Government Health Care Insurance?” to understand why the health care insurance market is so important for this industry.
- Employer-based insurance may diminish as the penalties for not providing insurance for employees are eliminated or are significantly less than the cost of health insurance; more employees will likely shift to government sponsored policies.

Technological Changes

- Further growth in the adoption of electronic health records (EHRs) will produce more data to improve the quality of care, that will be used to determine payments for hospitals and physicians (value-based payment).
- Significant advances in medical information technology are anticipated, such as automation of basic business processes, clinical information interfaces, data analysis, and telehealth.
- New technologies will emerge in the areas of drug design, imaging, minimally invasive surgery, genetic mapping and testing, gene therapy, vaccines, artificial blood, and xenotransplantation (transplantation of tissues and organs from animals into humans).

Competitive Changes

- The disintegration of some health care networks can be expected. In 2016 Aetna and United Health, two of the largest U.S. insurance companies,

announced they could not sustain the losses and were significantly reducing their participation in government health care exchanges.

- A changing role for public health is expected, moving back to “core” activities (prevention, surveillance, disease control, assurance) and away from the delivery of primary care.
- According to the Bureau of Labor Statistics, more than 1.2 million vacancies will exist for registered nurses (the largest segment of the health care workforce) through 2022.

ESSENTIALS FOR A STRATEGIC THINKER 1-1



What Is Private Health Insurance?

Private health insurance buys health care coverage offered by commercial and non-profit organizations that requires enrollment (membership) and premiums (fees) usually paid monthly to cover some or all costs of care. According to the U.S. Census Bureau, over 214 million people had private health insurance in the United States at some time during 2015¹ – representing two-thirds of the population and over four times the number of people that have Medicare coverage.

Private coverage is offered in three market segments: the large-group, small-group, and individually-purchased markets. The distinction between large and small groups varies but is often defined as having more or less than 500 covered lives; most such groups are employer-based.

Virtually all private health plans are either health maintenance organizations (HMOs) or preferred provider organizations (PPOs). HMOs typically have a relatively narrow set of hospital and physician providers who are contracted to provide health services for enrollees. PPOs typically offer a broader panel of providers, but some of these will require higher cost sharing on the part of enrollees. HMOs usually bear underwriting risk (a guarantee made by an insurer that will pay for losses incurred), while PPOs often do not. Increasingly many private plans are high-deductible health plans; lower premiums are offered for these PPO or HMO insurance plans that require that the first few thousands of dollars of health care costs be paid by the enrollee before insurer coverage begins.

In the large-group market virtually all employers offer health insurance to employees and their dependents, often sponsoring two or more plans. In this market segment the PPOs offered are almost always self-insured (meaning that the employer is effectively its own insurer). It pays an administrative-services-only fee to a traditional insurer or a third party to manage the plan; however, the actual medical claims are paid from the employer's funds. The HMOs offered are usually simple insurance products

offered by insurers and paid for by premiums.

The small-group market is more diverse. Only about half of firms with three to nine employees offer coverage and about 70 percent of those with 10 to 24 employees offer coverage. Nearly all firms with more than 50 employees offer coverage, and did so even prior to the Affordable Care Act's employer mandate. Most of these employers offer a single health plan that is purchased from a traditional insurer; however, around 30 percent of the larger small employers (more than 100 workers) are self-insured.

The individually-purchased market segment is much smaller, covering only 18 to 24 million people. Individuals and families buy coverage from an insurer licensed by their state. This segment tends to be dominated by a single insurer in most states although multiple insurers often offer coverage. This market segment has been most affected by the ACA. The law established Health Insurance Marketplaces or exchanges through which people may buy coverage, although they may buy coverage through an agent or directly from an insurer. The exchanges, however, provide access to subsidies for coverage. Prior to the ACA, premiums in this market segment were often determined, in part, by the health status of the applicant; the ACA precluded the use of pre-existing conditions to set premiums.

REFERENCE

1. J. C. Barnett and M. S. Vornovitsky, Current Population Reports, P60–257(RV), *Health Insurance Coverage in the United States: 2015* (Washington, DC: U.S. Government Printing Office, 2016).

Source: Michael A. Morrissey, PhD, Professor and Head, Department of Health Policy & Management, School of Public Health, and Adjunct Professor, Bush School of Government & Public Service, Texas A&M University.

Coping with Change

How can leaders of health care organizations deal with the diversity and magnitude of change anticipated in the industry? Which issues are most important or most pressing? Furthermore, what new issues will emerge? Undoubtedly, issues that have yet to be identified or fully assessed will arise. Surviving rapid, complex, and often discontinuous change requires strong leadership. Successful health care organizations have leaders who understand the nature and implications of external change, possess the ability to develop effective strategies to navigate change, and have the will as well as the ability to actively manage the momentum of the organization. These activities are collectively referred to as “strategic management.” More specifically, *strategic management* is the process of strategic thinking, strategic planning, and managing the strategic momentum of an organization to provide direction and achieve the organization’s mission and vision. Strategic management is essential for leading organizations in dynamic industries.

Organizational change is a fundamental part of success. As health care leaders chart new courses into the future, in effect, they create new beginnings, new chances for success, new challenges for employees, and new hopes for patients. Therefore, it is imperative that health care managers understand the changes taking place in their industry; they should not simply be responsive to them, they must envision and create the future. Health care leaders must be prospective, construct new visions for success, and be prepared to make significant improvements. Such preparation may include educating staff concerning the necessity for change. For example, the Jersey City Medical Center in Jersey City recognized that moving from a paper system to electronic records would require helping doctors understand the value of an EHR and assuring them that education and individual mentoring would be available to assist in the implementation.⁵

This chapter provides a practical model for dealing with change, transforming an assessment of the implications of that change into a workable plan, and managing the plan. Coping with change requires leadership as well as careful management. Therefore, the chapter examines the role of leadership and its relation to strategic management. In addition, the foundations and evolution of strategic management provide an excellent underpinning for understanding its nature and function.

The Foundations of Strategic Management

A *strategy* is a consistent, relatively enduring approach to achieve a goal or objective; a type of plan that provides a set of guidelines or a line of attack for an organization to move from where it is today to a desired state sometime in the future. In political and military contexts, the concept of strategy has a long history. For instance, the underlying principles of strategy were discussed by Sun Tzu, Homer, Euripides, and many other early strategists and writers. The English word strategy comes from the Greek *stratgs*, meaning “a general,” which in turn comes from roots meaning “army” and “lead.”⁶ The Greek verb *stratg* means “to plan the destruction of one’s enemies through effective use of resources.”⁷ Similarly, many of the terms commonly used in relation to strategy – objectives, strategy, mission, strengths, and weaknesses – were developed by the military.

Long-Range Planning to Strategic Planning

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

As industries became more volatile, long-range planning was replaced by strategic planning because the assumption underlying long-range planning – that the organization will continue to produce its present products and services – was not necessarily valid. In contrast, the assumption underlying strategic planning is that there is so much economic, social, political, technological, and competitive change taking place that the leadership of the organization must periodically evaluate whether it should even be offering its present products and services, whether it should start offering different products and services, or whether it should be operating in a fundamentally different way.

Although strategies typically take considerable time to implement, and thus are generally long range in nature, the time span is not the principal focus of

strategic planning. In fact, strategic planning, supported by the management of the strategy, compresses time. Competitive shifts that might take generations to evolve instead occur in a few short years.⁸ In a survey of senior executives, 80 percent indicated that the productive lives of their strategies were getting shorter and 75 percent believed that their leading competitor would be different within five years.⁹ Therefore, it is preferable to use “long range” and “short range” to describe the time it will take to accomplish a strategy rather than to indicate a type of planning.

Strategic Planning to Strategic Management

The 1960s and 1970s were decades of major growth for strategic planning in business organizations. Leading companies such as General Electric were not only engaged in strategic planning but also actively promoted its merits in the business press. The process provided these firms with a more systematic approach to managing business units and extended the planning and budgeting horizon beyond the traditional 12-month operating period. In addition, business managers learned that financial planning alone was not an adequate framework.¹⁰ In the 1980s the concept of strategic planning was broadened to strategic management. This evolution acknowledged not only the importance of the dynamics of industries and that organizations may have to totally reinvent themselves, but also that continuously managing and evaluating the strategy are keys to success. Thus, strategic management was established as an approach or philosophy for managing complex enterprises and, as discussed in Essentials for a Strategic Thinker 1–2, “What are These?”, should not be viewed as a passing fad.

ESSENTIALS FOR A STRATEGIC THINKER 1–2

What Are These?



“Management fads” is usually the flippant answer. However, each of these management approaches was a genuine attempt to change and improve the organization – to focus efforts, to improve the quality of the products and services, to improve employee morale, to do more with less, to put meaning into work, and so on. Some of the approaches worked better than others; some stood the test of time and others did not. Yet, it would be too harsh to simply dismiss them as fads or techniques. The goals for all of these management approaches were to manage and shape the organization – to make it better and move it toward excellence. One thing that has distinguished all of these “fads” is the enthusiasm and commitment they have engendered among managers and workers. For many, these approaches have significantly increased the meaning of work – no small accomplishment in an era in which people are increasingly hungry for

purpose.¹ A definition for each of these management approaches may be found in Resource 4 – Glossary of Strategic Management Terms at the end of this textbook.

1950s	• Theories X and Y • Management by Objectives • Quantitative Management • Diversification
1960s	• Managerial Grid • T-Groups • Matrix Management • Conglomeration • Centralization/Decentralization
1970s	• Zero-Based Budgets • Participative Management • Portfolio Management • Quantitative MBAs
1980s	• Theory Z • One-Minute Managing • Organization Culture • Intrapreneuring • Downsizing • MBWA (Management by Wandering Around) • TQM/CQI
1990s	• Customer Focus • Quality Improvement • Re-engineering • Benchmarking • Resource-Based View
2000s	• Six Sigma • Balanced Score Card • Transformational Leadership

	• Self-Managed Teams • Dynamic Capabilities • Virtual Organizations • Blue Oceans • The Learning Organization
2010s	• Knowledge Management • LEAN Six Sigma • Strategic Mapping • Black Swan • Disruptive Innovation • Predictable Surprises • Big Data Analytics

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

What will be the “management fads” of the next decade?² Will you be an active participant in such efforts to make the organization better or will you simply dismiss them as fads? Perhaps benchmarking, quality improvement, the learning organization, or LEAN Six Sigma will turn your organization around. One of these approaches may help to make your organization truly excellent or save it from decline.

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

REFERENCES

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Strategic Management in the Health Care System

Strategic management concepts have only been seriously employed within

health care organizations since the adoption of prospective payment in 1983. Prior to that time, individual health care organizations had few incentives to employ strategic management because typically they were independent, freestanding, not-for-profit institutions, and health services reimbursement was on a cost-plus basis. The prospective payment system, established by Medicare (now the Centers for Medicare and Medicaid Services, or CMS), was a result of the Social Security Act of 1983 that created a fee structure (diagnosis-related groups or DRGs) for services to determine reimbursements. The change in reimbursement policy forced health care organizations to begin to develop strategies to deliver high-quality care and, at the same time, become more efficient.

Strategic management provided the tools for health care leaders to think through reimbursement and other changes taking place in the industry. As a result, in many respects, health care became a complex business using many of the same processes and much of the same language as the most sophisticated business corporations. Certainly, as the health care system continued to evolve, many health care organizations had much to learn from strategically managed businesses. As a result, many of the management methods adopted by health care organizations, both public and private, were originally developed in the business sector.

Although the values and practices of business enterprises in the private sector have been advocated as appropriate models for managing health care organizations, a legitimate question arises concerning the appropriateness of the assumption that business practices are always relevant to the health care system. Certainly, not all the “big ideas” have delivered what was promised, even in business.¹¹ It has been pointed out that:

1. Some strategic alternatives available to non-health care organizations may not be realistic for many health care organizations.
2. Health care organizations have unique cultures that influence the style of and participation in strategic planning.
3. Health care has always been subject to considerable outside control.
4. Society and its values place special demands on health care organizations.¹²

Over time business approaches increasingly have been modified to fit the unique aspects of health care organizations, and today health care organizations have strategic management processes uniquely their own. Strategic management, especially when customized to health care, provides the necessary processes for health care organizations to cope with changes in health policy as well as other changes that have been occurring in the industry. As can be observed world-wide, referendums, elections, and changes in government can have a substantial impact on organizations and a clear understanding of the difference in health policy and strategic management is essential.

Strategic Management Versus Health Policy

There has been and continues to be substantial health planning (policy) in the

United States. Health planning is initiated by either state or local governments and the resulting health policies are implemented through legislation or private or non-governmental agencies. Generally, *health policy* sets the rules, regulations, legislation, and executive actions that apply to consumers and providers of health care. Many health policies are disease specific; that is, they are categorical approaches directed toward specific health problems (e.g. the work of the National Tuberculosis Association that stimulated the development of state and local government tuberculosis prevention and treatment programs).¹³ As a result, a variety of state and federal health planning or policy initiatives have been designed to: (1) enhance quality of care and reduce medical errors; (2) provide or control access to care; and (3) contain costs.

These health-planning efforts are not strategic management. Health planning is the implementation of local, state, and federal health policy and affects a variety of health care organizations. As explained in Essentials for a Strategic Thinker 1–3, “What Is Health Policy?” the intent of health policy is to provide the context for the development of the health care infrastructure as a whole. In contrast, strategic management concerns the activities of only one organization. Strategic management helps an individual organization to respond to state and federal policy and planning efforts, as well as to a variety of other external forces.

ESSENTIALS FOR A STRATEGIC THINKER 1–3

What Is Health Policy?



Formally, health policy is the development and maintenance of an infrastructure to efficiently enhance the health of the public. Informally, health policy determines the rules that apply to all consumers and providers.

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

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

Congress, the state legislatures, and the administrative authority given to

executive branches and their agencies set health policy. Therefore, the Center for Medicare and Medicaid Services determines much of the health policy for federally funded Medicare and federal/state funded Medicaid. The Centers for Disease Control and Prevention, the Food and Drug Administration, and the Occupational Health and Safety Administration set and enforce health and safety standards. State departments of health, insurance, and environmental quality set health policy within their own spheres of influence.

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

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

Source: Michael A. Morrissey, PhD, Professor and Head, Department of Health Policy & Management, School of Public Health, and Adjunct Professor, Bush School of Government & Public Service, Texas A&M University.

The Dimensions of Strategic Management

Many ways are possible to think about strategic management in organizations.¹⁴ These approaches can be broadly grouped into two distinct views – those that assume that with proper analysis a workable strategy can be prescribed in advance, then carried out, versus those with the underlying assumption that too much complexity and change exists for a complete and viable plan to be worked out in advance, thus the strategy will emerge over time. These two fundamental views of strategic management are referred to as the analytical or rational approach and the emergent approach.¹⁵ Specifically, *analytical* or *rational approaches* to strategic management rely on a logical sequence of steps or processes (linear thinking) to develop a predetermined logical plan and carry it out without change. An *emergent approach*, on the other hand, relies on intuitive thinking, leadership, and learning with the understanding that because of external change, strategic plans evolve as strategy unfolds and the organization learns what works and what does not. Both approaches are valid and useful in explaining an organization's strategy and neither the analytical approach nor the emergent view, by itself, is enough. As one author explains:

The key question is not which of these approaches of action is right, or even which is better, but when and under what circumstances they are useful to understand what managers should do. Modern organizational life is characterized by oscillations between periods of calm, when prospective rationality seems to work, and periods of turmoil, when nothing seems to work. At some times, analysis is possible; at other times, only on-the-ground experiences will do.¹⁶

As a result, both approaches are required. It is difficult to initiate and sustain organizational action without some predetermined logical plan. Yet in a dynamic industry, such as health care, managers must expect to learn and establish new directions as they progress. The analytical approach is similar to a map, whereas the emergent model is similar to a compass. Both may be used to guide one to a destination. A *map* is a convenient metaphor for a predetermined plan, guideline, or method. Maps are better in known worlds – worlds that have been charted before. A *compass* serves as a useful metaphor for an intuitive sense of direction and leadership. Compasses are helpful when leaders are not sure where they are and have only a general sense of direction.¹⁷

Managers may use the analytical approach to develop a strategy (map) as best they can from their understanding of the industry and by interpreting the capabilities of the organization. Once they begin pursuing the strategy, new understandings and strategies may emerge and old maps (plans) must be modified. Harvard Professor Rosabeth Moss Kanter concluded from her research that pacesetter organizations “did not wait to act until they had a perfectly conceived plan; instead, they create the plan by acting.”¹⁸ Therefore, managers must remain flexible and responsive to new realities – they must learn. However, the direction must not be random or haphazard. It must be

guided by some form of strategic sense – an intuitive, entrepreneurial sensing of the “shape of the future” that transcends ordinary logic. The concept of the compass provides a unique blend of thinking, performance, analysis, and intuition.¹⁹ Similar to the scientific method, which in theory has clear specific steps to be followed, in reality strategy making is a messy process with many starts and stops.

What is needed is some type of model that provides guidance or direction to strategic managers, yet incorporates learning and change. If strategy making can be approached in a disciplined way, then there will be an increased likelihood of its successful implementation. A model or map of how strategy may be developed will help organizations view their strategies in a cohesive, integrated, and systematic way.²⁰ Without a model or map, managers run the risk of becoming totally incoherent, confused in perception, and muddled in practice.²¹

Combining the Analytical and Emergent Views

In this text, a series of “strategic thinking maps” are presented. A *strategic thinking map* depicts an intellectual process guided by a logical plan of action (set of guidelines) and is used to describe approaches, guidelines, or analytical methods leading to a strategic plan or components of a strategic plan. These maps are designed to initiate strategic thinking as well as strategic planning and foster new thinking and planning when required. The strategic thinking maps start the journey to develop a comprehensive strategy for the organization, yet maps are not dynamic and cannot anticipate every change or contingency. Managers will learn a great deal about their strategic plans as they manage them. Therefore, strategic managers will have to think, analyze, use intuition, and reinvent the strategy as they proceed. As the physicist David Bohm observed, the purpose of science is not the “accumulation of knowledge” but rather the creation of “mental maps” that start our journey to further discovery.²²

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



Exhibit 1.1 Model of Strategic Management

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

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

Strategic Thinking

Strategic thinking is an intellectual activity underlying strategic management that is perceptive to emerging changes, considers strategic implications, and develops transformative responses. At its most fundamental level, strategic thinking includes the states of awareness, anticipation, analysis, interpretation, synthesis, and reflection. The abilities and behaviors associated with and supportive of each of the strategic thinking states are described in [Exhibit 1-2](#).

Strategic Thinking States	Supporting Abilities and Behaviors

Awareness	Mindfulness and external orientation; perception of and hypersensitivity to change.
Anticipation	Projects the present; keenly considers/envisions (imagines) the future; links issues and finds new meanings; high level of expectancy; conceptualization.
Analysis	Systems perspectives and critical thinking to examine changing issues; combining and assessing quantitative and qualitative data.
Interpretation	Transformative, divergent, innovative, creative, and visionary perspectives; accurate assessment and use of data; ability to incorporate different perspectives.
Synthesis	Links issues and summarizes their implications using systems perspectives and vision grounded in reality.
Reflection	Re-consideration of interpretation and synthesis; reality testing; evaluation; and opinion seeking.

Exhibit 1.2 Strategic Thinking Activities

Strategic thinking may proceed as a linear process; however, most of the time these are non-linear activities and may occur in any order and in combination with each other. Indeed, reflection may occur before interpretation or with anticipation, and synthesis may occur simultaneously with all the states. More broadly, although strategic thinking is depicted in the model of strategic management in [Exhibit 1-1](#) as a separate process from strategic planning and strategic momentum, it is inherent to both. Strategic thinking does not necessarily come first or before strategic planning takes place; it is a part of every step in the strategic planning process and managing strategic momentum. Strategic thinking affects and is affected by strategic planning and strategic momentum.

Central to Leadership

Strategic thinking asks people to position themselves as leaders and see the “big picture.” It has been observed that leaders, similar to great athletes, must simultaneously play the game and observe it as a whole.²³ Mired in a complex situation, the leader must rise above it to understand it. Preserving distance may be the only way to see the full picture.²⁴ This skill is similar to an athlete leaving the playing field and going to the press box to observe the game and see its broader context. Thus, strategic managers must be able to keep perspective and see the big picture – not get lost in the action. Continuing the sports metaphor, to truly understand the big picture, one must not only go to the press box to observe the “game,” but must also have a “quiet room” to periodically think about it, to understand it, and perhaps to change the strategy or players.

Strategic thinkers see the future. Vision and a sense of the future are inherent parts of strategic thinking. Strategic thinkers are constantly reinventing the future – creating windows on the world of tomorrow. James Kouzes and Barry Posner in their book *The Leadership Challenge* indicated: “All enterprises or

projects, big or small, begin in the mind's eye; they begin with imagination and with the belief that what is merely an image can one day be made real.”²⁵ Strategic thinkers draw on the past, understand the present, and envision an even better future. Strategic thinking requires a mindset – a way of thinking or intellectual process that accepts change, analyzes the causes and outcomes of change, and attempts to direct an organization's future to capitalize on the changes. More specifically, strategic thinking:

- Acknowledges the reality of change.
- Questions current assumptions and activities.
- Builds on an understanding of systems.
- Envisions possible futures.
- Generates new ideas.
- Considers context, organizational fit, and industry dynamics.

Strategic thinking generates ideas about the future of an organization and ways to make it more relevant – more in tune with the world. Strategic thinking assesses the changing needs of the organization's stakeholders and the changing technological, social and demographic, economic, legislative/political, and competitive demands of the world. In that assessment, strategic thinking includes and employs several types of thinking or framing perspectives, including thinking that is systems oriented, critical or logical, innovative, creative, transformative, divergent, and visionary. The essential focus of these framing perspectives is illustrated in [Exhibit 1-3](#).

Framing Perspectives	Essential Focus
Creative Thinking	Focuses on unique imaginative solutions that are new to the organization for all types of issues or problems.
Critical Thinking	Focuses on rationality; a logical, fact-based analysis and critique.
Divergent Thinking	Focuses on non-traditional solutions; explores different innovative responses rather than commonly accepted solutions.
Innovative Thinking	Focuses on introducing something new, better, or different – a pioneering breakthrough in processes, product/services, or solutions to issues.
Transformative Thinking	Focuses on challenging accepted beliefs, assumptions, perspectives, and premises; redefines issues using a different perspective.
Systems Thinking	Focuses on understanding the whole and the relationships of its components including interrelationships and interdependencies.
Visionary Thinking	Focuses on the future and possible future states.

Exhibit 1.3 Strategic Thinking Framing Perspectives

Strategic thinkers are always questioning: “What are we doing now that we should stop doing?” “What are we not doing now, but should start doing?” and “What are we doing now that we should continue to do but perhaps in a fundamentally different way?” For the strategic thinker, these questions are applicable to everything the organization does – its products and services, internal processes, policies and procedures, strategies, and so on. Successful strategies often require being what you haven’t been, thinking as you haven’t thought, and acting as you haven’t acted.²⁶ Strategic thinkers examine assumptions, understand systems and their interrelationships, and develop alternative scenarios of the future. Strategic thinkers forecast external technological, social, and demographic changes, as well as critical changes in the legislative and political arenas. Strategic thinking is very much a leadership activity and quite different from the work of subject matter experts. For example, strategic thinkers specialize in relationships and context, whereas expert thinkers specialize in well-defined disciplines and functions. Strategic thinkers act on intuition and “gut feel” when data is incomplete, whereas experts pay rigorous attention to knowledge, evidence, and existing data. Strategic thinkers focus on action and moving forward; experts focus on understanding.

Everyone a Strategic Thinker

Strategic thinking provides the foundation for strategic management; however, strategic thinking is not just the task of the CEO, health officer, or top administrator of the organization. For strategic management to be successful, everyone must be encouraged to think strategically – think as a leader. *Leadership* is a performing art – a collection of practices and behaviors – not a position.²⁷ Everyone, at all levels, should be encouraged to think strategically and consider how to reinvent what he or she does. For example, understanding that a nursing home’s image is based on the customers’ perception of cleanliness can motivate custodians to think strategically and reinvent the way the nursing home is cleaned. Strategic thinking is supported by the continuous management of the strategy and documented through the periodic process of strategic planning.

Strategic Planning

Strategic planning is the next activity in the general model of strategic management illustrated in [Exhibit 1-1](#). *Strategic planning* is the periodic process of developing a set of steps for an organization to accomplish its mission and vision using strategic thinking. Therefore, periodically, strategic thinkers should come together to reach consensus on the desired future of the organization and develop decision rules for achieving that future. The result of the strategic planning process is a plan or strategy. More specifically, strategic planning:

- Provides a sequential, step-by-step process for creating a strategy.

- Involves periodic group strategic thinking (brainstorming) sessions.
- Requires data/information, but incorporates consensus and judgment.
- Establishes organizational focus.
- Facilitates consistent decision making.
- Reaches consensus on how the organization fits within its industry.
- Results in a documented strategic plan.

The process of strategic planning defines where the organization is going, sometimes where it is not going, and provides focus. The plan sets direction for the organization and – through a common understanding of the vision and broad strategic goals – provides a template for everyone in the organization to make consistent decisions that move the organization toward its envisioned future. Because strategic planning provides a platform for setting direction for an organization, it is seen as essential for all types of organizations. Bain and Company, a global consulting firm, tracks the trends in management concepts. They accomplish this tracking by means of a survey of executives throughout the world. In most years of the survey, strategic planning has ranked as the number one management concept used by the responding executives. In its most recent ranking, strategic planning was tied with benchmarking as the second most often used management tool.²⁸

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

Decision consistency is central to strategy; when an organization exhibits a consistent behavior it is, at least implicitly, manifesting a strategy. Therefore, strategy is the consistent behavior of an organization in coping with technological, social and demographic, economic, legislative/political, and competitive forces. Optimally, the strategy is well thought out and moves the organization from where it is today to a desired state in the future. The strategic plan is the set of decision-making guidelines or road map for carrying out the strategy and helps to ensure decision consistency. Developing the road map (strategic plan) requires situational analysis, strategy formulation, and planning the implementation of the strategy.

Situational analysis is a process of understanding and documenting an organization's: (1) external analysis; (2) internal analysis; and (3) the development or refinement of the organization's directional strategies. The

interaction and results of these activities form the basis for the development of strategy. These three interrelated activities drive the strategy (see [Exhibit 1-4](#)). External forces, such as a change in health policy or an increase in competition, suggest “what the organization should do.” That is, success is a matter of being effective – doing the “right” thing. Strategy is additionally influenced by the internal resources, competencies, and capabilities of the organization and represents “what the organization can do.” Finally, strategy is driven by a common mission, common vision, and common set of organizational values and goals – the directional strategies “what the organization wants to do.”



Exhibit 1.4 Interrelated Activities that Drive Strategy

The directional strategies are the result of considerable thought and analysis by top management. *Directional strategies* are the broadest strategies, set the fundamental direction of the organization, and generally include the organization’s mission, vision, values, and strategic goals. Together, these forces are the essential input to strategy formulation. They are not completely distinct and separate; they overlap, interact with, and influence one another.

Whereas situational analysis involves a great deal of strategic thinking – awareness, anticipation, analysis, interpretation, synthesis, and reflection – strategy formulation involves decision making that uses the synthesis to create a plan. Hence, *strategy formulation* is the process of developing strategic alternatives, evaluating alternatives, and making strategic choices. Typically, these decisions are made in strategic planning sessions.

Once the strategy for the organization has been formulated (including directional, adaptive, market entry/exit, and competitive), implementation plans that accomplish the organizational strategy are developed. An

implementation plan is a series of steps/activities that are formulated to accomplish strategic goals and are developed in the key areas that create value for an organization – service delivery and support activities. Strategies must be developed that best deliver the products or services to the customers through pre-service, point-of-service, and after-service activities. In addition to service delivery strategies, strategies must be developed for value-adding support areas, such as the organization’s culture, structure, and strategic resources.

A Group Process of Key Players

The CEO or a separate planning department can develop a strategy. However, such approaches run into trouble during implementation, as there is no common “ownership” of the plan or the tasks associated with it. Therefore, strategic planning for organizations typically should be a group process. It involves a number of key participants working together to develop a strategy. Although strategic planning provides the structure for thinking about strategic issues, effective strategic planning also requires an exchange of ideas, sharing perspectives, developing new insights, and critical analysis. Strategic planning efforts will be diminished without future-oriented highly provocative thinking and dialog.²⁹

For most organizations, it is not possible for everyone to be a full participant in the strategic planning process. Decision making is protracted if everyone must have a say – and a consensus may never be reached. A few key players – senior staff, top management, or a leadership team – are needed to provide balanced and informed points of view. Often, representatives of important functional areas are included as well. An effective leader will incorporate a variety of individuals with different backgrounds and perspectives to provide input to the process. Some participants may be mavericks and nudge the group in new ways. If everyone is pre-programmed to agree with the leader, participation is not required – but neither will an actionable and exciting plan be realized.

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

Strategic Momentum

Sometimes a strategic plan is created but nothing really changes, strategic momentum is lost, and plans are never implemented. As the next year rolls around, it is once again time for the annual strategic planning retreat and the cycle repeats itself. This example is one of strategic planning without managing strategic momentum. Alan Weiss, in his irreverent book *Our Emperors Have No Clothes*, explains that in these situations the problem is that “[s]trategy is usually viewed as an annual exercise at best, an event that creates a ‘product,’

and not a process to be used to actually run the business.”³⁰

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

- Addresses the management of the actual work to accomplish specific objectives.
- Concerns decision-making processes and their consequences.
- Shapes the style and culture.
- Evaluates strategy performance.
- Controls strategy implementation by making necessary adjustments.
- Is a learning process.
- Relies on and initiates new strategic thinking and new periodic strategic planning.

For many organizations, strategic planning is the easiest part of strategic management and the planning process receives the greatest attention. However, plans must be implemented to create momentum and realize strategic intent. Poor implementation or lack of adequate control has rendered many strategic plans worthless. Whereas the strategic plan and its underlying strategic thinking must be viewed as critical elements of the strategy-making process, without attentive implementation and the decision-making guidelines provided for managers at all levels in the organization, they become useless. If the strategy is not actively controlled, it will not happen. See Essentials for a Strategic Thinker 1–4, “What Is Management Control?” that examines the nature of management control.

ESSENTIALS FOR A STRATEGIC THINKER 1–4

What Is Management Control?



To control means to regulate, guide, or direct. To manage means to control, handle, or direct. Therefore, management and control both focus on guiding, influencing, and directing behavior; indeed, management is control and control is management. The very act of managing suggests controlling the behavior or outcome of some process, program, or plan. Vision, mission, values, and strategies are types of controls. Similarly, policies, procedures, rules, and performance evaluations are clearly organizational controls. All of these are attempts to focus organizational efforts toward a defined end. Yet,

if these tools are improperly used, employees may perceive control to be dominating, overpowering, dictatorial, or manipulative.

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

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

At the same time, managers often need to react to unanticipated developments and new competitive pressures. Such shifts may be subtle, other times they can be discontinuous and extremely disruptive. When external changes occur, new opportunities emerge and new competencies are born, while others die or are rendered inconsequential. Inevitably, the basic rules of competing and survival will change.³¹ Managing strategic momentum is how an organization constructively manages change, evaluates strategy, and reinvents or renews the organization. As management expert Henry Mintzberg has indicated, “... a key to managing strategy is the ability to detect emerging patterns and help them take shape.”³²

Learning as the Strategy Unfolds

Changing societal and industry characteristics and evolving organizational forms require new and different ways of defining strategy.³³ Strategy may be an intuitive, entrepreneurial, political, culture-based, or learning process. In these cases, past maps are of limited value. Managers must create and discover an unfolding future, using their ability to learn together in groups and interact politically in a spontaneous, self-organizing manner. However, learning is difficult in organizations. Learning requires engagement, mastering unfamiliar ideas, and adopting new behaviors. Engaged learning demands that executives share leadership, face harsh truths, and take learning personally. It requires them to fundamentally change the way they manage.³⁴ It requires a renewed concentration on managing strategic momentum.

Clearly, just because a strategy is rational does not mean that it will work out as envisioned or planned (an *unrealized strategy*). In other cases, an organization may end up with a strategy that was unexpected, developed as uncontrollable and unanticipated external events unfolded – as a result of having been “swept

away by events” (an *emergent strategy*). Leadership, vision, and “feeling our way along” (learning) often provide a general direction without a real sense of specific objectives or long-term outcomes. It is quite possible for a strategy to be developed and subsequently work out successfully (a *realized strategy*); however, we must be realistic enough to understand that when we engage in strategic management the theoretical ideal (strategy developed, then realized) may not, and in all probability will not, be the case. A great deal may change. The possibilities include:

1. There is a reformulation of the strategy during implementation as the organization gains new information and feeds that information back to the formulation process, thus modifying intentions en route.
2. Society or the industry is in a period of flux and strategists are unable to accurately predict conditions; the organization may therefore find itself unable to respond appropriately to powerful external forces.³⁵
3. Other organizations implementing their own strategies may block a strategic initiative, forcing the activation of a contingency strategy or a period of “groping.”

Obviously, health care organizations formulate strategies and realize them to varying degrees. For instance, as a part of a deliberate strategy to broaden their market, improve service to the community, and retain referral patients, many community hospitals began offering cardiac services such as catheterization and open-heart surgery. As a result, some of these hospitals have broadened their market share and increased profitability. Other community hospitals have not fared as well. Their managers had unrealistic expectations concerning the profitability of cardiac services and the number of procedures required. A large volume is crucial to cardiac services because it allows the hospital to order supplies in bulk and provides physician experience that produces better outcomes and shorter lengths of stay. In addition, some community hospital managers misjudged the level of reimbursement from Medicare, thereby further squeezing profitability. The strategies of those community hospitals that ultimately left the cardiac services market were not realized.

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

Everyone Must Manage the Strategic Momentum

As with strategic thinking, everyone plays a role in managing strategic momentum. Everyone in the organization should be working for the strategy and understand how their work contributes to the accomplishment of the strategic goals. As leadership author Max DePree has suggested, “Leaders are obligated to provide and maintain momentum.”³⁶ Although organizations may

accomplish superior results for a brief period of time, it takes the orchestration of management as well as leadership to perpetuate these capabilities far into the future.³⁷

The Benefits of Strategic Management

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

- Ties the organization together with a common sense of purpose and shared values.
- Often improves financial performance.³⁸
- Provides the organization with a clear self-concept, specific goals, and guidance as well as consistency in decision making.
- Helps managers to understand the present, think about the future, and recognize the signals that suggest change.
- Requires managers to communicate both vertically and horizontally.
- Improves overall coordination within the organization.
- Encourages innovation and change within the organization to meet the needs of dynamic situations.

Strategic management is a unique perspective that requires everyone in the organization to cease thinking solely in terms of internal functions and operational responsibilities. It insists that everyone adopt what may be a fundamentally new attitude – an external orientation and a concern for the big picture. It is basically optimistic in that it integrates “what is” with “what can be.”

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

What Strategic Management Is Not

Strategic management should not be regarded as a technique that will provide a “quick fix” for an organization that has fundamental problems. Quick fixes for organizations are rare; it often takes years to successfully integrate strategic management into the values and culture of an organization. If strategic management is regarded as a technique or gimmick, it is doomed to failure.

Similarly, strategic management is not just strategic planning or a yearly retreat where the leadership of an organization meets to talk about key issues only to return to “business as usual.” Although retreats can be effective in refocusing management and for generating new ideas, strategic management must be adopted as a philosophy of leading and managing the organization.

Strategic management is not a process of completing paperwork. If strategic management has reached a point where it has become simply a process of filling in endless forms, meeting deadlines, drawing milestone charts, or changing the dates of last year’s goals and plans, it is not strategic management. Effective strategic management requires little paperwork. It is a process, not a series of documents. Similarly, strategic management should not be undertaken solely to satisfy a regulatory body’s or an accrediting agency’s requirement for a “plan.” In these situations, no commitment is made on the part of key leadership, no participation is expected from those in the organization, and the plan may or may not be implemented.³⁹

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

A Systems Perspective

A *system* may be defined as “a perceived whole whose elements ‘hang together’ because they continually affect each other over time and operate toward a common purpose.”⁴⁰ More simply, a system is a set of interrelated elements. Each element connects to every other element, directly or indirectly, and no subset of elements is unrelated to any other subset. A system must have a unity of purpose in the accomplishment of its goals, functions, or desired outputs. Further, biological as well as organizational systems must continually adapt to their environments to survive.

The problems facing organizations are often so complex that they defy simple solutions. Understanding the nature of the health care system, the relationship of the organization to that industry, and the often-conflicting interests of the organization’s internal departments requires a broad conceptual paradigm. Yet, it is difficult to comprehend so many multifaceted and important relationships. Strategic managers have found viewing organizations as *complex adaptive systems* – interacting structures evolving in response to change – to be useful for organizing their strategic thinking.⁴¹

A *systems perspective* is a way of understanding a phenomenon by perceiving the whole as well as its interactive elements (subsystems). Understanding complicated adaptive systems through a systems perspective:

- Aids in identifying and understanding the big picture.

- Facilitates the identification of major components.
- Helps to identify important relationships and provides proper perspective.
- Avoids excessive attention to a single part.
- Allows for a broad scope solution.
- Fosters integration.
- Provides a basis for redesign.

Using a systems perspective and viewing organizations as complex adaptive systems requires strategic managers to define the organization in broad terms and to identify the relevant variables and interrelationships that will affect decisions. By defining systems, strategic managers are able to accurately see the “big picture” and avoid devoting excessive attention to relatively minor aspects of the total system. A systems perspective permits strategic managers to concentrate on those facets of the problem that deserve the most attention and allows for a more focused attempt at resolution. As American systems scientist and lecturer Peter Senge has indicated, systems perspectives help us to see the total system and how to change the pieces within the system more effectively and intelligently.⁴²

Recognizing the importance of a systems framework, health care managers commonly refer to “the health care system” or “the health care delivery system” and strive to develop logical internal organizational systems to succeed in the industry.⁴³ In a similar manner, health care strategic managers must use systems to aid in strategically thinking about the external conditions. The community and region may be thought of as an integrated system with each part of the system (subsystem) providing a unique interdependent contribution.

The Level and Orientation of the Strategy

A systems perspective will be required to specify the level of the strategy and the relationship of the strategy to the other strategic management activities. Therefore, the organizational level and orientation should be carefully considered and specified before strategic planning begins. For example, as illustrated in [Exhibit 1-5](#), strategies may be developed for large, complex organizations, divisions within a broader organization, individual organizations such as for a hospital, or for well-focused functional units. The range of the strategic decisions that are considered at different organizational levels is quite different, but all entities can benefit from strategic management and all engage in strategic thinking, strategic planning, and strategic momentum.

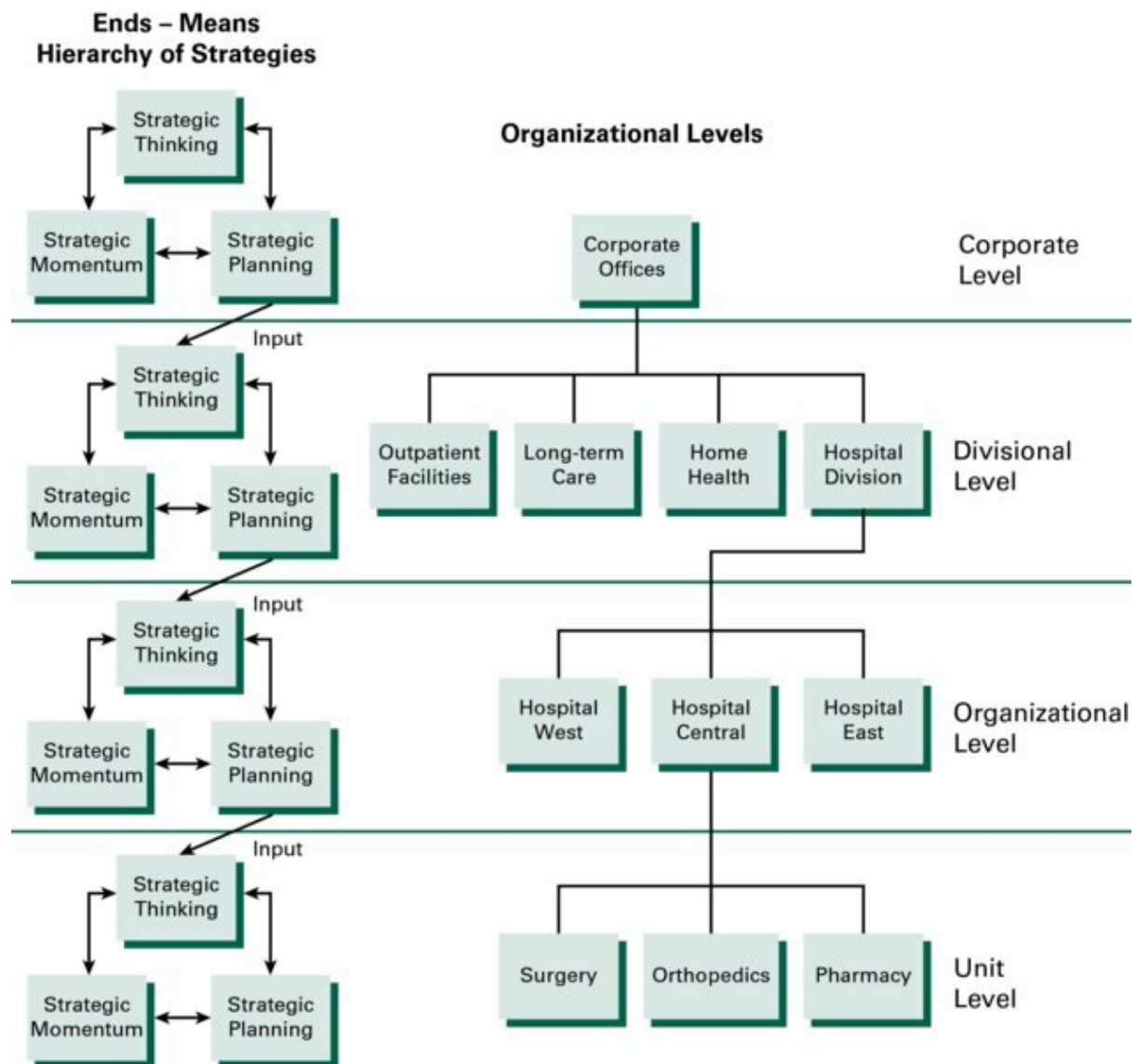


Exhibit 1.5 The Link between Levels of Strategic Management

A large integrated health care system would likely develop strategy for a number of levels – a corporate level, a divisional level, an organizational level, and a unit level. When considered together, these strategic perspectives create a hierarchy of strategies that must be consistent and support one another. Each strategy provides the “means” for accomplishing the “ends” of the next level. Thus, the unit level provides the means for accomplishing the ends of the organizational level. The organizational level, in turn, provides the means for accomplishing the ends of the divisional level. Finally, the divisional level is the means to the ends established at the corporate level. As illustrated in the hypothetical example in [Exhibit 1-5](#), the strategic planning of higher-order strategies provides part of the context or input for lower-order strategy – the corporate strategic plan is an input to strategic thinking at the divisional level (Hospital Division). Similarly, the divisional strategic plan is an input to the organizational level strategic thinking (Hospital Central) and so on.

As a practical example, Trinity Health is an integrated health system that develops strategic plans at a number of organizational levels. Trinity Health is

one of the largest multi-institutional Catholic health systems in the United States and serves people in 22 states. As of the beginning of 2017, Trinity had over \$23.4 billion in assets, \$15.9 billion in revenues, and was comprised of 93 hospitals, and 120 continuing care facilities, home care agencies, and outpatient centers. Clearly, strategies should be developed for the corporate level – Trinity Health, for each major division such as Saint Joseph Mercy Health System, for each distinct organization within the division such as Saint Joseph Mercy Ann Arbor Hospital, and within the various hospital units (clinical operations).

Corporate-Level Strategy

A *corporate-level strategy* is an overall plan for the broadest organizational level that positions the organization in multiple markets served with multiple products and addresses the question: “What business(es) should we be in?” Such strategies consider multiple, sometimes unrelated, markets and typically are based on return on investment, market share or potential market share, and system integration. For Trinity Health, clearly the corporate perspective is an important one. The question of “What businesses should we be in?” has resulted in several semi-autonomous “businesses” operating in a number of different markets, including hospitals, outpatient facilities, long-term care, home health, and hospices. Key strategic questions might include: “What other types of businesses, such as wellness or mental health centers, should Trinity consider?” Once consensus is reached regarding the corporate strategy, the process continues at the next organizational level – the divisional level.

Divisional-Level Strategy

A *divisional-level strategy* is an overall plan for a corporate division or a single product, single market organization. These strategies are more focused than corporate-level strategies and provide direction for a single business type. Divisional strategies are most often concerned with positioning the division to compete. These semi-autonomous organizations are often referred to as SBUs (*strategic business units*) or SSUs (*strategic service units*). Therefore, strategic managers for these units are most concerned with a specified set of competitors in well-defined markets.

For Trinity Health, strategies must be developed for the hospital division, outpatient facilities division, long-term care division, and so on. For the hospital division, key strategic questions may include: “How many hospitals are optimal?” or “Which markets should Trinity enter with a new hospital?” This perspective concerns a single business type and its markets. Therefore, it is quite different from the corporate perspective of considering different types of businesses. Once divisional-level strategies have been developed, strategy making continues down the organizational chain to the organizations within the division.

Organizational-Level Strategy

Within a division, individual organizations may develop strategies as well. An

organizational-level strategy is an overall plan for one organization competing within a specified well-defined market. For example, each hospital in Trinity's hospital division may develop a strategic plan to address its own particular market conditions. Key strategic questions for this level of strategy may include: "What combination of hospital services is most appropriate for this market?" and "What strategies are the competitors using to increase market share?" After organizational strategies have been developed, the process may continue within the departmental units of the organization.

Unit-Level Strategy

A *unit-level strategy* is an overall plan for an individual department within an organization that supports higher-level organizational strategies through accomplishing specific objectives. Unit operational strategies may be developed within departments of an organization such as clinical operations, marketing, finance, information systems, human resources, and so on. Unit strategies are intended to integrate the various subfunctional activities as well as creating internal capabilities across functions (for example, quality programs or changing the organization's culture).⁴⁴

Strategy Hierarchy

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

The Importance of Leadership

Ultimately, strategic decision making for health care organizations is the responsibility of top management. The CEO is a strategic manager with the pre-eminent responsibility for positioning the organization for the future. At this level of leadership, such an individual must be able to inspire, organize, and implement effective pursuit of a vision and maintain it even when sacrifices are required.⁴⁵ A 10-year study of CEO performance across all major industries found that the most effective CEOs: (1) were able to be decisive, recognizing that they could not wait for perfect information, (2) worked to understand the priorities of stakeholders and incorporate those needs into goals of value creation, (3) were able to adjust to rapidly changing conditions, and (4) reliably produced results over time.⁴⁶

As a result, the leader must have an ability to identify what needs to be done today and what can wait. They prioritize constantly; aware that wars are lost by fighting on too many fronts. They know the key messages to communicate day to day, from audience to audience.⁴⁷ If the CEO, as the organization's leader, does not fully understand or faithfully support strategic management, it will not happen. The Essentials for a Strategic Thinker 1–5 further answers the question “What is Leadership?”

ESSENTIALS FOR A STRATEGIC THINKER 1–5

What Is Leadership?



Leadership involves creating a vision and sharing it, aligning individuals and building coalitions, motivating and inspiring.¹ Leadership is a choice, not a rank or a position. It is a behavior, not a trait. Behaviors can be learned and so can leadership. Some have argued that leaders are born; but the evidence suggests that anyone can become an effective leader.

We, the authors of this textbook, think of leaders as people who: (1) establish organizational direction and (2) shape organizational culture. Setting direction involves understanding the organization's industry and developing and communicating the mission, vision, values, and goals for the future that make the organization as relevant as possible. Internally, shaping culture is a matter of affecting the intrinsic habits, customs, and norms of individuals as well as the social, structural, and decision-making context of the organization.

Establishing direction is accomplished by shaping strategic consensus through the strategic management processes of strategic thinking, strategic planning, and strategic momentum. Shaping the organization's culture

involves instilling attributes such as teamwork, quality, trust, innovation, customer orientation, and so on to make the organization adaptive to change. In addition, leaders create an organizational context by creating an appropriate culture for adaptation and response to external change while shaping internal organizational practices, rules, procedures, decision making, and views of risk.

Although they are equally important to create efficient and effective organizations, leadership and management are different in many respects. Management is about efficiency and order while leadership is about change. More specifically, comparing managers and leaders indicates that:²

- Managers administer; leaders innovate.
- Managers are copies; leaders are originals.
- Managers focus on systems and structure; leaders focus on people.
- Managers rely on control; leaders inspire trust.
- Managers have a short-term view; leaders have a long-term perspective.
- Managers ask “how” and “when”; leaders ask “what” and “why.”
- Managers have an eye on the bottom line; leaders have an eye on the horizon.
- Managers initiate; leaders originate.
- Managers accept the status quo; leaders challenge it.
- Managers are classic good soldiers; leaders are their own person.
- Managers do things right; leaders do the right things.

There are no honorary leaders. Leadership is an art that must develop and evolve. Leadership is an achievement that no organization can bestow. It is something that must be earned through hard work, enthusiasm, and commitment.

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Leadership Roles throughout the Organization

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

Over the past two decades, many large formal planning staffs have been dissolved as organizations learned that strategy development cannot take place in relative isolation. Therefore, the development of the strategy has become the responsibility of key managers. The coordination and facilitation of strategic planning may be designated as the responsibility of a single key manager (often the CEO), but the entire leadership team is responsible for strategy development and its management. The rationale underlying this approach is that no one is more in touch with the external conditions (regulations, technology, competition, social change, and so on) than the managers who must deal with it every day and lead change. The leadership team must coordinate the organization's overall strategy and facilitate strategic thinking throughout the organization. As a result, the organization's top managers act as an extension of the CEO to ensure that an organized – and one that is used – planning process ensues.⁴⁸

The remainder of this text provides processes for strategic management presented in the model of strategic management ([Exhibit 1-1](#)). Chapter 2 provides strategic thinking maps for examining the general environment and health care systems as well as the service area and Chapter 3 concentrates on service area competitor analysis. Chapter 4 discusses internal analysis and provides strategic thinking maps for evaluating the organization's strengths and weaknesses and the creation of competitive advantage. The development of the directional strategies through strategic thinking maps is explored in more detail in Chapter 5. Strategic thinking maps for strategy formulation are presented in Chapters 6 and 7. Strategy implementation is discussed further in Chapters 8 through 10.

Chapter Summary

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

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

The strategic planning portion of the model incorporates situational analysis, strategy formulation, and strategy implementation. The strategic thinking activities – awareness, anticipation, analysis, interpretation, synthesis, and reflection – within situational analysis combine to influence strategy formulation. Strategy formulation in turn affects planning the implementation. Finally, the strategy must be managed, evaluated, controlled, and modified as needed. Managing strategic momentum is an iterative process that may incorporate new understandings of the situation, change the fundamental strategy, or modify strategy implementation. Strategic momentum essentially continues strategic thinking and strategic planning.

The model of strategic management (the strategic thinking map) presented in this text is designed to provide the essential logic of the activities involved in strategic management and therefore is based on both analytical (rational) as well as emergent (learning) approaches to understand strategy making in organizations. The analytical model provides an excellent starting point for understanding the concept of strategy and a foundation for comparing and contrasting strategies. However, the strategic management model does not perfectly represent reality and must not be applied blindly or with the belief that “life always works that way.” Strategic management is not always a structured, well-thought-out exercise. In reality, thought does not always precede action, perfect information concerning the industry and organization never exists, and rationality and logic are not always superior to intuition and luck. Sometimes organizations “do” before they “know.” For instance, intended strategies are often not realized strategies. Sometimes managers are able to just “muddle through.” Or, managers may have a broad master plan or logic underlying strategic decisions; but, because of the complexity of external and internal factors, incremental adjustments and guided evolution are the best they can do.⁴⁹

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

Practical Lessons for Health Care Strategic Thinkers

1. A conceptual model of strategic management is not just an academic exercise nor is it a passing fad. If managers are going to engage in strategic planning in an organization and be successful, they must understand how strategic thinking, strategic planning, and strategic momentum fit together and the nature of each.
2. The strategic management processes provide the “road map” for all the activities and decisions in the organization. They create organizational momentum and keep everyone informed – one has to have a plan to start a journey.
3. Even the best strategic plans may not work out; therefore, strategic managers must be ready to learn what is working and what is not working as the plan unfolds and adjust the implementation, the strategy itself, or their understanding of the situation.
4. All strategies are temporary; there is just too much social, economic, competitive, and political change for a strategy to be effective forever; therefore, in the long term, to be successful the strategy has to change.
5. In organizations, strategic management and leadership are the same thing; vision and a future orientation are essential.
6. Strategic managers should focus on keeping the organization relevant and creating momentum.

THE LANGUAGE OF STRATEGIC MANAGEMENT: KEY TERMS AND CONCEPTS

Analytical/Rational Approach

Compass

Complex Adaptive System

Corporate-Level Strategy

Directional Strategies

Divisional-Level Strategy

Emergent Approach

Emergent Strategy

Health Policy

Implementation Plan

Leadership

Long-Range Planning

Map

Organizational-Level Strategy

Realized Strategy

Situational Analysis

Strategic Business Unit (SBU)

Strategic Management

Strategic Momentum

Strategic Planning

Strategic Service Unit (SSU)

Strategic Thinking

Strategic Thinking Map

Strategy

Strategy Formulation

System

Systems Perspective

Unit-Level Strategy

Unrealized Strategy

Questions for Class Discussion

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

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Chapter 2

External Analysis

“Change is the law of life. And those who look only to the past or present are certain to miss the future.”

—JOHN F. KENNEDY, 35TH PRESIDENT OF THE UNITED STATES

Why External Analysis Is Important

President Kennedy's quote reminds us that organizational failure is often the result of failing to look to the future. Organizations fail to anticipate significant external changes and subsequently do not make the necessary adjustments in strategy that might save them. Organizational success is predicated on tailoring strategy – not to the past or even the present – but rather to well-informed, credible assumptions about the future.

Looking to the future is both an art and a science. The art involves strategic thinking and the science involves rigorous external analysis. Together, strategic thinking and external analysis processes enable the generation of realistic strategic assumptions about the future for strategy building. Both the art and science are critical for envisioning the future.

The art of looking into the future requires a strategic manager who is informed about and perceptive to an organization's external changes – requiring an external orientation and inquisitive awareness. Strategic managers must be able to see the big picture, understand relationships, and use systems thinking. They have to use critical thinking to determine the consequences and implications of what they see. These leaders need creativity to transform change signals into actions as well as create visions and strategic goals. As introduced in Chapter 1, strategic thinking is an art made up of awareness, anticipation, analysis, interpretation, synthesis, and reflection driven by a passion to know, understand, and succeed.

The science of anticipating the direction of change involves using structured processes for understanding an organization's external conditions – the general (macro-environment), health care system, and service area changes – utilizing the processes of a number of external analysis tools and techniques. These processes help organize and structure information, aid in focusing on what is important, and provide a foundation for integrative strategic thinking. External analysis coupled with strategic thinking will generate new perspectives and insights to provide a plausible glimpse of tomorrow.

Use the concepts in this chapter to see into the future!

Learning Objectives

After completing the chapter you will be able to:

1. Discuss the significance of external analysis for health care organizations.
2. Articulate the specific goals of external analysis.
3. Point out some limitations of external analysis.
4. Describe how various types of organizations in society (the macro-

environment), the health care system, and the service area influence the delivery of health care.

5. Identify major general environment, health care system, and service area trends affecting health care organizations.
6. Describe the utilization of key sources of external information.
7. Discuss important techniques used to identify and analyze external issues, trends, and events.
8. Suggest several questions to initiate strategic thinking that focus on identifying and responding to external change.

Strategic Management Competency

After completing this chapter you will be able to map and analyze external issues, trends, and events in the general environment, the health care system, and the service area for a health care organization.

The External Nature of Strategic Management

External analysis requires strategic managers who search for ways to radically alter the status quo, create something totally new, or revolutionize processes. They search for opportunities to do what has never been done or to do known things in a new way. Therefore, the fundamental nature of strategic management requires awareness and understanding of outside forces. Strategic managers encourage adoption of new ideas in the system, maintain receptivity to new ways of operating, and expose themselves to broad views. More specifically, leaders must have an understanding of the current and potential external issues, trends, and events that may impact the organization and be able to see new possibilities that these changes may bring. This understanding is informed through the process of external analysis. *External analysis* is a strategic thinking activity directed toward identifying, aggregating, and interpreting the issues outside an organization to determine the implications of those issues on the organization as well as providing information for internal analysis and the development of the directional strategies. External analysis can remove the protective covering in which organizations often seal themselves.¹ External analysis is a part of the situational analysis section of the strategic thinking map presented in Chapter 1 (Exhibit 1–1).

The Goals of External Analysis

Although the overall intent of external analysis is to position the organization within its industry and service area, more specific goals may be identified. The specific goals of external analysis are:

- To identify and analyze current important issues and changes that will affect the organization.
- To detect and analyze early or weak signals of emerging issues and changes that will affect the organization.
- To speculate on the likely future issues and changes that will have significant impact on the organization.
- To classify and order issues and changes generated by outside organizations.
- To provide organized information for the development of the internal analysis, mission, vision, values, goals, and strategy of the organization.
- To foster further strategic thinking throughout the organization.

In addition to the identification of current issues, external analysis attempts to detect early or weak signals outside the organization that may portend a future issue. Weak signals are early evidence of emerging trends from which it might be possible to deduce important changes in demography, technology, customer tastes, social, political or regulatory shifts, or economic patterns.² Sometimes based on little hard data, managers attempt to identify patterns that suggest emerging issues that will be significant for the organization. Such issues, if they

continue or actually do occur, may represent significant challenges or opportunities. Timely identification of external issues aids in developing strategy.

Strategic managers must go beyond what is known and speculate on the nature of the industry, as well as the organization, in the future. This process often stimulates creative thinking concerning the organization's present and future products and services. Such speculation is valuable in the formulation of a guiding vision and the development of mission and strategy. The bulleted list of evolving external issues at the beginning of Chapter 1 provided some of the emerging and speculative forces that strategic managers might incorporate into their thinking today. There is an abundance of such external data. For it to be meaningful, managers must identify the data sources and aggregate and classify the information. Once classified, important issues that will affect the organization may be identified and evaluated. This process encourages managers to view external changes as issues that may affect the organization.

When strategic managers – top managers, middle managers, and front-line supervisors – throughout the organization are considering the relationship of external forces to the organization, innovation and improved customer satisfaction are likely. Strategic thinking within an organization fosters adaptability, and those organizations that adapt best will ultimately displace the rest.

The Limitations of External Analysis

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

- External analysis cannot foretell the future.
- Managers cannot see everything.
- Sometimes pertinent and timely information is difficult or impossible to obtain.
- There may be delays between the occurrence of external events and management's ability to interpret them.
- Sometimes there is a general inability on the part of the organization to respond quickly enough to take advantage of the detected issue.
- Managers' strongly held beliefs sometimes inhibit them from detecting issues or interpreting them rationally.³

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

Perhaps the greatest limiting factor in external analysis is the preconceived beliefs of management. In many cases, what leaders already believe about the industry, important competitive factors, or social issues, inhibits their ability to

perceive or accept signals for change. Because of managers' beliefs, signals that do not conform to what they believe may be ignored. What an individual actually perceives is often determined by established paradigms (ways of thinking and beliefs). Thus, data that exist in the real world that do not fit the paradigm will have a difficult time permeating the individual's filters – he or she will simply not see it.⁴ As creativity expert Edward De Bono explains, “[w]e are unable to make full use of the information and experience that is already available to us and is locked up in old structures, old patterns, old concepts, and old perceptions.”⁵ Despite long and loud signals for change, some organizations do not change until it is too late.

The Process of External Analysis

External analysis often is a complex undertaking. Therefore, a step-by-step process helps the identification and assessment of external issues likely to affect the organization. As illustrated in [Exhibit 2-1](#), there are six steps to effective external analysis efforts.⁶ The strategic thinking states of awareness, anticipation, analysis, interpretation, synthesis, and reflection are particularly important in external analysis.

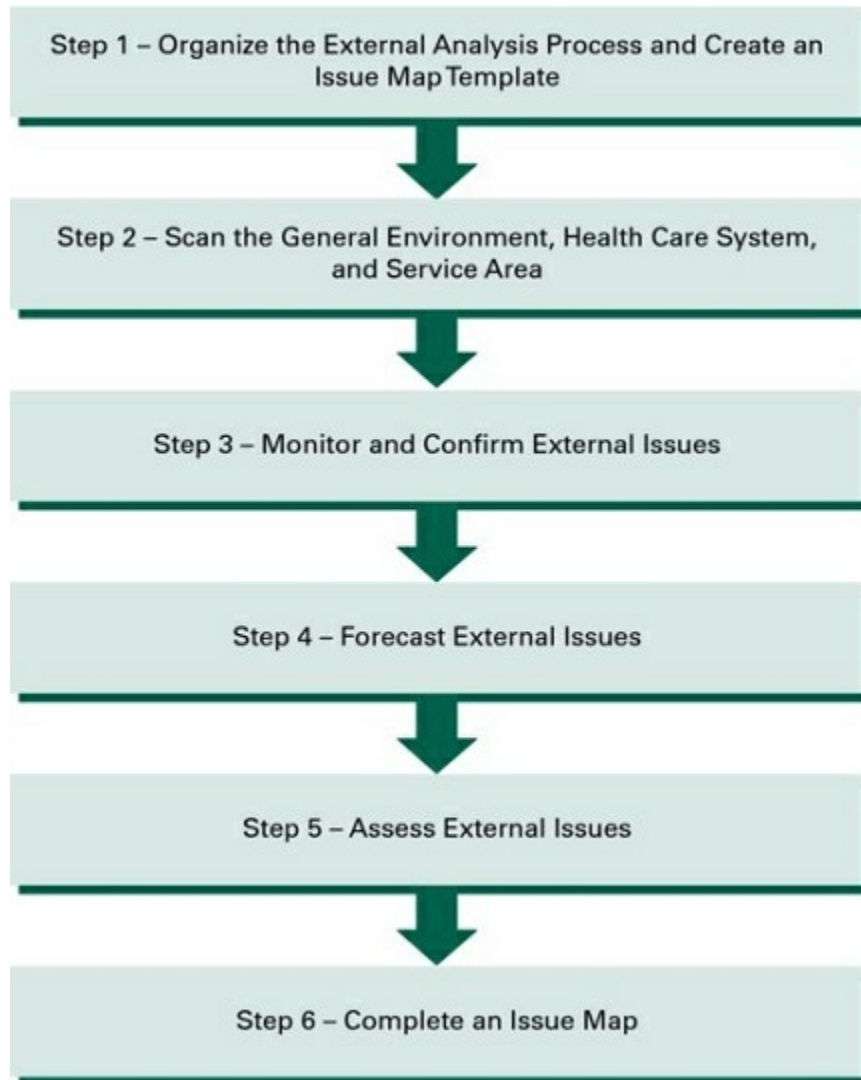


Exhibit 2.1 Process for External Analysis

Step 1: Organize the External Analysis Process

Engaging in strategic thinking and the process of external analysis can be overwhelming without some organization. Therefore, breaking the external analysis process into logical components can help focus strategic thinking to engage in the analysis process. In many respects organizations are similar to biological species – both are complex adaptive systems that are nested in

broader systems. For example, natural systems are nested in the ecosystem, which is nested in the broader biological environment. Similarly, health care organizations are nested in their service areas, the service areas are nested in the industry, and the industry is nested in the broader general or macro-environment as conceptualized in [Exhibit 2-2](#).⁷ In these *nested systems*, changes in one system will initiate changes in another system. For example, a change in national health policy, made in the macro-environment, will affect how the health industry works (the health care system). These changes in the health care system affect the service areas in which health care organizations operate and ultimately influence the way in which health care organizations operate in those service areas. Reciprocally, actions by the organization will change the nature of the service area, changes in service area will be a factor in determining the nature of the health care system, and how the health care system will impact the general environment.



Exhibit 2.2 The Nested Environments of a Health Care Organization

Within these nested systems, organizations and individuals create change. Therefore, if health care managers are to become aware of the changes taking place outside their own organization, they must have an understanding of the

types of organizations that are creating change and the nature of the change. When systems are nested, change generally cascades from one system to another; however, similar to the natural environment, changes in any one system may simultaneously affect the other systems as well as individual organizations.⁸

In this chapter we will explore the types of change initiated in the general environment, health care system, and the service area. Chapter 3 will focus on service area competitor analysis and Chapter 4 will examine the organization.

The General Environment

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

- Government institutions.
- Business organizations.
- Educational institutions.
- Religious institutions.
- Research organizations and foundations.
- Individuals and consumers.

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

In general, external changes affect a number of different sectors of the economy. For example, passage of the prescription drug bill during the George W. Bush presidency affected a variety of organizations as well as individuals, including insurance companies, organizations representing the elderly, and retirees. Similarly, the early health care reform initiatives of the Obama administration resulted in the passage of ACA; however, its implementation was spread over a number of years and affected virtually all institutions in society, not just health care organizations. As U.S. national health care legislation evolves during the Trump administration, virtually all institutions and organizations will again be impacted.

The organization itself may be affected rather quickly by the economic,

social/demographic, legislative/political, technological, and competitive change initiated and fostered by organizations in the general environment. In the aggregate, these alterations represent the general direction of societal change that may affect the success or failure of any organization. Therefore, an organization engaging in strategic management must try to sort out the fundamental general environment changes and detect major shifts taking place. A shift in consumer attitudes and expectations concerning health care is an example of a societal change that may affect the success or failure of health care organizations. Demographic changes are somewhat more predictable and the growing number of seniors in the U.S. population will impact every aspect of society as well as the health care system. Sometimes the demographics of the general environment provide leading indicators of health care trends.

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

The Health Care System

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

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

- Planning/Regulatory Organizations.
- Organizations that provide health services (*primary providers*).
- Organizations that provide resources for the health care system (*secondary providers*).
- Organizations that represent the primary and secondary providers.
- Individuals involved in health care delivery and patients (consumers of health care services).⁹

[Exhibit 2-3](#) lists the types of organizations and individuals within each segment and provides examples. The categories of health care organizations listed under each of the health care segments are not meant to be all-inclusive, but rather to provide a starting point for understanding the wide diversity and complexity of

the industry.

Planning/Regulatory Organizations

- Federal regulating agencies
 - Department of Health and Human Services (DHHS)
 - Center for Medicare and Medicaid Services (CMS)
 - Centers for Disease Control and Prevention (CDC)
 - Food and Drug Administration (FDA)
 - U.S. Agency for Toxic Substances and Disease Registry (ATSDR)
 - Environmental Protection Agency (EPA)
- State regulating agencies
 - Public Health Departments
 - State Health Planning Agency (e.g. Certificate of Need or CON)
- Voluntary regulating groups
 - The Joint Commission (accredits 21,000 health care organizations in the United States)
 - National Committee for Quality Assurance (NCQA)

Primary Providers (Organizations that Provide Health Services)

- Hospitals
 - Voluntary (e.g. Barnes/Jewish Hospital)
 - Governmental (e.g. Veteran's Administration Hospitals)
 - Investor-owned (e.g. HCA – The Healthcare Company, Tenet)
- State public health departments
- Non-hospital health care facilities
 - Skilled nursing facilities (e.g. HCR ManorCare)
 - Assisted living facilities (e.g. Brookdale Senior Living Solutions)
 - Intermediate care facilities (e.g. Avalon Memory Care)
 - Ambulatory care institutions (e.g. Ambulatory Care Centers)
 - Hospices (e.g. Hospice Care & Palliative Care, Inc.)
 - Home health care institutions (e.g. CareGivers Home Health)
- Physicians' offices

Secondary Providers (Organizations that Provide Resources)

- Educational institutions

Medical schools (e.g. Johns Hopkins, University of Alabama at Birmingham [UAB])

Schools of public health (e.g. The University of North Carolina at Chapel Hill, Harvard)

Schools of nursing (Presbyterian School of Nursing)

Health administration programs (University of Washington, The Ohio State University)

- Organizations that pay for care (third-party payers)

Government (e.g. Medicaid, Medicare) (See Essentials for a Strategic Thinker 2–1, “What is Government Health Care Insurance?” for an overview of public health insurance)

HMOs and IPAs (e.g. United Healthcare)

Insurance companies (e.g. Prudential, Metropolitan)

Businesses (e.g. Microsoft, Ford Motor Company)

Social organizations (e.g. Shriners, Rotary Clubs)

- Pharmaceutical and medical supply companies

Drug distributors (e.g. McKesson)

Drug and research companies (e.g. Bristol Myers Squibb)

Medical products companies (e.g. Johnson & Johnson, 3M, GE)

Organizations that Represent Primary and Secondary Providers

- National associations

American Medical Association (AMA)

American Hospital Association (AHA)

- State associations (e.g. Illinois Hospital Association, New York Medical Society)

- Professional associations

Health care (e.g. American College of Healthcare Executives [ACHE] or Medical Group Management Association [MGMA])

Physicians (e.g. American College of Physician Executives [ACPE])

Medical products (e.g. Pharmaceutical Manufacturers Association [PMA])

Individuals and Patients (Consumers)

- Independent physicians

- Nurses

- Non-physician professionals (Physician Assistants, X-ray Technicians)

- Patients and consumer groups (American Heart Association)

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

Exhibit 2.3 Organizations in the Health Care System

ESSENTIALS FOR A STRATEGIC THINKER 2-1

What Is Government Health Care Insurance?



In the United States, there are several government programs that enhance access to health care for specific groups of eligible beneficiaries. Some programs only provide health insurance coverage such as Medicare, Medicaid, and Children's Health Insurance Program (CHIP), whereas others may also deliver services directly to beneficiaries such as TRICARE (Military Health Care System, formerly CHAMPUS), the Veterans Administration (VA), and the Indian Health Service (IHS).

Medicare is a federal program that provides health insurance coverage to persons over the age of 65, some disabled workers, and people with end-stage renal disease (ESRD). Individuals who are assessed a payroll tax for forty quarters of employment and are over the age of 65 are eligible for Medicare coverage. People over the age of 65 may also buy into Part A. There is no dependent coverage under Medicare, but an individual that receives a spousal benefit under Social Security is also eligible for Medicare. The Medicare program consists of four parts: Part A (Hospital Insurance), Part B (Medical Insurance), Part C (Medicare Advantage), and Part D (Prescription Drug Insurance). Although Part A is funded by the Hospital Insurance Trust Fund (tax revenues), Parts B and D are funded by a combination of monthly premiums and general tax revenues. Part D coverage is provided by private insurers (premiums). Many Medicare beneficiaries purchase private Medigap policies (sold by insurance companies such as Humana, Blue Cross Blue Shield, and Aetna) to help with cost-sharing and supplement coverage. Rather than participating in traditional Medicare (i.e. Parts A, B, and D), beneficiaries may enroll in private Medicare Advantage Plans that typically provide more coverage than traditional Medicare, but utilize narrower provider networks (e.g. HMOs, PPOs). Additional premiums for Medicare Advantage Plans may be charged plus enrollees usually are required to pay the government-funded Part B premiums. For Medicare Advantage (Medicare beneficiaries have had the option to receive their Medicare benefits through managed capitated-fee health plans), Medicare pays the health plan a set amount every month (a per person set fee or capitation) at a capitated rate that is 95 percent of expenditures for beneficiaries under Medicare Parts A and B.

State *Medicaid* programs receive federal matching funds from the Federal Matching Funds Program (Maternal Health and Family Planning Program) to provide coverage to low-income pregnant women and children, low income families, the elderly, persons on Supplemental Security Income (SSI), and disabled persons. Medicaid eligibility standards for the non-elderly vary greatly from state to state. Under the ACA Medicaid expansion, all adults with incomes below 138 percent of the Federal Poverty Level (FPL) are eligible for Medicaid coverage, but a number of states refused to expand Medicaid. A majority of states now contract with Medicaid Management Care Organizations (MCOs) to deliver services and most beneficiaries receive benefits through such plans. The Children's Health Insurance Plan (CHIP) provides federal matching funds for coverage of children in families with incomes up to 300 percent FPL.

TRICARE provides health care in accordance with a group-priorities list to active duty/retired military, National Guard/Reserve members, and spouses and children through military facilities and civilian networks. In addition, the VA may pay for private care when wait times or commutes are excessive.

The Indian Health Services (IHS) provides care to members of federally-recognized tribes in the form of direct care (DC) and purchased/referred care (PRC). Tribal members may receive DC from any IHS facility, but the availability of PRC care is geographically restricted to areas in close proximity to the home reservation. In addition, tribal members are eligible to participate in all government programs open to the general population.

Source: Leonard J. Nelson, III, Adjunct Professor at UAB School of Public Health and Professor Emeritus at Samford University.

The Service Area

The *service area* is the geographic space surrounding the health care provider from which it pulls the majority of its customers/patients. It is often limited by sometimes ill-defined geographic borders. Beyond these borders, services may be difficult to render because of distance, cost, time, and so on; however, in some circumstances the service area might be world-wide. Nevertheless, a health care organization must not only define its service area, but also understand the changes taking place that will directly affect the organization. Organizations generating change in the service area typically include:

- Competitors.
- Local government services.
- Local business organizations.
- Local not-for-profit organizations.
- Other local organizations.
- Individuals and patients.

Defining the Service Categories

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

The service area is further defined by customers' preferences and the health care providers that are available. The 21st-century consumer has become empowered by the amount of information available concerning disease conditions. [Exhibit 2-4](#) shows the determinants of a service area including the consumer variables and the market (provider) variables. For the consumer, the services needed could include health care that is preventive, diagnostic, alternative, routine, episodic, acute, chronic, or cosmetic. Usage rates would be related to a variety of economic, demographic, psychographic, and disease pattern variables.

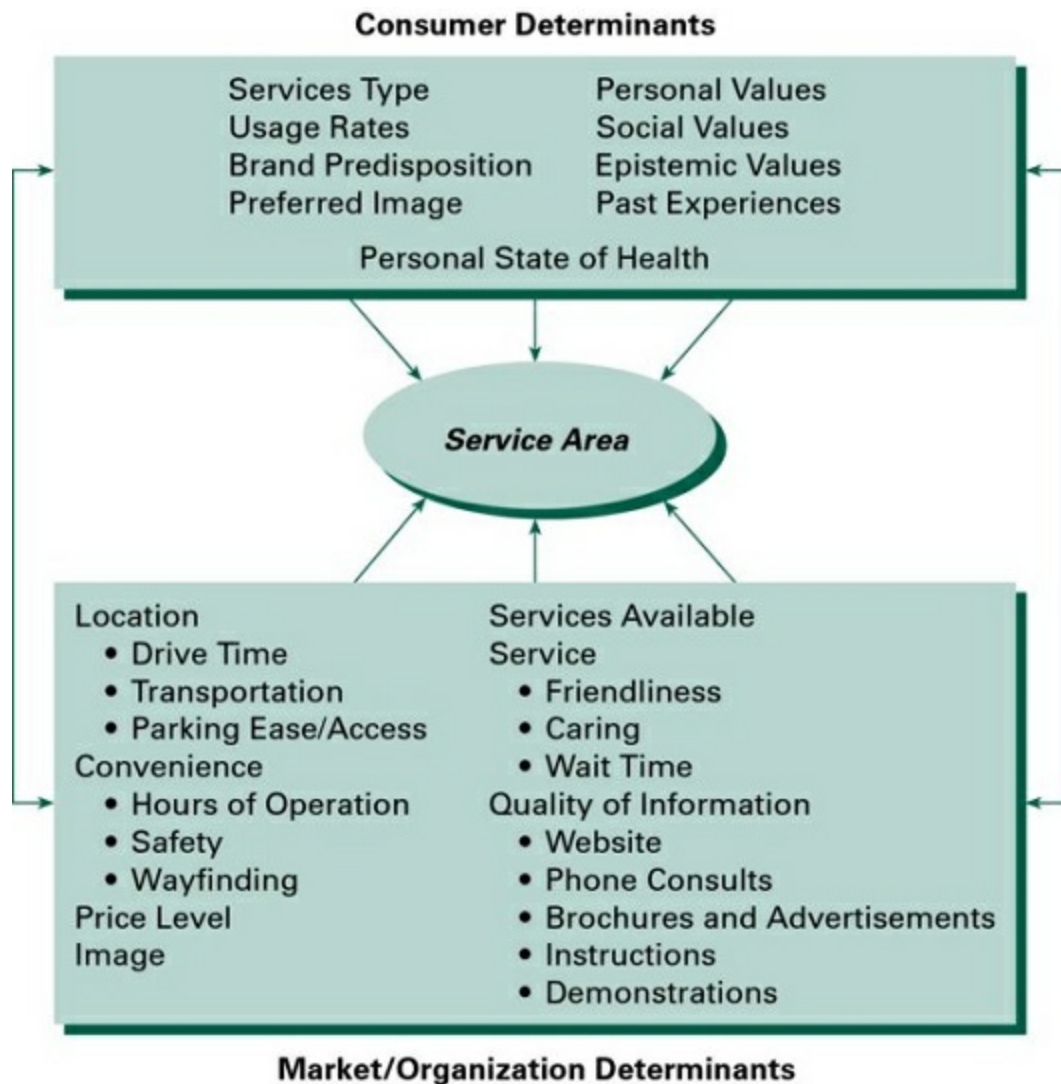


Exhibit 2.4 Service Area Determinants

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

Another group of consumer determinants will be related to personal factors such as personal and social values, epistemic (knowledge) values, past experiences, and the individual’s personal state of health. In concert, these variables develop the individual’s preferences for health care providers; however, if providers are not available – meaning that limited or no options are in the immediate area, the consumer will travel greater distances to gain the desired care.

Options or choices are controlled by the health care structure. The market and

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

Managed care interrupts the normal decision making by consumers. An employed individual today usually has some choice in health care insurance. The employer may offer one or more different health plans; however, once the consumer has selected a managed care plan, the ability to choose providers – both hospitals and physicians – becomes more restrictive. And, in fact, the more the HMO attempts to control health care costs by further structuring health care delivery, the more restricted the choice becomes for consumers. Restricted choice is not favored by most Americans and they have been quite vocal about it with their employers. The result is that many employers are only willing to commit to a health plan that offers choice (and thereby removes the quantity discounts previously offered) and, hence, these organizations have seen health care cost increases in double digits.

Multiple Service Areas

Understanding the geographic boundaries is important in defining the service area, but is often difficult because of the variety of services offered. In an acute care hospital, the service area for cardiac services may be the entire state or region, whereas the service area for the emergency room might be only a few blocks. Thus, for a health care organization that offers several service categories, it may be necessary to conduct several service area analyses. For example, the Des Moines, Iowa market has two geographic components: the metropolitan area of the city as well as the suburbs of Polk County (population approximately 446,700) and the 43 primarily rural counties of central Iowa that surround the capital (population of over 1 million). The issues for each of these multiple service areas may be quite different; therefore, considerable effort is directed toward understanding and analyzing the nature of the health care organization’s various service areas. At the same time, for certain organizations, defining only one service category may suffice (such as in the case of a long-term care facility in a major metropolitan area).

Service areas will be unique for each organization. A national for-profit hospital

chain may define its service area quite generally, but even then, different strategies may be in place. For example, HCA Holdings Inc. (HCA) is a holding company that owns and operates hospitals and related health care entities. As of 2017, it operated 171 hospitals and 118 freestanding surgery centers in 20 states and the United Kingdom.¹⁰ HCA's strategy is to become a major health care presence in highly concentrated markets in the nation. On the other hand, the Hospital Association of Southern California owns more than 184 hospitals, 40 hospital systems, and numerous related professional associations and associate members.¹¹ Its strategy is to improve the operating environment for member hospitals and the health status of the communities they serve in Los Angeles, Orange, Riverside, San Bernardino, Santa Barbara, and Ventura counties in California (note that this six-county service area contains a population of over 19 million – larger than the population of all states except California, Texas, Florida, and New York).

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

Determining the geographic boundaries of the service area may be highly subjective and is usually based on factors such as patient histories, the reputation of the organization, available technology, physician recognition, and so on. In addition, geographic impediments such as rivers, mountains, and limited access highways can influence how the service area is defined. The definition of communities (see Essentials for a Strategic Thinker 2–2, “What Is a Community?”) is often helpful in determining a service area.

ESSENTIALS FOR A STRATEGIC THINKER 2–2

What Is a Community?



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

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

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

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

- The level and scope (federal, state, regional, local) of governmental entities that regulate the health system and the extent of regulation directed at health care organizations.
- The nature and scope of professional organizations that set standards, accredit, or otherwise engage in accountability functions for health care organizations.
- The nature and scope of health care financing agencies, including purchasers and private and public insurers, that participate in the health care marketplace in the community.
- The availability of health care providers, facilities, supplies, and ancillary services across the community.
- The characteristics of the populations ultimately paying for and receiving health care services. These characteristics could include socioeconomic status (education, occupation, and income), race and ethnicity, language, family structure, health status, health risk, and health-seeking behaviors.

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

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

External Information Categories

Breaking the external macro-environment into the general environment, the health care system, and the service area components helps focus strategic thinking and external analysis. Similarly, categorizing issues by type – economic, social/demographic, legislative/political, technological, and competitive – further aids in focusing on the identification of issues. Such categories not only assist in tracking but also facilitate the subsequent assessment of the issues. Issues are not inherently categorical; however, using these categories helps managers to understand the nature of the issues and aggregate and organize information. Through the aggregation and organization process, patterns may be identified and evidence accumulated on an issue.

Combining the system components with these categories of issues results in an issue map. More specifically, an *issue map* is a matrix of issues that combines the components of the external systems (general environment, health care system, and service area) on one axis with categories of issues (economic, social/demographic, legislative/political, technological, and competitive) on the other axis. The format of the issue map that organizes the external analysis process is shown in [Exhibit 2-5](#). The cells of the issue map may be filled in with identified issues and their implications through the remaining steps of the external analysis process – the scanning, monitoring, forecasting, and assessing stages. Additionally, the issue map will provide the foundation for a more focused analysis of the organization's competitors in the service area (Chapter 3).

Issue Map			
Categories of Issue	General Environment	Health Care System	Service Area
Economic			
Social/ Demographic			
Legislative/ Political			
Technological			
Competitive			

Exhibit 2.5 External Issue Map

Step 2: Scan the General Environment, Health Care System, and Service Area

Scanning is the process of identifying and documenting a number of external organizations in the general environment, health care system, and service area in search of pertinent, current, and emerging trends/issues. Scanning the external systems requires the strategic thinking states of awareness and anticipation. Strategic managers who practice effective external analysis are so “close” to the external issues that by the time change becomes apparent to others, they have already detected the signals of change and have explored the significance of the changes. These managers are often called visionaries; however, vision is often the result of their *strategic awareness* – thoughtful detection and interpretation of subtle signals of change. Such strategic managers are able to eliminate *predictable surprises* for the organization – surprises that should not have been. These managers are able to avoid disasters by recognizing the issue, making it a priority in the organization, and mobilizing the resources required to address it.¹² “The most important task of an organization’s leader is to anticipate crisis. Perhaps not to avert it, but to anticipate it. To wait until the crisis hits is already abdication. One has to make the organization capable of anticipating the storm, weathering it, and in fact, being ahead of it.”¹³

To be successful, health care organization leaders must have an understanding of the external systems in which they operate; they must anticipate and respond to the significant shifts taking place within those systems. Strategic thinking, and the incorporation of that thinking into the strategic plans for the organization, is now more important than ever. “In times of turbulence the ability to anticipate dramatically enhances your chances of success. Good anticipation is the result of good strategic exploration.”¹⁴ Organizations that fail to anticipate change, ignore external forces, or resist change will find themselves out of touch with the needs of the market, especially because of antiquated technologies, ineffective delivery systems, or outmoded management. Institutions that anticipate and recognize significant external forces and modify their strategies and operations accordingly will prosper. Essentials for a Strategic Thinker 2–3, “What Are Inevitable and Predictable Surprises and Gray Rhinos?” examines the nature of these “surprises.”

ESSENTIALS FOR A STRATEGIC THINKER 2–3

What Are Inevitable and Predictable Surprises and Gray Rhinos?



Inevitable surprises are events occurring in the future that have discernable signs, patterns, or signals of their occurrence today. By examining the dynamics at work, the strategist can predict the inevitable

surprises of tomorrow; thus the future is foreseeable.¹ Occurrence is inevitable and prediction is possible because many “surprises” are already taking place through predetermined events – forces that can be anticipated with certainty. If these events are identified, will there be surprises? The answer is simple – while the events are predetermined, the timing, results, and consequences are not.

Predetermined events can be anticipated because their early stages are already in motion – either they have already happened or they are currently happening, and experienced strategists are able to characterize likely implications. Leaders can increase the probability of successfully predicting future events and trends by using a systems approach and incorporating the elements of strategic thinking into the decision making process (awareness, anticipation, analysis, interpretation, synthesis, reflection). By training themselves to carefully consider external systems, analyze data, question assumptions, and generate new ideas, decision makers can develop the ability to forecast predetermined events and even second- and third-degree effects that will impact the organization.

A related concept, that of predictable surprises, indicates that leaders may not be able to anticipate crises because of their cognitive, organizational, or political shortcomings.² Such faults may include inherent biases (cognitive); faulty external scans that do not identify threats or do not collect and analyze information appropriately (organizational); or specialized interests that invoke individuals or groups to act in their own self-interest rather than the organization as a whole (political). Those in leadership positions must champion the recognition of threats that are emerging, the subsequent prioritization of threats, and the activation of effective response.

In contrast to inevitable and predictable surprise, *gray rhinos* are high-probability, high-impact issues that everyone acknowledges as threats because a series of signals and visible evidence has occurred. Leaders can see them coming yet fail to address them (obvious but neglected risks).³ These issues tend to be significant social, economic, and political issues or unsolved problems that threaten a profound impact and yet are not typically addressed until they create disaster. Such issues might include growing income inequality, a deepening racial divide, global warming (climate change), political gridlock, or lack of access to health care for millions of people. Charging gray rhinos may pose significant risks to organizations; therefore, leaders must work to induce momentum for positive change or be flattened by inaction.⁴

Leaders can improve their organization’s ability to anticipate and respond to events by learning to recognize behaviors that cloud judgment (such as cognitive, organizational, and political imperfections) and incorporating lessons learned into the organizational culture.

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3. Michele Wucker, *The Gray Rhino* (St. Martin's Press, 2016).
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See also: *Predictable Surprises: The Disasters You Should Have Seen Coming and How to Prevent Them* (Parameters, 2006). Book Review by Mark J. Eshelman, retrieved from www.thefreelibrary.com/Predictable+Surprises%3A+The+Disasters+You+Should+Have+Seen+Coming+and+...-a0148856135.

Source: Lauren Wallace MPH, MPA, DrPH Candidate, University of Alabama at Birmingham.

Organizational and Individual Focus

A number of organizations and individuals comprise the general environment, health care system, and service area. Some external organizations and individuals have little direct involvement with the health care system while others are directly connected. The distinction is not always clear. These organizations and individuals, through their normal operations and activities, are generating changes that may be important to the future of other organizations. Changes in the general environment are always “breaking through” to the health care system. For example, health care often advances hand in hand with technology, as is the case with the convergence of imaging technology and biotechnology – enabled by advanced health care information technology – which promises to radically change diagnosis and treatment for many chronic diseases.¹⁵

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

1. View external data.
2. Organize external information into several desired categories.
3. Identify issues within each category.

Strategic issues are external trends, developments, dilemmas, and possible events that affect an organization and its position. Strategic issues are often ill-structured and ambiguous and require effort in interpretation.¹⁶ Often, in attempting to identify important external issues, general labels such as opportunities or threats are used to classify issues. However, signals are typically neutral in their implications and their interpretation can only be assessed in the context of strategy.¹⁷ Therefore, at this stage in strategic

planning, it is beneficial to avoid using the terms opportunities/threats, positive/negative, gain/loss, or controllable/uncontrollable, and instead consider the consequences of the issue itself. Strategies can be worked out later, after leaders have a better understanding of external issues as well as internal resources, competencies, and capabilities.

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

Information Sources

There are a variety of sources for external information. Although organizations create change, they are often difficult to monitor directly. However, various secondary sources (published information) are readily available. Essentially, people and publications both outside and inside the organization serve as external information sources. Typically, within the organization, there are a variety of experts who are familiar with external issues and who may be the best sources of such information. In addition, many organizations collect patient and consumer information, and subscribe to and archive industry, technical reports, and databases. Outside the health care organization, patients, physicians, nurses, suppliers, third-party payers, pharmaceutical representatives, and managed care companies may be considered important direct sources. Indirect sources are mostly newspapers and journals, the internet, television, libraries, and public and private databases.

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

Step 3: Monitor and Confirm External Issues

Monitoring is the tracking of issues identified in the scanning process to add data concerning the issue to confirm or deny its impact. This activity accomplishes four important functions:

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

Once the organizations creating change and the publications or other information sources reporting change have been identified, special attention should be given to these sources.

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

The intensity of monitoring is reflected in management's understanding of the issue. When managers believe they understand the issue well, less monitoring will be done. However, when external issues appear ill-structured, vague, or complex, the issues will require a larger amount of data to arrive at an interpretation.¹⁸

Step 4: Forecast External Issues

Forecasting external change is a process of extending the trends, developments, dilemmas, and events that the organization is monitoring to predict the future state. Further, forecasting looks at how hidden trends in the present signal possible changes in direction for organizations and societies in the future. The forecasting function attempts to answer the question: "If these trends continue, or if issues accelerate beyond their present rate, or if this event occurs, what will the issues and trends 'look like' in the future?" An organization's forecasting competence (coupled with its assessment) can yield a competitive advantage.¹⁹

Three processes are involved in the forecasting function:

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

Step 5: Assess External Issues

Information concerning external issues, though abundant, is seldom obvious in its implications. Strategic managers must interpret the data they receive. After all, facts do not speak for themselves; one has to make sense of the facts, not just get them straight.²⁰ *Assessing* is a process for the evaluation of the significance and impact of forecasted external issues on an organization that is largely non-

quantifiable and therefore judgmental. The assessment process includes evaluation of the significance of the extended (forecasted) issue on the organization; identification of the issues that must be considered in the internal analysis; development of the vision and mission; and formulation of the strategic plan. However, even when exposed to identical issues, different managers may interpret their meaning quite differently. Interpretations are a result of a variety of factors, including perceptions, values, past experiences, and context. Assessing may also initiate additional scanning, monitoring, and forecasting as part of the assessment process. Today, organizations are increasingly turning to “Big Data” and analytics in the assessment process. Essentials for a Strategic Thinker 2–4, “What Is Big Data Analytics” examines Big Data and analytics in assessment.

ESSENTIALS FOR A STRATEGIC THINKER 2–4

What Is Big Data Analytics?



Simplistically stated, Big Data means too much disparate data from too many sources to process with non-distributed techniques; thus analytics are employed. Big Data actually comprise multiple large datasets that are analyzed in conjunction to uncover patterns and correlations among the data that likely would not be apparent if the datasets were analyzed independently. These collections of datasets include structured, semi-structured, and unstructured data extracted from many public and private sources that contribute to understanding or solving a complex problem. Such analyses are useful for operational purposes such as improving work processes and reducing cost, and for strategic purposes such as making future market predictions based on past sales behavior patterns.

DATA VOLUME

Compiling Big Data is not the point – Big Data provide no competitive advantage without analytics (unless you are selling some exceptionally important data to other users) – it is about the knowledge to be gleaned through expert exploration of the unique elements of the datasets in their combined contexts.

Data mining, the process of extracting knowledge about previously unknown relationships from massive datasets, is possible because of technological innovations such as cost-effective data storage options, high-speed distributed processing capability, robust device connectivity with high-speed data transmission, and distributed data platforms. Despite these and other technological capabilities available, Big Data still present many challenges to optimal utilization beyond the obvious challenge of volume.

DATA VARIETY (DISPARATE DATA STRUCTURES)

Significant data from source databases may take many forms, including text, aggregated statistical data, raw data transmitted from mobile devices, video and graphic data, and other formats, that require sophisticated data management and analytical approaches. Data scientists with these skills are scarce.

DATA VELOCITY

In the current environment, large volumes of data are captured and transmitted rapidly, often in real-time at exceptionally high speeds. Repositories of these data are dynamic or moving targets from an analytics perspective. Processing speed must be compatible with capture speed.

DATA VERACITY

The accuracy and reliability of data is a concern with any data analysis, and is compounded in Big Data rather than minimized, because analysis is based on numerous highly variable datasets, rather than a single constructed and cleaned dataset. Errors in one component dataset may affect a conclusion drawn from a complex relationship involving multiple datasets. Cleaning Big Data to enable analytics requires skilled data scientists, specific data tools, and much time.

DATA CURATION

The extreme volume of combined data, the variation among the multiple source datasets, and the velocity of data capture and processing all contribute to the challenge of establishing metadata for Big Data. Defining the logic model underlying the metadata structure and crafting a searchable data structure requires special technical skills and data tools. Again, data scientists with these skills are scarce. Big Data, of necessity, are cloud-based, stored and processed on multiple servers that may be subscription-based, involve multiple vendors, and require comprehensive data sharing agreements.

REGULATION AND OVERSIGHT

Enforcement of consumer protection laws, such as those regulated by the Federal Trade Commission, as well as information security and privacy regulations such as the Health Insurance Portability and Accountability Act (HIPAA) are evolving with regard to Big Data.

Source: Donna J. Slovensky, PhD, RHIA, FAHIMA, Professor and Senior Associate Dean, School of Health Professions, University of Alabama at Birmingham.

Strategic decisions are made in the context of changing financial, social,

political, technical, and competitive forces – understanding the context in which an organization operates is, therefore, fundamental. Understanding the context of a situation so that complexity can be better explained is called

sensemaking.²¹ Strategic leaders who have a sense of context know how to quickly capture the complexities of their situation and explain them to others in simple terms. This explanation helps to ensure that everyone is working from the same map, which makes it far easier to discuss and plan for the journey.²²

The assessment process is not an exact science, and sound human judgment and creativity may be bottom-line techniques for sensemaking – a process without much structure. For example, assessing the commercial potential of drugs in clinical trials requires not only an understanding of the science but also sound business judgment.²³ The fundamental challenge is to make sense out of vague, ambiguous, and unconnected data. Strategic leaders have to infuse meaning into data; they have to make the connections among discordant data such that signals of future events are created. Sensemaking involves acts of perception and intuition. It requires the capacity to suspend beliefs, preconceptions, and judgments that may inhibit connections being made among unclear and disparate data.²⁴

Several different strategic thinking frameworks and techniques may be used to examine issues identified in the scanning, monitoring, and forecasting stages of external analysis. These frameworks, which are informal and generally not overly sophisticated, have been variously described as “judgmental,”

“speculative,” or “conjectural.”²⁵ Indeed, external analysis is largely an individual effort and is directed to person-specific interests. Further, external analysis usually is not limited to just one of the external analysis tools and techniques. The remainder of this chapter will discuss external analysis frameworks that identify and help assess issues in the general environment, the health care system, and the service area. An approach and techniques for more specific market segmentation and competitive analysis will be discussed in Chapter 3.

Issue Impact and Probability Prioritization

Issue impact and probability prioritization is the classification of external issues based on an assessment of the importance of the issue and the likelihood that the issue will continue to remain an issue in the future. Perhaps because of its relative simplicity, issue prioritization is a widely practiced analysis method. Unfortunately, external issues are rarely presented as a neat set of quantifiable data; rather, external issues are ill-structured and conjectural. Thus, in many cases, external analysis is a matter of reaching consensus on the existence and impact of an issue and speculating on the likelihood of its continuance.

As illustrated in [Exhibit 2-6](#), the issue impact and probability prioritization process for a nursing home includes the identification of issues by external system category and the determination of its probable impact on the organization. Additionally, managers may assess the likelihood that the trend, development, or dilemma will continue or that the event will occur, and then

identify the sources for additional information.

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

10 = High impact or probability; 1 = Low impact or probability

Exhibit 2.6 Issue Impact and Probability Prioritization by a Nursing Home

These issues may then be plotted on the chart shown in [Exhibit 2-7](#). The assumption is that the issues to the right of the curved line in the exhibit have a significant impact (high impact) on the organization and are likely to continue or occur (high probability) and should be addressed in the strategic plan.

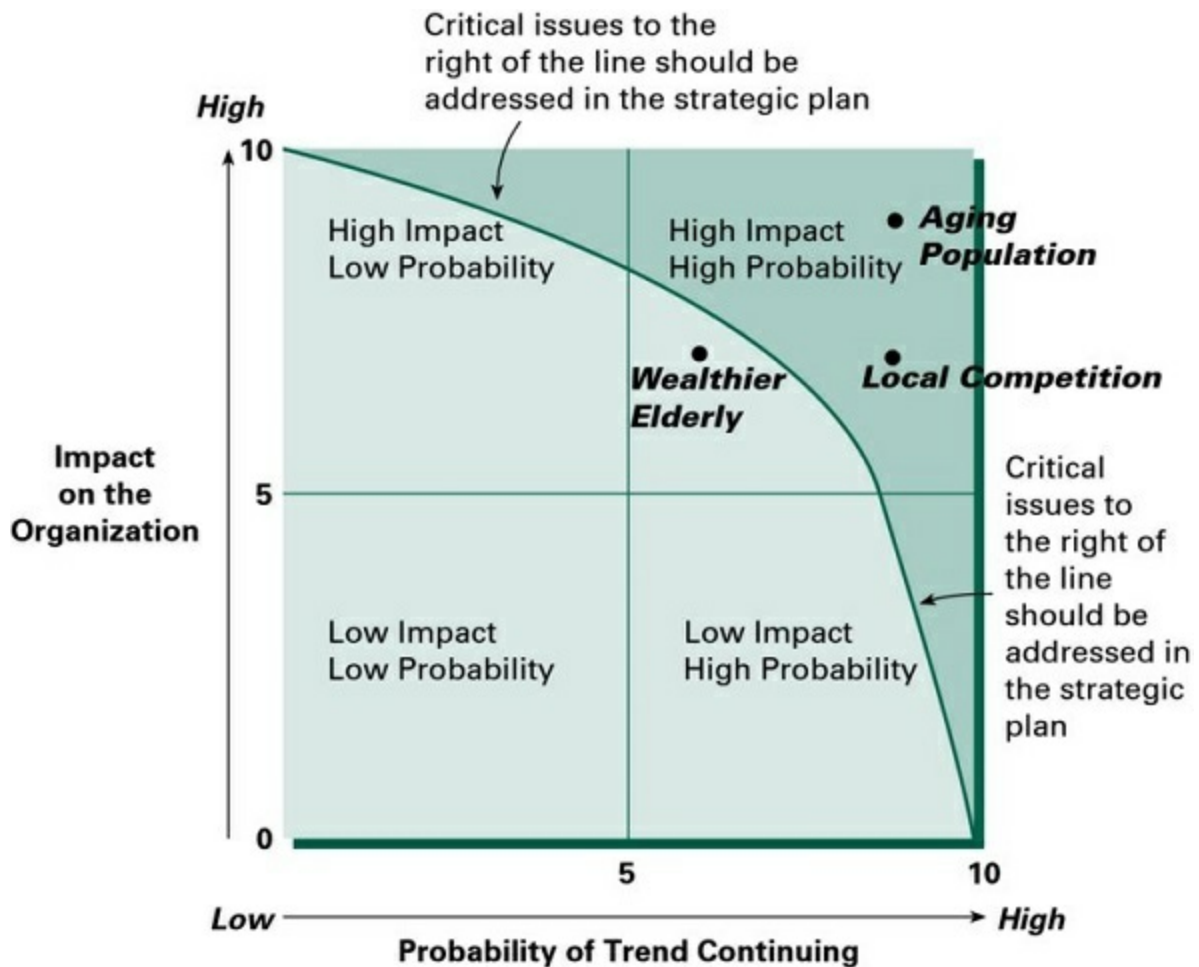


Exhibit 2.7 External Trends/Issues Plot

The formats illustrated in [Exhibit 2-6](#) and [Exhibit 2-7](#) are useful for organizing external data and providing a starting point for speculating on the direction and rate of change for identified trends. However, trend extrapolation of external issues requires extensive familiarity with the issues and a great deal of sound judgment.

Solicitation of Expert Opinion

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

The Delphi Method

The *Delphi method* is a process for the development, evaluation, and synthesis of individual points of view through the systematic solicitation and collation of individual judgments on a particular topic; it is a popular, practical, and useful approach for identifying issues and analyzing external data. The Delphi method may be used to identify and study current and emerging trends within each issue category (technological, social/demographic, economic, and so on). Opinions are summarized and then sent back to the participating individuals for the development of new judgments concerning the topic. After several rounds of solicitation and summary, a synthesis of opinion is formulated.²⁶

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

1. Identify recognized experts in the field of interest.
2. Seek their cooperation and send them a summary paper (based on a literature search).
3. Conduct personal interviews with each expert based on a structured questionnaire.²⁷

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

The Delphi method is particularly helpful when health care managers want to understand a specific external issue. For example, a Delphi study was designed to define the role and responsibilities of sports medicine specialists in the United Kingdom. A mail questionnaire was sent to a random sample of 300 members of the British Association of Sport and Exercise Medicine. The original questionnaire contained 300 attributes and allowed participants to modify their responses based on feedback from other participants. The study was recognized as the first systematic attempt to define the role and responsibilities of the sports medicine specialist and concluded that sports medicine was an evolving specialty in the United Kingdom.²⁸ More recently, methods and experts from other disciplines have been applied to health care issues such as the forecasting of infectious diseases.

Nominal Group Technique, Brainstorming, and Focus Groups

The nominal group technique (NGT), brainstorming, and focus groups are interactive group problem identification and solving techniques. The *nominal group technique* is a facilitated group discussion process for developing consensus on an issue or problem where individuals present ideas, discussion occurs, and consensus is reached through a voting process. In the nominal group technique, a group is convened to address an issue, such as the impact of consolidation within the health care system or the impact of an aging population on hospital facilities. Each individual independently generates a written list of ideas surrounding the issue. Following the idea-generation period, group

members take turns reporting one idea at a time to the group. Typically, each new idea is recorded on a large flip chart for everyone to consider. Members are encouraged to build on the ideas of others in the group. After all the ideas have been listed, the group discusses the ideas. After the discussion, members privately vote or rank the ideas. After voting, further discussion and group generation of ideas continue. Typically, additional voting continues until a reasonable consensus is reached.²⁹

Brainstorming is a group process of free flowing idea generation and discussion, typically used in strategic management to better understand an issue, assess the impact of an issue, or to generate alternatives. In this process, participants present ideas and are allowed to clarify them with brief explanations. Each idea is recorded, but evaluation is generally not allowed. The intent of brainstorming is to generate fresh ideas or new ways of thinking. Participants are encouraged to present any ideas that occur to them, even apparently risky or impossible ideas. Such a process often stimulates creativity and sparks new approaches that are not as risky, crazy, or impossible as first thought.³⁰

NGT and brainstorming could be used to understand and respond to the increasing competition for ambulatory surgery. Non-hospital access points, such as specialized ambulatory surgery centers, represent a rapidly growing trend and hospitals are very concerned about the impact this growth could have on their bottom line. Inpatient surgeries requiring a one-day or longer length of stay constitute a small and decreasing percentage of hospital surgery profits. The most popular outpatient areas are gastroenterology, orthopedics, gynecology, ophthalmology, as well as podiatry, ENT, and general surgery. However, increasingly there are signs that angioplasty, peripheral vascular surgery, and low-risk coronary interventions such as pacemakers and cardiac defibrillators may be next.

These changes and the prospect of even greater changes offer an opportunity for hospital managers to employ brainstorming groups to plan for the future. Some of the major uncertainties that could be addressed by the groups include the future of Medicaid, Medicare, and other forms of government health care insurance (see *Essentials for a Strategic Thinker* 2–1). Brainstorming groups could provide serious insights into how willing physicians are to continue performing their procedures in hospitals and turn away from investments in outpatient facilities that could provide a 25 percent return on invested capital. Moreover, outpatient surgeries are easier for physicians to schedule without the aggravation of sharing operating rooms with inpatient and emergency services. Brainstorming groups might also be used to project the future direction of hospital reimbursement. Although both of these factors represent major uncertainties, informed groups could be very useful in preparing for the increasingly competitive health care system.³¹

Similar to the process of brainstorming, *focus groups* bring together 10 to 15 key individuals to surface issues and develop, evaluate, and reach conclusions. Focus groups provide an opportunity for management to discuss particularly important organizational issues with qualified individuals. Hospitals and large

group practices have used focus groups of patients to better understand the perceived strengths and weaknesses of the organization from the patient's view. For example, Johns Hopkins was considering the establishment of an integrated delivery system under one umbrella name. Focus groups of physicians, present and past patients, non-patients, and others convinced them to change plans. Focus groups can provide new insights for understanding issues and suggest fresh alternatives for their resolution.

Dialectic Inquiry

Dialectic inquiry is a “point and counterpoint” process of argumentation in which a thesis is argued against an antithesis to develop a synthesis of ideas or issues. The 19th-century German philosopher Hegel suggested that the surest path to truth was the use of a dialectic process – an intellectual exchange in which a thesis is pitted against an antithesis. According to this principle, truth emerges from the search for synthesis of apparently contradictory views.³²

More specifically, in external analysis, dialectic inquiry is the development, evaluation, and synthesis of conflicting points of view (concerning issues) through separate formulation and refinement of each point of view.³³ For instance, one group may argue that health care costs will be declining between 2018 and 2025 (thesis) because of changes in health regulation. Another group may present a case that the trend toward rising health care costs will continue (antithesis) because of hospital failures, the high cost of new technology, shortage of primary care providers, and so on. Debating this issue will unearth the major factors influencing health care costs and the implications for the future.

Any health care provider can utilize this technique by assigning groups to debate specific external issues. The groups make presentations and debate conflicting points of view concerning the issues. After the debate, the groups attempt to form a synthesis of ideas concerning the likely future.³⁴

Stakeholder Analysis

Stakeholder analysis is the systematic identification and evaluation of external and internal individuals, groups, and organizations that have an interest (or stake) in the success or failure of an organization. It is based on the belief that there is a reciprocal relationship between an organization and certain other organizations, groups, and individuals. Examples of possible health care stakeholders, shown as a “stakeholder map,” are presented in [Exhibit 2-8](#).

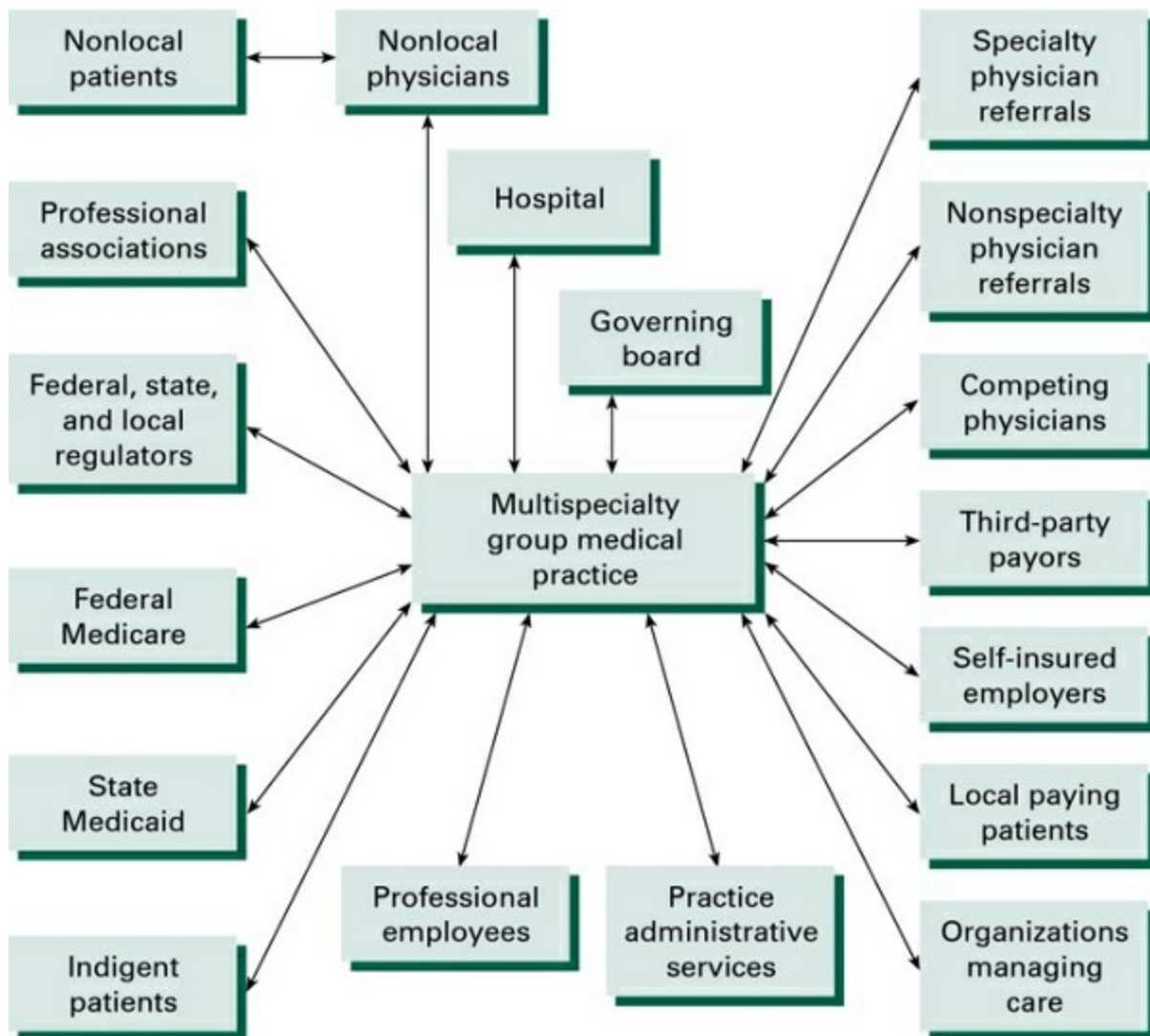


Exhibit 2.8 A Stakeholder Map for a Large Multispecialty Group Practice

Stakeholders are individuals, groups, and organizations that are directly or indirectly impacted by the success or failure of the organization and may be categorized as internal, interface, and external. Internal stakeholders are those who operate primarily within the bounds of the organization, such as managers and other employees. Interface stakeholders are those who function both internally and externally, such as the medical staff and the corporate officers of the parent company. External stakeholders operate outside the organization and include such entities as suppliers, third-party payers, competitors, regulatory agencies, the media, the local community, and so on.³⁵ Such stakeholders have been referred to as the “organization ecosystem”— organizations that affect and are affected by the creation and delivery of the organization’s product or service. Part of stakeholder analysis is to systematically identify the organizations with which their future is most closely intertwined and determine the dependencies that are most critical.³⁶

Some of these stakeholders are almost always powerful or influential; others are influential regarding only certain issues; still others have little influence or power. If the stakeholders can be identified and evaluated, then the “forces”

affecting the organization may be specified. The needs and wants of these constituencies may dramatically affect the strategy of an organization.³⁷

Typically, managers tend to focus attention on known, salient, or powerful stakeholders to help protect existing competitive advantages. However, there is growing evidence that “fringe” stakeholders are important as well – particularly for developing new ways of thinking. Researchers suggest that “the knowledge needed to generate competitive imagination and to manage disruptive change increasingly lies outside the organization, at the periphery” of the organization’s established stakeholder network.³⁸ Therefore, strategic thinkers must be open to fringe ideas and non-traditional thinking developed by fringe players. At first, these stakeholders may appear to be poor, weak, isolated, non-legitimate, or radical.³⁹ In reality, they may be strong purveyors of change.

Scenario Writing and Future Studies

Many businesses regularly use scenarios when assessing the external trends. *Scenarios* are probable visions, stories, or pictures of the future based on forecasting the impact of current trends, events, and issues. The popularity of scenario analysis is due in large part to the inability of other, more quantitative, forecasting methods to predict and incorporate major external shifts and provide a context for strategic thinking. Scenarios avoid the need for single-point forecasts by allowing users to explore several alternative futures.⁴⁰ Scenario analysis is an alternative to conventional forecasting that is better suited to situations with numerous uncertainties or imponderables – where there is no map.

A scenario is a coherent story about the future, using the world of today as a starting point. Based on data accumulated in the scanning and monitoring processes, a scenario or narrative that describes an assumed future is developed. The objective of scenarios and future studies is to describe a point of time in the future as a sequence of timeframes or periods of time. Scenario writing often requires generous assumptions. Few guidelines prescribe what to include in a scenario. In most cases several plausible scenarios should be written. It is an all-too-common mistake to envision only one scenario as the “true picture of the future.”⁴¹ Most authorities advocate the development of multiple scenarios. However, to avoid decision makers focusing only on the “most likely” or “most probable” scenario, each scenario should be given a distinctive theme name, such that they appear equally likely.

Multiple scenarios allow the future to be represented by different cause–effect relationships, different key events and their consequences, different variables, and different assumptions. The key question is: “If this external event happens (or does not happen), what will be the effect on the organization?” The use of multiple scenarios is particularly helpful in considering the future of public health. See *Essentials for a Strategic Thinker* 2–5 to answer the question “What Is Public Health in the United States?” and [Exhibit 2-9](#) to examine four scenarios or alternative futures for public health care through 2030. The scenarios were developed by the Institute for the Future to provide a description

of critical factors that will influence public health in the 21st century.

Scenario 1: One Step Forward, Half a Step Back

Amidst continued fiscal constraints, public health agencies and health care slowly advance their capabilities. Many use automation and advanced analytics to improve services and community and population health. However, climate change challenges continue to grow, and there is little progress in improving the social determinants of health. Great variations in technological capabilities, funding, and approaches to prevention – along with a continuous rise in health care costs – significantly limit public health gains.

Scenario 2: Overwhelmed, Under-Resourced

Funding cuts and a hostile political context undermine the role of public health agencies, which subsequently fail to attract talented young people. Public health crises grow worse and more frequent, largely due to climate change. Private sector initiatives produce significant innovations for health and wellness, but these primarily benefit the middle-class and affluent groups. Technological, economic, educational, and health disparities grow, and the institutions of public health have little capacity for doing anything about them.

Scenario 3: Sea Change for Health Equity

National and local economies gradually grow, and changes in values and demographics lead to “common sense” policies and support for health equity. Public health agencies develop into health development agencies that use advanced analytics, gamification, and diverse partnerships to identify problems and opportunities, and catalyze and incentivize action to improve community health. While some disparities persist, in 2030 the vast majority of U.S. residents have attained greater opportunity for good health through quality improvements in housing, economic opportunity, education, and other social determinants of health.

Scenario 4: Community-Driven Health and Equity

Public health agencies, partners, and local health improvement initiatives coalesce via technology and social media into a national web of community-health enhancing networks. These networks help communities exchange their innovations and best practices, and leverage the expertise of public health agencies and others. The nation also strives to come to terms with its racial and socioeconomic histories, and supports real changes and legislation to create a more equitable society. This value shift to equity is accelerated by the proliferation of new community economic models that help households sustain themselves and improve health and well-being. Public health sheds many functions and facilitates these movements to improved health.

Source: Institute for Alternative Futures. Public Health 2030: A Scenario Exploration. Alexandria, VA. May 2014. Available from www.altfutures.org/pubs/PH2030/IAF-PublicHealth2030Scenarios.pdf.

Exhibit 2.9 Public Health 2030: A Scenario Exploration

ESSENTIALS FOR A STRATEGIC THINKER 2–5

What Is Public Health in the United States?



The work of public health developed over time in response to community need and is carried out at federal, state, and local levels. In 1988, after an intense study of public health in six states, the Institute of Medicine defined the basic functions of public health as assessment, policy development, and assurance. The Centers for Disease Control and Prevention (CDC) proposed organizational practices to implement the three core functions. In spring 1994, a national working group comprised of representatives of the Public Health Services Agencies and the major public health organizations developed a consensus list of the “essential services of public health.” The new statement on essential services provided a vision for public health in America – “Healthy People in Healthy Communities” – and stated the mission of public health – “Promote physical and mental health and prevent disease, injury, and disability.” The statement described what public health seeks to accomplish in providing essential services to the public and how it carries out these basic public responsibilities.

THE ESSENTIAL SERVICES

The fundamental obligation or purpose of public health agencies responsible for population-based health is to:

- Prevent epidemics and the spread of disease.
- Protect against environmental hazards.
- Prevent injuries.
- Promote and encourage healthy behaviors and mental health.
- Respond to disasters and assist communities in recovery.
- Assure the quality and accessibility of health services.

Part of the function of public health is to assure the availability of quality health services. Both distinct from and encompassing clinical services, public health’s role is to ensure the conditions necessary for people to live healthy lives, through community-wide prevention and protection programs.

Public health serves communities (and individuals within them) by

providing an array of essential services. Many of these services are invisible to the public. Typically, the public only becomes aware of the need for public health services when a problem develops (for instance, when an epidemic occurs). The practice of public health is articulated through the list of “essential services.”

ASSESSMENT SERVICES INCLUDE

- Monitoring health status to identify community health problems.
- Diagnosing and investigating health problems and hazards in the community.
- Researching for new insights and innovative solutions to health problems.

POLICY DEVELOPMENT SERVICES INCLUDE

- Informing, educating, and empowering people about health issues.
- Mobilizing community partnerships and actions to identify and solve health problems.
- Developing policies and plans that support individual and community health efforts.

ASSURANCE SERVICES INCLUDE

- Enforcing laws and regulations that protect health and ensure safety.
- Linking people to needed personal health services and ensuring the provision of health care when otherwise unavailable.
- Assuring a competent public and personal health care workforce.
- Evaluating effectiveness, accessibility, and quality of personal and population-based health services.

Source: Ray M. Nicola, MD, MHSA, FACPM, Senior CDC Consultant to the Turning Point National Program Office.

Select the Strategic Thinking Framework

The purpose of analyzing the general environment, the health care system, and the service area is to identify and understand the significant shifts taking place. [Exhibit 2-10](#) summarizes the primary focus, advantages, and disadvantages of each strategic thinking framework.

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

	Assessing	• Management/expert interaction. • New viewpoints.	- participate. • No specific structure for reaching conclusions. • Multiple focus groups needed to gain insight.
Dialectic Inquiry	Forecasting Assessing	• Surfaces many sub-issues and factors. • Conclusions are reached on issues. • Based on analysis.	• Does not provide a set of procedures for deciding what is important. • Considers only a single issue at a time. • Time consuming.
Stakeholder Analysis	Scanning Monitoring	• Considers major independent groups and individuals. • Ensures major needs and wants of outside organizations are taken into account.	• Emerging issues generated by other organizations may not be considered. • Does not consider the broader issues of the general environment.
Scenario Writing	Forecasting Assessing	• Portrays alternative futures. • Considers interrelated external variables. • Gives a complete picture of the future. • Focus is on what might be.	• Requires generous assumptions. • Always a question as to what to include. • Difficult to write.

Exhibit 2.10 Primary Focus, Advantages, and Disadvantages of External Analysis Techniques

The approach selected for evaluating the general environment, health care system, and service area will depend on such factors as the size of the organization, the diversity of the products and services, and the complexity and size of the markets (service areas). Organizations that are relatively small, do not have a great deal of diversity, and have well-defined service areas may opt for a simple strategic thinking framework that may be carried out in-house, such

as trend identification and extrapolation, in-house nominal group technique or brainstorming, or stakeholder analysis. Such organizations may include independent hospitals, HMOs, rural and community hospitals, large group practices, long-term care facilities, hospices, and county public health departments.

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

Step 6: Complete an Issue Map

[Exhibit 2-11](#) shows the abbreviated results of a general environment, health care system, and service area external analysis with the issues categorized as economic, social/demographic, legislative/political, technological, and competitive.

Issue Categories	General Environment – United States	Health Care System – United States	Service Area Charlotte, NC
Economic	• Economy experiencing slow overall growth. • Decrease in regulations of businesses and financial institutions. • Emphasis on keeping jobs in the United States. • Economic fallout of Brexit.	• Continued growth in the industry. • Procedure costs falling, total spending is rising. • Many employers unwilling to shoulder costs for health care. • Over 27.3 million Americans still without health insurance. • Provisions of the Affordable Care Act have resulted in an	• After 9.6 percent unemployed during the recession Charlotte back to its norm of a 4.5 percent • The focus banking has been broadened include e and analy technolog

	• Likely changes in corporate/individual tax policy.	estimated 20 million people gaining health insurance coverage.	• Cost of living 96.2 percent the national average. • Top city for entrepreneurs
Social/Demographic	• By 2020, the U.S. population over the age of 65 is expected to increase from 47.5 million to 53.7 million or approximately 20 percent of the U.S. population. • Hispanics are the largest minority population representing about 18 percent of the U.S. population by 2050. • Rising social unrest/protests. • The U.S. population is becoming more ethnically diverse; the trend continues.	• An aging population and increased average life span will place capacity burdens on some health care organizations while a lessening of demand threatens the survival of others.	• Charlotte 17th largest city in the United States with a growing population (842,051 in 2017); 2.4 million in area. • The city is diverse: African American (percent), Hispanics (percent). • More than percent increase in population in the last five years. • Year-round outdoor activities. • Sports (professional and college) are supported. • Philanthropic support for arts, education
Legislative/Political	• Changes to the Patient Protection and Affordable Care Act	• Passage of the ACA generally supported by the Supreme Court (only the	• NC rejects Medicaid expansion under ACA

	Act (ACA). • General deregulation occurring, e.g. environmental. • Moves to stop corporate inversion (moving funds to foreign countries). • United States moves more to the right politically. • New concerns on immigration.	mandate/penalty for Medicaid was disallowed, resulting in the right of states to opt out of that requirement). • Employer-based insurance may diminish as the penalties to be paid under ACA are less than the cost of health insurance.	• HB2 limit LGBT rights partially repealed : 18 month • NC is conservative Charlotte not. • Charlotte sanctuary for immigrants (cities/counties in the United States that chose not partner with the federal government to enforce immigration laws).
Technological	• Virtual reality. • Increasing use of automation. • Increasing number of on-demand services. • Robotics applications continue to be developed. • Big Data and Analytics increasingly being used. • Increased application of 3-D printer technology. • Increased applications of artificial	• Electronic health records will supply copious amounts of data and many will struggle to utilize the information to improve the quality of care; will be used to determine payments for hospitals and physicians. • Significant advances in medical information, such as automation of basic business processes, clinical information interfaces, data analysis, and telehealth. • New technologies	• FinTech (financial services technology) growing but on need for security in banking. • Energy sector research, especially and alternative • Google Fiber and AT&T verse High Speed internet connectivity • Adoption of electronic health records (EHRs) is widespread

	intelligence (AI).	emerging in drug design, imaging, minimally invasive surgery, genetic mapping and testing, gene therapy, vaccines, artificial blood, and xenotransplantation (transplantation of tissues and organs from animals into humans).	MD office urgent care hospitals. • Telemedicine and other remote care medicine growing.
Competitive	• Global competition – threat of “trade wars.” • Increasing importance of market niche strategies and services marketing. • Increasing emphasis on adaptability. • Increasing concerns for data security (avoiding hackers) for businesses.	• The disintegration of some health care networks. In some markets this significantly reduced the options available to patients insured under the ACA. • A changing role for public health is expected, moving back to “core” activities (prevention, surveillance, disease control, assurance). • Nurses, the largest segment of the health care workforce will be in short supply – 1.2 million vacancies will emerge for RNs between 2014–2022.	• Two major hospitals purchased many physician practices not many dermatologists or plastic surgeons) during the recession • Fewer health insurance companies the state; coverage dominated by Blue Cross Blue Shield

Exhibit 2.11 Example of a Completed Issue Map

Strategic Momentum: Validating the Strategic Assumptions

A strategic plan is based in part on an external analysis. Initially this analysis provides the basic beliefs or assumptions that management holds concerning various external trends, issues, and events. Once strategic management is adopted as the operating philosophy of managing, strategic thinking, strategic planning, and strategic momentum require frequent validation of the strategic assumptions to determine whether external issues have changed and to what extent. Continued strategic thinking is vital to maintaining strategic momentum.

The strategic thinking map presented in [Exhibit 2-12](#) provides a series of questions designed to detect signals of new perspectives regarding these assumptions. The questions examine management's understanding of the external situation and the effectiveness of the strategy. The board of directors, strategic managers, or others may use these questions as a beginning point to confirm the assumptions underlying the strategy. Such strategic thinking questions may indicate the emergence of new external opportunities or threats that will affect the organization and may suggest areas where additional information will be required in future planning efforts. Current, accurate information may mean survival for many health care organizations. Questions concerning the external situation may reveal that a group practice knows far too little about the views of its major constituents (stakeholders) or the existence of new technologies or social trends. A validation (or invalidation) of the strategic assumptions reinvigorates strategic thinking and provides a basis for investigating whether to change the strategy.

1. Has the organization's performance been adversely affected by unexpected or new general environment trends or issues?
2. Has the organization's performance been adversely affected by unexpected or new trends or issues in the health care system?
3. Has the organization's performance been adversely affected by unexpected or new trends or issues in the service area?
4. Have new opportunities emerged as a result of new external trends, issues, or events?
5. Is the strategy acceptable to the major stakeholders?
6. Are there new technological developments that will affect the organization?
7. Have there been social or demographic changes that affect the market or strategy? Changes in ethnic mix? Language barriers? Family structure?
8. Has the legislative/political environment changed?
9. Are there new local, state, or federal regulations or laws being introduced, debated, or passed that will affect operations or performance?

0. Are there new economic issues?
11. Have new competitors outside the industry considered entering – or actually entered – into health-related areas?
2. Is the strategy subject to government response?
3. Is the strategy in conformance with the society's moral and ethical codes of conduct?

Exhibit 2.12 Strategic Thinking Questions for Validation of the Strategic Assumptions

Chapter Summary

Health care managers must be able to understand and analyze the general environment, the health care system, and their service area to be effectively positioned. The goal of external analysis is to classify and organize issues and changes generated outside the organization. In the process, the organization attempts to detect and analyze current, emerging, and likely future issues. The gathered information is used for internal analysis; development of the vision and mission; and formulation of the strategy for the organization. In addition, the process should foster strategic thinking throughout the organization.

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

The steps in external analysis include organizing the process, active scanning to identify signals of change, monitoring and confirming identified issues, forecasting the future direction of issues, and assessing organizational implications. External changes that may be important to health care organizations are generated by organizations and individuals in the general environment (government institutions and agencies, business firms, educational institutions, research organizations and foundations, individuals and consumers); organizations and individuals in the health care system (organizations that regulate, primary providers, secondary providers, organizations that represent providers; and individuals and patients); and competitors and local organizations in the service area. Typically, such change is classified as economic, social/demographic, legislative/political, technological, or competitive. Such a classification system aids in aggregating information concerning the issues and in determining their impact.

People, organizations, databases, and publications both outside and inside the organization serve as external information sources. There are a variety of experts who are familiar with external issues; in addition, many organizations collect patient and consumer information, and subscribe to and archive industry, technical reports, and databases. Further, patients, physicians, nurses, suppliers, third-party payers, pharmaceutical representatives, and managed care companies as well as newspapers and journals, the internet, television, libraries, and public and private databases may be important information sources.

Scanning is the process of viewing and organizing external information in an attempt to detect relevant issues that will affect the organization. Monitoring is the process of searching for additional information to confirm or disprove the issue (trend, development, dilemma, or likelihood of the occurrence of an event). Forecasting is the process of extending issues, identifying their interrelationships, and developing alternative projections. Finally, assessing is the process of evaluating the significance of the issues.

There are several strategic thinking frameworks to conduct the scanning, monitoring, forecasting, and assessing processes. These methods include issue impact and probability prioritization, solicitation of expert opinion, dialectic inquiry, stakeholder analysis, and scenario writing. The information garnered from external analysis may be documented in an issue map and serves as a foundation for competitor analysis, internal analysis, the development of the vision and mission, and formulation of the strategy for the organization. Finally, as part of managing the strategic momentum, evaluation of the strategic assumptions (external issues) should periodically take place. The next chapter focuses on service area competitive analysis.

Practical Lessons for Health Care Strategic Thinkers

1. External analysis is one of the most important steps in developing a strategic plan and provides an understanding of the context in which the organization has to be successful.
2. Strategic thinking – awareness, anticipation, analysis, interpretation, synthesis, and reflection – is key in external analysis. Awareness and anticipation help identify issues, trends, and events; analysis and interpretation infuse meaning and consequences; and synthesis and reflection provide conclusions that serve to build a strategic plan.
3. External analysis is an ongoing process and requires organization. Using a systems perspective to focus strategic thinking can help in identifying and tracking important external trends, issues, and events that will impact the organization.
4. External analysis tools and techniques provide no answers in themselves; but rather they are processes that help strategic managers identify and think through issues and reach conclusions.
5. The issue map provides a foundation for the analysis of competitors in the service area.

THE LANGUAGE OF STRATEGIC MANAGEMENT: KEY TERMS AND CONCEPTS

Assessing
Brainstorming
Community
Delphi Method
Dialectic Inquiry
Expert Opinion
External Analysis
Focus Groups
Forecasting
General Environment
Gray Rhinos
Inevitable Surprise
Issue Impact and Probability Prioritization
Issue Map
Medicaid
Medicare
Monitoring
Nested Systems
Nominal Group Technique (NGT)
Predictable Surprise
Primary Providers
Scanning
Scenarios
Secondary Providers
Sensemaking
Service Area
Service Category
Stakeholder Analysis
Stakeholders

Strategic Awareness
Strategic Issues

Questions for Class Discussion

1. What types of changes are likely to occur in the health care system in the next several years?
2. Describe the “setting” for health care management. Is the setting too complex or changing too rapidly to accurately predict future conditions?
3. Why is external analysis important for an organization?
4. What are the specific goals of external analysis?
5. What are the limitations of external analysis? Given these limitations, is external analysis worth the effort required? Why?
6. What processes are involved in external analysis? What are their subprocesses?
7. Why must the service categories be specified first in service area analysis for health care organizations?
8. Why is it important to clearly define the service area?
9. How does the scanning process create a “window” to the external systems? How does the window concept help in understanding organizations and the types of information they produce?
10. Why is the process of external analysis as important as the product?
11. Which of the external analysis strategic thinking frameworks are most useful? Why?
12. Using [Exhibit 2-7](#) as an example, develop a “stakeholder map” for a health care organization in your metropolitan area or state. On this map show the important health care organizations and indicate what impact they may have on the industry.
13. Which of the scenarios in [Exhibit 2-8](#) do you think is most likely? Why?
14. What is an issue map? How is it helpful for strategic thinking?
15. What are an organization’s strategic assumptions? How may the strategic assumptions be evaluated as part of managing strategic momentum?

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Chapter 3

Service Area Competitor Analysis

“Your most dangerous competitors are those most like you.”

—BRUCE D. HENDERSON, AMERICAN ENTREPRENEUR AND FOUNDER OF THE BOSTON CONSULTING GROUP (BCG)

Why Service Area Competitor Analysis Is Important

As Bruce Henderson concluded, not all organizations competing in the same broad market are necessarily direct competitors; however, organizations with the same or similar strengths serving a particular market will be rivals – the more similar they are, the greater the rivalry. Diverse competitors may all do well in a single market by focusing on different market dimensions.

Organizations that compete in several different markets may find that their competitors in one market are completely different from those in another market.

The amount of competition varies from market to market as well. Service area competitor analysis helps strategic managers structure their thinking to determine on what market dimensions they desire to compete, the specific organizations that are most like their own organization in a market segment, and what other products or services may be seen as effective replacements or substitutes for a given product or service. Identifying direct competitors and understanding the nature of the market itself is essential.

In some markets, competition is quite genteel, whereas in others competition is quite fierce. Understanding why competitive intensity in markets varies and what makes a market attractive is profoundly important for strategic managers. Organizational strategy is drawn to attractive markets.

Strategic thinking and structured processes for service area competitor analysis work together to help strategic managers accurately assess their markets (service areas) for their product or service, the nature of the competition, and the attractiveness of the market. Further, strategic thinking and its disciplined processes can determine the specific organizations that compete with each other in a given market. The strategy developed by most organizations rests on this analysis.

Use the concepts in this chapter to assess and understand competitors and markets!

Learning Objectives

After completing the chapter you will be able to:

1. Describe the process of service area competitor analysis. Why is it important?
2. Examine the relationship between the general environment, the health care system, and service area for identification of issues and competitors.
3. Explain the importance of a service area structure analysis for a health care organization.
4. Develop critical factors for success for a product or service in a service

area.

5. Identify strategic groups and map competitors' strategies along important service and market dimensions.
6. Assess likely competitor strategic responses.
7. Synthesize a service area competitor analysis into some strategic conclusions.
8. Validate strategic assumptions to reinitiate strategic thinking concerning the service area and competitors.

Strategic Management Competency

After completing this chapter you will be able to conduct a comprehensive service area competitor analysis for a health care organization.

Further Focus within External Analysis

External analysis involves strategic thinking and strategic planning, focusing on increasingly more specific issues. Chapter 2 provided the fundamental approach and strategic thinking frameworks for organizing, scanning, monitoring, forecasting, assessing, and mapping issues and trends in the general environment, health care system, and service area. Once these trends and issues have been identified and mapped, a more focused competitor analysis is required. A *service area competitor analysis* is a more specific process to understand the nature of competition, evaluate competitors, identify critical success factors, and anticipate competitors' strategic moves in a defined geographic area (neighborhood, city, state, United States, or in the world). Along with the economic, social/demographic, legislative/political, technological, and competitive issues assessed in the general environment, health care system and service area, the service area competitor analysis will provide an understanding of the competitive context in which the strategy of the organization will have to be successful.

Clearly a new competitive marketplace is emerging in the health care system and competition is expected to increase over the next decade. As reimbursement incentives move to delivering value, outcomes data become more transparent, and consumers are asked to pay a greater portion of their health care costs, health care organizations will have to develop new, more competitive care-delivery models.¹ Health care organizations that attempt to avoid competing or deny industry changes currently underway will find their patients moving to other providers. Therefore, within the health care community there is an understanding that health care organizations must be positioned effectively *vis-à-vis* their competitors. Competitor information is essential for selecting viable strategies that successfully position the organization in the market. Many health care managers agree that an organized competitor intelligence system is necessary for survival. The system acts like a radar grid constantly monitoring consumer and competitor activity, filtering the raw information picked up by external and internal sources, processing it for strategic significance, and efficiently communicating intelligence to those who need it.²

A Process for Service Area Competitor Analysis

Service area competitor analysis is a process of understanding the market and identifying and evaluating competitors within that market. Together with the results of the general environment, health care system, and service area trends and issues, service area competition will be analyzed and the results synthesized into the strategic issues facing the organization. The synthesis is an explicit input into the formulation of the organization's strategy. Not every potential competitor in a service area is of concern because of targeting differences, positioning differences, quality differences, pricing differences, and so on. The process for service area competitor analysis is illustrated in the strategic thinking map in [Exhibit 3-1](#). The conclusions will provide crucial information for strategy formulation.

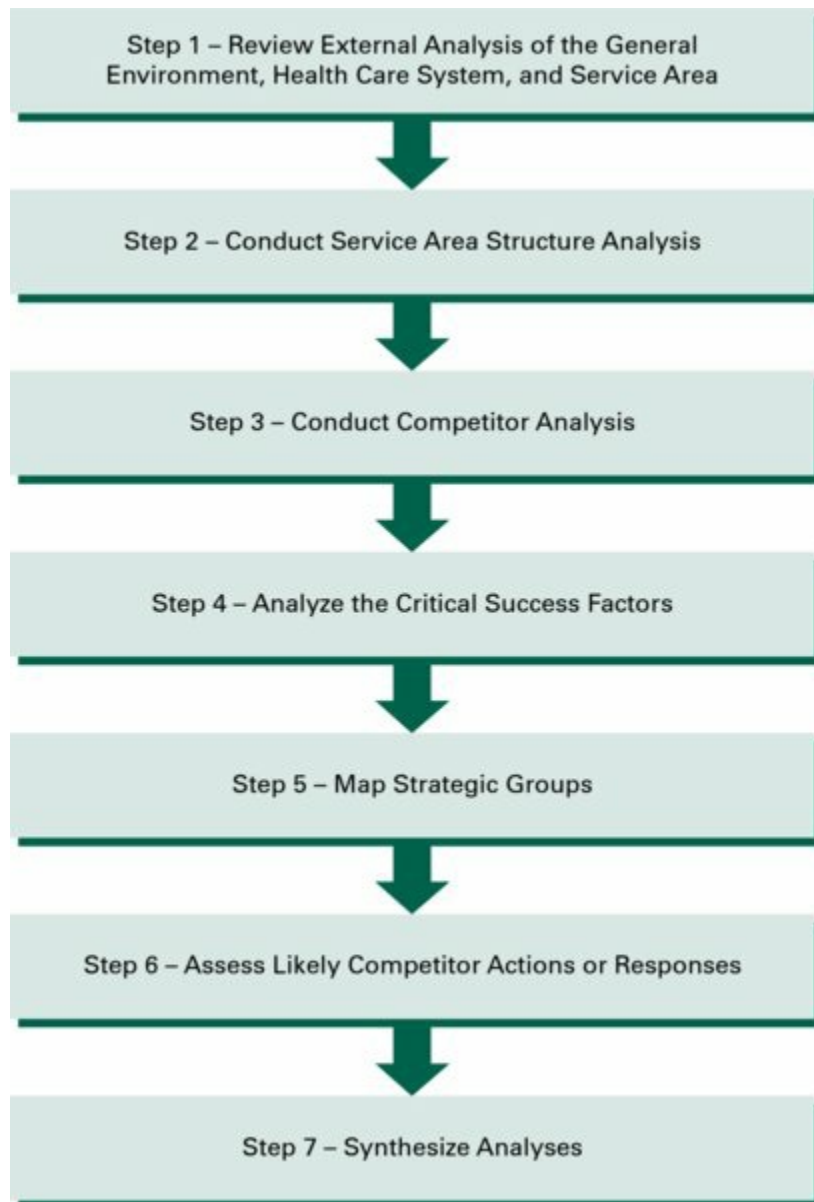


Exhibit 3.1 Process for Service Area Competitor Analysis

An Application of Service Area Competitor Analysis

By employing an actual service category (plastic surgery) and service area (Charlotte, North Carolina), each step of the service area competitor analysis process will be illustrated. First, the general required actions of each step of the service area competitor analysis process will be examined and then the application of the actions for each of the steps will be demonstrated.

As an overview of the service category and service area, plastic surgery represents a highly competitive and low market share industry, especially for cosmetic procedures that are rarely covered by health insurance. Reconstructive plastic surgery (required because of accidents and disfigurements, birth defects, ravages of disease, and so on) is often covered by insurance; however, reimbursement rates have been declining. Typically, a number of board-certified plastic surgeons have offices in any given service area. These physicians compete not only among themselves; but also against emergent niche providers who are often board certified in a specialty other than plastic surgery – physicians in ophthalmology (eye), dermatology (skin), EENT (eye, ear, nose, and throat), dental (teeth and jaw), and OB/GYN (women's reproductive system). In addition, laser centers and medi-spas are competition, seeking to capture the lucrative and less invasive sectors of the cosmetic plastic surgery market such as Botox®, injectables, laser peels, cool sculpting, and so on. For an overview of the plastic surgery service category see Essentials for a Strategic Thinker 3–1, “What Is the Plastic Surgery Service Category?”

ESSENTIALS FOR A STRATEGIC THINKER 3–1

What Is the Plastic Surgery Service Category?



Plastic surgery is a medical specialty with two major subspecialties: cosmetic plastic surgery and reconstructive plastic surgery. A simple definition of cosmetic plastic surgery is that it involves procedures to modify a person's natural appearance and is generally (medically) non-essential. Reconstructive plastic surgery may be performed to lessen the physical signs of an accident, disease, or congenital defect, and may be necessary to sustain or improve health. Although cosmetic procedures are not covered by insurance, most reconstructive procedures are. In many states, legislation requires insurance companies to provide coverage for reconstructive plastic surgery for congenital (birth) defects and breast reconstruction after mastectomies.

To become a plastic surgeon, one must earn an MD (Medical Doctor) degree from an accredited medical school or college, of which there are 126 in the United States. Most plastic surgeons have residency and fellowships before

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

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

Plastic surgeons often establish solo practices. Other arrangements include solo practices that share facilities, small group practices (with 2–5 physicians), medium multispecialty group practices (6–20 physicians), and large multispecialty group practices (more than 20 physicians). In addition, plastic surgeons may work in military and academic facilities (with and without private practice).

The majority of plastic surgeons do not offer “spa” services (e.g. wraps, facials, massages) in conjunction with their medical practices. Further, most of these doctors do not work in conjunction with medical spas where non-surgical procedures, such as injections and laser procedures, are performed. Plastic surgeons generally consider medical spas to be less professional and potentially dangerous if someone other than the surgeon is performing procedures.

According to the American Society of Plastic Surgeons, the top five reconstructive procedures are tumor removal, laceration repair, maxillofacial surgery, scar revision, and hand surgery. The top five cosmetic plastic surgical procedures are breast augmentation, lipoplasty (liposuction), rhinoplasty (nose reshaping), blepharoplasty (cosmetic eyelid surgery), and rhytidectomy (facelift). The top five cosmetic minimally invasive procedures are Botulinum Toxin Type A (Botox®), soft tissue fillers, chemical peels, laser hair removal, and microdermabrasion.

Sources: ASPS and ASAPS websites; Association for American Medical Colleges website. Accessed March 2017.

If a plastic surgeon were to consider establishing a practice in Charlotte, North Carolina, the completion of a service area competitor analysis would be essential to evaluate whether the area represents a potentially profitable location. Cosmetic plastic surgery requires a reputation for excellent work that takes some time to establish; selecting the wrong service area could force relocation,

causing the surgeon to begin anew in establishing a reputation. Similarly, established competitors should periodically re-evaluate the competition in their service area as a part of maintaining an effective strategy. In addition, any new entrant to the service area should trigger service area competitor analysis.

Plastic surgery can be defined as a service category as it is recognized as a board-certified specialty within medicine; however, there are additional service categories that need to be explored to determine direct and indirect competitors for a given practice. For instance, plastic surgeons may offer a full range of services or they may specialize on the face (such as congenital deformities and injuries due to trauma) or they may focus on cosmetic procedures for purely aesthetic reasons. Eye, ear, nose, and throat physicians as well as oral surgeons perform some of the same procedures. Furthermore, plastic surgeons may specialize on the basis of procedures they use, such as laser or liposuction. As they often deal with skin, dermatologists may become competitors, especially in terms of the less invasive procedures such as Botox® injections that may be administered by any physician and in many instances by nurses (RNs) with physician supervision. Thus, the service category is important to identify and understand because it affects the service area as well.

The general service area for the plastic surgery example is Charlotte, North Carolina. Charlotte is the largest city within North Carolina and resides on the border with South Carolina. Charlotte (also known as the Queen City as it was named after King George III's wife, Sophia Charlotte, who was born in Mecklenburg, Germany) has grown to be a major city with the fifth busiest airport in North America by total aircraft movement and eighth busiest in North America by total passengers in 2017. Charlotte's population is younger, upwardly mobile, educated, and relatively affluent – and it is one of the fastest growing cities in the United States. Little need exists to travel outside the city for medical or health care services. The city is sufficiently large with 842,051 in population such that the people in the seven-county, nearly 2.5 million surrounding metropolitan area are pulled to Charlotte for medical and health care, including plastic surgery. In 2017, the number of active, board-certified plastic surgeons practicing in the Charlotte metropolitan area was 37 (an increase of nine compared to the 28 practicing five years ago; two retirements and two surgeons leaving the area resulted in a net gain of nine board-certified plastic surgeons).³

Step 1: Review of External Analysis

The results of the general environment, health care system, and services area external analysis, as covered in Chapter 2, provide the foundation for the service area competitor analysis. The issues, trends, and events identified in external analysis represent the context in which the organization must operate to be successful. Results of the external analysis were then documented in an external issue map (Exhibit 2–5). Review of the issue map is critical and will guide decisions made in service area competitor analysis.

Step 1: Review of External Analysis – Plastic Surgery in Charlotte, NC

The example of a completed external analysis issue map conducted for the general environment, health care system, and the Charlotte, North Carolina service area was presented in Chapter 2, Exhibit 2–11 and provides the context for the service area competitor analysis in this chapter. The health care system analysis indicates turmoil. The Patient Protection and Affordable Care Act (often referred to as Obama Care) was enacted in 2010; however, most aspects of that law were not effective until 2014 (or later as some parts were “delayed”). No doubt further legislative changes will be forthcoming under President Trump’s administration as legislators weigh costs, coverage, access, as well as impacts on private and government health insurance and health care providers.

Key points from the service area analysis affecting plastic surgery: (1) the population of Charlotte is growing (from 730,000 in 2012 to over 840,000 in 2017) and the city is now the 17th largest in the United States; (2) unemployment is down considerably from 2012 (9.6 percent) to a more normal-for-Charlotte unemployment rate of 4.5 percent; (3) cost of living remains low at 96.2 percent of the national average; (4) diversity has increased, especially from Hispanics; (5) millennials moving to the city increased by 30 percent; and (6) the recession began later in Charlotte and lasted longer (well into 2012) but in 2017 the city had recovered.

Step 2: Conduct Service Area Structural Analysis

Harvard’s Michael E. Porter developed a “Five Forces” framework for external analysis through an examination of the competitive nature of the industry. Porter’s framework has been applied to a variety of industries; however, because of the nature of competition in health care, it is more appropriate to apply the framework more narrowly to the service category/service area. The use of Porter’s Five Forces in health care can be referred to as service area structural analysis. A *service area structural analysis* assesses the attractiveness of an identified geographic region for a product/service category. Service area structural analysis provides considerable insight into the attractiveness of a service category in a service area and its competitive dynamics.

Porter suggested that the level of competitive intensity within an industry is the most critical factor in an organization’s environment. In Porter’s model, intensity is a function of the threat of new entrants to the market, the level of rivalry among existing organizations, the threat of substitute products and services, the bargaining power of buyers (customers), and the bargaining power of suppliers.⁴ The strength and impact of these five forces must be carefully monitored and evaluated to determine the viability of the service category and may be used to assess the changes likely to occur in the future. As illustrated in [Exhibit 3-2](#), Porter’s industry structural analysis can be adapted to service areas to understand the competitive forces for health care organizations.

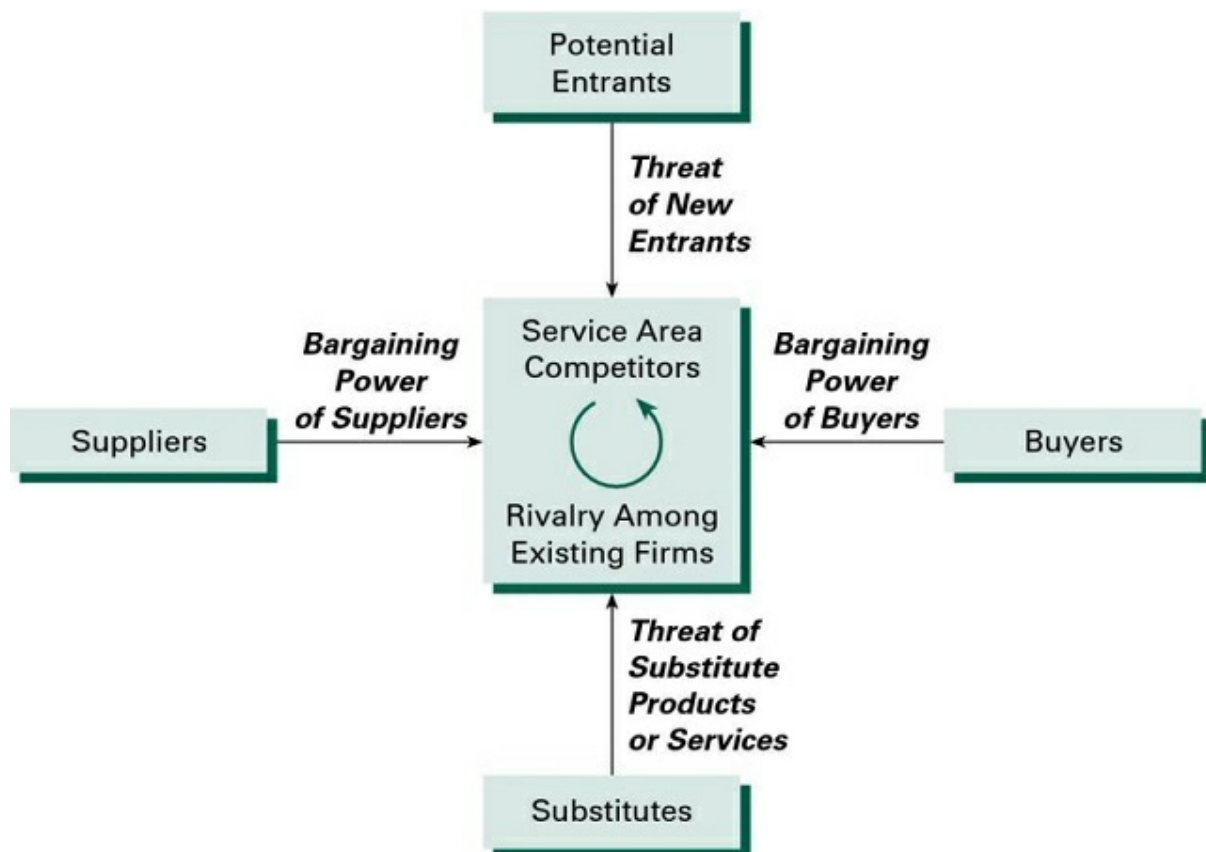


Exhibit 3.2 Service Area Structural Analysis: Forces Driving Service Area Competition

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

Threat of New Entrants

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

- Existing organizations' economies of scale – cost advantages made possible by increased volume.
- Existing product or service differentiation.
- Capital requirements needed to compete.
- Switching costs – the one-time economic, logistic, and emotional costs for consumers in selecting and adopting an alternative product/service over their present product/service.

- Access to distribution channels.
- Cost advantages (independent of scale) of established competitors.
- Government and legal constraints.

These barriers should be assessed to determine the current or expected level of competition within an industry or service area. In health care markets, the barriers to entry for new “players” may be substantial. Consolidation (creation of large health care systems) and system integration (the level of control by physicians and insurers) may make entry into a particular service area difficult because existing organizations have built economies of scale and cost advantages making it difficult for a newcomer. In an effort to create cost efficiencies, managed care has had the effect of limiting the ease of market entry. In areas where managed care penetration is high, market entry by new competitors will be more difficult because switching costs for some populations are prohibitive. However, the difficulty of adding new service categories for existing organizations in an established managed care market may be lessened; such service categories may be added to better serve a captured (managed care) market.

Certificate of Need (CON) laws and regulations, for example, can present significant barriers to entry for providers (see Essentials for a Strategic Thinker 3–2, “What Is CON?”). CON laws are the reason some specialty hospitals in cardiology and orthopedics were built in states in the southwestern United States and the Midwest, where there were no CON barriers or the CON laws were much less restrictive than other areas of the nation.

ESSENTIALS FOR A STRATEGIC THINKER 3–2

What Is CON?



Certificate of Need (CON) legislation encompasses federal/state authorizations to acquire, expand, or create facilities and is used to regulate supply of services relative to demand by eliminating overspending or limiting (protecting) access. As of 2017, 36 states retain some type of certificate of need (CON) program, law, or agency. CON programs originated to regulate the number of beds in hospitals and nursing homes and to prevent overbuying of expensive equipment. In 1964, New York became the first state to enact a statute granting the state government power to determine whether there was a need for a new hospital or nursing home before it was approved for construction. In 1972, an amendment to the Public Health Service Act included withholding of Medicare and Medicaid funds for facilities and projects – which in effect became the first CON legislation, although a version was incorporated into the Hill-Burton Act (1946) that provided federal funds for new hospital construction completed through state planning and evaluation. The National Health

Planning and Resources Development Act in 1974 strengthened CON regulations by requiring all 50 states to implement such regulations to receive funds through the federal government; however, sanctions from this law were not imposed.

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

In 1986, Congress repealed the mandate requiring states to have CON programs, along with elimination of the federal funding for the program. In 2017, California, Colorado, Idaho, Indiana, Kansas, Michigan, New Hampshire, New Mexico, North Dakota, Pennsylvania, South Dakota, Texas, Utah, and Wyoming (14 states) have no CON requirements; three other states (Arizona, Minnesota, and Wisconsin) have CON-like state-developed requirements; and the other states maintain CONs for various types of facilities (building a new hospital or adding beds to a nursing home) and dollar amounts for technology (a physician’s office request for a second MRI machine). Although the CON process across states is similar, no two states are exactly alike, and the scope of regulation varies a great deal by state. Some states require providers to document the community need for all regulated services regardless of cost, whereas others do not require CON approval for any project under certain cost thresholds; however, the capital expenditure thresholds range from hundreds of thousands to millions of dollars. Recently, Florida (2017) and Maine (2013) have attempted repeal of CON laws. Maine was unsuccessful and Florida had to remove nursing homes and hospices, but has maintained its charge to avoid CONs in hospitals for the state.

CON regulations attempt to protect access to safety net hospitals in urban areas and access to care in rural areas, either by requiring the provision of a specified amount of charity care or by having applicants address the potential impact of the CON on charity care. Enforcement is challenging because penalties for not meeting the standard are frequently not included; however, in a few states an organization’s failure to meet its charity care commitment requires the organization to pay the difference to the state (a sort of tax on the organization that does not provide enough charity care).

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

CONs have been used as a way for organizations to claim territory. Such situations are typically contentious and require a significant amount of time to resolve and finalize. Applications can be challenged at various stages, and decisions can be overturned by hearing officers, courts, or sometimes state legislatures. CON boards generally include appointed state officials, physicians, hospital representatives, and other stakeholders. The substantial scrutiny, coupled with a lack of enforcement power to uphold decisions, has made the role of CON boards increasingly challenging.

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

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

SUGGESTED READING

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Lisa Schencker, “State Certificate of Need Laws Weather Persistent Attacks,” *Modern Healthcare* (January 23, 2016), pp. 14–15.

Intensity of Rivalry among Existing Organizations

Organizations within an industry are mutually dependent because the strategy of one organization affects all relevant competitors. Rivalry is the intensity of competition for a product/service category in a service area. Rivalry occurs because competitors attempt to improve their position. Typically, actions by one competitor foster reactions by others. Intense rivalry is the result of the following factors:

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

Often, consolidation has created several balanced large health care systems in a service area. For example, in the Portland, Oregon market, consolidation has resulted in three large integrated systems – a large academic medical center university hospital with a large children’s hospital ranked first in the Portland market and two other systems – Providence and Legacy – all within four miles of each other, resulting in extremely high strategic stakes. For some markets, consolidation has resulted in competition between large for-profit and not-for-profit systems. Additionally, because of managed care, switching costs for consumers are high. Because many markets have supported too many providers in the past, the strategic stakes are great. Most experts agree that further consolidations are likely, rivalry will intensify, and still more providers will not survive.

Threat of Substitute Products and Services

For many products and services various substitutes are available that perform the same function as the established products. Substitute products limit returns to an industry because at some price point consumers will switch to alternative products and services. Usually, the more diverse the industry, the higher the likelihood that there will be substitute products and services. A major substitution taking place in health care has been the switch from inpatient care to outpatient alternatives as well as the use of drugs that keep individuals out of hospitals. In addition, alternative therapies such as chiropractic, massage therapy, acupuncture, biofeedback, and so on are increasingly substituted for traditional health care (see Essentials for a Strategic Thinker 3–3, “What Are Complementary and Alternative Medicine?”).

ESSENTIALS FOR A STRATEGIC THINKER 3-3

What Are Complementary and Alternative Medicine?



Complementary and alternative medicine (CAM) is a group of diverse medical and health care systems, practices, and products used for medical interventions, health promotion, or disease prevention that are generally not considered to be part of conventional medicine nor generally underwritten by health insurance plans.¹ CAM includes acupuncture, herbal medicine, homeopathy, massage, osteopathy, biofeedback, chiropractic, hypnotherapy, meditation, aromatherapy, yoga, tai chi, guided imagery, and naturopathy. CAM systems are characterized by a holistic and highly individualized approach to patient care with an emphasis on using the body's inherent healing ability and involving patients as active participants in their own care.

Integrative medicine incorporates elements of CAM with traditional western medicine and over time some CAM therapies have become mainstream. Integrative medicine provides a new paradigm that incorporates core CAM values in contemporary medicine; however, the extent to which integration occurs depends on the attitudes of physicians.

A national survey of hospitals that offer complementary services found a number of significant barriers for CAM therapies: lack of evidence-based research (39 percent), physician resistance (44 percent), and budgetary constraints (65 percent). In addition, hospitals that are considering use of integrative medicine have a number of legal/liability hurdles to overcome. A hospital's basic duty is to ensure that those who treat patients within its facilities are qualified and competent to do so. Reasonable steps must be taken to control and supervise practitioners by appropriate credentialing. In addition, the hospital has a duty to create a safe environment for patients that includes going to reasonable lengths to allow CAM – at least evidence-based therapies that current evidence indicates could improve patients' health or help manage their symptoms.²

In 1998, Congress expanded the Office of Alternative Medicine (renamed in 1992; previously known as the Office of Unconventional Therapies) by creating the National Center for Complementary and Alternative Medicine (NCCAM). NCCAM was renamed the National Center for Complementary and Integrative Health (NCCIH) in 2015. NCCIH's mission is: "to define, through rigorous scientific investigation, the usefulness and safety of complementary and integrative health interventions and their roles in improving health and health care."³

The NCCIH's strategic plan focuses primarily on researching, advancing, and disseminating information concerning CAM, and the Director,

Josephine P. Briggs M.D., stated concerning the NCCIH 2016 strategic plan:

We remain committed to making investments in research areas that show scientific opportunity and promise, are amenable to rigorous scientific inquiry, foster discovery and innovation, and have an impact on public health and health care. The burden of a disease or chronic condition on people's lives is another important consideration when setting research priorities. Some complementary and integrative health approaches have shown promise for managing some of these conditions and their associated symptoms. Chronic pain will remain an important emphasis. Going forward, the Center will continue to work to build the evidence base on symptom management, including pain, but also depression and anxiety. In addition, we will continue to build our disease prevention research portfolio and focus more on pragmatic clinical trials to test complementary and integrative health interventions in "real world" settings. The evidence base is growing in these areas, and I am eager to explore these research opportunities as we map the path forward.⁴

CAM is expected to increase substantially in the future. More than 70 percent of adults state that they have tried some form of integrative medicine. Involvement in integrative medicine has become so widespread that the Food and Drug Administration has issued guidelines that threaten new, costly regulation of complementary and alternative medicine.

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Bargaining Power of Customers

Buyers of products and services attempt to obtain the lowest price possible while demanding impeccable quality and superior service for health care. If buyers are powerful, then the competitive rivalry will be high. A buyer group is powerful if it:

- Purchases large volumes.
- Concentrates purchases in an industry (service area).

- Purchases products that are standard or undifferentiated.
- Has low switching costs.
- Earns low profits (low profits force lower purchasing costs).
- Poses a threat of backward integration (an organization taking on ownership of its supply chain).
- Has low quality requirements (the quality of the products purchased by the buyer is unimportant to the final product's quality).
- Has enough information to gain bargaining leverage.

Perhaps the greatest change in the nature of the health care system in the past decade has been the growing power of the buyers. Managed care organizations (MCOs) purchase services in large volume and control provider choices. The increasing power of those buyers has fueled system integration as well as blurring of providers and insurers. Large employers as buyers have power because they determine whether the MCO will be on the list that employees have to choose from for their health care.

Bargaining Power of Suppliers

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

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

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

Step 2: Service Area Structural Analysis – Plastic Surgery

Michael Porter’s Five Forces analysis is used to evaluate the viability of cosmetic plastic surgery within the Charlotte service area. Competitive intensity and ultimately the profitability of the service category in the service area is determined by a number of favorable factors. As described in [Exhibit 3-3](#), the Five Forces model suggests that it would be somewhat challenging to enter this market of 37 board-certified plastic surgery practices when these existing competitors face increased competitive pressure. The cosmetic plastic surgery segment will remain competitive because there are few barriers to entry for new competitors (one barrier to entry is high: participants generally have some form of medical or dental degree). However, 76 physicians list plastic surgery as their primary area or a secondary area of practice but only 37 of the 76 physicians (49 percent) practicing plastic surgery in Charlotte are board-certified plastic surgeons. Many of the non-certified doctors have performed plastic surgery for many years and tout their experience, expertise, and great outcomes over “paper credentials.” For the less invasive plastic surgery procedures, such as Botox® and other injectables, face peels, etc., barriers to entry are not very high as they are often administered by RNs under physician supervision.

Five Forces	Forces Driving Service Area Competition	Conclusion
Intensity of Rivalry	Approximately 41 practices with 23 having one or more board-certified plastic surgeons (56 percent of practices board certified in 2017 vs. 45 practices with 24 having at least one board-certified plastic surgeon for 53 percent in 2012) actively advertise that they have physicians who perform procedures or provide products for plastic surgery in the Charlotte, NC area. Diverse competitors – mostly solo and a few small group practices employing distinctly different strategies (also diverse personalities). All strategic competitors are plastic surgeons and members of one of the professional plastic surgery associations: the American Plastic Surgery Association (APSA), the American Cosmetic Plastic Surgery Association, or the American Board of Plastic	High Rivalry is likely to remain intense in this market as the competitors are more numerous relative to the “need” for plastic surgeons, strategic stakes are high, and it is moderately difficult to exit the market (hard to find and establish a practice in a new, better market); establishing referral relationships and credentialing at new hospital(s); some investment in equipment).

	Surgery; however, not all patients know to look for board-certified surgeons. Other competitors are in different specialties: ophthalmology (eye), dermatology (skin), dentistry (oral-maxillofacial surgery), etc. and are willing to perform “plastic surgery” on patients. Still others like to state they are “board eligible,” meaning they have training or experience in plastic surgery but have not passed the boards or have not attempted board certification.	
Threat of New Entrants	Existing providers have established reputations and been in practice in the Charlotte area for a number of years. Experience, artistic ability, “good hands,” and great personality to easily and confidently interact with patients are important in maintaining a successful cosmetic plastic surgery practice. Board certification is a major hurdle; however, many consumers do not understand that when an MD states on his/her website that they are “board certified” it does not necessarily mean that it is in the plastic surgery specialty. Capital requirements are not high. For example, the cost of new equipment that may be used in the office is less than \$50,000; however, used equipment is readily available to purchase or lease. Equipment is generally upgraded before it becomes obsolete to maintain	Medium Threat of new entrants (new plastic surgeons) into the Charlotte market is medium, primarily because of growth in the population and the economy; however, the existing service area already has numerous competitors. To obtain board certification in plastic surgery is a major hurdle to accomplish by the physician; however, consumers’ lack of awareness of the meaning of certification in plastic surgery dilutes it as a hurdle. In Charlotte, 23 practices (37 physicians) are board certified; 18 practices identify “plastic surgery” as their medical specialty using non-board-certified plastic surgeons.

	cutting-edge technology. Most single practices operate on a 3+1 office: one doctor and three staff (operating room nurse, office administrator, office nurse).	
Threat of New Entrants	Many of the procedures are performed in a hospital or surgery center setting that can be used by physicians who are credentialed by that hospital or surgery center (costs are passed on to the patient). Existing service differentiation – perceived differentiation (high image) for high-end providers through referral from “stars” who freely discuss the procedures they have had. Market leaders have a strong market position given their experience and consistency in providing great outcomes.	Financial barriers for setting up an office are low.
Threat of Substitutes	Cosmetics that can enhance appearance at a fraction of the cost. Injectables, face peels, etc. by any MD – internist, general practitioner, primary care physician, or other non-board-certified plastic surgeons. New, strong chins by oral-maxillofacial surgeons. For most patients, cosmetic plastic surgery is elective. Cosmetic plastic surgery is expensive.	High There are a number of low-cost, non-surgical substitutes provided over-the-counter (OTC). Less invasive procedures are considerably less expensive, less painful, less time (to no time) for recovery, and less intimidating.
Bargaining Power of Customers	The elective procedure of cosmetic plastic surgery is rarely covered by insurance and is a cash business, although some credit is offered – using	High Consumers have high bargaining power because of the elective nature of the procedure and its

	MasterCard, VISA, or a medical procedure credit card, CareCredit® which is a subsidiary of GE Capital (has a reputation for aggressive collections and charges 29.5 percent to carry a balance). Consumers can easily defer purchase to a later time – or never – after numerous sessions with a number of surgeons. Patients/consumers have the ability to negotiate the price, but many of them are embarrassed to do so; most physicians are uncomfortable with a negotiation. Patients/consumers may prefer to travel away from Charlotte to keep the procedures confidential; others may travel to exotic destinations where the costs for cosmetic surgery are considerably lower and a vacation “recovery” period is enjoyable. Word-of-mouth referral is very powerful.	out-of-pocket cost. Consumers can opt for a much less expensive substitute, shop price, wait for prices to decline, or forego the procedure. Brazil has an international reputation for excellent outcomes with plastic surgery, offering a more affordable price (including air fare and top-tier hotels for recovery), plus greater confidentiality.
Bargaining Power of Suppliers	A significant number of suppliers of laser, liposuction, etc. equipment compete in the market space. Rent-to-own, purchase, or lease – equipment is essential to the business. Many procedures can be performed in the office or in surgery centers.	Low There are multiple major suppliers of professional-grade equipment for cellulite reduction and more than ten suppliers of laser equipment.

Exhibit 3.3 Service Area Structural Analysis – Plastic Surgery, Charlotte, NC

Competitive rivalry is high as more board-certified plastic surgeons than would be expected are located in Charlotte and are already established in practice in the service area. Given the rule-of-thumb of one plastic surgeon for every 50,000–75,000 in population, Charlotte exceeds the number of plastic surgeons needed (and is considerably over the number when both board-certified and

non-board-certified physicians with practices in this medical specialty are considered). In addition, most of the board-certified physicians in the area have practices that are long established (average: 19 years, 12 physicians have practiced in Charlotte for over 25 years, six physicians have been in the area for five years or less).

Consumers (buyers) wield a great deal of choice power because aesthetic plastic surgery in particular is a cash business (no insurance company to dictate choices, little to no integration of these services in a health care system) and a number of substitutes exist – the most important of which is to choose not to elect any of the procedures. Suppliers of medical devices, such as lasers and cellulite reduction (liposuction) machines, are relatively stable with few new entrants and a number of manufacturers. Lumenis, Sharplight, Syneron-Candela, Cynosure, Alma Lasers, Solta Medical, Hoya Combio, Sciton, and Cutera were the top ten companies manufacturing laser medical devices for plastic surgery. Cellulite reduction (liposuction) machine manufacturers include (in alphabetical order): Alma Lasers, Ambicare, Bruker Corporation, Carl Zeiss Meditec Inc, Cutera Inc, Cynosure/Deka, Ellex Medical, Ellipse A.S., Hamilton Thorne, Invasix, NIKON, Olympus, Sciton, WellsJohnson, and Zeltiq Aesthetics. The power of these suppliers has decreased somewhat because plastic surgeons no longer purchase a line of products from the same company (such as the market leader), rather, they purchase the best product for the processes desired by consumers or the product that the surgeon is most comfortable with or has used the most in training.

Thus, for cosmetic plastic surgery in the Charlotte service area, only one of Porter's Five Forces is favorable (power of suppliers) and four are unfavorable, resulting in thin profit margins and intense competition. In the future, the Five Forces for this service category, in this service area, are not likely to change dramatically. Barriers to entry for new competitors will remain consistent, rivalry will remain high, the consumer will be able to shop on price and defer purchase, and substitutes will likely increase, such as home cellulite reduction machines that are widely available in 2017 (and prices have been falling). At the same time, the reconstructive plastic surgery market overall remains stable and not greatly affected by swings in the economy; however, the cosmetic plastic surgery market is subject to swings in the economy as the consumer pays out-of-pocket for nearly all procedures.

Step 3: Conduct Competitor Analysis

The next step in service area competitor analysis (refer to [Exhibit 3-1](#)) is to evaluate the strengths and weaknesses of competitors. In assessing the rivalry of the service area, the competitors are identified. Next, the strengths and weaknesses of each competitor should be specified and evaluated. Organizations have a unique resource endowment and a comparison with a given competitor will help to illuminate the relationship between them and to predict how they compete with (or respond to) each other in the market.⁵ Evaluation of competitors' strengths and weaknesses provides clues as to their future strategies and to areas where *competitive advantage* might be achieved.

Both quantitative and qualitative information may be used to identify strengths and weaknesses. Competitor information is not always easy to obtain, and it is often necessary to draw conclusions from sketchy information. A list of possible competitor strengths and weaknesses is presented in [Exhibit 3-4](#).

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

Exhibit 3.4 Potential Competitor Strengths and Weaknesses

Relevant information may be obtained through multiple sources such as local newspapers, trade journals, websites, focus groups with customers and stakeholders, consultants who specialize in the industry, securities analysts, or outside health care professionals. Identification of competitor strengths and weaknesses will aid in speculating on competitor strategic moves. The range of possible competitive actions available to organizations varies from tactical moves such as price cuts, promotions, and service improvements that require few resources, to strategic moves, such as service category/area changes, facility expansions, strategic alliances, and new product or service introductions that require more substantial commitments of resources and are more difficult to reverse. Such competitive actions represent clear, offensive challenges that invite competitor responses.⁶ See Essentials for a Strategic Thinker 3–4 “What Is Medical Tourism?”

ESSENTIALS FOR A STRATEGIC THINKER 3–4



What Is Medical Tourism?

Medical tourism is the practice of travelling to a country, other than one's own, for the purpose of obtaining medical treatment. The most common procedures that people undergo on medical tourism trips include cosmetic surgery, dentistry, and heart surgery. The term "medical tourism" is evolving based on increasing specialization and heterogeneity in services, thereby leading to the use of more specific terms such as reproductive tourism, organ transplant tourism, and abortion tourism. It excludes health or wellness tourism, which generally refers to all the non-invasive (external) treatments including visits to spas, homeopathy treatments, or traditional therapies that improve the health or the mind of the patient.¹

In 2017, medical tourism accounted for 11 million people travelling annually (valued at \$100 billion); approximately 4 percent of the world's population travelled internationally for medical care. Along with the United States, the most popular destinations for medical tourism are Canada, United Kingdom, Israel, Singapore, India, Germany, France, South Korea, Italy, and Colombia.

Health care consumers today are motivated to engage in medical tourism because of lower overall costs, high copay insurance plans, high deductible insurance plans, treatments and medications not approved or available in their home country, the availability of higher quality care and services, increased comfort of returning to their home country, or the opportunity for medical treatment combined with an attractive destination. The primary factors driving the cost differential in many medical tourism destinations are lower labor costs, the lack of malpractice insurance costs, and lower pharmaceutical costs. Of course, each of these factors suggests additional risks such as quality of care, counterfeit medications, and security and purity of blood supplies.²

The main risk is quality of care although this risk is being alleviated by the number of global hospitals, centers, and clinics being accredited by the Joint Commission International (JCI). Even though hospitals may be accredited by the JCI, other critical activities such as clinical analysis laboratories, radiology centers/departments, medical imaging and interpretation, plus the differences in malpractice laws and lack of post-operative follow-up care may cause problems.

With medical tourism expected to grow at 25 percent per year, there are implications for defining service areas and identifying competitors. Clearly the service area boundaries for categories such as gall bladder surgery, orthopedic surgery – such as full hip replacement surgery – and numerous other procedures extend well beyond the boundaries of the United States to

Thailand, India, Mexico, Hungary, and Singapore. In addition, medical tourism presents a business model in itself. With reasonably inexpensive air travel costs, globalization of markets and providers, the availability of information online, frequency of international travel, potentially long waits for local care, and more people taking responsibility for their own health care, strategically positioning as a “destination” and utilizing the medical tourism business model appears to be viable for many institutions.

REFERENCES

¹Naiade Anido Freire, “The Emergent Medical Tourism: Advantages and Disadvantages of the Medical Treatments Abroad,” *International Business Research* 5, no. 2 (2012), pp. 41–50.

²www.medicaltourismindex.com/2016-medical-tourism-industry-valuation/.

Step 3: Conduct Competitor Analysis – Plastic Surgery

The strengths and weaknesses may be assessed for providers of plastic surgery procedures. For this analysis, a few representative plastic surgery providers are profiled in [Exhibit 3-5](#). Assessing strengths and weaknesses of competitors is often difficult for outsiders and, as suggested in the Exhibit, weaknesses (in particular those not manifest in the market) are often difficult to identify and assess. However, careful observation, data gathering through websites and media, and a local resource can make this somewhat speculative process fairly accurate. In addition, the understanding of competitors’ strengths and weaknesses can be refined and improved as data gathering and analysis continue and new information is used to update the competitive analysis.

The Abner Center, run by the only black female plastic surgeon in Charlotte, closed as did the Lifestyle Lift Center (a franchised experiment that failed).

Competitor*	Strengths	Weaknesses
Aesthetic Surgery of Charlotte	Board certification in plastic surgery + otolaryngology. Plastic and reconstructive surgery. Contributes to science with journal articles. Uses TouchMD® for education, illustrating on a photo of the patient’s own face/body part any proposed/desired changes, and offers a patient portal for	Plastic surgery board certification 2013. Quite new to Charlotte; practice established in 2015. Photo gallery is excellent but not all procedure types have photos (supports authenticity of photos, but also an indication of a not-quite-two-year-old practice).

	post-op communication. Each patient is authenticated along with the photography of before/after. Tech savvy. Financing through Alphaeon or CareCredit®. Accepts Medicare.	
Criswell & Criswell	Husband/wife team allowing choice of male or female surgeon. 15 percent off skin care products and sunscreens during July. Opened a new office in a very upscale area of the city. Website suggests artistry; they state talented, passionate, artistic, and experienced physicians. Both doctors have art backgrounds (undergraduate major/minor). Both speak Spanish. Committed to both cosmetic and reconstructive surgery. Many research papers and lectures on reconstructive surgery. Both are children of physician parents.	Consultation fee is applied to surgical procedures. Use CareCredit®, a subsidiary of GE Capital which has a reputation for aggressive collections; reconstructive plastic surgery is typically paid for by private or public insurance.
Matthews Plastic Surgery	In practice for over 25 years. Cosmetic and significant amount of reconstructive surgery. Serves on the local hospital ethics board. Performs medical mission trips every year to Third World countries to perform	Initial consultation fee will be credited to patient's bill if procedure is performed within six months. Cosmetic is cash basis; however, major credit cards accepted, financing provided by CareCredit®, a subsidiary of GE Capital which has a reputation for aggressive collections;

	reconstructive surgery; donates supplies as well. Board certified in cosmetic and reconstructive plastic surgery. Informative website.	reconstructive is private or public insurance.
Premier Plastic Surgery Center	Many videos about procedures. Over 10,000 patients. 24/7 access to the doctor. Promotions (price and additional services). Wrote a book: <i>Body by Ferrari</i>. Some international reconstructive work.	Incredible number of typos on the website. Not easy to find information on the website about financing: cost (or not) of initial consultation nor any info about financing for procedures. Website is difficult to navigate: too many clicks to find desired information.
Charlotte Plastic Surgery	Established 1951, five from Charlotte Plastic Surgery among “15 Best Plastic Surgeons” selected by <i>NC Business</i>. Photo gallery very realistic. Complimentary consultations. Financing through CareCredit® and Prosper. “Member” program (for a fee) to obtain specials and reduced prices. Staff is RitzCarlton trained. AAAASF (American Association of Accredited Ambulatory Surgical Facilities) certified. BOB (Best of the Best) award winner, a Charlotte regional award voted on by the area population.	Not all physicians are board certified. Online store loads very slowly or not at all. Web design likely meant to be “classic” but comes across as old-fashioned.
Voci Center	Upscale spa services –	May be too pricey for many

	aromatherapy, soothing organic candles, calming essential oils, fine lip balms, facial moisturizers, and massage. Also supply an assortment of herbal teas, juices, and purified water. Updated website with excellent photography and realistic before and after photos; informative on financing, procedures, etc. Computerized imaging to determine what would look best for an individual.	Charlotteans. Consultation fee of \$50 charged; however, four or more open house events per year.
Voci Center	Focus on face, breast, and body. Private office operating room suites, accredited for general anesthesia by the AAAASF (American Association of Accredited Ambulatory Surgical Facilities) with a board-certified anesthesiologist. Private overnight rooms for patients after surgery are staffed all night by an RN with ACLS training. More than 32 years of experience.	As of June 15, 2017 the open house events listed were for November and December 2016 (newspaper ads have been current).

*All physicians are board-certified plastic surgeons. Board certifications are tracked by accessing the North Carolina Board of Medicine's database and the American Board of Plastic Surgery database, February 2017.

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

Exhibit 3.5 Competitor Strengths and Weaknesses**

Step 4: Analyze Critical Success Factors

Critical success factor analysis is the identification of a limited number of activities for a service category within a service area for which the organization

must achieve a high level of performance if it is to be successful. The rationale behind critical success factor analysis is that there are five or six areas in which the organization must perform well (a critical success factor) and they are identifiable through careful external analysis. In addition, critical success factor analysis may be used to examine new market opportunities by matching an organization's strengths with critical success factors.

Typically, once the service category critical success factors have been identified, several goals may be developed for each success factor. At that point, a strategy may be developed around the goals. Important in critical success factor analysis is the establishment of linkages among the external environment, the critical success factors, the goals, and the strategy. In addition, it is important to evaluate competitors on these critical success factors. Indeed, excellence in any (or several) of these factors may be the basis of competitive advantage. Further, these factors form the fundamental dimensions of strategy.

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

Specialization

The degree to which the organization focuses its efforts in terms of the number of product categories, the target market, and size of its service area.

Reputation

The degree to which it seeks name recognition rather than competition based on other variables.

Service/product quality

The level of emphasis on the quality of its offering to the marketplace.

Technological leadership

The degree to which it seeks superior technology in medical, health care, and information systems advances in diagnostics or therapeutic software, equipment, and procedures.

Vertical integration

The extent of value added as reflected in the level of forward and backward integration.

Cost position

The extent to which it seeks the low-cost position through efficiency programs and cost-minimizing facilities and equipment.

Service

The degree to which it provides ancillary services in addition to its main services.

Price policy

Its relative price position in the market (although price positioning will usually be related to other variables such as cost position and product quality, price is a distinct strategic variable that must be treated separately).

Relationship with the parent company

Requirements concerning the behavior of the unit based on the relationship between a unit and its parent company (the nature of the relationship with the parent will influence the objectives by which the organization is managed, the resources available to it, and perhaps determine some operations or functions that it shares with other units).⁷

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

Step 4: Analyze Critical Success Factors – Plastic Surgery

From the service area competitor analysis conducted thus far, the critical success factors may be inferred for plastic surgery in Charlotte:

1. Surgical and aesthetic expertise in procedures performed:
 - Expertise in initial consultation to set expectations and build a good relationship with the consumer (personality, time investment in a potential patient, “bedside manner”).
 - Extensive practice (high number of procedures performed with satisfactory results – such as performing intricate surgeries with minimal scarring).
 - Medical service – pre-screening, pre-op, post-op.
 - Pleasing results for the consumer.
2. Competitive pricing (secondary to #1) for cosmetic plastic surgery procedures. Free consultation is expected by consumers but this is time consuming for the physician and often not productive. Some doctors require an upfront consultation fee which is used to reduce the cost of the procedure(s) if the consumer chooses his/her practice.
3. Managing and meeting consumers’ expectations, whether from surgery or less invasive techniques:
 - Patient’s satisfaction with the new look.

- No complications (such as infections or scarring that calls for further procedures).
4. Positive word-of-mouth; estimates are that a satisfied patient refers an average of five others (a somewhat lower average than other medical recommendations because some cosmetic plastic surgery patients want to keep procedures secret):
 - Satisfaction of the clients.
 - Latest procedures and products, newest technologies.
 5. Non-surgical products for surgical after care/appearance.
 6. Use of less invasive cosmetic plastic surgery as a gateway to more intense surgical procedures:
 - Botox® and other injectables.
 - Medical spa.
 7. Knowledge and profile development of desired specific target market (whether female/male, young/older, single/multiple procedures, cosmetic/reconstructive, etc.).
 8. Office environment:
 - Aesthetically attractive physical space; appropriate look and feel for the target market identified.
 - Adoption of new office technologies.
 - Three-person staff (minimum) for solo practitioner.

Step 5: Map Strategic Groups

Strategic group analysis concentrates on the characteristics of the strategies of the organizations competing within a given service area. Strategic groups have been studied in many different industries and several strategic groups often exist within a service area. A *strategic group* is a number of organizations within a service area that are similar and compete directly against each other on the same competitive dimensions and, therefore, make similar strategic decisions. Members of a strategic group have similar “recipes” for success or core strategies.⁸ Therefore, members of a strategic group primarily compete with each other and do not compete with organizations outside their strategic group – although there may be other organizations outside offering similar products or services. These other organizations are not considered competition because they focus on different customers, products/services, quality, price, and so on. For example, members of one strategic group may base strategies on appealing to a specific group of customers; organizations basing strategy on something else, such as low cost, may offer the same services but will not be in the same strategic group.

External stakeholders have an image of the strategic group and develop an idea of the group’s reputation. The reputation of each strategic group differs because

the identity and strategy of each group differ.⁹ Organizations within a strategic group use similar resources to serve similar markets. However, leadership in an individual organization must find ways (sometimes subtle) to have its organization stand out from the group (differentiation) to develop competitive advantage over other group members.¹⁰

Reputation has been defined as an organization's true character and the corresponding emotions held by its stakeholders. Strategic group reputation may be a mobility barrier leading to increased performance. If reputation does lead to increased performance, individual organizations within the strategic group may need to consider the impact of their actions on the collective reputation of the group.¹¹ Thus, if several nursing home organizations in a service area are in the same strategic group, the action of one influences the reputation of them all. The grouping of organizations according to strategic similarities and differences among competitors can aid in understanding the nature of competition and facilitate strategic decision making. There are four major implications for the strategic group concept:

1. Organizations pursue different strategies within service categories and service areas. Creating competitive advantage is often a matter of selecting an appropriate basis on which to compete.
2. Organizations within a strategic group are each other's primary or direct competitors.
3. Strategic group analysis can indicate alternative formulas for success for a service category; such insight may broaden a manager's view of important market needs.
4. Strategic group analysis may surface important market dimensions or niches that are not being capitalized on by competitors. Lack of attention to critical success factors by other competitive organizations offering the same or similar service may provide an opportunity for creation of competitive advantage.

Strategic group membership defines the essential characteristics of an organization's strategy. Within a service category or service area there may be only one strategic group (if all the organizations follow the same strategy) or there may be many different groups. Usually, however, there are a small number of strategic groups that capture the essential differences among organizations in the service area.¹²

The analysis of competitors along key strategic dimensions can provide considerable insight into the nature of competition within the service area. Such an analysis complements Porter's structural analysis and provides additional insights. As a means of creating a broad picture of the types of organizations within a service area and the kinds of strategy that have proven viable, strategic group analysis can contribute to understanding the structure, competitive dynamics, and evolution of a service area as well as the issues of strategic management within it.¹³ More specifically, strategic group analysis:

- Can be used to preserve information characterizing individual competitors

that may be lost in studies using averaged and aggregated data.

- Allows for the investigation of multiple competitors concurrently.
- Allows assessment of the effectiveness of competitors' strategies over a wider range of variation than a single organization's experience affords.
- Captures the intuitive notion that "within-group" rivalry and "between-group" rivalry differ.¹⁴

When analyzing strategic groups, care must be taken to ensure that they are engaging in market-based competition. Many organizations may not be direct or primary competitors because of a different market focus. Organizations will have little motivation to engage each other competitively if they have limited markets in common. It is not unusual for organizations that serve completely different markets yet have similar strategic postures to be grouped together and assumed by analysts to be direct competitors when in fact they are not.¹⁵ For example, a pediatric group practice affiliated with a children's hospital and a community health clinic emphasizing preventive and well care may serve the same population but not be direct competitors because of a different market focus.

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

The best approach to mapping competitors is to select two critical factors for success and evaluate each competitor according to whether it is high or low on these dimensions. Competitors may then be plotted on the basis of these two dimensions (see [Exhibit 3-6](#)). Competitors that are similar on these dimensions will cluster together (strategic groups) and are thus competing directly against each other. Several strategic maps may be constructed demonstrating different strategic views of the service area. In addition, a single dimension may be so important as a critical factor for success that it may appear on several strategic maps.

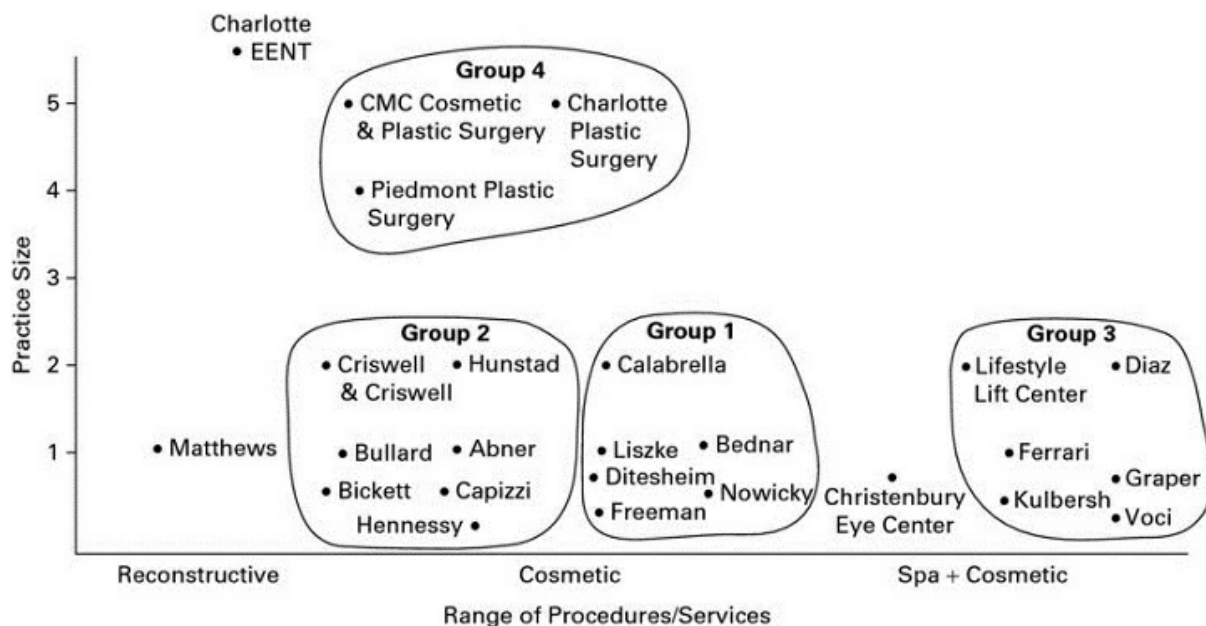


Exhibit 3.6 Competitor Analysis – Mapping Competitors 2012

Step 5: Map Strategic Groups – Plastic Surgery

All plastic surgery practices within the Charlotte service area are not the same – products/services offered, emphasis, and patient focus differ greatly. For example, there are numerous single practice surgeons who have built their practices on word-of-mouth (WOM) referrals and reputation focusing on certain segments of the service category (such as specialization in rhinoplasty). These practices may offer other services to their primary patients but undertake little new patient promotion. In contrast, some practices within the service area offer specialty cosmetic treatments, patient pampering, and luxurious surroundings in full-scale medical spas and focus on recruiting new patients. These two types of practices are generally not competing for the same patients.

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

There are 39 physicians in 18 practices in Charlotte who promote plastic surgery as their area of specialization who are not board certified in plastic (cosmetic or reconstructive) surgery. Some of them are board certified in other specialties such as dermatology, general surgery, obstetrics/gynecology, or EENT, and some have had residencies or fellowships in plastic surgery, but they are not board certified. This analysis only considers the board-certified plastic surgeons

in the service area.

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

Strategic Group 1 – Single practitioners who focus on cosmetic plastic surgery

This strategic group comprises providers that only offer cosmetic procedures and are paid out-of-pocket (they do not accept medical insurance). These practices provide traditional cosmetic plastic surgery procedures. Many provide service in their own offices as well as operating in hospitals or surgery centers. If they advertise, it is primarily through the internet (all have websites), social media, and WOM communication – patients recommending a surgeon based on the great experience and outcome they had. Most common (and most valuable) is WOM which the physician can stimulate but cannot control. Some patients do not want anyone to know they have had a plastic surgery procedure.

Strategic Group 2 – Single practitioners who perform both reconstructive and cosmetic plastic surgery

Members of this strategic group provide cosmetic procedures as well as reconstructive procedures. They are typically reimbursed from insurance for the reconstructive portion of their practice and often accept Medicare and Medicaid patients as a result. These practices often work “on call” and are provided emergency cases or patients referred by other physicians. Reimbursement rates have declined significantly over the past few years for reconstructive plastic surgery.

A number of the physicians in this group are dedicated to maintaining reconstructive surgery in their practice despite the low reimbursement. For the cosmetic portion of their practice, they rely on some advertising, the company website, and WOM. The cosmetic portion of the practice is similar to Group 1; however, these surgeons do not have to rely solely on a cash business.

Strategic Group 3 – Cosmetic Medical Spas

Members of this strategic group provide full-service cosmetic plastic surgery as well as medical spas with luxurious surroundings and a wide variety of procedure and product options. They provide ancillary services to support patient convenience, charge high prices, and rely on WOM referral as well as sophisticated marketing campaigns that include advertising in newspapers and other paid media as well as excellent websites. More attention is paid to the details of product and procedure offerings, as well as office aesthetics and holistic care. Prices of the procedures and products for members of this

strategic group are higher than those in the other strategic groups, but pampering is desired by this target market. In addition, these practices may offer discounts on specific services (such as complementary fat grafting). Competitive rivalry is most intense within this group and members compete primarily on reputation, hours of operation, website information, and a great deal of advertising.

Strategic Group 4 – Multispecialty Practices

Only three practices have more than two plastic surgeons in the Charlotte area. They offer full-service plastic surgery – both reconstructive and cosmetic using a variety of technologies. One of the practices is associated with a teaching hospital and many patients are referrals from within the hospital system.

Although multispecialty group practices or even single-focus multiphysician group practices are not common in plastic surgery, it was forecasted that developing larger practices would become more common over time because of the pressures to have IT systems and electronic health care records (very expensive for a solo practitioner). This new technology is costly and physicians may need to share the expenses; however, before that could occur, the “great recession” caused some changes in the Charlotte marketplace.

[Exhibit 3-6](#) shows a map of the strategic groups with 24 practices in the Charlotte plastic surgery market in 2012. The market has split into four distinctive groups that, for the most part, do not engage in between-group competition. Strategic Groups 1 and 2 have some overlap, but the commitment to perform reconstructive plastic surgery is such that a number of the physicians in Group 2 participate in medical missionary trips to Third World countries to perform surgery on cleft palates and other congenital deformities as well as disfigurement caused by diseases such as cancer. They tackle some of the most challenging plastic surgery work and are proud of what they do to help others.

Outliers to this 2012 strategic map are one plastic surgeon who devoted his practice to reconstructive surgery; two physicians who are board certified in both otolaryngology and plastic surgery and work at Charlotte Eye, Ear, Nose, and Throat; and one physician who is board certified in both ophthalmology and plastic surgery and advertises his lasik practice continuously.

The “great recession” caused challenging times for plastic surgeons in Charlotte from 2009 until 2013. Other areas of the country felt the recession as early as 2007 or 2008, but Charlotte entered into the recession later and struggled with it longer than other places in the United States. It was a major disruption to the status quo of the plastic surgery strategic groups and caused some practices to make significant moves from one strategic group to another (see [Exhibit 3-7](#) where these moves are illustrated by the arrows to show the shifts from 2012 to 2017).

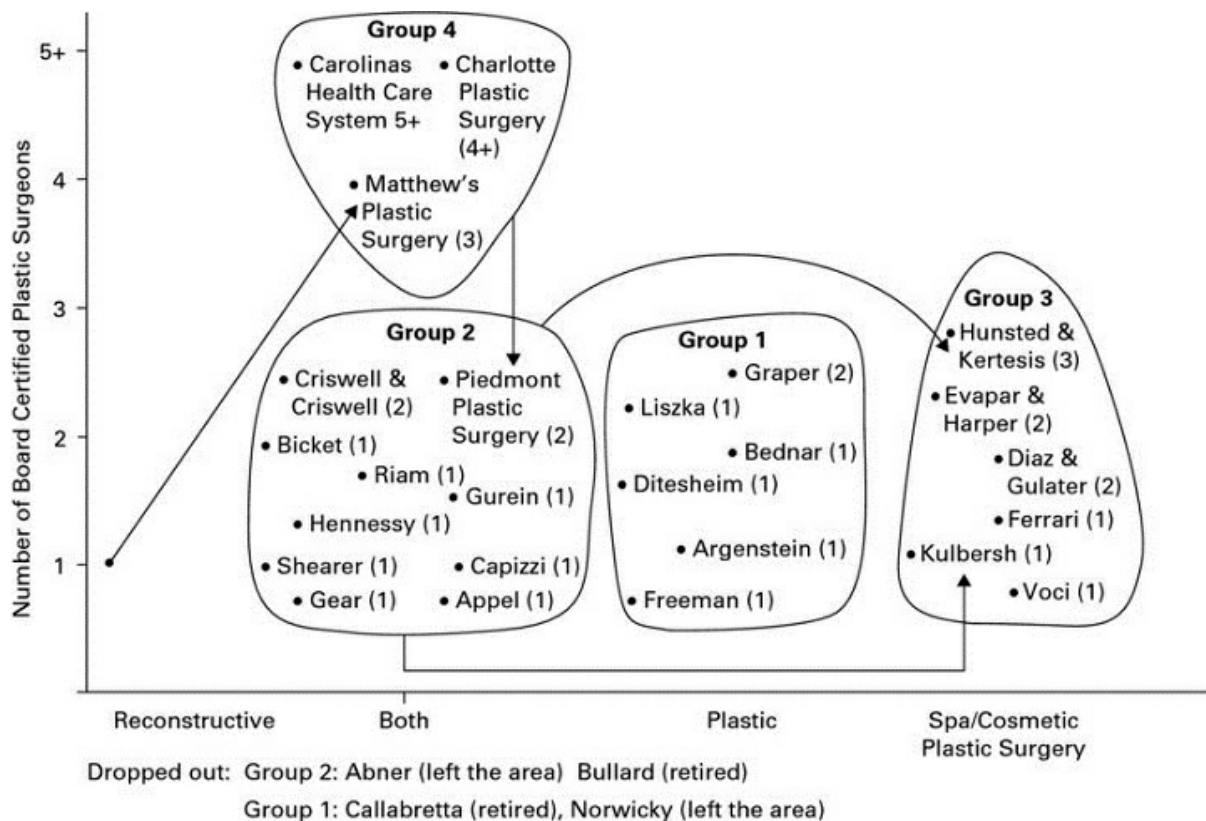


Exhibit 3.7 Competitor Analysis – Mapping Competitors 2017

One solo practitioner who focused on reconstructive surgery joined with two other non-board-certified plastic surgeons to form a larger practice, joining Strategic Group 3 and one of the practices in Group 3 downsized, moving into Group 2. The other change was that a solo practitioner in Group 2 combined with two other board-certified plastic surgeons and hired in four others who are not board certified and began competing with plastic surgeons in Group 3 who provide high-end medi-spa services engaging in many forms of advertising to attract patients to the practice. Two more mature plastic surgeons gave up their surgical practices and now focus on the more cosmetic procedures such as Botox® injections and providing skin care.

Considerable within-group competition occurs in all the groups but particularly within Strategic Group 3 where a number of non-surgical procedures are offered in luxurious surroundings with a great deal of personal attention to attract consumers to the practice along with extensive marketing and advertising to build awareness of the procedures offered.

Note that the practices without board-certified plastic surgeons are in different categories (not shown on this map) and tend to engage in significantly more marketing.

Step 6: Assess Likely Competitor Actions or Responses

Strategy formulation is future oriented, requiring that management anticipate the strategic moves of competitors. These moves may be projected through an evaluation of competitor strengths and weaknesses, membership in strategic

groups, and the characterization of past strategies. In many cases competitor strategic goals are not difficult to project, given past behaviors of the organization. Strategic thinking is a matter of anticipating what is next in a stream of consistent decisions. Strategic behavior is the result of consistency in decision making, and decision consistency is central to strategy. Therefore, in determining competitors' future strategies, strategic managers must look for the behavioral patterns that emerge from a stream of consistent decisions concerning the positioning of the organization in the past.

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

Step 6: Assess Likely Competitor Actions or Responses – Plastic Surgery

New or existing competitors must realize the following:

- Price decreases will likely be matched by competitors, particularly within strategic groups. Consumers do some “shopping” for a cosmetic plastic surgeon.
- Competition within Strategic Group 1 is likely to remain based on cosmetic plastic surgery; however, when finances are tight more lower-cost procedures (more spa-like products and services) are introduced into the practice and non-medical treatments/products will be offered. People may not be able to afford surgical procedures but will continue to purchase products/services they feel they can afford to look their best. This modification in the practice strategy places the surgeons into greater competition with Strategic Group 3; however, in 2017 most of those practices have reverted back to surgical procedures dominating their practices.
- Competition within Strategic Group 3 is likely to remain intense. The practices within this group will continue to invest resources in better and more upscale facilities to try to maintain differentiation from Strategic Group 1.
- Members of Strategic Group 2 will continue to be the early adopters of new products and procedures and will compete on the basis of cutting-edge procedures and products with an increasing emphasis on reconstructive surgery. Members of this strategic group will likely match competitors' upgrades in procedures and products very quickly so as to maintain focus on “doing good.”
- Strategic Group 4 will continue its intergroup competition and its members

will focus on maintaining parity within the group. Practice size is not likely to change very much, despite the national data that verifies a number of larger, multispecialty practices for physicians (who specialize in specific conditions or disease states and often make inter-group referrals). Because most plastic surgeons deal with a cash business, they may be more prone to go it alone, making their own decisions to control costs and attempt to generate revenues to increase personal income.

- The wild card in trying to forecast likely response to a new competitor in the service area is the potential retirement of a number of currently practicing plastic surgeons. As in other specialties and subspecialties, physicians may decide to retire rather than adopt more aggressive activities to maintain profitability, opening the door to additional young physicians. Skill in plastic surgery comes with practice; however, most consumers do not want to be the patient who provides the practice! Providers have to gain enough experience to avoid complications and generate positive word-of-mouth.

Step 7: Synthesizing the Analyses

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

Step 7: Synthesizing the Analyses – Plastic Surgery

Although once the domain of the rich and famous, plastic surgery today is more accessible to the public. One website (realself.com) provides feedback from ordinary people (who personally feel they have benefited from plastic surgery) concerning various physicians by specialty and by city. The out-of-pocket costs for plastic surgery are high and a deterrent to many; however, financing by regular credit cards (MasterCard, VISA, AmEx) or CareCredit® (CareCredit® works as a health care credit card enabling patients to pay off the cost of plastic surgery over time) or Alpheon credit has enabled many middle-class Charlotteans to find their real self through cosmetic plastic surgery.

The Charlotte plastic surgery service area is saturated with a number of providers offering a wide range of procedures, products, and prices. The number of plastic surgeons needed is generally estimated to be 1 to 50,000–75,000 in population. Given the Charlotte region's population, around 25 plastic surgeons are needed; 37 board-certified plastic surgeons have offices in the area plus there are another 39 practitioners who present themselves as plastic surgeons. Thus, significant competition exists for patients.

There are four distinct strategic groups, all of which achieved the hurdle of board certification in plastic surgery to enter the market. There is high competitive rivalry as well as high customer power, and there are myriad substitutes for the services offered. Therefore, competition in all four strategic

groups is intense and providing excellent service and maintaining the latest technology is always an issue.

There is limited competition across strategic groups and members of one strategic group do not view members of other strategic groups as serious competitors. The surgical practices of each group tend to be distinct to the group, with Strategic Group 1 increasing its focus on a more upscale, well-appointed office; Strategic Group 2 maintaining more traditional practices and office environments; and Strategic Group 3 focusing on elite surroundings with an extremely upscale spa environment that exudes personal attention. Strategic Group 4 represents more traditional medical practices today with multiple physicians: office space is more limited and a budget set by the group is followed.

Market share is dominated by Strategic Groups 1 and 3 that more aggressively market their cosmetic surgery services. The basis for competition for Strategic Groups 1 and 3 is cosmetic plastic surgery services whereas Strategic Groups 2 and 4 incorporate reconstructive surgery into their product mix. Members of Strategic Group 4 focus on offering any type of plastic or reconstructive surgery needed by having specialists on various body parts. If a hand specialist is needed, one is available down the hall in the office. If a hand and face specialist is needed, the practice covers those subspecialties, as well.

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

Obstacles to Effective Service Area Competitor Analysis

Monitoring the actions and understanding the intentions of competitors is often difficult. Health care executives agree that it is necessary and growing in importance, yet many are still not engaged in effective competitor analysis. Six common obstacles slow an organization's response to its competitors' moves or cause the selection of the wrong competitive approach. Flawed competitor analysis, resulting from these blind spots, weakens an organization's capacity to seize opportunities or interact effectively with its rivals, ultimately leading to erosion in the organization's market position and profitability.¹⁶ Obstacles to effective competitor analysis include:

- Misjudging industry and service area boundaries.
- Poor identification of competitors.
- Overemphasis on competitors' visible competencies.
- Overemphasis on where, rather than how, to compete.
- Faulty assumptions about the competition.
- Paralysis by analysis.¹⁷

A major contribution of competitor analysis is the development of a clear definition of the industry, industry segment, or service area. The service area is the geographic area from which an organization draws the majority of its customer/patients. Traditionally, health care managers have focused their analysis on locally served markets. Patients were treated by the local doctor, in a local hospital (or the closest one available). There was little travel for medical or health care. Thus, doctors and hospitals were insulated from other health care organizations outside their geographic service area; however, that is no longer the case. Market entry by competitors from outside the metropolitan area, the region, the state, and from around the world, is now quite common (refer back to *Essentials for a Strategic Thinker* 3–4, "What Is Medical Tourism?"). To avoid a focus that is too narrow, the industry, industry segment, and service area must be defined in the broadest terms that are useful. In addition, in today's health care environment, competition may come from non-traditional competitors (outside the health care system). As competition increases from non-traditional competitors, social activities, décor, meals, and housekeeping may become more important competitive factors.

In the past, only cursory attention has been given to other segments of the health care system. For example, hospitals traditionally focused on acute care. Management was not concerned with intermediate care, home care, or hospice care as a competing segment. Today, all of those segments are commonly incorporated into the continuum of care. With length-of-stay issues, and the increasing emphasis on quality of care and unnecessary readmissions, hospitals want to control the flow of patients (integrated delivery systems) and assure the care is appropriate (continuum of care) to increase revenues, provide seamless care, and promote customer satisfaction with the quality of care received. As a

result there are fewer but more direct competitors in many market areas. Clearly, misjudging how the industry, industry segments, or service area is defined will lead to poor competitor analysis.

Another possible flaw of competitor analysis is the improper or poor identification of precisely which organizations are the competitors. In many cases, health care executives focus on a single established major competitor and ignore emerging or lesser-known potential competitors.¹⁸ Such myopia is especially true when the perceived strengths of competitor organizations do not fit traditional measures or there is an inflexible commitment to historical critical success factors (traditional inpatient services instead of outpatient approaches). Academic medical centers (AMCs), with their focus on research, have traditionally viewed only other AMCs as competitors; however, with lowered reimbursements and increased numbers of charity care, AMCs are struggling to increase revenues and have had to redesign their business model. For example, the Louisiana State University (LSU) hospitals and its medical clinics are the state's predominant provider of health care for the poor and uninsured. Because of reduced financial allocations, LSU is seeking public-private partnerships to deliver care. The discussions with community hospitals in several areas are coming down to dollars and cents and how to preserve uninsured care. The talks are just the beginning of LSU's exploration of potential cooperative endeavor agreements, leases, or the possible sale of some facilities.¹⁹

Another problem in performing competitor analysis is the tendency to be concerned only with the visible activities of competitors. Less visible attributes and capabilities such as organizational structure, culture, human resources, service features, intellectual capital, management acumen, and strategy may cause misinterpretation of a competitor's strengths or strategic intent. Certainly the Mayo Clinic's strong culture of excellence has played an important role in shaping its strategic decisions. Operating from only one location for 135 years, Mayo expanded carefully first to Scottsdale/Phoenix, Arizona (1998) and then to Jacksonville, Florida (2008) to make sure the Mayo culture could be maintained in dispersed locations. Similarly, in an environment of rapid change, intellectual capital represents a primary value-creation asset for the organization.²⁰ Competitor analysis requires predicting how competitors plan to position themselves. Although difficult, determining competitors' strategic intent is at the heart of competitor analysis. An effective competitor analysis should focus on what rivals can do with their resources, capabilities, and competencies – an extension of what competitors are currently doing – and include possible radical departures from existing strategies.²¹ See Essentials for a Strategic Thinker 3–5, “What Is a Black Swan Event?”

ESSENTIALS FOR A STRATEGIC THINKER 3–5

What Is a Black Swan Event?



Portraying different types of external change by the nature of their predictability is an established strategic management practice – for example, predictable and inevitable surprises and gray rhinos (see *Essentials for a Strategic Thinker* 2–3). Similarly, a *Black Swan Event* is a metaphor for major impact events that are a complete surprise and are often then rationalized as explainable and predictable. Black swans have three important characteristics: (1) they are “outliers” meaning outside the realm of expectations; (2) they have extreme impact; and (3) although they are outliers, human nature causes us to generate explanations that, after the fact, make the events explainable and even predictable.¹ The concept of the black swan comes from the old story that only white swans had been seen, therefore people naturally assumed all swans were white. Then, in Australia explorers saw a black swan. That discovery highlighted the “fragility of our knowledge – one single observation can invalidate a general statement derived from millennia of confirmatory sightings of millions of white swans. All you need is a single black bird.”²

Consider a global pandemic influenza outbreak. Although outbreaks of influenza are not unheard of, pandemics do not happen often and are rightfully considered outliers; for generations they exist outside of normal expectations. If a pandemic occurs, the impact is devastating. For example, the 1918 influenza pandemic is estimated to have killed 50 million or more people world-wide. Should a pandemic happen, scientists would be quick to remind us that such events have occurred throughout human history and some might even say that we should have expected an outbreak since pandemics occurred with some regularity in the past.

Strategic thinkers must beware of black swans and the kind of attitudes that lead to their emergence. Nassim Nicholas Taleb, the author of the book *The Black Swan*, calls these attitudes the “triplet of opacity”³ that involves:

- The illusion of understanding. Experienced decision makers sometimes believe they understand the situation better than is the case in reality. Human beings tend to create categories to simplify an external analysis to make it more organized and logical.
- Retrospective distortion. Decision makers assess events after the fact and in doing so are tempted to see the external environment as more orderly and less complicated.
- Overvaluation of factual information. The more experienced and learned the decision maker the more likely he or she is to overvalue factual information. Experience and education encourage us to rely on information and data often to the exclusion of more subjective feelings and intuition.

Black swans have important implications for strategists. First, be careful not to assume that the only situations that the organization faces are those that have been seen before and are understood. Second, when unique events do occur, resist the temptation to insist that this is nothing new by forcing the events into pre-established categories and classifications. Third, embrace

outlier events as opportunities to innovate.

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

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

Strategic Momentum: Validating the Strategic Assumptions

As with the general environment and health care system, the initial analysis of the service area provides the basic beliefs or assumptions underlying the strategy. Once the strategic plan has been developed, managers will attempt to carry it out; however, as implementation proceeds, new insights will emerge and new understanding of the competitive services will become apparent. Changes within (and perhaps outside) the service area or from new competitor strategies will directly affect performance of the organization and therefore must be monitored and understood. Competitive awareness and analysis are ongoing activities. The strategic thinking map presented in [Exhibit 3-8](#) provides a series of questions designed to surface signals of new perspectives regarding the service area assumptions.

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

[Exhibit 3.8](#) Strategic Thinking Questions Validating the Strategic Assumptions

The Use of External Analysis and Competitor Analysis

In health care organizations today there is a real understanding that not every organization will survive; that no one health care organization can be “everything to everybody.” Understanding the external environment – including the general, health care, and service area/competitor environments – is fundamental to strategic management and survival. A comprehensive general and health care environmental analysis and service area competitor analysis,

combined with an assessment of competitive advantages and disadvantages (Chapter 4), and establishment of the directional strategies (Chapter 5) provide the basis for strategy formulation.

Chapter Summary

Service area competitor analysis focuses on the nature of competition and competitors within a defined service area and provides an understanding of the competitive context in which the strategy of the organization will have to be successful. Specifically, service area competitor analysis is the process of evaluating competition in the service area, identifying competitors, assessing the strengths and weaknesses of rivals, determining the critical success factors for the product/service category in the service area, determining the strategic groups, and anticipating competitors' strategic moves. The synthesis of the results of this process provides a foundation for determining competitive advantage and subsequent strategy formulation.

Service area competitor analysis can be accomplished through a seven-step process. Step 1 is the identification of the issues in the general environment, health care system, and service area, which provides a foundation for the competitor analysis. In Step 2, a service area structural analysis is used to evaluate the nature and level of competition. Service area structural analysis may be accomplished through a Porter Five Forces analysis: evaluating the threat of new entrants into the market, the service area rivalry, the power of the buyers, the power of the suppliers, and the threat of substitute products or services. In Step 3, a comprehensive competitor analysis is undertaken that includes an identification and evaluation of competitor strengths and weaknesses. In Step 4, critical success factors are identified and analyzed – the limited number of activities that competitors in a service category in a service area must perform well within a strategic group to be successful (includes reputation, quality, low cost, or others). From the critical success factors, strategic groups may be classified and mapped in Step 5. Strategic groups are made up of competitors that most directly compete with each other. In Step 6, competitors' likely future strategies or strategic moves (and the organization's likely responses to strategic moves made by strategic competitors) must be considered for strategy development. Finally, service area and competitor information should be synthesized and strategic conclusions drawn to enable better recommendations to be made.

Health care organizations engage in service area competitor analysis to gather information and to make important offensive and defensive decisions. However, analysts must be careful not to misjudge the service area boundaries – incorrectly identifying strategic competitors, focus only on visible competence, overemphasize where – rather than how – to compete, create faulty assumptions, or be paralyzed by analysis.

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

Practical Lessons for Health Care Strategic Thinkers

1. Specifying the service category frames the scope of service area competitor analysis. The service category may be defined very broadly such as hospital services or defined very narrowly such as pediatric hematology–oncology, depending on the intent of the strategic planning process.
2. Generally, competitively relevant issues in the service area will impact the organization more directly than issues in the general environment and broader health care system except for “game changing” policy shifts or major issues such as large shifts in the economy.
3. The service area structural analysis reveals the attractiveness of a service category in a service area and provides insight into the desirability of entering the market as well as how best to compete within the market.
4. The process of mapping competitors on important market dimensions shows which competitors are most similar to the organization and therefore the most dangerous. Use the critical factors for success for the product category in the service area to map competitors. Those critical factors determine the “winners” and “losers.”

THE LANGUAGE OF STRATEGIC MANAGEMENT: KEY TERMS AND CONCEPTS

Black Swan Event

Competitive Advantage

Critical Success Factor Analysis

Mapping Competitors

Service Area Competitor Analysis

Service Area Structural Analysis

Strategic Group

Strategic Response

Questions for Class Discussion

1. What is entailed in service area competitor analysis? Why should health care organizations engage in competitor analysis? Should not-for-profit organizations perform such a competitor analysis?
2. What is the relationship between external analysis and service area competitor analysis?
3. What competitor information categories are useful in competitor analysis? Are these categories appropriate for health care organizations? How can these categories provide focus for information gathering and strategic decision making?
4. Explain the steps and logic of service area competitor analysis.
5. How does the use of Porter's Five Forces framework help to identify the major competitive factors in the service area?
6. Why is an identification and evaluation of competitors' strengths/weaknesses and strategy essential in service area competitor analysis?
7. What are the benefits of strategic group analysis and strategic mapping?
8. How are the critical success factors for a strategic group determined?
9. Why should a health care organization attempt to determine competitors' strategies and likely strategic responses?
10. What is the purpose of the synthesis stage of service area competitor analysis?
11. What are some obstacles to effective competitor analysis? How may these obstacles be overcome?

Notes

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Chapter 4

Internal Analysis and Competitive Advantage

“Competitive advantage is a company’s ability to perform in one or more ways that competitors cannot or will not match.”

—PHILIP KOTLER, AMERICAN MARKETING AUTHOR AND DISTINGUISHED PROFESSOR

Why Internal Analysis and Competitive Advantage Are Important

As defined by Professor Kotler, enhancing and leveraging competitive advantage is central to strategy. Organizations are constantly trying to “distance themselves” from competitors; responding to the demands of their situation in unique ways enables them to be separated from their competitors. Competitive advantage is created inside the organization through the development of a unique bundle of resources, exclusive technology, access to the market, or new product/service characteristics, that competitors “cannot or will not match.” Differentiation is typically the basis for competitive advantage.

Competitive advantage is found in the strengths of the organization; however, these strengths must be relevant to the markets served. Moreover, competitive advantage does not exist in a vacuum – there is no one universal competitive advantage. Competitive advantage occurs in context – what is a competitive advantage in one market may not be a competitive advantage in another market. Finally, competitive advantage must differentiate the organization enough from its competitors to make a meaningful difference in the mind of the buyer. If competitive advantages are easy to copy, they do not remain competitive advantages for long.

An organization’s self-examination is difficult – strengths are sometimes over estimated and weaknesses difficult to acknowledge. Therefore, methods to help strategic managers objectively surface their organizational strengths and weaknesses as well as assessment guidelines for determining sustainable current and potential competitive advantages are essential. An organization’s external analysis, service area analysis, and internal analysis are the basis for identifying competitive advantage.

Use the concepts in this chapter to appraise internal strengths and weaknesses, identify unique characteristics, and create competitive advantages for a health care organization!

Learning Objectives

After completing the chapter you will be able to:

1. Explain how external analysis creates the context for internal analysis and the development of competitive advantage.
2. Discuss the ways in which value can be created at various places in the organization.
3. Articulate the rationale of using the organizational value chain to conduct internal analysis.

4. Use the value chain to identify organizational strengths and weaknesses.
5. Determine the competitive relevance of each organizational strength and weakness.
6. Describe how competitively relevant strengths and weaknesses can be used as the basis for developing strategic plans.
7. Discuss the importance of identifying and developing competitive advantage for a health care organization.

Strategic Management Competency

After completing this chapter you will be able to perform an internal analysis and determine the competitive advantages and competitive disadvantages for a health care organization.

The Process for Internal Analysis and the Search for Competitive Advantage

Although an understanding of an organization's external environment is critical and provides the context for strategic planning, it is the organization's strengths that provide the foundation for creating a competitive advantage. *Competitive advantage* is derived from organizational strengths that are valuable to external stakeholders, relatively rare among competitors, difficult to duplicate by competitors, and can be sustained by the organization. Typically, these strengths are directed toward achieving a cost advantage or differentiating the organization from its competitors. Therefore, a detailed understanding of the organization's internal strengths and weaknesses relative to the changes taking place externally is a necessary element for developing a viable strategic plan. The search for competitive advantage consists of five steps as shown in [Exhibit 4-1](#).



[Exhibit 4.1](#) The Process for Internal Analysis

Step 1: Review Results of External Analysis and Service Area Competitor

Analysis

To this point, situational analysis has concentrated on external factors in an attempt to answer the first of three strategic questions – “What *should* the organization do?” Before undertaking an internal analysis, it is important to understand the external analysis – the legislative/political forces, economic trends, social/demographic changes, and technological issues affecting the organization, as well as competitors’ abilities to be successful in the marketplace. Therefore, at a minimum, the issue map (Chapter 2, Exhibit 2-5) and the synthesis of the service area competitor analysis (Chapter 3, Step 7) should be reviewed.

After external analysis, the emphasis of situational analysis shifts to the organization itself and the ways in which competitive advantage may be established – the internal analysis. Successful organizations “focus relentlessly on competitive advantage ... [they] strive to widen the performance gap between themselves and competitors. They are not satisfied with today’s competitive advantage – they want tomorrow’s.”¹ As Essentials for a Strategic Thinker 4–1, “What Is the Red Queen Effect?” illustrates, obtaining and maintaining a competitive advantage is a difficult challenge.

ESSENTIALS FOR A STRATEGIC THINKER 4-1

What Is the Red Queen Effect?



The Red Queen appeared in Lewis Carroll’s *Through the Looking Glass* with Alice running hand-in-hand with the Red Queen who keeps telling her to run faster and faster. To Alice’s amazement, no matter how fast they run everything around them remains in the same place. Alice says to the Red Queen, “Well, in our country you’d generally get to somewhere else – if you ran very fast for a long time, as we have been doing.” The Queen responds, “A slow sort of country. Not here, you see, it takes all the running you can do, to keep in the same place, if you want to get somewhere else, you must run twice as fast as that!”

William Barnett in his book, *Red Queen among Organizations: How Competitiveness Evolves*, demonstrates what many health care executives know intuitively – “you have to run as fast as you can just to stay where you are” in a highly competitive environment.¹ Consider the case of a long-term care facility in a prosperous retirement market that decides to seek a competitive advantage by providing a number of ancillary services to its residents not offered in the general market. The facility builds a state-of-the-art wellness center, an on-site Olympic size swimming pool, and provides on-demand transportation services to local health care offices and shopping malls.

Initially the facility gains a competitive advantage by offering these services. Retirees move from other facilities and a larger percentage of prospective residents select the facility because of the enhanced services. Rivals, recognizing they are operating at a disadvantage, upgrade their facilities and add more amenities such as an on-site chef, customized menus, and a spa. This competitor becomes the recipient of transfers from other facilities and acquires a larger market share for a while.

Barnett notes that although it appears every-one is staying in the same relative place, it is really an illusion to the insiders.² The *Red Queen effect*, viewed from the perspective of the customer or patient, is that competition has forced both organizations to learn and grow. Organizations that rest on their past offerings and insist on doing things the “way we have always done them” fail to improve and eventually lose their competitive advantage. Constantly “running faster” leads to innovation, learning, and continuous improvement. Strategic leaders must embrace competition and change – the pathways to improvement.

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The task of establishing competitive advantage is sometimes perplexing, and not always successful. Developing a better product, establishing a cost advantage, or delivering superior service does not necessarily guarantee success. Competitive advantage requires an organization to develop a distinctiveness that is valued by customers, not offered by competitors, and cannot easily be imitated.

Identifying this distinctiveness requires an introspective view that enables the organization to answer the second strategically relevant question of situational analysis – “What can the organization do?” To answer this question, a method of internal analysis must be adopted that will enable the strategist to effectively determine what customers value.

Step 2: Organize the Internal Analysis Process – Using the Value Chain

Internal analysis can be accomplished by evaluating the strengths and weaknesses of the functional areas such as clinical operations, information systems, marketing, clinical support, human resources, financial administration, and so on. With such an approach, each function or organizational subsystem is carefully analyzed. Although this approach has been successful in some instances, by itself it does not adequately address strategic issues. A better approach is to evaluate the various ways that organizations

create value for stakeholders. *Value* is defined as the degree of satisfaction received relative to the price and the expected outcome or results.² For example, a patient may go to a plastic surgeon and pay an extremely high price to correct scarring from an automobile accident. Despite the high price, the perception of social acceptance, increased self-esteem, and improved self-confidence may provide so much satisfaction that the patient perceives a very high value. By contrast, patients may go to a free family practice clinic where services are provided in a rude and disrespectful manner and perceive that they have received little or no value. Value is the perceived relationship between satisfaction and price; it is not based solely on price.³ The organizational *value chain* is a useful tool for identifying and assessing how health care organizations create value through service delivery and organizational support activities.

Organizational Value Chain

Health care organizations have numerous opportunities to create value for patients and other stakeholders.⁴ For example, efficient appointment systems, courteous doctors and nurses, “patient-friendly” billing systems, easy-to-navigate physical facilities, and the absence of bureaucratic red tape can greatly increase satisfaction.⁵ The organizational value chain is an effective means of determining how and where value may be created.⁶

The value chain illustrated in [Exhibit 4-2](#) has been adapted from the value chain used in business organizations to more closely reflect the value-adding components for health care organizations. The value chain utilizes a systems perspective; value may be created in the service delivery subsystem (upper portion of the value chain) and by effective use of the support activities (lower portion). *Service delivery* is the primary way organizations create value for the customer/patient through pre-service, point-of-service, and after-service activities. Service delivery activities are placed above the support activities, as they are the fundamental value creation activities; however, they are buttressed (supported) by activities that facilitate and improve service delivery.

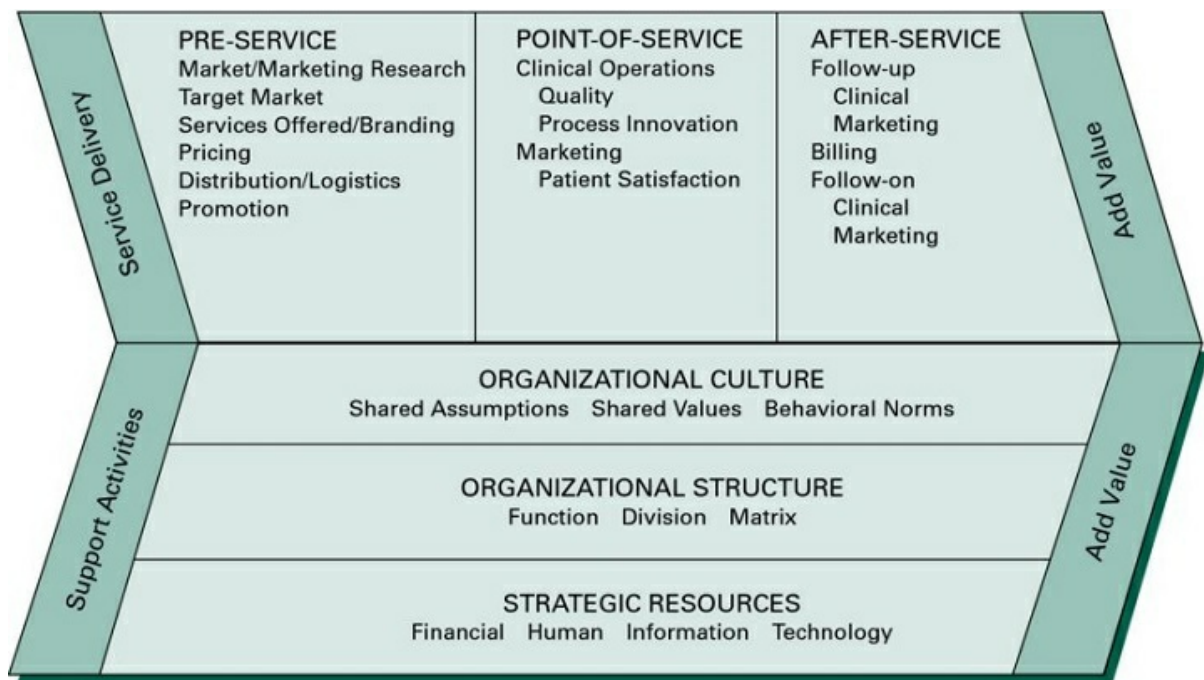


Exhibit 4.2 The Value Chain

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

The three elements of service delivery – pre-service, point-of-service, and after-service – incorporate the production or creation of the service (product) of health care and include primarily operational processes and marketing activities. Organizational culture, organizational structure, and strategic resources are *support activities* that may add value to service delivery by ensuring an inviting and supportive atmosphere, an effective organization, and sufficient use of resources such as finances, highly qualified staff, information systems, and appropriate facilities and equipment. Although not always apparent, such support systems and the value they add are critical for an effective and efficient organization. The value chain as a strategic thinking map provides the health care strategist with a framework for internal analysis of the organization (see [Exhibit 4-2](#) and [Exhibit 4-3](#)).

Value Chain Component	Description
Service Delivery Activities	Creation of value that is directly involved in ensuring access to, provision of, and follow-up for health care services.
Service Delivery – Pre-Service	These activities create value prior to the actual delivery of health care.
Market/Marketing Research	Identification of recognizable groups (segments) that make up the market; information gathering to improve quality, how to meet consumers' needs.
Target Market	Determination of the appropriate segment(s) to satisfy with specific health care services.

Services Offered/Branding	Dissemination of information to prospective patients and other stakeholders regarding the prices, range of products, and location of available services by an identified health care organization; promotional information; brand-quality relationship.
Pricing	Determination of the charge schedule (prices) for available services.
Distribution/Logistics	Actions that aid patient/customer entry into the health care delivery system, including appointments, registration, and parking.
Promotion	Communication of information to customers concerning the health care offering; includes advertising, events (health fairs, 10K sponsorships), social media, and so on.
Service Delivery – Point-of-Service	These activities create value at the point where health care is actually delivered to the patient.
Clinical Operations	Delivery of health care to patients.
Quality	Improvements in the efficiency and effectiveness of health care services as perceived by the patient.
Process Innovation	Improvements in existing or new operational processes.
Marketing	Determination of new products and prices; identification of new customers; provision of information to customers; convenience of access.
Patient Satisfaction	Enhancement of the patient/customer health care experience.
Service Delivery – After-Service	These activities create value after the patient/customer has received the initial health care.
Follow-up	Determination of additional services needed to supplement the initial health care need.
Clinical	Tracking of subsequent procedures and appointments.
Marketing	Actions that provide information, assessment of patient/customer satisfaction, and continuous improvement in quality of care.
Billing	Implementation of clear, easy to understand billing procedures and documents.
Follow-on	Facilitation of patient/customer entry into another health care setting.
Clinical	Referrals to the proper clinical settings.
Marketing	Provision of information concerning follow-on clinical settings for further (extended) care, tracking of

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

Exhibit 4.3 Description of Value Chain Components

Service Delivery Activities

Health care organizations can create value and significant advantages over competitors in all three of the service delivery subsystems. For example, in late summer and early fall, public health officials begin to remind citizens that it is time for immunization against influenza. Numerous methods are available for a provider to create value even before the patients arrive for their flu shot. *Pre-service* is a key area in the value chain where value can be created for the customer/patient before the service is actually delivered. A provider that views administering flu shots as an effective way to build a caring, quality image might do considerable research to determine which patients need flu shots (or would benefit most from having flu shots); where those patients live or work and where they might find it convenient to go for the immunization; how much they might be willing to pay; and how they might best find out about the benefits, convenience, and affordability (promotion). In this manner the clinic develops a distinctive market orientation that is not common in public health or many private health care organizations.⁷

Once the patient arrives, point-of-service activities occur. Regarding the actual delivery of health care, there are multiple ways to create value for the customer. *Point-of-service* is the key area in the value chain where the service is actually delivered and value can be created through clinical operations and marketing. Point-of-service value might be added if the physical surroundings are clean and attractive, there is no waiting time, the nurse is courteous, and information is received concerning the possible side effects of the services to be provided. Numerous public and private organizations have attempted to improve point-of-service by ensuring the delivery of higher-quality services. However, there continues to be considerable controversy as to how effective service improvements alone can lead to sustainable competitive advantage.⁸ At the same time, when patient services are enhanced through innovation that results in an improvement in perceived outcomes, a competitive advantage may result – at least in the short run.⁹ Perhaps the most important single area of the point-of-service evaluation relates to patient satisfaction. Essentials for a Strategic Thinker 4–2, “What Is Patient Satisfaction?” illustrates one of the established survey methodologies for assessing patient satisfaction, and a more recently developed effort to evaluate and make available to the public the patient satisfaction scores for hospitals.

ESSENTIALS FOR A STRATEGIC THINKER 4–2

What Is Patient Satisfaction?



Patient satisfaction is the individual's perception of the quality of his or her care experience, including such factors as care outcomes, communication with and attitudes of nurses and doctors, responsiveness of staff, facility cleanliness, communicating about medicines, discharge information, overall rating of the facility, pain management, and so on. Assessment of patient

satisfaction enables comparisons of care to be made longitudinally for a single provider as well as across a number of providers or facilities and, thus, provides a basis for tracking the quality of care and determining where improvements may be made. Patient satisfaction measures may or may not reflect the actual quality (technical expertise) of care as the patient may not be awake, may not have any medical procedure experience, nor be realistic in terms of pain management.

The most recognized name in health care patient satisfaction is Press Ganey – a company that has provided consulting services for more than 30 years to more than 26,000 health care organizations.¹ Many people who visit their doctors are familiar with the follow-up Press Ganey surveys that appear a few days after the visit. Patients are asked to assess the quality of care from providers as well as the treatment afforded by office personnel, laboratory technicians, and health educators where appropriate.

The Cleveland Clinic became concerned about its patient satisfaction scores when it discovered its physician communication scores were among the lowest when compared to 15 other top hospitals such as the Mayo Clinic, Johns Hopkins Hospital, and Massachusetts General Hospital. Through the collection of quantitative and qualitative data, the Cleveland Clinic determined that patients' top three concerns were: respect, good communication among staff, and happy employees during their stay.

When the Clinic implemented a pilot program in its emergency department to improve patient satisfaction, patient experience scores began to rise when employees at all levels were encouraged to communicate with each patient during their wait. For example, a receptionist might ask, "Is there anything I can get you? I know you have been waiting a long time ..." Doctors, nurses, and all other employees were trained in communicating with patients. The Cleveland Clinic's doctor communication scores are now in the top percentile of all reporting hospitals.²

In 2002 the Centers for Medicare & Medicaid Services (CMS), working with the Agency for Healthcare Research and Quality (AHRQ) and the Department of Health and Human Services (HHS), began developing a patient satisfaction survey for hospitals.³ This survey is called the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. This instrument has three major goals:

1. To produce data from a patient perspective that will allow objective and meaningful comparisons of hospitals.
2. To enable public reporting of data to provide an incentive for hospitals to improve patient care.
3. To improve health care accountability by increasing transparency of the quality of services provided by hospitals.

Utilizing this instrument, consumers/patients are able to compare and assess participating hospitals and gain valuable information about the quality of services.

The HCAHPS survey includes 27 questions addressed to discharged patients regarding their hospital stay. The survey is administered to patients within 48 hours to six weeks after they are discharged. The survey is available in English, Spanish, Chinese, Russian, and Vietnamese. CMS publishes the participating hospital results on its “Hospital Compare” website (<https://www.medicare.gov/hospitalcompare/search.html?>).

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Finally, value can be created through effective after-service activities. *After-service* activities can add value through subsequent patient interactions. A friendly call (follow-up) from someone the next day to check that there were no adverse side effects of the treatment is a thoughtful gesture and can create considerable consumer/patient satisfaction. Billing may provide assistance in filing the necessary insurance papers or assuring payment methods. Patient satisfaction surveys at a later date can serve to remind the consumer of the outstanding care received or can identify areas that need improvement. Follow-on activities may be as simple as setting up the post-hospital stay check-up with the physician or assistance in determining a rehab facility for after surgery to repair a broken hip.

Support Activities

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

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

Step 3: Identify Organizational Strengths and Weaknesses

An organizational *strength* is an attribute or characteristic (resource, competency, capability) that the organization believes it possesses and utilizes successfully. In the past, a stable environment allowed static strategies based on one or two strengths to be successful for years, particularly for large, dominant organizations. A particular location may be a visible strategic strength because it prohibits other organizations from occupying that specific space and cannot be exactly replicated. Some strengths that health care organizations possess are clear and easily recognizable; however, organizational characteristics that appear to represent key strengths to strategists may have little importance to patients or other key stakeholders. Further, it may be a strength possessed by competitors. In today's health care market, strengths can quickly become weaknesses as competitors challenge successful strategies.

Comparatively, a *weakness* is an attribute or characteristic (resource, competency, capability) that the organization assesses that it needs to improve. Weaknesses may be easy to recognize as well. To be competitively relevant, the weakness must be of value to stakeholders, relatively rare among competitors, difficult for the organization to fix, and sustainable by competitors. Dominant organizations may become complacent, rest on their laurels, and refuse to consider that the factors that made them a success may become a liability in the future.¹³

Strengths and weaknesses are *subjective* in that they represent the opinions of evaluators. For example, employees stating that the long-term care facility offers a caring environment would be a subjective strength. Employees may believe they provide a caring environment, but do the patients? Some strengths and weaknesses are *relative* – they are not obvious and can only be determined in relationship to the strengths and weaknesses of primary competitors.¹⁴ For example, a world-renowned academic health center may lose a famous surgeon to a local hospital that is attempting to build more strength in the clinical area of the surgeon's specialty. The health center may remain very strong in terms of the services it provides, but have a relative weakness with regard to the facility where the surgeon is now located. Finally, strengths or weaknesses may be *objective* in that most everyone recognizes that the organization possesses the strength or weakness. A pharmaceutical company that wins a patent for an important new drug has an objective or absolute strength (at least until the patent runs out or another company wins a patent that is superior).

Competitive advantage of an organization may be based on having rare or abundant resources, special competencies or skills, or superior management or logistical capabilities. Similarly, competitive disadvantages may result from a

lack of resources, competencies, or capabilities. In most cases the search for competitive advantages begins with an assessment of organizational strengths followed by an assessment of organizational weaknesses. Essentials for a Strategic Thinker 4–3, “What Is the Resource-Based Theory of Competitive Advantage?” illustrates one view of competitive advantage, based on the tangible and intangible resources possessed by the organization.

ESSENTIALS FOR A STRATEGIC THINKER 4–3

What Is the Resource-Based Theory of Competitive Advantage?



The resource-based theory argues that sustained competitive advantage is a function of the organization's tangible and intangible resources. Tangible resources include capital facilities, human, informational, financial, and similar types of observable resources. Resources such as reputation, goodwill, and so on are intangible. Although not directly observable, they are real none the less. How much goodwill does St. Jude's Research Hospital for Children possess? What is the reputation of the Cleveland Clinic worth? How can anyone put a true value on the name Mayo Clinic?

Although the roots of resource-based theory can be traced to early economic thought, researchers indicate that the most direct origins of the theory emerged in the early 1980s.¹ Although resource-based theory might appear logical, even self-evident, notable exceptions to the argument are identifiable. In almost all industries some examples of relatively weak companies (resource wise) exist that effectively compete against their richer industry neighbors. In 1968, how could Hospital Corporation of America (HCA) expand by building new hospitals, acquiring and upgrading existing facilities, and building one of the first national hospital companies in the midst of so many well-established and successful hospitals and health care organizations? Perhaps the best explanation for this seemingly contradictory evidence is that HCA was able to develop certain intangible resources such as leadership and managerial capabilities that enabled it to muster and combine its limited resources in innovative ways.

An entrepreneurial spirit might be a unique resource possessed by an organization with less tangible resources that allows it to be effective against larger and more resource rich competitors. Titan Spine, which produces only a small number of products used in back surgeries, offers a five-year warranty on the devices it manufactures shielding some of the risk of product failure from its customers.² In a highly litigious society even the removal of a small amount of risk might provide a competitive edge.

Sometimes an organization can convert a resource weakness into an advantage. Younger, smaller, and more creative organizations can react to and take advantage of developing opportunities faster than large, complex,

and bureaucratic competitors. Moreover, smaller and more nimble organizations are often closer to their customers/patients and increase the value of their products and services by listening more carefully to user preferences.

The resource-based theory provides an important insight for strategic thinkers. To some extent, the thinking prior to the emergence of this theory was for organizations to adapt similar strategies and do the same things better or at a lower cost/price than competitors. The resource-based theory altered this view by suggesting that a more productive approach is to leverage unique resources and exploit the differences among competitors.³

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Resources

Resources include factors that are available for use in producing goods and services. Resources may be tangible, as in the case of land and capital, or they may be intangible, as in the case of intellectual property, reputation, and goodwill.¹⁵ The importance of intangible resources should not be underestimated. Robert Kaplan and David Norton, co-creators of the “Balanced Scorecard” strategy performance tool, point out that unlike financial and physical resources, intangible resources are hard for competitors to imitate, making them a powerful source of sustainable competitive advantage.¹⁶ Furthermore, according to a Harris Interactive Health Care Poll, a good reputation and a trusted physician’s recommendation are two of the most important indicators of the quality of medical care as perceived by patients. These factors ranked above more tangible indicators of resources, including location, appearance, and condition of physical facility.¹⁷

The *resource-based theory* of strategy argues that valuable, expensive, or difficult-to-copy resources provide a key to sustainable competitive advantage.¹⁸ Although the resource-based viewpoint has been an integral part of strategic thinking for more than two decades, it has consistently evolved and matured into a comprehensive theory in more recent years. The basic assumption is that “resource bundles” used by health care organizations to create and distribute services are unevenly developed and distributed, explaining – at least to some extent – the ability of each organization to compete effectively. Organizations

with marginal resources may break even; those with inferior resources might disappear; and those with superior resources typically generate profits. Interestingly, some researchers suggest that the deployment of unique resources does not necessarily increase profits or explain the difference between the deploying firm's profit and that of competitors.¹⁹

Basing strategy on the resource differences between organizations should be automatic rather than noteworthy; however, appropriate utilization of this basis for strategy is far from evident, especially in light of the overwhelming attention given to external analysis in strategy formulation.²⁰ In addition, there are many different types of resources. More recently the issue of resource orchestration has emerged, calling for an increased focus on the amount of resources an organization possesses as well as the effectiveness of health care managers in structuring, bundling, and leveraging resources.²¹

Competencies

Competency includes intellectual and skills-based knowledge or know-how and may be a powerful source of sustained competitive advantage. For a growing number of health care organizations, competitive advantage lies in the ability to create an economy driven not by cost efficiencies but by ideas.²² For example, some researchers have suggested that intellectual capital is the single most important factor in the development of competitive advantage.²³

In many cases, competencies are socially complex and require large numbers of people engaged in coordinated activities.²⁴ Generally, to enter a particular market or deliver specific services, the organization must possess *threshold conditions* – the minimally required resources, competencies (knowledge and skills), or capabilities necessary to compete in a particular area. For example, to offer cardiac services, an acute care hospital must have a minimum number of clinical personnel with specific knowledge and skill in cardiac care. Although all organizations offering cardiac services presumably possess threshold competencies, only one or two will develop a particular type of knowledge or specific skill to the point that it becomes a distinctive competency. This type of competency is a highly developed strength that can be critical in developing a competitive advantage.

Capabilities

A health care organization's ability to muster, coordinate, and deploy resources and competencies, usually in combination, to produce desired services is known as its *capability*. The capability to purposefully coordinate resources and competencies is another potential source of competitive advantage. The ability to effectively and efficiently coordinate resources and competencies to achieve integrative synergies through leadership and management is a strategic capability. For example, some assets almost never create value by themselves, and need to be combined with other assets – investments in IT (a resource) have little value unless complemented with effective HR training (competencies). Conversely, many HR training programs have little value unless complemented

with modern technology and managerial tools. Another example involves the effective management of the health care organization's supply chain.²⁵ Individuals who are capable of building and maintaining relationships with suppliers can develop significant advantages over competitors.²⁶

Capabilities fall into one of the two following categories – dynamic capabilities or disruptive capabilities:

1. The ability to make ongoing improvements to the organization's activities through learning, renewal, and change over time is referred to as a *dynamic capability* and relates to an organization's skill at adapting its resources, or competencies, or both to external changes.²⁷
2. The ability to develop strategic insights, recognizing and arranging or rearranging resources and competencies to develop novel strategies before or better than competitors is a *disruptive capability*.²⁸

Capabilities, therefore, are integrating and coordinating abilities (bonding mechanisms) of managers and leaders to bring together resources and competencies in ways superior to those of competitors.²⁹

The stock of resources, knowledge, and integrative skills contained in a health care organization may not be sufficient to ensure a competitive advantage over time. It is likely that two or more organizations competing in the same health care market could have essentially the same resources and similar competencies. When this is the case, the competitive advantage is likely to be the result of different capabilities – a unique culture, strategic leadership, or a set of processes.³⁰

Health care organizations that do not have superior resources or unique competencies may still develop competitive advantages if they are extraordinarily competent at converting ordinary resources and skills into genuine strategic assets.³¹ For example, effective management of technology is more important than new computers and software. Effective IT management results in services that respond uniquely to customer needs and, thereby, provide a competitive advantage. The development of this type of capability is based on four interrelated principles:

1. The building blocks of strategy may be processes as well as people, products, services, and markets.
2. Competitive success depends on transforming an organization's key processes into services that consistently provide superior value to customers.
3. Organizations create these capabilities by making strategic investments in a support infrastructure that link together and transcend traditional functions of any single component of the value chain.
4. Because capabilities necessarily cross functions and value chain components, the champion of capabilities-based strategy must be the chief executive.³²

Step 3: Identify Organizational Strengths and Weaknesses – Hill-Rom

Using an actual organization, Hill-Rom, Inc., the steps in the process of determining competitive advantage will be illustrated. The first action of Step 3 is to carefully assess the activities that Hill-Rom does well and the activities it does not do as well within each component of the value chain (Exhibit 4–2). After the organization’s strengths and weaknesses have been identified, each is assessed (Step 4) to determine whether it is – or could become – a competitive advantage or competitive disadvantage.

Hill-Rom, headquartered in Chicago, is the dominant manufacturer of hospital beds in the United States – some observers estimate the company controls 70–90 percent of the hospital bed market. Hill-Rom, however, is much more. It is a leading global technologies company with three major global businesses: Patient Support Systems, Surgical Solutions, and Front Line Care. With more than 10,000 employees and partners in more than 100 countries world-wide, the company states that its focus is on improving clinical and economic outcomes in eight core areas: advancing mobility, wound care and prevention, patient monitoring and diagnostics, surgical safety and efficiency, respiratory health, patient support systems, surgical solutions, and front line care.

Hill-Rom pioneered in making hospitals safer and more comfortable for patients. The company has expanded its portfolio through acquisitions by purchasing Allen Medical, the world’s leading manufacturer of accessories for operating room tables; Liko, a Swedish firm specializing in products for the safe lifting and transferring of patients in health care settings; Aspen, a British company that makes surgical blades and scalpels (Aspen’s successful Bard-Parker scalpel sells more than a 115 million units per year); Völker, a German company that is a leader in the production of long-term care beds; Trumpf Medical, a German company specializing in the production of advanced operating room products and services as well as innovative lighting technologies, cameras, and surgical assistance systems; and its largest acquisition, Welch Allyn, the company that developed the first direct illuminating hand held ophthalmoscope and manufactures other instruments to assist physicians in examining patients. Today, Hill-Rom is a fully integrated medical technologies company with revenues of \$2.7 billion and has virtually doubled its revenues since 2009.³³

Service Delivery Activities

Hill-Rom possesses both important value-creating strengths and value-reducing weaknesses in service delivery for the medical device industry. Incorporated into that is a large and diversified industry segment with some exceptionally powerful competitors (see Essentials for a Strategic Thinker 4–4, “What Is the Medical Device Industry?”). Yet, Hill-Rom, or its antecedents, has existed for more than 90 years. Because of its market share in the hospital bed industry, it enjoys considerable name recognition, although it is a relatively small company compared to the overall market leaders (Johnson & Johnson, GE, Medtronic, Baxter). Hill-Rom has a diverse but remarkably interrelated portfolio ranging from hospital beds to operating room beds, patient mobility equipment, physician exam equipment, and medical supplies.

ESSENTIALS FOR A STRATEGIC THINKER 4-4



What Is the Medical Device Industry?

The World Health Organization defines a medical device as an “article, instrument, apparatus or machine used in the prevention, diagnosis or treatment of illness or disease, or for detecting, measuring, restoring, correcting or modifying the structure or function of the body for some health purpose. Typically, the purpose of a medical device is not achieved by pharmacological, immunological or metabolic means.”¹ The primary customers for medical device firms are physicians or hospitals (acting on behalf of physicians). These firms typically receive payments directly from insurance companies.

The Food and Drug Administration (FDA) divides the types of medical devices into 17 medical specialty panels. These include orthopedic instruments, surgical instruments, diagnostic apparatus, stents and catheters, syringes and hypodermic needles, blood transfusion and IV equipment, and others. The American medical device industry represents almost half of the sales world-wide. The industry includes 7,000 companies, employs 400,000, and is expected to grow 6 percent per year over the next five years.

The market is dominated by five mega corporations, including Johnson & Johnson, General Electric, Medtronic, Baxter International, and Cardinal Health. These five companies alone account for over \$91 billion in revenues. Johnson & Johnson has revenue of almost \$30 billion; although growing rapidly, Hill-Rom, has annual revenues of \$2.7 billion. Aside from the five behemoths, 80 percent of the firms in the medical device industry are small to medium size businesses with less than 50 employees.

Medical devices benefit from an aging population; thus the outlook for the industry is favorable. As the population ages, more frequent injuries, required surgeries, and more chronic diseases occur. One of the most interesting opportunities in new technology is the introduction of 3D printers. The medical device industry is finding multiple ways to use this technology, including pre-surgery planning, hearing aids, prosthetics, and dental implants.²

Threats include value-based reimbursement (versus volume-based reimbursement) becoming more prevalent and the increase in regulation. The degree of government regulation in this industry depends a great deal on the nature of the device. The FDA does not require a lot of premarket regulation if the device is simple and does not pose a significant risk to human beings; however, other devices such as cardiac defibrillators, are high risk and highly regulated. Congress imposed taxes on many medical devices, effectively raising the price for patients; however, because of

industry pressure and patient outrage, the tax was suspended after one year and is expected to be repealed.

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Hill-Rom's scale of operations makes it a formidable competitor in the specialized markets where it operates. Hill-Rom's reputation for exceptional products and services is backed up by an extensive service operation – it has more than 160 service centers in North America and 45 more internationally, employing more than 1,600 service personnel.

Although Hill-Rom was forced to eliminate a number of jobs in 2014 and closed two manufacturing facilities because of the uncertainties associated with the hospital industry, 2016 was recognized as a “record-setting year” by the President and CEO. Of particular importance were the integration of its \$2 billion acquisition of Welch Allyn and its development of the Enterprise Account Teams that resulted in several major contracts. These teams work with the largest health systems in an effort to identify customers' needs across the entire Hill-Rom portfolio.

As with all organizations, Hill-Rom has some apparent service delivery weaknesses. The company competes in eight core areas and faces competition from well-known firms. Some of its powerful competitors specifically in the hospital bed component of the health care device industry include Stryker Corporation, Invacare, Electromed, and Linet.

Whereas large-scale and global operations represent great strengths, Hill-Rom's geographic footprint subjects the company to complex and diverse FDA and international regulations. The diversity of the product and service portfolio presents the usual challenges of managing diversified operations. In addition, the company is obliged to deal with Group Purchasing Organizations (GPOs) that frequently require discounts and strongly resist price increases.

Hill-Rom faces potential quality control problems if raw material supplies do not comply with quality standards. Furthermore, the dominant market share relative to hospital beds suggests the danger of antitrust actions. One of the most serious operational risks is the limited number of manufacturing locations; the loss of any single location would present a major challenge to meet customer needs. Some important financial issues include the company's pension plan being underfunded by about \$80 million and that Hill-Rom self-insures up to a stop-loss level, representing considerable financial risk with regard to its products' associated liabilities.

Support Activities

Despite the fact that Hill-Rom was faced with a reduction in force in 2014, the company appears to enjoy supportive human resources – it has not experienced a work stoppage in over 40 years despite 6 percent of its manufacturing workforce being covered under collective bargaining agreements; another 18 percent of employees are covered by various collective bargaining agreements or national agreements outside the United States. In addition, Hill-Rom has gone on record with a strong statement of socially responsible operations.

Virtually all of Hill-Rom’s executive team have experience in the health care system as well as other areas, such as management consulting. As a pioneer in the hospital bed industry, the company holds a number of patents enabling it to continue its industry leadership; however, none of the patents are considered to materially affect the value of the business. In recent years Hill-Rom has made significant investments in information technology, although it faces a number of challenges trying to integrate the systems of its various acquisitions.

As expected, there are some weaknesses in Hill-Rom’s support activities. International operations present the challenge of managing individuals from such a variety of cultures. With the company’s diverse product portfolio, culture clash among the existing and acquired firms is an ever-present potentiality.

Financially, it has to be noted that much of the growth in recent years has come from acquisitions. Continuing to locate and acquire related firms at its present rate is doubtful. Moreover, the acquisitions have had both positive and negative effects. Acquisitions primarily accounted for the over 200 percent increase in total assets since 2014, plus a 33 percent increase in total revenues and a 150 percent increase in net income during the 2016 fiscal year. Although total long term obligations have been reduced over the past year, they remain significantly higher than they were in 2014.

With the constantly evolving health care system, it is reasonable to assume that Hill-Rom will be required to maintain and even accelerate its rate of innovation with regard to its core areas. During 2016, the company spent about four percent of its revenues on research and development which, although significant, is not particularly impressive when compared with other companies in health care. In addition, almost all of its research and development is internal.

Finally, the impressive record of acquisitions has associated problems of increasing debt. For example, the Welch Allyn acquisition added substantial debt to Hill-Rom’s balance sheet in 2015; however, operating profits showed a significant increase in 2016.

After carefully searching through the value chain of an organization and reflecting on its resources, competencies, and capabilities to develop value, a more detailed look must be undertaken to evaluate the competitive relevance of each strength and weakness. [Exhibit 4-4](#) categorizes value-creating strengths and value-reducing weaknesses for Hill-Rom, Inc.

Value Chain Component	Value-Creating Strength*	Value-Reducing Weakness*

Service Delivery – Pre-Service	1. 90-year history of delivering quality products (reputation). 2. Strong market position; dominant market share in hospital beds. 3. Diverse but related product portfolio. 4. Innovative sales approach – Enterprise Account Teams.	1. Undifferentiated products in competitive markets. 2. Diverse product line presents management challenges.
Service Delivery – Point-of-Service	1. Scale of operations – 10,000 employees and over 100 global partners. 2. Integrated strategy focusing on patient care solutions and economic outcomes. 3. Executive team with significant health care and management consulting expertise.	1. Quality products offered to Group Purchasing Organizations (GPOs) that seek discounts and resist price increases. 2. Management of diversified companies involves unique challenges. 3. No backup for limited manufacturing facilities.
Service Delivery – After-Service	1. Extensive service operation with 160 service centers in North American and 45 more world-wide with 1,600 service personnel.	1. Litigation in areas of product liability, environment, and employment.
Support Activities – Culture	1. Favorable human resources; no work stoppages in over 40 years. 2. Published and circulated social responsibility statement. 3. Aggressive growth strategy based on acquisitions.	1. Culture clashes among acquired companies. 2. Difficulties in coordinating global operations.

Support Activities – Structure	None	None
Support Activities – Strategic Resources	1. Numerous patents and registered trademarks. 2. Significant increase in total assets. 3. Significant increase in research and development expenditures.	1. Significant reductions in net revenue, net income, and operating profit during the 2015 fiscal year. Although substantial turnaround occurred in 2016, significant demands on operations. 2. Substantial long-term debt. 3. Self-insured and underfunded pension plan. 4. Difficulty integrating information systems of acquired companies.

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

Exhibit 4.4 Value-Creating Strengths and Value-Reducing Weaknesses for Hill-Rom, Inc.

Step 4: Determine Competitive Advantages and Disadvantages

Assessing an organization's current and potential competitively relevant strengths and weaknesses is the goal of internal analysis. Competitively relevant strengths are those that are valued by the external stakeholders, are relatively rare among competitors, relatively difficult to duplicate by competitors, and can be sustained by the organization. They are the pathways to sustained competitive advantage.³⁴

In today's competitive and dynamic health care environment, the ability to develop a sustained competitive advantage is increasingly difficult. *Sustained competitive advantage* is the result of an enduring value differential between the services of one organization and that of its competitors in the minds of patients, physicians, and other stakeholders.³⁵ Health care organizations must consider how their resources, competencies, and capabilities – strengths and weaknesses – relate to those of competitors.

Competitively Relevant Strengths

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

Competitive relevance is determined by critically considering four important questions:

1. *Question of value.* Is the resource, competency, or capability of value to customers?
2. *Question of rareness.* Is this organization the only one that possesses the resource, competency, or capability or do many or all of its competitors possess it?
3. *Question of imitability.* Is it easy or difficult to duplicate the resource, competency, or capability?
4. *Question of sustainability.* Can the resource, competency, or capability be maintained over time?³⁶

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

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

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

Finally, the fourth question involves a judgment as to whether the organization can sustain the resource, competency, or capability. A “yes” (Y) or “no” (N) answer is required to this question. If the strength cannot be sustained it will provide, at best, only a short-term advantage over competitors. The difficulty or ease with which competitors can imitate the strengths and the organization’s ability to sustain them determines the extent of its long-term or short-term advantage. [Exhibit 4-5](#) provides a strategic thinking map for possible combinations of the four questions regarding strengths and the implications for strategic leaders.

Is the Value of the Strength High or Low?	Is the Strength Rare? (Y/N)	Is the Strength Easy or Difficult to Imitate?	Can the Strength be Sustained? (Y/N)	Implications

(H/L)		(E/D)		
H	N	E	Y	No competitive advantage. Most competitors have the strength and those that do not can develop it easily and sustain it. Because the strength is widely possessed and can be sustained, it is likely that it already has become a threshold condition for success.
H	N	E	N	No competitive advantage. Most competitors have the strength and it is easy to develop; however, the strength generally is not sustainable. If the organization is the only organization in the service area that cannot sustain the strength, it will become a short-term competitive disadvantage.
H	N	D	Y	No competitive advantage. Many competitors possess the strength but it is difficult to develop, so care should be taken to maintain this strength. Because the strength is widely possessed and can be sustained, it is likely that it already has become a threshold condition for success.
H	N	D	N	No competitive advantage. Many competitors possess the strength yet it is difficult to develop, and those who do possess it will not be able to sustain the strength. If the organization is the only organization that cannot sustain the strength, it will become a long-term competitive disadvantage.
H	Y	E	Y	Short-term competitive advantage. Because the strength is valuable and rare, competitors will do what is necessary to develop this easy-

				to-imitate strength. The organization should exploit this short-term advantage but should not base long-term strategies on this type of strength. Over time, this strength is likely to become a threshold condition for success.
H	Y	E	N	Short-term advantage but not a source of long-term competitive advantage. The strength is easy to imitate but cannot be sustained. The organization should not base long-term strategies on this type of strength but may obtain benefits for a short-term advantage.
H	Y	D	Y	Long-term competitive advantage. This strength is rare in the service area, difficult to imitate by competitors, and can be sustained by the organization. If the value is very high, it may be worth “betting the organization” on this strength.
H	Y	D	N	Short-term competitive advantage but not a strength that can be sustained over the long run. Although rare and difficult to imitate, the strength cannot be sustained. This strength should be exploited for as long as possible.

Exhibit 4.5 Strategic Thinking Map of Competitive Advantages Relative to Strengths

Competitively Relevant Weaknesses

The strategic relevancy of each weakness can be determined by asking questions similar to those used to evaluate strengths. Weaknesses are serious competitive disadvantages if they have high value to patients and other stakeholders (H), are not possessed by competitors (N), cannot be easily eliminated or corrected (D), and competitors can sustain their strengths (Y). [Exhibit 4-6](#) provides a strategic thinking map listing the suggested actions of strategic leaders relative to

possible combinations of weaknesses.

Is the Weakness of High or Low Value? (H/L)	Is the Weakness Common (Not Rare) Among Competitors? (Y/N)	Is the Weakness Easy or Difficult to Correct? (E/D)	Can Competitors Sustain their Advantage? (Y/N)	Implications
H	Y	E	Y	No competitive disadvantage. Although a weakness of the organization, most other competitors are also weak in this area; however, the weakness is easy to correct and competitors will likely work to correct the weakness. If the organization fails to correct it, competitors could achieve a short-term competitive advantage. Over time, correction of this weakness is likely to become a threshold condition for the market.
H	Y	E	N	No competitive disadvantage. Although a weakness of the organization, most other competitors are also weak in this area; however, the weakness is easy to correct. It is likely that most competitors will work to correct it and therefore no organization will be

				able to sustain an advantage; likely to become a threshold condition for the market.
H	Y	D	Y	No competitive disadvantage. Although a weakness of the organization, most other competitors are also weak in this area and it is difficult to correct; however, this situation is dangerous and should be addressed to ensure that competitors do not overcome this difficulty and correct it first. If competitors correct the weakness and continue to sustain their advantage, the weakness could become a long-term competitive disadvantage.
H	Y	D	N	No competitive disadvantage. Although a weakness of the organization, most other competitors are also weak in this area and it is difficult to correct. It is likely this weakness is chronic among competitors in the service area as corrections in the weakness tend to erode over time.
H	N	E	Y	Short-term

				competitive disadvantage. Most competitors are not weak in this area; however, the weakness is easy to correct. The organization should move quickly to correct this type of weakness. Correcting this weakness is likely to become a threshold condition for the market.
H	N	E	N	Short-term competitive disadvantage. Competitors are not weak in this area; however, the weakness is easy to correct. The organization should move quickly to correct the weakness. It is likely that all competitors will correct the weakness and therefore cannot sustain any advantage.
H	N	D	Y	Serious competitive disadvantage. The weakness is valuable, most competitors do not have it, it is difficult for the organization to correct, and competitors can sustain their advantage. If the weakness is of very high value, it may threaten the survival of the organization.

H	N	D	N	Short-term competitive disadvantage. The weakness is valuable, most competitors do not have it, it is difficult for the organization to correct; however, competitors cannot sustain their advantage. Until this area becomes a weakness for most competitors in the service area or the weakness is corrected by the organization, it will continue to be a serious disadvantage.

Exhibit 4.6 Strategic Thinking Map of Competitive Disadvantages Relative to Weaknesses

Step 4: Determine Competitive Advantages and Disadvantages – Hill-Rom

Identification of the strengths in the various components of the value chain in an organization such as Hill-Rom inevitably results in a lengthy list of activities in which the organization excels. As noted, not all of the strengths will necessarily be sources of competitive advantage for the organization and only a few may be competitively relevant. For example, executives often believe that “our reputation is our greatest asset.” However, in the medical device industry, there are numerous firms with excellent reputations (e.g. Boston Scientific, General Electric, St. Jude Medical), so it is unlikely that reputation alone would constitute a significant competitive advantage. Similarly, an identified weakness may not necessarily be a competitive disadvantage if it is not competitively relevant (others share the same or similar weaknesses).

Competitively Relevant Strengths – Hill-Rom

To further illustrate how this process may be used, the strengths of Hill-Rom, Inc. as listed in Exhibit 4-4, are evaluated with regard to the four questions (found in Exhibit 4-5) to generate [Exhibit 4-7](#): Competitive Relevance of the Strengths of Hill-Rom, Inc. From the initial assessment, Hill-Rom, Inc. has 14 potentially important strengths that have high value in the marketplace. These strengths with high value are assessed using the remaining three characteristics (rare, easy to imitate, and can be sustained) to determine which strengths may

become the basis for competitive advantage. The last column in Exhibit 4–7 indicates the implications for Hill-Rom’s identified and analyzed strengths.

Strengths*	Is the Value of the Strength High or Low? (H/L)	Is the Strength Rare? (Y/N)	Is the Strength Easy or Difficult to Imitate? (E/D)	Can the Strength be Sustained? (Y/N)	Implications
Service Delivery – Pre-Service					
1 90-year history of delivering quality products (reputation).	H	Y	D	Y	Long-term competitive advantage.
2 Strong market position; dominant market share in hospital beds.	H	Y	D	Y	Long-term competitive advantage.
3 Diverse but related product portfolio (one-stop shop for many medical devices).	H	Y	D	Y	Long-term competitive advantage especially for large-scale customers.
4 Innovative sales approach – Enterprise Account Teams.	H	N	E	Y	Threshold condition.
Service Delivery – Point-of-Service					
5 Scale of operations – 10,000	H	Y	D	Y	Long-term competitive advantage.

employees and over 100 global partners.					
6 Integrated strategy focusing on patient care solutions and economic outcomes.	H	N	E	Y	Threshold condition.
7 Executive team with significant health care and management consulting expertise.	H	N	E	Y	Threshold condition.
Service Delivery – After-Service					
8 Extensive service operation with 160 service centers in North America; 45 in other countries; 1,600 service employees.	H	Y	D	Y	Long-term competitive advantage; 160 centers for fast service.
Support Activities – Culture					
9 Favorable human resources with no work stoppages in 40 years.	H	N	D	Y	Threshold condition.
10 Published and circulated social	H	N	E	Y	Threshold condition.

responsibility statement.					
11 Aggressive growth strategy based on acquisitions.	H	N	D	N	No competitive advantage unless sustained.
Support Activities – Structure					None apply.
Support Activities – Strategic Resources					
12 Numerous patents and trademarks.	H	N	D	Y	Threshold condition.
13 Significant increase in total assets.	H	N	D	N	No competitive advantage unless sustained.
14 Significant increase in research and development expenditures.	H	N	E	N	No competitive advantage.

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

Exhibit 4.7 Competitive Relevance of the Strengths of Hill-Rom, Inc.

Strengths that are valuable, but not rare, easy or difficult to imitate, and can be sustained (HNEY or HNDY) should be maintained by Hill-Rom because they are possessed by others and represent a threshold condition for success. They include: No. 4 Innovative sales approach; No. 6 Integrated strategy – patient care solutions and economic outcomes; No. 7 Executive team experience; No. 9 Favorable HR – no work stoppages; No. 10 Published/circulated social responsibility statement; and No. 12 Patents and trademarks. These strengths are necessary to be competitive in the market but are unlikely to become a competitive advantage.

Hill-Rom has one strength that, although valuable, is not rare, is easy to imitate, and cannot be sustained (HNEN) – No. 14 Increase in R and D; however, it offers no competitive advantage as most competitors spend 4 percent of revenue

on R and D; thus it needs to be sustained or could become a competitive disadvantage.

Five strengths offer potential as competitive advantages (HYDY): No. 1 Established reputation; No. 2 Domination of hospital beds market; No. 3 Related and diverse product portfolio; No. 5 Large scale operations; and No. 8 Extensive service operation.

Competitively Relevant Weaknesses – Hill-Rom

An assessment of the value chain for Hill-Rom revealed a number of weaknesses as first included in Exhibit 4-4. Using the questions and implications found in Exhibit 4-6, [Exhibit 4-8](#) “Competitive Relevance of the Weaknesses of Hill-Rom, Inc.” was developed to list and assess Hill-Rom’s weaknesses.

Weaknesses*	Is the Weakness of High or Low Value? (H/L)	Is the Weakness Common (Not Rare) Among Competitors? (Y/N)	Is the Weakness Easy or Difficult to Correct? (E/D)	Can Competitors Sustain Their Advantage? (Y/N)	Imp
Value Chain Component					
Service Delivery – Pre-Service					
1 Undifferentiated products in competitive markets.	H	Y	D	N	No com disa for a com diffe is di
2 Diverse product line presents management challenges.	H	N	D	Y	Cou serie com disa
Service Delivery – Point-of-Service					
3 Quality	H	Y	D	N	No

products offered to Group Purchasing Organizations (GPOs) that seek discounts and no price increases.					com disa indu proh
4 Management of diversified companies involves unique challenges.	H	N	D	N	Shor com disa
5 No backup for limited manufacturing facilities.	H	N	D	Y	Seri com disa
Service Delivery – After-Service					
6 Litigation in areas of product liability, the environment, and employment.	H	Y	D	N	No com disa indu proh
Support Activities – Culture					
7 Culture clashes among acquired companies.	H	N	D	Y	Cou seric com disa maje disti
8 Difficulties in coordinating global operations.	H	N	D	N	Shor com disa
Support Activities					

– Strategic Resources					
9 Significant reductions in net revenue, net income, and operating profit during the 2015 fiscal year. Although substantial turnaround occurred in 2016, significant demands on operations.	H	N	D	Y	Cou seri com disa strai grov
10 Substantial long-term debt.	H	N	D	Y	Seri com disa
11 Self-insured and underfunded pension plan.	H	N	D	Y	Seri com disa
12 Difficulty integrating information systems of acquired companies.	H	N	D	N	Cou shor com disa

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

Exhibit 4.8 Competitive Relevance of the Weaknesses of Hill-Rom, Inc.

Three of Hill-Rom's weaknesses (HYDN): No. 1 Undifferentiated products; No. 3 Quality products offered to Group Purchasing Organizations (GPOs) that seek deep discounts; and No. 6 Litigation in the areas of product liability, environment, and employment are serious issues – but they are not unique to Hill-Rom. Management must be aware of these challenges but they do not constitute a competitive disadvantage.

The more serious weaknesses are primarily the result of Hill-Rom's conscious strategy to diversify its product lines and grow through acquisitions. These include six weaknesses in the form of (HNDY): No. 2 Diverse product line challenges management; No. 5 No backup for limited manufacturing facilities; No. 7 Culture clashes among acquired companies; No. 9 Significant reductions in net revenues/income/profit in 2015 pressures operations; No. 10 Significant increase in long-term debt; and No. 11 Self-insured, underfunded pension plan

are serious disadvantages. It should be pointed out that these competitive disadvantages occurred because management is betting in the long run that these very same weaknesses will provide competitive advantages for the company.

Three additional short-term weaknesses are oriented around Him-Rom's rapid growth: No. 4 Management of diversified companies involves unique challenges; No. 8 Difficulties in coordinating global operations; and No. 12 Difficulty integrating information systems of acquired companies. These weaknesses represent high value areas, are not shared by all competitors, and are difficult to correct; however, the advantages may not be sustainable by others in the industry (HNDN). They are short-term competitive disadvantages but must be addressed based on Hill-Rom's expansion strategy through acquisition.

Step 5: Synthesize and Determine the Implications of the Competitive Advantages and Disadvantages

As illustrated in Exhibit 4–1, the final step in exploiting competitive advantage is to determine how each competitively relevant strength and weakness is likely to affect an organization's ability to compete in the marketplace. *Competitively relevant strengths* are those that are valued in the marketplace, are rare, are difficult to imitate, and can be sustained (HYDY) providing the basis for long-term competitive advantage and should be developed to the greatest extent possible. *Competitively relevant weaknesses* relate to areas that are valued in the marketplace, are not common weaknesses among competitors, are difficult for organizations to correct, and offer advantages that can be sustained by others (HNDY), are serious competitive disadvantages and may threaten the survival of the organization. Results of the determination of both long- and short-term competitive advantages and disadvantages are a part of situational analysis and provide one part of the basis for strategy formulation (what an organization can do).

Step 5: Synthesize and Determine the Implications of the Competitive Advantages and Disadvantages – Hill-Rom

[Exhibit 4–9](#) lists each of Hill-Rom's competitively relevant strengths and weaknesses that have been identified (those displaying the pattern HYDY for strengths and HNDY for weaknesses from Exhibit 4–7 and Exhibit 4–8) and speculates as to whether or not Hill-Rom has the potential to differentiate itself from competitors or to provide a cost advantage over competitors.

Competitively Relevant Strengths*(from Exhibit 4–7)	Strategic Implications
1 90-year history of delivering quality products; reputation.	Brand recognition and institutional history.
2 Strong market position; dominant	Leadership position in hospital beds

market share in hospital beds.	provides entrée to selling many other products to large hospital systems.
3 Diverse but related product portfolio.	Name recognition and superior reputation in health care system.
5 Scale of operations; 10,000 employees and over 100 global partners.	Market domination in hospital beds and economies of scale.
8 Extensive service operation with 160 service centers in North America and 45 more world-wide with 1600 service personnel.	Ability to provide prompt and continuing after service.
Competitively Relevant Weaknesses*(from Exhibit 4–8)	Strategic Implications
2 Diverse product line presents management challenges.	Although the diverse product portfolio is a strength, coordination challenges occur for management.
5 No backup for limited manufacturing facilities.	Majority of manufacturing taking place in only one location. Facility shutdown because of severe weather, labor shut-down, or terrorism could have catastrophic impact.
7 Culture clashes among acquired companies.	Merging cultures is challenging, takes time, and impacts the bottom line.
9 Significant reductions in net revenue, net income, and operating profit during 2015; substantial turnaround in 2016, however, demands on financial resources remain.	Growth by acquisition is over without infusion of capital to continue the strategy.
10 Substantial long-term debt.	Current long-term debt obligation will limit acquisitions.
11 Self-insured and underfunded pension plan.	May lose talented people to other organizations that have a fully funded pension program or disaster might cause a plant shutdown.

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

Exhibit 4.9 Strategic Implications of Hill-Rom’s Competitively Relevant Strengths and Weaknesses

For Hill-Rom, the strengths have been collected into Exhibit 4–9 “Strategic Implications of Hill-Rom’s Competitively Relevant Strengths and Weaknesses” to determine competitive advantages. The company’s strengths, No. 1 90-year reputation; No. 2 Strong market position, dominant market share in hospital

beds; No. 3 Diverse but related product lines; No. 5 Scale of operations; and No. 8 Extensive aftermarket service support organization in North America and around the globe, represent potential long-term sustainable competitive advantages. Of particular significance is the company's carefully selected range of associated products ranging from hospital beds, patient mobility machines, operating room supplies and equipment, and medical instrumentation. It will be very difficult for any competitor to imitate this product portfolio.

Note that the assessment indicates that Hill-Rom's strategic leadership has the ability to differentiate the organization and its services through its long-term market presence, dominance in the hospital bed industry, diversity of its present product line, and the breadth of its service centers and personnel. Leaders must be careful, however, because competitors have the potential for a substantial advantage if the expansion through acquisitions strategy is not successful. Hill-Rom is stretched to the limit financially and faces considerable risk in successfully managing diverse, although related, companies.

A Final Challenge

Careful internal analysis provides a better understanding of where strategic leaders should focus their efforts to compete effectively and where they should be careful to avoid vulnerability relative to competitors. It is not possible to be every- thing to everyone; an organization must focus its efforts.

The basic endowment of resources, competencies, and capabilities in a health care organization and the way they are allocated are critical determinants of the organization's ability to compete effectively. Arguably, the essential character of strategic thinking is the acceptance of "an aspiration that creates, by design, a chasm between ambitions and resources." It is further argued that spanning the chasm and encouraging stretch "is the single most important task senior management faces."³⁷

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

Leveraging may be accomplished by concentrating, accumulating, complementing, conserving, and recovering resources.³⁸ Prioritizing goals and focusing on no more than a few things at one time aids the concentration of limited resources. Successful concentration of resources, competencies, and capabilities requires not only focusing on relatively few things but also focusing on the right things – those activities that make the greatest impact on patients' perceived value. Nurses, receptionists, therapists, maintenance employees, and others come into contact with patients and observe organizational realities in ways that are different from physicians, CEOs, and management personnel. The stockpiles of experience accumulated by the individuals with extensive patient contact are valuable competitive resources if properly mined.

Complementary resources, competencies, and capabilities can be combined to create *synergy* – where value and performance combined will be greater than the sum of the separate individual parts. In the value chain, linking activities will provide unique opportunities to integrate functions such as service delivery, organizational culture, and strategic resources. In other words, there is a creative interweaving of different types of skills that assists in creating competitive advantage.

The potential for effectively leveraging a particular resource, competency, or capability becomes greater the more often they are used. The ability to quickly switch knowledge from delivering one service to another conserves service development resources and reduces the learning curve in introducing and perfecting service delivery. Conserving and recovering resources by restricting

their exposure to unnecessary risks is essential to the conservation of limited resources. An aspiring competitor in a health care market should think carefully before attacking the dominant player at the point of that competitor's greatest strength. Challenging a stronger competitor requires creativity and innovation.

Expediting success – increasing the resource multiplier by reducing the time between expenditure of resources and their recovery through revenue generation – is an important means to leverage resources. Reducing the payback period of technological improvements in health care organizations is a substantial resource recovery challenge. On the one hand, high-quality service delivery depends on state-of-the-art technology. On the other hand, this type of technology is expensive and usually has a relatively short economic life. Careful planning is required to ensure that paybacks are evaluated and accelerated in every possible way.

Essentials for a Strategic Thinker 4–1, “What Is the Red Queen Effect?” illustrated the importance of not allowing a competitive advantage to lead to complacency. Competitive advantage can be lost faster than it can be gained, requiring vigilance on the part of strategic leaders. Resource leveraging is a matter of attitude and willingness to take reasonable risks, to do things in new and innovative ways, to learn from the experiences of others, and generally pursue excellence in all aspects of organizational performance. Management consultants Hamel and Prahalad note that traditional strategic, as well as behavioral, factors may lead to competitive advantage: “Cross-functioning teams, focusing on a few core competencies, strategic alliances, programs of employee involvement, and consensus are all parts of stretch.”³⁹ These factors are relevant to all type of health care organizations including public health and community health organizations. See Essentials for a Strategic Thinker 4–5, “What Are Federal Health Centers?” for an understanding of this important industry segment.

ESSENTIALS FOR A STRATEGIC THINKER 4–5

What Are Federal Health Centers?



The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) awards grants to four types of Federal Health Centers (FHCs): (1) Community Health Centers (CHCs); (2) health centers for the homeless; (3) health centers for public housing residents; and (4) health centers for migrants. FHCs are governed by community boards with a majority of members (at least 51 percent) being patients. FHCs provide direct access to health care services as part of the health safety net.

More specifically:

Health centers are community-based and patient-directed organizations that deliver comprehensive, culturally competent, high-quality primary health care services. In addition, health centers often integrate access to pharmacy, mental health, substance abuse, and oral health services in areas where economic, geographic, or cultural barriers limit access to affordable health care services. Health centers deliver care to the Nation's most vulnerable individuals and families, including people experiencing homelessness, agricultural workers, residents of public housing, and the Nation's veterans.¹

Most FHCs are CHCs, i.e. public, not-for-profit entities that provide primary, preventive, and emergency services to the general population of low-income individuals. CHCs also receive grants from state and local sources, private foundations, and other federal programs. CHCs are required to provide health care to all individuals regardless of ability to pay and are located in medically underserved areas. Most CHC patients have incomes at or below the federal poverty level.

Although CHC Patients with incomes at or below 100 percent of the federal poverty level (FPL) pay only nominal fees, patients with incomes greater than 200 percent FPL pay full charges. CHCs are required to collect reimbursement from third-party payers (e.g. private insurance plans, Medicare, Medicaid, CHIP) for insured patients. CHCs are also eligible for designation as Federally Qualified Health Centers (FQHCs) and as such participate in the Medicare and Medicaid programs.

In addition to providing medical services (e.g. diagnosis and treatment), CHCs provide preventive health services including immunizations, free vaccines for children, family planning, prenatal care, and preventive dental care. Further, CHCs provide behavioral health treatments and services including mental health services, substance abuse treatment, and diabetes self-management training. CHCs are required to have arrangements with outside providers for emergency medical services and after-hours care.

CHCs employ physicians and physician extenders to provide services for patients; its workforce includes many primary care clinicians from the National Health Services Corps that work in medically underserved areas in return for student debt reduction. Physicians must be licensed and are ordinarily required to have admitting privileges at a local hospital. CHC physicians are not required to carry medical malpractice insurance coverage because under the Federal Tort Claims Act (FTCA) they are immune from liability for care provided within the scope of employment; however, the Federal government may still be subject to liability for patients injured by malpractice in these cases.²

REFERENCES

1. What is a Health Center? <https://bphc.hrsa.gov/about/what-is-a-health-center/index.html>.

2. “Federal Health Centers: An Overview,” Congressional Research Service, Jan. 6, 2016.

Source: Leonard J. Nelson, III, Adjunct Professor at UAB School of Public Health and Professor Emeritus at Samford University.

Sustained competitive advantage does not necessarily lead to continuous value creation; yet long-term success requires ongoing satisfaction of ever-increasing expectations. Success builds the expectation of continued success. Ongoing value creation requires an organization to have a theory or a consistent means of choosing among all the options with regard to activities, resources, etc. In other words, it requires not just a strategy but a “strategy for strategies.”⁴⁰ In the end, determination of competitive advantage requires an integration of what health care strategists know about the external forces with a sophisticated understanding of competitively relevant strengths and weaknesses.

Strategic Momentum

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

The questions presented in [Exhibit 4-10](#) provide for such an ongoing evaluation of the effectiveness of the internal analysis. Ensuring appropriate strategic fit requires that the internal as well as the external analysis be continuously evaluated.

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

[Exhibit 4.10](#) Questions for Evaluating the Internal Strategic Assumptions

Chapter Summary

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

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

Although understanding competitive advantage is important to health care strategists, more is required. Successful health care organizations must always insist on stretching their resources, competencies, and capabilities while creatively looking for new opportunities. Sustaining competitive advantage requires that leaders understand what the marketplace demands of successful health care organizations, configuring competitively relevant strengths to the organization's greatest advantage, eliminating or minimizing the adverse effects of competitively relevant weaknesses, and establishing demanding aspirations that require strategic assets to be synergistically pursued while constantly searching for new opportunities. Chapter 5 examines the development of directional strategies that set strategic direction and create buy-in among stakeholders.

Practical Lessons for Health Care Strategic Thinkers

1. External analysis indicates what the organization should do; internal analysis indicates what the organization can do.
2. Finding strengths that are competitively relevant involves more than a listing of strengths. Each strength must be evaluated to ensure it is of value to stakeholders, is something rare that the organization possesses, is difficult for competitors to copy, and can be sustained.
3. Leaders must evaluate the organization's weaknesses to ensure they do not constitute a competitive disadvantage. Competitive disadvantages, without corrective action, place the organization in danger of extinction.
4. Competitive advantage is not an excuse for complacency; the things that made an organization great in the past may be the very things that will cause problems in the future.

THE LANGUAGE OF STRATEGIC MANAGEMENT: KEY TERMS AND CONCEPTS

After-Service
Capability
Competency
Competitive Advantage
Competitively Relevant Strength
Competitively Relevant Weakness
Disruptive Capability
Dynamic Capability
Leveraging
Objective Strength or Weakness
Point-of-Service
Pre-Service
Red Queen Effect
Relative Strength or Weakness
Resource-Based Theory
Resources
Service Delivery
Strength
Stretch
Subjective Strength or Weakness
Support Activities
Sustained Competitive Advantage
Synergy
Threshold Condition
Value
Value Chain
Weakness

Questions for Class Discussion

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

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Chapter 5

Directional Strategies

“Strategic decisions are those that determine the overall direction of an enterprise and its ultimate viability in light of the predictable, the unpredictable, and the unknowable changes that may occur in its most important surrounding environments. They ultimately shape the true goals of the enterprise.”

—JAMES BRIAN QUINN, STRATEGY AUTHOR AND DARTMOUTH PROFESSOR

Why Directional Strategies Are Important

As suggested by James Brian Quinn, strategic decisions set the overall direction for an organization and shape its goals as well as its products and services, markets, and service delivery and support activities. The broadest strategic decisions are the directional strategies – vision, mission, values, and strategic goals – because they provide general limits for all subsequent organizational decisions. The directional strategies essentially document strategic thinking concerning “who we are, what we want to be, how we are going to behave, and what we want to achieve.”

Directional strategies are profoundly important; they initially set all other activities in motion. The directional strategies create the first signs of momentum for the organization. They rest solidly on a close examination of the reasonably predictable changes that the strategic thinking activities (awareness, anticipation, analysis, and interpretation) have synthesized concerning the organization’s environment (external environmental analysis) and itself (internal analysis). In addition, to a considerable extent, the directional strategies must be able to weather the unpredictable and unknowable changes that will inevitably occur to guide subsequent organizational decisions. Vision, mission, and values are relatively enduring, whereas strategic goals may be short or long term, and will naturally evolve as some are accomplished and others are modified in a changing environment.

A change in the directional strategies is usually evolutionary rather than revolutionary. Therefore, directional strategies should be re-examined and modified over time, allowing an organization to remain nimble enough to maneuver in its changing environments. Transforming an organization’s identity and what it does is never an easy task. Re-invention can be traumatic for the organization, but sometimes necessary for survival.

Because the directional strategies are relatively enduring, they must take an organization through good times and bad, and are difficult to change *en masse*; therefore, strategic managers must carefully create the organization’s directional strategies.

Use concepts in this chapter to craft exciting and enduring directional strategies!

Learning Objectives

After completing the chapter you will be able to:

1. Discuss how external environmental analysis, service area analysis, and internal analysis provide the context for developing the directional strategies.
2. Describe the roles of and relationships among mission, vision, values,

and strategic goals.

3. Develop a mission statement incorporating the important characteristics and components of organizational missions.
4. Compose an organizational vision statement using the relevant characteristics and components of organizational visions.
5. Develop a values statement based on established characteristics and components of organizational values.
6. Use service category critical success factors to imbue strategic goals.
7. Develop a set of strategic goals that contribute to the mission, move the organization toward the realization of its vision, and are consistent with the organization's values.
8. Discuss the important issues in the governance of health care organizations and the role of boards of directors in creating and maintaining policy-making direction.

Strategic Management Competency

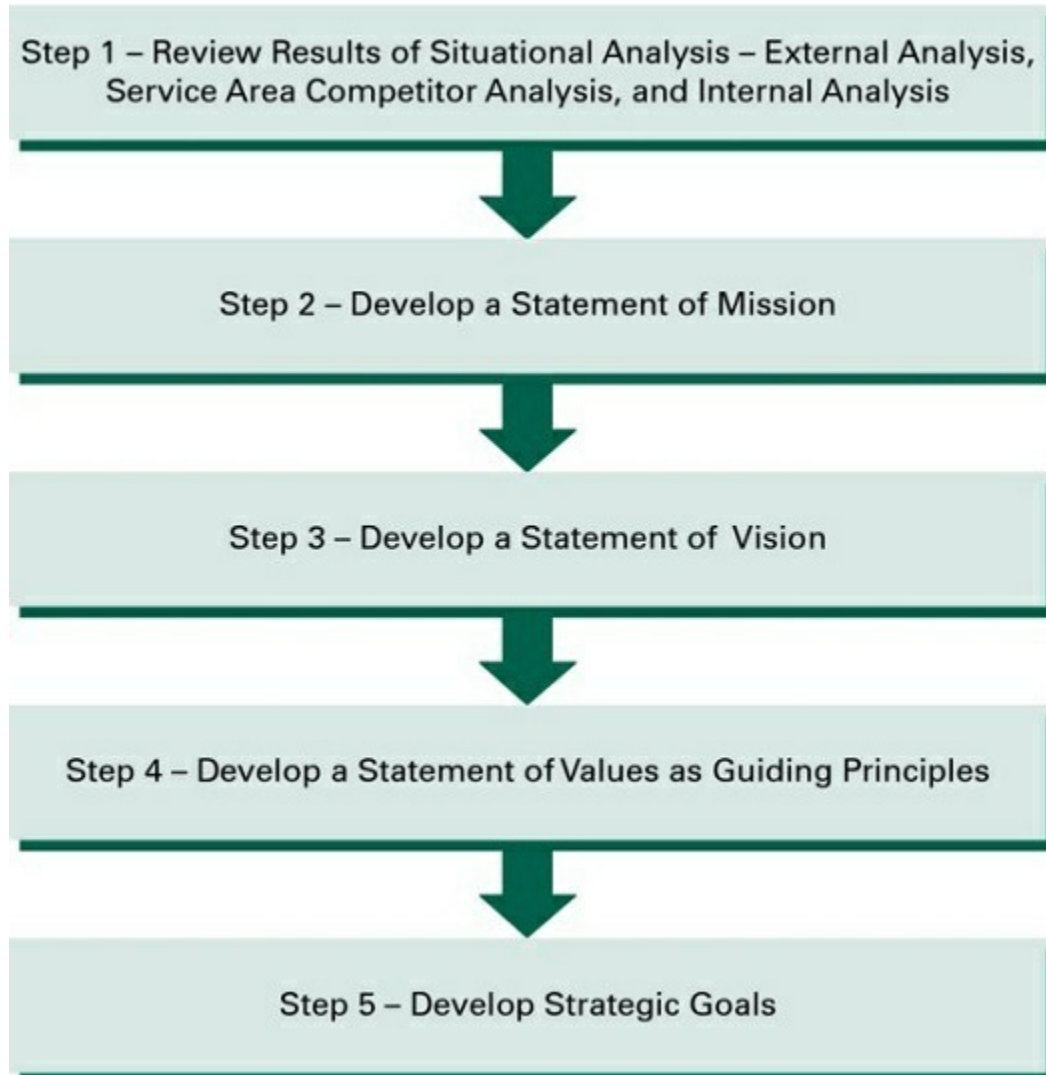
After completing this chapter you will be able to develop directional strategies for a health care organization.

Directional Strategies

Mission, vision, values, and strategic goals are appropriately called directional strategies because they guide strategists when they make key organizational decisions. The *mission* captures the organization's distinctive purpose or reason for being – it is a broadly defined and enduring statement of purpose that distinguishes one organization from other organizations of its type and identifies the scope of its operations in product, service, and market (competitive) terms. The *vision* creates a mental image of what leaders want the organization to achieve. It is an expression of hope for a desired future state – a description of what leaders want the organization to accomplish when it is fulfilling its mission. *Values* are the fundamental or guiding principles that are held dear by members of the organization and shape the organization's culture. These are principles the managers and employees will not compromise while they are in the process of achieving the mission and pursuing the vision and strategic goals. *Strategic goals* are benchmarks or end results related to critical success factors; consequently, the goals should provide more specific direction that accomplishes the mission and vision. Unfortunately, there is rarely a clear distinction among the concepts and terms actually used in these statements – especially in the mission, vision, and value statements. Studies of actual statements reveal that even when the statements are clearly labeled there is a wide variety of terms used to express the ideas contained in them.¹ From an analysis of 100 firms in the *Fortune 500*, it was suggested that many mission statements are written at an educational level above what would be effective to communicate to all stakeholders.²

The Process for Establishing Directional Strategies

[Exhibit 5-1](#) provides an overview of the process for establishing the directional strategies. The exhibit demonstrates the sequence and the need to understand the broadest external analysis to the more narrow internal analysis followed by the narrower still service area competitor analysis. Only after a thorough understanding of the situation the organization faces are the directional strategies formulated.



[Exhibit 5.1](#) The Process for the Development of Directional Strategies

Step 1: Review Results of Situational Analysis

In Chapter 2 guidelines for a situational analysis were developed and it was noted that an understanding of the external environment is essential for organizations to answer the question, “What should we be doing?” The “rules of success” are written outside the organization and these rules must be clearly understood before an effort is made to develop the mission, vision, values, and

strategic goals of the organization. A critical aspect of the external environment is the nature of the competitors in the organization's market space (Chapter 3, Service Area Competitor Analysis).

The more organizational leaders know about the strengths and weaknesses of competitors, the more likely they will be able to position the organization to establish or maintain its ability to compete effectively (its competitive advantage) as covered in Chapter 4. A complete review of the organization's situation with regard to external and internal factors is necessary before beginning the process of formulating the directional strategies.

Step 2: Develop a Statement of Mission

Chester Barnard, in his seminal book, *The Functions of the Executive*, stated that only three things are needed to have an organization: (1) communication, (2) a willingness to serve, and (3) a common purpose. The inculcation of the "belief in the real existence of a common purpose" is, according to Barnard, "the essential executive function."³ Purpose, among other things, helps managers make sense of the environment. When the purpose of an organization is clearly understood, the complexity of the environment can be reduced; leaders are able to analyze their situation in light of the goals the organization wishes to achieve. Thus the complex environment is no longer a "mere mess of things." As a statement of purpose, the mission plays an important role in focusing strategists' attention on relevant aspects of the environment.

For example, if the CEO of a long-term care facility attempts to consider all the turbulence in the organization's environment, it will be overwhelming. Can anyone effectively track all of the changes taking place in biotechnology, cultural values, demographics, and politics? However, if the CEO focuses on only those aspects of the environment that relate to the mission of the long-term care organization, the task becomes more manageable. Essentials for a Strategic Thinker 5-1, "What Is the Long-Term Care Industry?" provides an overview of this expanding industry.

ESSENTIALS FOR A STRATEGIC THINKER 5-1

What Is the Long-Term Care Industry?



The long-term care industry is comprised of organizations that provide rehabilitative, restorative, or ongoing skilled nursing care to patients who require assistance with daily living. A variety of facilities dedicated to the intensity of care required have developed over time. The "old folks home" may now be a memory care facility, a skilled nursing facility, a rehab facility, and so on. The following list represents the main types (listed in ascending order by intensity of care).¹

INDEPENDENT LIVING

Adult communities usually impose age restrictions, offer social activities, and provide increased security. Generally, these facilities do not offer medical services but may facilitate access to care by providing convenient transportation, scheduled visits from contract providers, and so on. Typically, residents are age 75 or younger.

CONGREGATE CARE FACILITIES (CCFs)

These facilities provide social activities, security, and non-health related services such as meals, housekeeping, and transportation for shopping and health care appointments. The target age population is 75–82 years.

ASSISTED LIVING FACILITIES (ALFs)

Although there is no uniformly accepted definition of ALFs, the U.S. Department of Health and Human Services defines ALFs as residences that provide either routine general protective oversight or assistance with activities necessary for independent living to mentally or physically limited persons. These facilities generally provide care for individuals between the ages of 70 to 90+ years.

SKILLED NURSING FACILITIES (SNFs)

The statutory definition of a skilled nursing facility as provided in the Social Security Act is an institution (or a distinct part of an institution) that is engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehab services (for the rehabilitation of injured, disabled, or sick persons), and is not primarily for the care and treatment of mental diseases. Nursing facilities offer the most intense level of long-term care for individuals requiring around the clock care; they generally have transfer agreements with one or more hospitals.

Medicaid is the primary payer of long-term care services. Over 60 percent of the patients in nursing homes as well as almost 20 percent of residents in assisted living facilities,² are Medicaid recipients. Medicare recipients, by comparison, return to their home after a relatively short stay of 36½ days for purposes of rehabilitation.

The future of the long-term care industry appears very promising because of the aging of the population and advances in medical science that have prolonged human life. As the population ages, the demand for rehabilitative services, assisted living services, and treatment of chronic conditions increases.

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

Mission: A Statement of Distinctiveness

In the hierarchy of goals (end results and organizational plans to accomplish them), the mission captures the organization's distinctive character. Although a well-conceived mission is general, it is more concrete than vision. An organizational mission is an attempt to capture the essence of the organizational purpose and commit it to writing. Stryker Corporation, an international leader in the development of medical technologies, has a mission statement that is simple and to the point – “Together with our customers, we are driven to make healthcare better.”⁴ Emphasis is placed on the interactions with customers, physicians, researchers, and so on, in the development of innovative products and services. This simple statement is used to coordinate the actions of thousands of employees in more than 100 countries.

An organizational mission is a broadly defined and enduring statement of purpose that distinguishes a health care organization from other organizations of its type and identifies the scope of its operations in product, service, and market (competitive) terms.⁵ The mission statement of the University of Texas MD Anderson Cancer Center in [Exhibit 5-2](#), for example, distinguishes the center from other health care organizations in the service area by its relationship with the University of Texas; its emphasis on a specific disease (cancer); its commitment to the integration of patient care, research, education, and prevention; and its intention to accomplish these through education at the undergraduate as well as graduate levels.

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

Source: University of Texas MD Anderson Cancer Center.

Exhibit 5.2 Mission Statement of the University of Texas MD Anderson Cancer Center

MD Anderson developed an effective logo that states that MD Anderson Cancer Center is dedicated to “Making Cancer History” with a bold red line through the word “cancer”. With cancer “wiped” out, MD Anderson is definitely making history. Since 1990 when *U.S. News & World Report* began a ranking of hospitals, MD Anderson has been ranked first or second, and has received the

top ranking nine times in the past ten years.

Although mission statements are relatively enduring, they must be flexible in light of changing conditions. The changes facing academic medicine will continue to impose pressures on specialized centers of excellence such as MD Anderson because of the substantial costs involved in integrating patient care with the teaching and research mission and the increasing reluctance of payers to reimburse for educational costs. Essentials for a Strategic Thinker 5–2, “What Are Academic Medical Centers?” highlights the nature and some challenges facing academic medical centers. Despite the challenges, MD Anderson has retained its mission statement for a number of years and has remained focused on its distinctiveness in a rapidly changing environment.

ESSENTIALS FOR A STRATEGIC THINKER 5–2

What Are Academic Medical Centers?



According to the Association of American Medical Colleges (AAMC), an academic medical center (AMC) is a “university-based hospital or health system that is organizationally or administratively integrated with a medical school.” Despite the Association’s singular definition, AMCs are diverse and complex – no two are alike. They differ in organizational, operational, financial, and governance structures. At their core, AMCs typically include a medical school, a teaching hospital, and faculty who teach medical students and specialty trainees as well as provide clinical care for patients. The current trend is toward greater alignment among these three components, yet no single corporate structure is considered ideal. Of the approximately 140 allopathic medical schools, only 25 percent are fully integrated such as the University of Michigan Health System where the medical school, hospital, and faculty practice fall under one corporate structure. On the other end of the spectrum, fewer than 10 percent operate as separate entities, similar to George Washington University. In between are multiple examples of “corporate” alignment between school and hospital (University of Virginia), school and faculty (Columbia University Medical Center), and hospital and faculty (Vanderbilt University Medical Center). Where an AMC falls along this alignment continuum is a product of its institutional history, culture, and financial interrelationships.

Not only do AMCs provide patients and their communities with health care services ranging from everyday needs to the most specialized care, in addition, they:

- Offer unique care and services not available anywhere else in their market.
- Teach the next generation of health care professionals and train these professionals in new care delivery models.

- Develop technologies, forge new discoveries, and conduct research that improve the health and well-being of the citizens they serve.

According to a 2016 Advisory Board Outlook, AMCs account for only 5 percent of hospitals in the United States, but they deliver 25 percent of all clinical care and represent 100 percent of the hospitals featured on *U.S. News & World Report's* 2016–2017 Honor Roll. In addition, AMCs provide 41 percent of all hospital-based charity care and 28 percent of all Medicaid services while training over 100,000 residents annually.

Despite serving as a “safety net” for critical services, AMCs are economic engines, responsible for nearly \$34 billion in state tax revenue and more than 3.5 million full-time jobs (1 out of every 40 wage earners works either directly or indirectly for an AMC). A 2011 AAMC study estimated that the combined economic impact of AAMC member medical schools and teaching hospitals was over \$587 billion.

Most AMCs have characteristics that can make planning challenging, especially their tripartite mission of clinical care, research, and education. Planning around a single mission is difficult enough, but to embrace and acknowledge all three can be insurmountable. Many times the goals and objectives for one mission can be at odds or in conflict with another. Plans to grow and invest in a strategic clinical service may result in less funding or resources to pursue research initiatives. Conversely, using limited capital to build more lab research space may require postponing the expansion of patient clinics.

In addition to having several missions, AMCs have multiple stakeholders (i.e. chief executives, deans of medical schools, department chairs, hospital or service line directors, etc.) and multiple channels of engagement with varying levels of oversight and scopes of responsibility. The relationship among these various organizational components is often poorly defined but highly co-dependent and leads to an extensive consensus-driven decision-making process.

Source: David Randall, Senior Vice President, Strategy and Business Development, University of Alabama at Birmingham Health System.

Mission statements are sometimes not the true “living documents” that are capable of encouraging high performance. Studies of mission statements confirm that the full potential of this directional strategy is rarely achieved.⁶ Often mission statement creators seem to feel obligated to make reference to specific stakeholder groups such as patients or communities because of institutional pressures and refer to pressing social issues because of policy decisions within the organization.⁷ To be effective, mission statements must be carefully crafted to the organization’s unique purpose.⁸

One study of hospital mission statements found that almost 85 percent of the respondents had mission statements; however, some of the executives who completed the survey did not perceive a high level of commitment to the

statement by employees or that specific actions were influenced very much by the mission.⁹ Another study of state-level departments of public health indicated that more than 90 percent had formal, written mission statements. Despite the frequency with which formal mission statements are encountered, a great deal of confusion exists regarding their value and the influence that these statements actually have on behavior within organizations.¹⁰

This confusion is unfortunate because the mission statement is a crucially important part of strategic goal setting. It is the superordinate goal that stands the test of time and assists top management in navigating through periods of turbulence and change. It is, in other words, the stake in the ground that provides the anchor for strategic planning. It must be emphasized, however, that mission statements, even at their best, can never be substitutes for well-conceived and carefully formulated strategies.¹¹ A sense of mission is not a guarantee of success. A positive relationship between mission statements and performance assumes a commitment to the organizational purpose. This is especially true of health care organizations.¹² The organization has to adhere to the mission and regularly review it to be sure that it remains relevant. When the mission is carefully crafted, mission fulfillment influences a variety of key psychological states related to employee motivation (e.g. employee engagement, organizational identification, and so on).¹³ It has been suggested that “mythopoetic leaders,” who use the mission of the organization to anchor behaviors, can be instrumental in building robust cultures that can lead to a competitive advantage.¹⁴

Mission statements remind managers in health care organizations to ask questions of themselves and their colleagues. It is important to ask individuals throughout the organization the following questions as the answers radically affect how the organization performs. These questions include:

- *Are we not doing some things now that we should be doing?* A rehabilitative medicine center, after analyzing the environment and studying its own referral patterns, might determine that it should enter a joint venture with a group of surgeons to provide outpatient surgery services. The rehabilitative medicine center, located in a professional building adjacent to an acute care hospital, had simply been referring patients requiring surgery to the hospital. However, insurance company policies and patient preferences suggested that the majority of surgeries could be performed on an outpatient basis.
- *Are we doing some things now that we should not be doing?* The rehabilitative medicine center, after extensive analysis, concluded that it should divest its rehabilitative equipment business and contract with medical and sports equipment suppliers for needed services.
- *Are we doing some things now that we should be doing, but in a different way?* Throughout its history the rehabilitative medicine center required patients to come to the facility for services. For many patients, particularly those with serious injuries, travel to the facility was difficult and often impossible. As a strategic response, the center purchased a mobile trailer

with a fully equipped diagnostic and treatment facility that can transport services to local high schools and industrial locations.¹⁵

An organization should carefully evaluate strategic decisions using its mission statement when new opportunities are presented. The above three questions may be used to determine whether or not the new opportunity is consistent with its essential distinctiveness. Moreover, these questions are important guards against *mission drift*, which is the tendency to move into businesses and programs not in line with the stated mission.¹⁶ As an example, Cancer Treatment Centers of America's (CTCA) mission statement (see [Exhibit 5-3](#)) provides guidance for its leaders and employees in its network of hospitals across the country in determining whether or not new opportunities should be pursued. CTCA has established a reputation for "treating the whole person." In pursuit of this central goal, the use of state-of-the-art technologies is prioritized and treatment teams include medical oncologists, spiritual support personnel, rehabilitation therapists, dietitians, radiation oncologists, naturopathic clinicians, and more. Adherence to the mission enables CTCA to evaluate any and all innovative and even sometimes less conventional cancer care.

Cancer Treatment Centers of America (CTCA) is the home of integrative and compassionate cancer care. We never stop searching for and providing powerful and innovative therapies to heal the whole person, improve quality of life, and restore hope.

Source: Cancer Treatment Centers of America.

Exhibit 5.3 Mission Statement of Cancer Treatment Centers of America

Another important function of mission statements is to assist the strategic leader in asking "what should we not be doing?" If leaders do not ask this question each time they face a new opportunity they open themselves to two dysfunctional possibilities. The first is mission drift and the second is mission creep. Mission drift occurs when the mission is altered, often unintentionally, and the organization fades into areas it should not pursue. Indeed, mission statements do eliminate certain areas of operation (for example, a well formulated mission statement would discourage a health care organization from entering the construction industry). When organizations devoted primarily to health care delivery engage in businesses where they have little or no experience the results are unsuccessful more often than not.

Another temptation for organizations is *mission creep*. In this case the health care organization does not drift into an unfamiliar activity, it simply allows itself to add on more and more related activities to the point where the diversity of operations becomes unmanageable. Consider a local public health department founded by a local government to ensure the health of the public. Initially, this was interpreted as providing disease control services, vital records, and health policy advocacy. Then the absence of primary care resources for the local medically indigent population required the health department to open primary care clinics; because many in the local population did not have the transportation required to receive the services of the primary care clinics, health officers decided to devote some minimal resources to home health activities.

Over time the demand for home health grew and consumed more and more limited resources. Eventually, the local health department with essentially the same budget it had when it was founded, was providing a portfolio of services that included disease control, primary care, and home health and was considering additional services in the area of environmental health. This example demonstrates how organizations can overwhelm their resources by allowing too many activities and services to creep into their organizational missions, even while proceeding with the best of intentions.

Characteristics of Mission Statements

The mission statement of Shriners Hospitals for Children ([Exhibit 5-4](#)) illustrates some of the important characteristics of an effective mission statement. The product portfolio (specializing in services to children with neuromusculoskeletal conditions, burn injuries, and other special health care needs) is articulated in the mission statement so that interested parties can immediately understand the uniqueness of Shriners Hospital for Children. Clearly, this is not the typical children's hospital. Moreover, insights are given into the Shriners Hospital for Children's concern for family, diversity, and so on. Using the Shriners mission statement, four important characteristics of effective mission statements can be illustrated:

1. Missions are broadly defined statements of purpose. Well-formulated mission statements are written and communicated to those involved in doing the work of the organization. They are broad but also, in a sense, specific. The Shriners Hospital for Children's mission statement specifies the specific type of work it does. That is, mission statements should be general enough to allow for innovation and expansion into new activities when advisable (Shriners covers this with the phrase "other special healthcare needs") yet narrow enough to provide direction.¹⁷
2. Mission statements are enduring. The purpose, and consequently the mission, of an organization should not change often and should be enduring. People are committed to ideas and causes that remain relatively stable over time. Shriners Hospital for Children has evolved from specializing in pediatric orthopedic care in the 1920s, to burn units, to its present portfolio. The consistent underlying theme has been its focus on children and their families.
3. Mission statements should underscore the uniqueness of the organization. Shriners Hospital has a number of unique qualities including its focus on children, its emphases on education and research, and its non-discriminatory philosophy of providing care without regard to the patient's ability to pay.
4. Mission statements should identify the scope of operations in terms of service and market. However, it is important for the mission statement to specify what business the organization is in (health care) and who it believes are the primary stakeholders.¹⁸ Note that Shriners Hospital for Children clearly identifies the type of conditions it is committed to treating.

Shriners Hospitals for Children has a mission to:

- Provide the highest quality care for children with neuromusculoskeletal conditions, burn injuries and other special healthcare needs within a compassionate, family-centered and collaborative care environment.
- Provide for the education of physicians and other healthcare professionals.
- Conduct research to discover new knowledge that improves the quality of care and quality of life of children and families.

This mission is carried out without regard to race, color, creed, sex or sect, disability, national origin or ability of a patient or family to pay.

Source: Shriners Hospitals for Children.

Exhibit 5.4 Mission Statement of Shriners Hospital for Children

These characteristics illustrate the essential properties of well-conceived and communicated mission statements and outline worthy ideals that are always in the process of being achieved by strategic leaders in health care institutions.¹⁹ The mission provides direction. Mission statements are not easy to write, but fortunately there is general agreement on what they should include.

Components of Mission Statements

There is no one best way to develop and write mission statements. Research has shown, however, that in non-profit organizations the content of mission statements is influenced by interorganizational peers or other non-profits in their own networks.²⁰ Studies of Canadian not-for-profit hospitals indicate that they emphasize a variety of factors in their mission statements.²¹ To define the distinctiveness of an organization, mission statements must highlight uniqueness. Some of the more important components of a mission are discussed and illustrated with the use of mission statements from a variety of health care institutions.

- Mission statements target customers and markets. Frequently the mission statement provides evidence of the kind of customers or patients the organization seeks to serve and the markets where it intends to compete. [Exhibit 5-5](#) provides the mission statement of the Cleveland Clinic. This mission statement clearly states who are considered the customers or stakeholders of the Clinic – the patients, researchers, and all employees. Ultimately, the mission is to provide better care for the sick by investigating the reasons for their illness, providing education to those who serve the patients, and engaging in research.

The mission of The Cleveland Clinic is to provide better care of the sick, investigation into their problems, and further education of those who serve.

Source: Cleveland Clinic.

Exhibit 5.5 Mission Statement of The Cleveland Clinic

- Mission statements indicate the principal services delivered or products provided by the organization. A specialized health care organization might highlight the special services it provides in its mission statement. Amedisys is a home health and hospice care company dedicated to providing a continuum of care in the home setting. Its mission statement reflects its goal to deliver complete home health and hospice services to patients in their homes (see [Exhibit 5-6](#)).

To provide patient-centered care every day and be the leading healthcare at home team in the communities we serve.

Source: Amedisys, Inc.

[Exhibit 5.6](#) Mission Statement of Amedisys, Inc.

- Mission statements specify the geographical area within which the organization intends to concentrate. This element is most frequently included when there is a local, state, or regional aspect to the organization's service delivery. The California Department of Public Health's mission statement provides an example of this component of mission statements (see [Exhibit 5-7](#)).

The California Department of Public Health is dedicated to optimizing the health and well-being of the people in California.

Source: California Department of Public Health.

[Exhibit 5.7](#) Mission Statement of California Department of Public Health

- Mission statements identify the organization's philosophy. Frequently the mission of an organization will include statements about specific and distinguishing beliefs, values, aspirations, and priorities. Although not specifically part of the mission statement, it is useful to see the statement of philosophy that Amedisys provides in addition to its mission statement (see [Exhibit 5-8](#)).

Taking care of your loved ones as we would our own – that is the philosophy Amedisys was built on. This simple concept, coupled with our core beliefs, has guided Amedisys growth in becoming one of the nation's leading health care companies focused on bringing home the continuum of care.

Source: Amedisys, Inc.

[Exhibit 5.8](#) Philosophy Statement of Amedisys, Inc.

- Mission statements confirm an organization's preferred self-image. How a health care organization views itself may constitute a singularity that should be included in the mission. The mission statement of Fresenius Medical Care makes it clear that it views itself as the standard setter when it comes to health care (see [Exhibit 5-9](#)).

To deliver superior care that improves the quality of life of every patient, every day, setting the standard by which others in the health care system are judged.

Source: Fresenius Medical Care.

Exhibit 5.9 Mission Statement of Fresenius Medical Care

- Mission statements specify the organization's desired public image. This image customarily manifests itself in statements such as the organization's desire to be a "good citizen" or a leader in the communities where its operations are located or a similar concern. However, organizations may have a particular approach or focus that they want to communicate to the public. The mission statement of Promise Healthcare, a long-term acute care hospital (LTACH) (see [Exhibit 5-10](#)), expresses its intent to be known as a high-quality, professional, and compassionate organization.²²

Promise Healthcare's mission is to deliver the highest quality of professional and compassionate care to our patients and their loved ones.

Source: Promise Healthcare

Exhibit 5.10 Mission Statement of Promise Healthcare

Not every one of the characteristics should necessarily be included in the mission statement.²² Any particular statement will likely include one or several of these components but seldom will include all. The organization must decide which of these, or some other characteristics, really account for its distinctiveness and emphasize them in the mission statement. Interestingly, studies have found that higher-performing organizations generally have more comprehensive mission statements. Elements such as organizational philosophy, self-concept, and desired public image were particularly associated with higher-performing organizations in the sample studied.²³

Building a Mission Statement

For a mission statement to be useful a leader must begin the discussion concerning the need to examine or re-examine the organization's mission to clearly state its purpose. This statement helps all employees focus their efforts on the most important priorities. One process that can be conducive to building mission statements is to convene a group of interested employees (administrative and non-administrative) who understand the issues facing the health care system as well as the strengths and weaknesses of the organization. Each member of the group should understand the "big picture" and be able to look at things from the perspective of the CEO, not just from his or her personal viewpoint.

Prior to actually writing the mission statement, everyone should understand why a mission statement is being written or rewritten and the desire for a well-understood and widely communicated statement of organizational distinctiveness. Without a common ambition shared among organizational members, the usefulness of the mission statement and its ultimate purpose will not be realized. Once commitment has been established, assessments should be made of what makes the organization successful from the perspectives of employees and other key stakeholders. Further, consideration should be given to what perceptions of success will be in the future.

After the group has been given time to think about the organization, its distinctiveness in its environment, as well as the likely future it will face, the group should meet in a planning retreat. Often it is useful to remove the participants from the office, and encourage unplugging from social media to have the opportunity to truly focus on the organization's mission. To stimulate strategic thinking, each person should be asked to reflect on the mission statement components listed in [Exhibit 5-11](#). Recognizing that some members may not have been previously involved in writing a mission statement, this exhibit was developed to encourage initial thought without introducing too much structure into the process. Group members should be asked to present key words relative to each of the components. The key words should be recorded and eventually used as the raw material for the mission statement. Participants can be encouraged to generate the key words through a series of fill-in-the-blank statements listed under each mission statement component.

Component	Key Words Reflecting Component
1. Target customers and clients:	
<i>"The individuals and groups we attempt to serve are ..."</i> Do not be limited to only the obvious.	
2. Principal services delivered:	
<i>"The specific services or range of services we will provide to our customers are ..."</i>	
3. Geographical domain of the services delivered:	
<i>"The geographical boundaries within which we will deliver services to our customers are ..."</i>	
4. Specific values:	
<i>"Specific values that constitute our distinctiveness in the delivery of our services to customers are ..."</i>	
5. Explicit philosophy:	
<i>"The explicit philosophy that makes us distinctive in our service area is ..."</i>	
6. Other important aspects of distinctiveness:	
<i>"Other factors that make us unique among competitors are ..."</i>	

Exhibit 5.11 Strategic Thinking Map for Writing a Mission Statement

After discussion and fine-tuning of the language, a draft of the mission statement can be developed. The draft should be refined by the group until there is consensus on the wording and meaning of the mission statement. Once the group is satisfied with the statement, it should be circulated among key individuals to gain their input and support.

Top-Level Leadership: A Must for Mission Development

For a mission statement to be a living document, employees must develop a sense of ownership and commitment to the mission of the organization. Involving employees is therefore essential in the development and communication of the mission. However, top-level leadership must be committed. Management must stay engaged in the mission development process but not dominate it. Board rooms and executive suites can produce great ideas for mission development but everyone must commit to the mission for it to be achieved.²⁴

Developing a mission statement is a challenging task. Frequently, attempts are made to formulate “blue sky” statements of environmental and competitive constraints and little more. For example, it is of little real value to state that a health care organization is devoted to being a good citizen in the community and to paying wages and benefits comparable to those of other organizations in the area. Realistically, the organization must be a good citizen and, if it wants employees, its wages and benefits must be competitive.

The role of the chief executive officer in formulating the mission should not be underestimated. Mission statement development is not a task that should be delegated to a planning staff. The CEO, the leadership team, and other key individuals who will be instrumental in accomplishing the mission should provide input.

Although the process appears to be simple, the actual work of writing a mission statement is time consuming and complex, with many “drafts” before the final document is produced. The strategic thinking map ([Exhibit 5-11](#)) is useful for identifying clients, services, and domain; however, the development and communication of a well-conceived mission statement requires use of the compass (leadership) as well.

Step 3: Develop a Statement of Vision

The mission is developed considering the needs of stakeholders – groups who have a vested interest in the success and survival of the organization. Vision, on the other hand, is an expression of hope. It is a description of the organization when it is fulfilling its purpose.²⁵ Vision involves creating compelling images of the future and produces a picture of what could be and, more importantly, what a leader wants the future to be.²⁶

Effective visions possess four important attributes: idealism, uniqueness, future orientation, and imagery.²⁷ Visions are about ideals, standards, and desired future states. The focus on ideals encourages everyone in the organization to

think about possibilities. It is dynamic and collaborative, a process of articulating what the members of an organization want to create. Vision communicates what the organization could be if everyone worked diligently to realize the potential. Health care organizations need leaders who are forward looking. Effective visions are statements of destination that provide direction to where the organization's leadership collectively wants to go. Finally, visions are built on images of the future. When people are asked to describe a desirable place or thing, they almost always do so in terms of images. Images motivate people to pursue the seemingly impossible. One study of archival information in 151 hospitals and experiments with 62 groups of full-time employees found that leaders who used specific combinations of large amounts of vision imagery and smaller amounts of values improved organizational performance by triggering a shared sense of organizational goals thereby improving coordination.²⁸

Origins of Vision

Health care leaders develop vision from an appreciation of the history of the organization, a perception of the opportunities present in the environment, and an understanding of the strategic capacity of the organization to take advantage of these opportunities. All these factors work together to form an organization's hope for the future.

History and Vision

An organization's history is comprised of a variety of events and activities including the founder's philosophy. The story of St. Jude Children's Research Hospital began with Danny Thomas, a struggling entertainer, who prayed to St. Jude Thaddeus, the patron saint of hopeless causes and said, "Show me my way in life and I will build you a shrine." Thomas' fortunes changed and he became one of the best known stars in the entertainment industry.

In the 1950s, Thomas enlisted members of the business community in Memphis to build a hospital for children. Supporters became convinced that rather than a general hospital for children, a research hospital devoted to childhood cancers would be a better option. Thomas and his wife devoted their time to funding the hospital and eventually enlisted fellow Americans of Arabic-speaking descent to assist. The American Lebanese Syrian Associated Charities (ALSAC) now raises hundreds of millions of dollars annually to support St. Jude. Over 9 million donors and more than one million volunteers contribute to make St. Jude's the nation's largest health care charity.

Think of the inspirational impact of the relationship between the history and vision of St. Jude to employees, donors, and all other stakeholders. Danny Thomas' dream was that "no child should die in the dawn of life." In 1962 the survival rate for childhood cancer, for example, was 20 percent. As of 2017, it is over 80 percent. And, no child is turned away for an inability to pay.²⁹

Vision and the Environment

The vision must be relevant to the larger system and be sensitive to the changes

taking place in the general and health care environments. For example, Essentials for a Strategic Thinker 5–3, “What Are Health Care Sharing Ministries?” demonstrates how some religious organizations reacted to the passage of the Affordable Care Act in 2010 that offered an exception to the individual insurance coverage mandate allowing individuals with similar ethical or religious beliefs to form organizations to share medical bills. This resulted in the emergence of health care sharing ministries.

ESSENTIALS FOR A STRATEGIC THINKER 5–3

What Are Health Care Sharing Ministries?



Health Care Sharing Ministries (HCSM) are faith-based not-for-profit organizations that allow members who share the same religious beliefs and values to share the risks of their health care expenses. Customarily, these ministries are 501(c)(3) organizations that are considered legal alternatives to the individual mandate under the Affordable Care Act. The ACA allowed an exception for individuals with a “common set of ethical or religious beliefs” to share one another’s medical bills.¹

Members join health sharing ministries for a variety of reasons. Some join because they can obtain less expensive coverage. The lower cost is made possible by the fact that these ministries are not required to include coverage in areas such as mental health, preventive care, and vision coverage for children. Others join because required procedures in insurance plans violate their personal religious beliefs.

It is estimated that half a million people rely on HCSMs for their health coverage. Some of the largest HCSMs include Samaritan, Medi-Share, Christian Healthcare Ministries, and Liberty HealthShare. It is important to note that HCSMs are not insurance companies in the conventional sense. Perhaps the most important issue is that they are not regulated and represent potentially riskier alternatives than traditional health care insurers. This risk was highlighted by the actions of a Circuit Judge in Kentucky who ruled that Medi-Share must cease operations in the state unless it obtains regulatory approval from the state Department of Insurance.² Kentucky and other states, notably Washington and Oklahoma, have been unsuccessful in their efforts to close down HCSMs. It is estimated that 30 states exempt HCSMs from the same regulations as insurance companies, although some fear this leaves members without protection if their health care costs are not covered.³

Monthly costs typically range from around \$64 for individual coverage to \$450 per month for family coverage. The larger plans do not have a maximum limit on the coverage, although some plans have maximum payout of \$125,000 per incident and \$1,000,000 per diagnosis. Annual

personal responsibility amounts (similar to a deductible) have a relatively large range depending on the actual HCSM involved. For example, Medi-Share offers six programs and the annual personal responsibility can range from \$1,250 to \$10,000 depending on the program selected. Christian Healthcare Ministries' Gold, Silver, and Bronze options have annual personal responsibility of \$500, \$1,000, and \$5,000 respectively.

Medi-Share members participate in a preferred provider organization and are charged negotiated rates as long as they stay in the network. Membership cannot be dropped for developing a medical condition and some HCSMs do not impose annual or lifetime limits.

REFERENCES

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Vision and Internal Capacity

A leader's vision is related to the perceived strengths and weaknesses of the organization. The challenge to reconcile vision with internal capacity is illustrated by Senge's integrative principle of creative tension.³⁰ *Creative tension* comes into play when leaders develop a view of where they want to be in the future (vision) and tell the truth about where they are now. The current reality is heavily determined by the organization's internal capacity and how this capacity relates to its aspirations.

Organizations deal with this creative tension in different ways. If the organization has been successful in the past, it may be aggressive about the future and raise its current aspirations in pursuit of the vision. If it has experienced failure, limited success, or merely has a cautious philosophy, management may choose instead to revise and reduce the vision to bring it more in line with current reality.

Leaders have visions; organizations gain and lose competitive advantage based on how the vision fits the environment and the strategic capability of the organization to capitalize on opportunities. However, developing a vision is "messy work," and for this reason it is necessary to examine more closely what organizational vision actually means.

Health Care Strategists as Pathfinders

Building a vision for an organization is frequently referred to as pathfinding.³¹ When the leader of a health care organization functions as a pathfinder, the focus is on the long run. The goal of the pathfinder is to provide a vision, find the paths the organization should pursue, and provide a clearly marked trail for those who will follow. As Senge notes, pathfinders have the opportunity to change reality by “holding a picture of what might be that is more important to people than what is.”³²

Strategic leaders are the key to establish a vision for an organization. The *vision-led approach* is a philosophy where leaders are committed to strive for high levels of performance that are inspiring although they cannot yet be achieved.³³ A primary role of management using this approach is to clarify goals and priorities and ensure that they are understood and accepted by employees.³⁴ Individuals become engaged in the organization when they see connections between vision, performance objectives, and personal contributions to the purpose of the organization.³⁵

The role of the strategic leader, however, is more than pathfinding. Because executives are responsible for inculcating the purpose into every employee, the leader must also be the *keeper of the vision* – a champion who communicates and models the vision. This is often the CEO or another high-ranking executive. Employees want to believe that what they are doing is important, and nothing convinces employees of the importance of their jobs more than a leader who reminds them of the shared inspirational vision (especially when things are not going well).

Strategic leadership has traditionally focused on top management, particularly the CEO. This individual is considered the person most responsible for scanning and influencing the environment, developing adaptive strategies, and managing key constituencies.³⁶ Unfortunately, the exclusive focus on the CEO’s role in strategic leadership has implied that middle management has little or no involvement in determining the strategic direction of the organization. Admittedly, the primary responsibility of middle management is strategy implementation; however, certain strategic directions require middle-management to give input and be actively involved. The increasing importance of quality as a strategic goal and middle management’s role in keeping this goal before all employees is a good example.³⁷ Quality is an important value to which employees at all levels are able to be committed; middle managers are in the best position to encourage and reinforce this dedication.

Another critical area in which middle management should be involved is in the redefinition of organizational vision. Grand strategies and futuristic visions are necessary for health care organizations. If the vision is to inspire nurses, pharmacists, medical laboratory technicians, and others, middle and first-line managers must take the lead in helping to redefine the organizational vision in terms that are meaningful to departments and work groups. Finally, with regard to promoting commitment to service and quality, middle managers are in the best position to appeal to the motives that matter most to their health care

employees. Unfortunately, “most people either don’t know their organization’s vision, don’t understand it, or feel so disconnected from it that they can’t explain how it relates to their day job.”³⁸

Characteristics of Effective Vision

If vision is based on hope, it is – in reality – a snapshot of the future that the health care leader desires to create. For an organizational vision to be successful it must be clear, coherent, consistent, communicative, and flexible.³⁹ A clear vision is simple. Basic directions and commitments should be the driving forces of a vision, not complex analysis beyond the understanding of most employees.⁴⁰

A vision is coherent when it “fits” with other directional strategies, including the mission and values. It is consistent when it is reflected in decision-making behavior throughout the organization.⁴¹ A vision “communicates” when it is shared and people believe in the importance of cooperation in creating the future that managers, employees, and other stakeholders desire. Finally, to be meaningful, a vision must be flexible. Because the future is uncertain, an effective vision must remain open to change as the future and the strategic capabilities of the organization evolve over time.

To effectively outline the future and facilitate the pursuit of organizational and individual excellence, visions should possess certain characteristics:

- Visions should be inspiring, not merely quantitative goals to be achieved in the next performance evaluation period. In fact, visions should rarely be stated in quantitative terms. They are, however, nothing less than revolutionary in character and in their potential impact on behavior. The vision of Shriners Hospital for Children speaks of the inspirational nature of “transforming children’s lives” ([Exhibit 5-12](#)).

Become the best at transforming children’s lives by providing exceptional healthcare through innovative research, in a patient and family centered environment.

Source: Shriners Hospital for Children.

[Exhibit 5.12](#) Vision of Shriners Hospital for Children

- Visions should be clear, challenging, and about excellence. There must be no doubt in the manager’s mind about the centrality of the vision. If the “keeper of the vision” has doubts, those who follow will have even more. The vision statement of MD Anderson Cancer Center provides a straightforward statement of the hope for this flagship cancer institute – to make cancer history. Individuals working at MD Anderson should be able to understand the leadership’s sense of the future from this vision statement (see [Exhibit 5-13](#)).

We shall be the premier cancer center in the world based on the excellence of our people, our research-driven patient care and our science. We are Making Cancer History.

Source: MD Anderson Cancer Center.

Exhibit 5.13 Vision Statement of MD Anderson Cancer Center

- Visions must make sense in the relevant community, be flexible, and stand the test of time. If the vision is pragmatically irrelevant, it will not inspire high performance.
- Visions must be stable, but challenged and changed when necessary. The vision statement of Fresenius makes it clear that it intends to be a trusted provider and valued partner in the area of renal disease (see [Exhibit 5-14](#)); however, the statement includes the possibility of moving to an expanded integrated chronic care network. Such a move could be accomplished with little or no change in the vision statement.

To be the trusted provider and valued partner by building the premier integrated renal disease network, expanding into a leading integrated chronic care network.

Source: Fresenius Medical Care.

Exhibit 5.14 Vision Statement of Fresenius Medical Care

- Visions are beacons and controls when everything else seems up for grabs. A well-formulated vision statement guides decision making because it provides inspiration for success in the future. The vision statement for Cancer Treatment Centers of America is simple and to the point both for decision makers and patients (see [Exhibit 5-15](#)).

To be recognized and trusted by people with cancer as the premier center for healing and hope.

Source: Cancer Treatment Centers of America.

Exhibit 5.15 Vision Statement of Cancer Treatment Centers of America

- Visions empower employees (the organization's own people) first and then the clients, patients, or others to be served. Because visions should be about inspiration and should drive excellence, it is critical to recognize that employees are the ones who must be inspired first. Many health care organizations make the mistake of devoting resources to pre-service promotion programs designed to enhance potential patients' image of the organization only to disappoint them when they arrive and are greeted by the same lack of service they experienced before the advertising campaign. The Cleveland Clinic documents point out that this was the founder's vision when the first patients were accepted in 1921 (see [Exhibit 5-16](#)). The doctors who founded this world class clinic believed in diverse specialists working and thinking "as a unit." That philosophy remains alive and well today.

Striving to be the world's leader in patient experience, clinical outcomes, research and education.

Source: The Cleveland Clinic.

Exhibit 5.16 Vision Statement of The Cleveland Clinic

- Visions prepare for events to come while honoring the past. Although vision is the hope an organization has for the future, it is important to always acknowledge and honor a history of distinction and service. The Mayo Clinic, for example, points out that the values that guide the pursuit of its vision are the expression of the vision of its founding physicians and the Sisters of Saint Francis (see [Exhibit 5-17](#)). This association dates back to a tornado that struck Rochester, Minnesota in 1883 when doctors in the Mayo family teamed with the Sisters of St. Francis to provide relief to those injured in the community. Six years later Saint Mary's Hospital was opened by the Sisters and the Mayo brothers began seeing patients.

The Mayo Clinic will provide an unparalleled experience as the most trusted partner for health care.

Source: The Mayo Clinic.

[Exhibit 5.17](#) Vision Statement of The Mayo Clinic

- Visions come alive in details, not broad generalities. The accomplishment of the vision eventually has to lead to tangible results. Although visions are futuristic and based on hope, they require strategic leaders who can articulate the vision and translate it into terms that everyone in the organization understands and supports.⁴²

In the past decade more and more attention has been given to formal vision statements. Vision statements are difficult to write because they require insights into the future. However, there are some useful aids that can assist managers in developing their vision and setting the direction they desire for the future.

[Exhibit 5-18](#) provides a strategic thinking map to assist in developing a vision statement and a series of questions that are a useful aid when thinking about vision statements. Planning retreats can be used as effective forums for gaining insights into the thinking of organization stakeholders regarding their hopes for the future.

Component	Key Words Reflecting Component
1. Clear hope for the future: “If everything went as we would like it to go, what would our organization look like five years from now? How would we be different/better than today?”	
2. Challenging and about excellence: “When stakeholders (patients, employees, owners) describe our organization, what terms would we like for them to use?”	
3. Inspirational and emotional: “When we think about the kind of	

organization we could be if we all contributed our best, what terms would describe our collective contributions?”	
4. Empower employees first: “How can we ensure that employees understand and are committed to the vision? What needs to be done to get everyone’s buy in?”	
5. Memorable and provides guidance: “What types of words should be included to ensure all organizational stakeholders remember and behave in accordance with the vision?”	

Exhibit 5.18 Strategic Thinking Map for Writing a Vision Statement

A Cautionary Note: The Problem of Newness

Strategic leaders are one of the most important elements in the strategically managed organization. Visionary leaders provide their greatest service by making the organization flexible and able to enter new markets, disengage from old ones, and experiment with new ideas. By entering into a new market first, organizations may achieve *first-mover advantages* that often accrue to those organizations who are the first into a new market.⁴³ *Pioneering* organizations are those that seek first-mover advantages. A reputation for pioneering can be generated and market position can be more easily established when there are no, or only a few, competitors. Sometimes it is expensive (monetarily and emotionally) for clients and patients to switch to other providers once loyalty and mutual trust have been developed.

However, visionary change, when directed toward early entry into markets, has its drawbacks. Referred to as the *liability of newness*,⁴⁴ disadvantages of early entry into new markets are typically in the form of risk (uncertainty), the steep (and sometimes long) learning curve, variable demand, and financial outlays for technological investments. Innovators often experience pioneering costs. Pioneers make mistakes that others learn from and eventually correct. First movers face greater uncertainty because the demand for the service has not been proven. Patient and client needs may change and, particularly when large technological investments are required, the first mover may be left with expensive equipment and little demand. Therefore, it is important that the demand for visionary management be tempered with realistic knowledge of the market, consumers, and other factors that will affect the organization. The most substantial rewards often go to the first mover, but the risks are greater.

Research confirms the dangers of being the first mover. Studies of companies that were first in their markets exclude those firms that failed by focusing only on those that survived, prospered, and eventually dominated their markets.⁴⁵ Note that market leadership has less to do with an organization’s entry into the

market and more to do with will and vision. Enduring leaders have inspiring visions and the will to realize the vision. These leaders are persistent in the pursuit of their vision, innovative, committed financially, and know how to leverage their assets.

Step 4: Develop a Statement of Values as Guiding Principles

Values are the fundamental principles that organizations and people stand for – along with the mission and vision, they shape organizational culture. Most often, discussions of organizational values relate to ethical behavior and socially responsible decision making. Ethical and social responsibility values are important, not just to a single hospital, HMO, or long-term care facility, but to all organizations and stakeholders. There are, however, other values that may be specific to an organization and characterize its members' behavior in the past or the behavior to which members collectively aspire. For example, total quality management or continuous improvement is a value, as are entrepreneurial spirit, teamwork, innovation, and so on.⁴⁶ It is important that managers, employees, and key stakeholders understand the values that are expected in an organization. In addition, values should be more than slick public relations statements. “Talking the talk” is insufficient; “walking the walk” is what matters when it comes to values. Essentials for a Strategic Thinker 5–4, “What Are Professional Ethics?” demonstrates the relationship among ethics, values, moral principles, and duties.

ESSENTIALS FOR A STRATEGIC THINKER 5–4

What Are Professional Ethics?



Ethics are guidelines for action that are based on values, moral principles, or moral rights and duties. Examples include honesty, respect, and compassion. Ethical guidelines may be reflected in laws, whereas others are norms, customs, and social expectations that develop and are maintained by mutual consent.

It is useful to distinguish two categories of ethics in the health care environment: professional ethics and applied ethics. Professional ethics are the customs, norms, expectations, values, rights, and duties that guide individuals as they carry out particular work roles in society. Professional ethics reflect the societal expectations for people who perform specific roles. We expect physicians and nurses to help rather than harm patients. We expect administrators and business officers to accept fiduciary responsibility (act for the benefit of the organization rather than themselves) and to be accountable to stockholders or boards of trustees for their decisions.

The norms guiding professional behavior can change over time, as society's

expectations change. For example, over the past few decades, physicians' roles have evolved away from the expectation that doctors will make decisions on behalf of patients and their health to the expectation that they will provide all relevant information to patients and families and help them to make their own decisions about their treatment. As another example, the implementation of the Health Insurance Portability and Accountability Act (HIPAA) in April 2003 represented the legal enforcement of a social expectation that health-related information on patients will be kept strictly confidential; some widely accepted practices of information sharing in health care organizations had to be altered under the HIPAA guidelines because they were not perceived to reflect the priority that members of society placed on confidentiality of medical information.

Health care organizations involve the interaction of many sets of health professionals who, by definition, are bound by differing sets of ethics and norms. Decisions that must be made by the organization as a whole must be negotiated across these norms. For example, the imperative to help anyone in need of medical care must be balanced with the imperative to operate organizations that are financially sound. Organizations are best served when professionals are able to represent their own guiding values and principles and comprehend the values and principles that guide their colleagues.

In contrast to professional ethics, applied ethics is the application of values, principles, and expectations to broader social choices, such as whether some basic level of health care is a universal right, or whether health care is a commodity that individuals can choose to purchase or not. Professional ethics are neutral on this issue; one may be an ethical physician or administrator and make either applied ethics choice. Some social choices have a broad consensus. In the United States the responsibility of society to cover the costs of health care for the elderly is generally accepted. Other social choices are the subject of considerable disagreement and conflict, even when one set of values or expectations has been codified into laws. The rights of individuals to have abortions or to enforce their care preferences at the end of life are examples of ethical conflict that impact health care organizations. Organizations whose decision-making processes are affected by ethical conflicts must consider carefully the values and norms that guide their stakeholders and the laws that represent the current societal consensus on the issue.

All actions have an ethical component, but the underlying values for a decision may be so widely shared that we do not recognize or consider the implications of ethical choices. For example, we do not question the principle that health care is meant to benefit those who are sick. When faced with a decision about whether to provide effective or harmful treatment to someone who is sick, we automatically make the ethical decision to help rather than to harm the person. On the other hand, we sometimes face situations where alternative courses of action reflect contrasting values. For example, we value individuals' autonomy and their right to make decisions about their own health. If an individual wants a treatment that we believe to be harmful, should we respect his or her wishes and provide the treatment,

or refuse the treatment and adhere to the principle that treatment should not be provided if it is known to cause harm?

Source: Janet M. Bronstein, PhD, School of Public Health, University of Alabama at Birmingham.

Core values, beliefs, and philosophy may be clear during the early stages of an organization's development but become less so as the organization matures.⁴⁷ Therefore, statements such as MD Anderson's demonstrate how the organization intends to treat patients, employees, and families (caring); deal with colleagues and vendors (integrity); and encourage personal and professional development; providing an excellent example of how to keep core values at the forefront of organizational operations, even as the organization grows and ages (see [Exhibit 5-19](#)).

Caring: By our words and actions, we create a caring environment for everyone.

- We are sensitive to the concerns of our patients and our co-workers.
- We are respectful and courteous to each other at all times.
- We promote and reward teamwork and inclusiveness.

Integrity: We work together to merit the trust of our colleagues and those we serve.

- We hold ourselves, and each other, accountable for practicing our values.
- We communicate frequently, honestly and openly.
- By our actions, we create an environment of trust.

Discovery: We embrace creativity and seek new knowledge.

- We help each other to identify and solve problems.
- We seek personal growth and enable others to do so.
- We encourage learning, creativity and new ideas.

Source: MD Anderson Cancer Center.

[Exhibit 5.19](#) Statement of Core Values, MD Anderson Cancer Center

[Exhibit 5-20](#) illustrates Mayo Clinic's well-developed and articulated set of organizational values. Their primary value is "the patient comes first." Throughout the values statement are references to ideals such as integrity, respect, compassion, and excellence. Anyone reading this set of guiding principles can understand the motivational force such a statement of values might have on employees and the comfort it might provide patients.

These values, which guide Mayo Clinic's mission to this day, are an expression of the vision and intent of our founders, the original Mayo physicians and the Sisters of Saint Francis.

Primary Value

The needs of our patients.

Respect

Treat everyone in our diverse community, including patients, their families and colleagues with dignity.

Compassion

Provide the best care, treating patients and family members with sensitivity and empathy.

Integrity

Adhere to the highest standards of professionalism, ethics, and personal responsibility, worthy of the trust our patients place in us.

Healing

Inspire hope and nurture the well-being of the whole person, respecting physical, emotional and spiritual needs.

Teamwork

Value the contributions of all, blending the skills of individual staff members in unsurpassed collaboration.

Excellence

Deliver the best outcomes and highest quality service through the dedicated effort of every team member.

Source: The Mayo Clinic.

Exhibit 5.20 Value Statement of The Mayo Clinic

Not all statements of values or guiding principles are as elaborate as that of the Mayo Clinic or MD Anderson; however, they need to be as well conceived. Value statements can be useful in clarifying to employees the specific behavioral norms that are expected of them as members of the organization. This clarification is effectively accomplished in the values of Stryker (see [Exhibit 5-21](#)).

Integrity. We do what is right.

Accountability. We do what we say.

People. We grow talent.

Performance. We deliver.

Source: Stryker.

Exhibit 5.21 Value Statement of Stryker

Mission, vision, and value statements are tools for “becoming better at what we do.” The usefulness of any of these statements comes from the ownership taken

by employees and the observed actions by stakeholders. Framed mission, vision, values, and slogans are merely exercises – and futile ones at that – if they are not made real by commitment and action.⁴⁸ The point is to motivate and guide all employees, managerial and non-managerial; provide high-quality care and respond to external as well as internal customers; to distinguish the organization from others in the perceptions of key stakeholders; and to let everyone know the organization stands for something important. To be most effective, the value statement for an organization should capture the guiding principles by which the staff is expected to function while achieving the organization's mission.⁴⁹

Step 5: Develop Strategic Goals

Once strategic leaders are confident that the mission, vision, and values are well formulated, understood, communicated, and expressed in writing, they are able to focus on the activities that will make the most progress toward accomplishing the mission and moving the organization toward a realization of its vision – its strategic goals. Well-written mission statements are the beginning point for strategic goal setting. Goal setting should be focused on those areas that are critical to mission accomplishment. Strategic thinking would entail asking this important question when attempting to ensure that mission statements and strategic goals are consistent:

Does the mission provide for the formulation of a set of goals that are specific enough to give guidance to the organization yet broad enough to provide for the necessary flexibility?⁵⁰

Critical success factors provide the targets for strategic goal setting. As discussed in Chapter 3 concerning service area competitive analysis, critical success factors for the service category are similar for all members of a strategic group; however, the factors may vary from one service category to another and one strategic group to another.⁵¹ The strategic goals, in turn, become the anchors for objectives and action plans.

Critical Success Factors for the Service Category

Critical success factors are the benchmarks that organizations must accomplish if they are to achieve high performance.⁵² The critical factors for success in a medical practice are not the same as the critical success factors in acute care hospitals.

As an example, Pacific Cataract and Laser Institute operates in the Pacific Northwest with ten locations in the State of Washington.⁵³ Cataract surgery (one service category) is most frequently performed on older adults, whereas refractive surgery (another service category) is performed to improve eyesight so that a person can see without corrected vision (no need for eye glasses or contact lenses) in younger adults. Cataract surgery is medically warranted and typically covered by insurance (Medicare for many). The critical success factors for the service category of refractive surgery in the Washington State service

area are identified in [Exhibit 5-22](#). These critical success factors provide an important bridge between external and internal environmental analysis.⁵⁴ Strategic leaders must continually ask themselves whether the mission, vision, and values of the organization are compatible with the critical success factors. Once compatibility is ensured, leaders must prioritize a relatively small number of activities that are absolutely essential to accomplish the mission and build momentum to realize the vision. The application of the critical success factors relative to Pacific is briefly noted in the second column. Strategic leaders need to ensure that they address the factors that lead to success in the service category.

Critical Success Factors	Related to Individual Organizations
Competitive price	Multiple providers are in the service area around Seattle, Washington. The procedure is rarely covered by insurance. Prices have fallen over the past 30 years; however, purchasers are price conscious and the procedure is offered just across the border in Canada at a much lower price.
Latest technology available but choices offered for lower cost, safe options.	State-of-the-art technology is offered and it is faster, less invasive (thus safer), but significantly more expensive. Some individuals are willing to undergo the procedure using older, slower, but safe technology to be able to afford the surgery.
Number of procedures performed	Greater numbers preferred, “practice makes perfect” is backed by research.
Positive satisfaction ratings/social media reviews	Today’s potential customers for refractive surgery read recommendations online and investigate satisfaction scores. Pacific Cataract and Laser has 97 percent of consumers saying they would recommend the Institute to a friend.
Name recognition	Many MDs who perform these surgeries advertise; however, Pacific relies on referrals from family eye doctors (over 1,000 of them in the six states where they have offices) and does no advertising.

Exhibit 5.22 Critical Success Factors Related to a Service Category (Refractive Surgery) in a Service Area (Washington State)

Strategic Goals

Strategic goals should be used to coordinate critical success factor activities, providing more specific direction to accomplish the mission and vision. At the same time, strategic goals should be broad enough to allow considerable discretion for managers to formulate their objectives for individual units.⁵⁵ The most appropriate strategic goals possess the following characteristics:

1. Strategic goals should relate specifically to activities that are critical to the mission; goals that focus on activities that are not mission critical have the potential to divert leadership attention and employee energy.
2. Strategic goals should be the link between critical success factors and strategic momentum (carrying out unit objectives).
3. Strategic goals should be limited in number. When too many goals are pursued, the “trivial many” rather than the “critical few” activities are accomplished.
4. Strategic goals should be formulated by leaders but should be stated in terms that can be easily understood and appreciated by everyone in the organization.

The Johns Hopkins Medical Center’s strategic plan includes six strategic priorities which are essentially Johns Hopkins Medicine strategic goals. When describing the priorities, the plan states these are “critical areas of focus for the success and sustainability of the institution.”

1. People – attract, engage, develop, and retain the world’s best people.
2. Biomedical Research – become the exemplary model for biomedical research by advancing and integrating discovery, innovation, translation, and dissemination.
3. Patient-and-Family-Centered Care – Be the national leader in the safety, science, teaching, and provision of patient- and family-centered care.
4. Education – Lead the world in the education and training of physicians and biomedical scientists.
5. Integration – become the model for an academically-based integrated health care delivery and financing system.
6. Performance – create sustainable financial success and implement continuous performance improvement.⁵⁶

Roles and Responsibilities of Boards of Directors (or Trustees) in Strategic Management

The discussion of directional strategies has emphasized the importance of the involvement and participation of as many people as practical. The governing board (e.g. board of directors, board of trustees) is an important group that should be involved in the development of the strategic direction of the health care organization. The board members should be regularly informed about the strategic goals and the progress being made toward their accomplishment. Governing boards have taken on particular importance in the past several years as ethical issues have escalated. Health care has not been exempt, as evidenced by major corporate scandals involving companies such as Bausch and Lomb's ReNu MoistureLoc contact lens solution and waiting time issues at the Veterans Administration. Increasingly, the question of the role and responsibility of governing boards is discussed in health care management. Often not only the individual involved in a scandalous act but the organization and individual board members or the board collectively suffer damages to their reputations.⁵⁷

Four modes of governance have been applied to boards of directors. First is the fiduciary responsibility mode or stewardship of assets; the second is the strategic mode which involves collaborating with management to develop a vision for the future; the third is the generative mode where the board engages in shared creative thinking to make sense of data available to decision makers, and the fourth is the idea of the progressive board that focuses on contributions of individual members to a cohesive and comprehensive whole – the board is viewed as engaging in lively debate, discussion of important issues, and learning from one another.⁵⁸

In the strategic mode, boards of directors or boards of trustees are responsible for making policies – providing general guidelines under which the organization will operate. Therefore, boards are important in formulating the mission, vision, and value statements of the organization and, depending on the nature of the membership, boards can represent very complex issues in organizational governance (see Essentials for a Strategic Thinker 5–5, “What Are Interlocking Directorates?”). Board members are not likely to be directly involved in the process although, in some cases, members do participate. More likely, board members are interviewed during the formulation of the mission, vision, and values and their input is incorporated into the statements. In addition, boards are involved in determining the compensation of key executives, executive succession planning, and similar high-level decision making. With regard to mission, vision, and values the board should be informed about the statements and involved in the strategic thinking that results in their formulation; therefore, the selection of board members is a critical strategic decision.⁵⁹

ESSENTIALS FOR A STRATEGIC THINKER 5-5



What Are Interlocking Directorates?

Interlocking directorates occur when members of two or more boards of directors simultaneously serve on the boards of the same organizations. The two or more organizations involved are said to be interlocked. There is a direct interlock of organizations when one or more members serve on the boards of each organization. Approximately one of every five directors sits on more than a single board, although service on multiple boards does not, in itself, constitute an interlock. Technically, it is a violation of the Clayton Act when an executive or board member serves on the board of a direct competitor. Although there are some exceptions, interlocking boards among competitors are risky.

Many experts believe distinct advantages of interlocking directorates result if the interlocked organizations are not competitors. In a sense, interlocking directorates can be viewed as a social network. This view suggests that directors and executives connected in this manner can communicate faster and more effectively. Because boards are comprised of the more elite corporate and health care leaders, interlocking directorates make it easier for these executives to discuss issues of common interest and it is possible that best practices and innovations are disseminated faster and more efficiently when board members are interlocked. Imagining how a member of one board might observe management practices in one organization that would be beneficial to other organizations is easy to envision. The repository of expert information a person possesses is the primary reason why individuals are asked to serve on boards; thus, information sharing is a significant benefit of interlocking directorates.

On the other hand, there must be some potential dangers if interlocks among competitors are outlawed by Section 8 of the Clayton Act. Some fear that interlocking directorates create an excessively powerful group of the most influential members of corporate America, academics, the legal profession, and other occupations. With the possible exception of not-for-profit boards, it is admittedly true that corporate boards are comprised of elite members of society. Because board members are most often business and health care leaders, their concern may be inherently more closely associated with the values of management rather than rank-and-file employees or, more importantly, society as a whole. In the rare cases where interlocks are among competitors, collusion, price setting, and anti-trust liability represent clear and present dangers and behaviors to be avoided.

Regardless of the pros and cons, interlocking directorates are a reality of modern business and health care life. Care must be taken when formulating boards of directors to ensure that the board is comprised of individuals who

possess the most critical combination of expertise. Further, a careful review of the associations of board members should be undertaken to ensure there are no conflicts of interest.

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Health Care Performance and the Usual Suspects

Much of the discussion regarding governing boards has related to issues that have been referred to as the “usual suspects.”⁶⁰ Primary attention has been given to questioning how these usual suspects influence the financial performance of an organization. Some usual suspects are the number of outsiders on the board, shareholdings of board members, board size, and CEO duality (CEO simultaneously functioning as the chief executive and board chair).⁶¹ An issue of particular interest has been board size. A comparative study of board composition by the executive search firm Spencer Stuart looked at the boards of the S&P 500. The results, reported in the *Harvard Business Review*,⁶² noted that boards of these leading corporations are smaller in size, comprised of older members, and are more independent compared with a study conducted decades earlier. A 2014 study by the Corporate Library indicated that the average size of a board was 9.2 members but the size ranged from 3 to 31. The study noted that some experts believe seven is an optimum size for a board; however, no universal agreement regarding board size was promulgated.⁶³

When compared with boards of directors of successful high-technology firms, governing boards in a sample of multihospital health care systems were almost twice as large (11 to 15 members).⁶⁴ In fact, boards are frequently too large to be effective aids in decision making, and where the goal is stakeholder representation, board members often know so little about health care that CEOs are forced to spend a great deal of their time informing and educating lay members.

Board independence has been another topic that has received attention and has been particularly influenced by the Public Company Accounting Reform and Investor Protection Act of 2002 (Public Law 107–240), also known as the Sarbanes–Oxley Act.⁶⁵ Essentially the issue of board independence relates to the number and nature of outside directors (those not employed by the organization). Generally, boards are considered more independent if they have a majority of outside members who are not significantly involved in doing

business with the focal organization.

Primarily because of corporate scandals of recent years and the passage of the Sarbanes–Oxley Act, board of director research has been reignited.⁶⁶ This law, which applies to publicly traded corporations, dramatically impacts the fiduciary responsibility of chief executive officers and boards of directors. Some states have considered enacting similar legislation that would apply to not-for-profit organizations.

Another study examined the issue of outside directors in large investor-owned health care organizations. Four major subsamples were examined, including hospitals, elder care organizations, HMOs, and alternative care facilities (such as psychiatric clinics and ambulatory care centers).⁶⁷ The results were that, in general, governing boards of health care organizations were comprised of more members from outside, rather than inside, the organization. Outside representatives were primarily physicians, financial professionals, attorneys, and academics. The inclusion of physicians was found to be particularly significant in terms of bottom-line performance. The presence of physicians on governing boards enhanced the support of the medical community, improving the organization's market share and quality.

There are basically two different types of governing boards – *philanthropic governing boards* are service oriented, broadly represent diverse stakeholders, and are concerned primarily with fundraising. *Corporate governing boards* are typically involved in oversight, strategic planning, and policy making. Philanthropic boards are larger and more diverse to gain as much community representation as possible. The inclusion of different types of stakeholders is important and requires that board members be selected from among business leaders, physicians, local politicians, consumers of health care services, and so on. The corporate board is smaller and comprised of individuals who possess expertise that will aid the organization in accomplishing its strategic goals.⁶⁸ Membership diversity is important, but less so than the actual skills or expertise possessed by the members.

The current trend in health care organizations is toward the corporate board. To a great extent, the trend is the result of the increasingly competitive environment facing health care organizations and the need for expertise in dealing with the complexities of the economic environment. However, it should be noted that virtually no research confirms any positive relationship between the size and nature of board membership and organizational financial performance.⁶⁹

Research findings on boards of directors suggest that when profound or radical organizational change confronts a health care organization, the corporate board is more likely to propose effective, positive responses. Philanthropic boards, on the other hand, are more likely to be associated with either no change or negative responses to profound change.⁷⁰ Boards of directors in health care organizations undergoing corporate restructuring (defined as the segmentation of the organization's assets and functions into separate corporations to reflect specific profit, regulatory, or market objectives) tend to become less

philanthropic and more corporate, not only in composition but also in the way they operate.⁷¹

The evidence is underwhelming with regard to the usual topics of board independence (percentage of outside members), board size, CEO duality, and so on.⁷² Although it is dangerous to generalize, some inferences can be drawn from the research on governing boards in health care organizations. In not-for-profit health care organizations, governing boards are more in line with the philanthropic model. They are generally large (in fact, too large to be effective aids in strategic decision making), do not compensate members, select members primarily as stakeholder representatives, and do not hold the CEO formally accountable for performance. In this case, the primary motivation for board membership is service and recognition. When health care organizations are profit oriented, their boards take on more corporate characteristics. They tend to be smaller, compensate members for service, select members for specific expertise, involve the CEO as a voting member, make him or her formally accountable to the board, and require the participation of board members in strategic decision making. From the perspective of the individual board member, the motivation to be on a board may be to provide a valuable service to the community, but board membership may be a source of income as well.

Board Process: Missing Link?

The lack of consistent association between factors such as board size, independence, CEO duality, member expertise, and organizational performance on financial measures has encouraged researchers to look at different variables. Of particular interest is the board process – the means by which boards of directors undertake their work.⁷³

Interviews with experienced board members indicate that several behaviors lead to more effective boards:

1. *Engage in constructive conflicts (especially with the CEO).* It is important that board members debate diverse views among themselves and with the CEO. An overabundance of insiders on a board may diminish the presence of constructive conflict since debate with the CEO amounts to debate with the boss.
2. *Avoid destructive conflict.* Personal friction and tension in the boardroom should be minimized. There must be a clear distinction between constructive debate and destructive conflict.
3. *Work together as a team.* The most important component of board process is teamwork, and it is the primary characteristic of the progressive board. The development of strong team norms, however, is difficult because board members spend little time together. Given the members' limited availability, maximizing board member interaction is critical.
4. *Know the appropriate level of strategic involvement.* Board members should limit their involvement to major strategic decisions. They should be very careful not to become too involved in the day-to-day management of the

organization.

5. *Address decisions comprehensively.* Board members should consciously attempt to address issues with sufficient depth to make sound decisions. Too often, time demands and conflicting priorities tempt boards to deal superficially with important issues. Effective boards find the time needed for important strategic decisions.⁷⁴

The work of boards of directors is crucial for health care organizations. Boards are created to ensure that strategic leaders have additional expertise available to them for making policy decisions that provide direction to the organization. The effectiveness of the board is a key factor in the effectiveness of the organization.

Strategic Momentum – Evaluating Directional Strategies

As part of managing strategic momentum, managers assess the performance of the organization and try to determine whether the mission, vision, values, and goals are – and continue to be – appropriate. To illustrate, hospices today reap billions of dollars annually in Medicare reimbursement. In just two decades since hospices began receiving reimbursement for their services, end-of-life care has emerged as an integral part of the health care system. The demand for palliative care (end-of-life and comfort care) has increased so rapidly that hospitals and other providers have seized opportunities in this area. One example is a hospice company which states that its mission is “to provide care for dying patients and their families in their homes.” Another hospice, aware of the changes in the environment and concerned with managing strategic momentum, has slightly revised its mission to reflect the change in the competitive environment. Its new mission is “to provide end-of-life and palliative care services.” If both organizations should decide to offer services to Alzheimer’s patients living in nursing homes, only the second hospice would be acting in accordance with its mission; therefore, this juxtaposition demonstrates how mission flexibility must be emphasized.⁷⁵

Decisions to change an organization’s mission, vision, values, and goals are complex and involve many variables. To manage strategic momentum, questions should be asked that concern the fundamental activities and direction of the organization. [Exhibit 5–23](#) provides guidance through several questions that will aid managers in their strategic thinking concerning the appropriateness of the organization’s directional strategies. Perhaps the best approach for managing the directional strategies is to place the vision for the future, the existing mission statement, statement of values, and the organization’s goals next to the questions in Exhibit 5–23 and ask the board of directors/trustees and the strategic management team to freely discuss and reach a consensus on each question. This process will either validate the existing mission, vision, values, and goals or indicate that there should be changes to maintain strategic momentum. This process invites clarification, understanding, and reinforcement of exactly “what this organization is all about” or “what this organization should be about.”

1. Are we not doing some things now that we should be doing?

2. Are we doing some things now that we should not be doing?
3. Are we doing some things now that we should do but in a different way?
4. Are our organization's mission and vision unique in some way?
5. Is our mission relatively enduring?
6. Do our mission and vision allow for innovation?
7. Do our mission and vision allow for expansion?
8. Is our scope of operations clear (market, products/services, customers, geographic coverage)?
9. Do our mission, vision, and values fit the needs of our stakeholders?
0. Do our fundamental values make sense?
11. Are our strategic goals moving us toward achievement of our mission?
- .2. Are our strategic goals moving us toward achievement of our vision?
- .3. Have we addressed the critical success factors?
- .4. Based on the mission, vision, and values, is the image of the organization what it should be?

Exhibit 5.23 Strategic Map for Evaluating Directional Strategies

Chapter Summary

Directional strategies allow leaders to state what they believe the organization should be doing and make explicit how they intend to conduct their business. Every attempt should be made to develop and communicate well-conceived and written statements of the organization's mission, vision, values, and strategic goals.

Directional strategies are the superordinate goals or outcomes that health care organizations plan to accomplish. Leaders should recognize that strategic planning is a logical process. The progression of directional strategies illustrates the importance of the logic. The mission of the organization drives decision making because it is the organization's reason for existing. The vision provides hope for the future and values tell everyone – employees, stakeholders, patients, and so on – how the organization will operate. The strategic goals more specifically state what the leaders believe is required to achieve the mission.

A mission alone is not enough. The mission, as a statement of purpose that distinguishes the organization from all others of its type, such as the care given to patients, physical location of the facility, the unusual commitment of physicians to research as well as to healing, or any other factor that is important in the minds of those served, is only the first step. The mission may motivate a few physicians and department managers, but real motivation comes from visionary leadership.

The vision is a hope that communicates what key stakeholders think the organization should be when the mission is being achieved. Values, as guiding principles, can be powerful motivating forces as well.

Even a well-developed and communicated mission is likely to leave the health care strategist with far too many areas of responsibility, resulting in an impossible task. For this reason, critical success factors for the service category must be identified and strategic goals must be set to accomplish the mission. Strategic goals help to make the strategist's job feasible and help focus strategists on those tasks that really make a difference with respect to organizational success.

Management research shows that the existence of goals can be powerfully motivating. Clearly stated and communicated strategic goals provide a sense of direction – they specify what leaders are expected to accomplish and remove anxiety from those who want to succeed. Formulating mission, vision, values, and strategic goals and identifying critical success factors are often “messy” and unappreciated. In the end, however, setting directional strategies is a major responsibility for all strategic leaders.

Engaging as many groups as practical in the process of developing directional strategies is important. The board of directors should be involved in the thinking that ultimately results in the mission, vision, and value statements. In addition, board members should be regularly informed about the strategic goals of the organization and the progress being made in their accomplishment. Most

importantly, the board should engage in a process that contributes to organizational effectiveness. Research confirms that merely electing or selecting a board of directors/trustees comprising an appropriate percentage of outsiders, of individuals with the appropriate expertise, and small enough to be manageable, will not ensure its effectiveness. The board must also be willing to engage in constructive conflict, minimize destructive interpersonal tensions, avoid micromanagement, and devote the time required to make important strategic decisions.

Chapter 6 builds on the directional strategies of mission, vision, values, and strategic goals to address strategy formulation and the strategic alternatives available to health care organizations.

Practical Lessons for Health Care Strategic Thinkers

1. Organizations need a carefully constructed statement of purpose or mission. Without such a deliberate statement the organization is likely to experience mission creep or mission drift.
2. A vision statement is equally important to provide direction and hope for the future.
3. Value statements provide tangible evidence of the behavioral norms that are expected of everyone. Value statements are, in effect, guiding principles as to how the mission and vision are to be accomplished.
4. Directional strategies are difficult to formulate so leaders are often tempted to hire a public relations firm or consultant to draft these statements; however, formulating statements of directional strategies represents an opportunity to build understanding and communicate expectations to all organizational members.
5. Top level executive buy-in is an absolute necessity for the formulation of directional strategies.
6. Strategic leaders need to understand the factors that are required for success in their industry. Once these critical success factors are identified they can be used to anchor the formulation of strategic goals.
7. Boards of directors have a critical role in the formulation of directional strategies.
8. Health care organizations should carefully consider the expertise needed to effectively set policies and appoint board members who possess and expand the skills required for success.

THE LANGUAGE OF STRATEGIC MANAGEMENT: KEY TERMS AND CONCEPTS

Corporate Governing Board
Creative Tension
Critical Success Factor
First-Mover Advantage
Keeper of the Vision
Liability of Newness
Mission
Mission Creep
Mission Drift
Philanthropic Governing Board
Pioneering
Strategic Goals
Values
Vision
Vision-Led Approach

Questions for Class Discussion

1. Is it necessary for organizational mission statements to include all the components discussed in this chapter? How do you decide what components to include?
2. Think of an organization that you know relatively well and attempt to construct a mission statement in light of the components of missions discussed in this chapter. What components did you choose to emphasize in the statement? Why? What component do you think really embodies the distinctiveness of the organization?
3. Where do organizational missions originate? How do you explain the evolution of organizational missions as an organization grows and matures? If mission statements are “relatively enduring,” how often should they be changed?
4. Indicate two ways in which an organizational vision is different from other types of directional strategies.
5. It has been said that vision is necessarily a responsibility of leaders. Why is it important for health care organizations to have “keepers of the vision?”
6. Who determines the values of the health care organization? What values do you think should be shared by all health care organizations? Why?
7. Why are values referred to as an organization’s guiding principles? In what sense do values constitute a directional strategy for the organization?
8. How many strategic goals should a health care organization develop?
9. How can health care managers more effectively use directional strategies to stimulate higher levels of performance among all personnel?
10. What are critical success factors for an organization? How are they determined? How may they be used?
11. Why is the board of directors an important group to include in the formulation of directional strategies? What is the board’s proper role in formulating these strategies?
12. What is the best way to involve the board in the development of directional strategies? Explain your answer.
13. List three reasons why boards of directors or trustees have become increasingly important factors in the effectiveness of health care organizations.

Notes

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Chapter 6

Identifying Strategic Alternatives

“The understanding that underlies the right decision grows out of the clash and conflict of divergent opinions and out of the serious consideration of competing alternatives ... Unless one has considered alternatives, one has a closed mind.”

—PETER F. DRUCKER, MANAGEMENT AUTHOR AND PHILOSOPHER

Why Identifying Strategic Alternatives Is Important

As Peter Drucker observed, understanding and seriously considering alternatives is the first step in making decisions. Careful evaluation of alternatives is even more critical for organizations making strategic choices because of the long-term consequences of such decisions.

Organizations typically have many strategic alternatives from which to choose – so many that selecting a strategy can become confusing at best and completely overwhelming at worst. Systematic classification of the strategic alternatives available, as well as a description of the intent and required conditions for selecting each alternative within each classification, can aid strategic managers in working through the “clash and conflict of divergent opinions of the serious consideration of competing alternatives.” Despite one course of action appearing obvious, examining alternatives will provide new information; test long held assumptions, biases, and opinions; and prevent tunnel vision.

Strategic decisions have a rational hierarchy. Decisions concerning the organization’s mission, vision, values, and strategic goals are made first and provide guidance for subsequent decisions. An understanding of the hierarchy of strategic decisions – a map that shows the classes of decisions and a logical order to follow – is important for strategic decision makers. In addition, strategic managers need clear delineations of the available strategic alternatives and an understanding of the implication of each. A logical map of strategic decision alternatives (the analytical approach) lays the groundwork for the strategic planning process. As the strategy unfolds, learning (the emergent approach) will guide alternative decision making.

A map of strategic alternatives for health care organizations helps begin the process of alternative analysis. Being able to envision the complete “big picture” of how strategic decisions must progress provides perspective on the scope and hierarchy of strategic decision making and illustrates the linkage of strategic alternatives in organizations. Considering strategic alternatives opens one’s mind to what can be.

Use the concepts in this chapter to identify and organize strategic alternatives.

Learning Objectives

After completing the chapter you will be able to:

1. Discuss the steps and logic of strategy development.
2. Identify the hierarchy of strategies and strategic decisions required in strategic planning.
3. Explain the relationship among directional strategies, adaptive strategies, market entry/exit strategies, and competitive strategies.

4. Identify strategic alternatives available to health care organizations.
5. Provide the rationale as well as advantages and disadvantages for strategic alternatives.
6. Demonstrate how strategies may be used in combination to accomplish the organization's goals.
7. Map strategic decisions showing how they are linked.

Strategic Management Competency

After completing this chapter you will be able to use the hierarchy of strategic decisions to identify strategic alternatives and begin the process of making rational strategic decisions for a health care organization.

The Process for Identifying Strategy Alternatives

Strategic thinking involves an awareness of the environment; intellectual curiosity that is always gathering, organizing, and analyzing information; and a willingness to be open to creative ideas and solutions. Strategic planning concerns reaching conclusions based on information, setting a course of action, and documenting the plan. Therefore, strategic planning is essentially decision making – determining which strategy to pursue from among the many available options. In addition, a health care organization may pursue several different types of strategies simultaneously or sequentially.

There is a logical order in making strategic decisions because as organizations make strategic choices, these choices will have downstream consequences that both limit and create opportunities. For instance, a merger or affiliation decision is part of a series of decisions rather than a single decision or an end in itself; there is a broader strategy that precipitated the merger or affiliation and there will be subsequent strategic decisions that will have to be made to ensure success. *Strategy formulation* is the process of developing strategic alternatives, evaluating alternatives, and making strategic choices. This chapter introduces and classifies the strategic alternatives for health care organizations and Chapter 7 discusses strategic thinking methods for analyzing alternatives to make a strategic choice.

[Exhibit 6-1](#) provides a six-step process for understanding the hierarchy of strategic decisions and identifying the strategic choices available to health care organizations. Beginning with a general understanding of the rationale or logic of the process, the chapter works through the different types of strategy choices. Understanding the decision logic is first, followed by directional strategies that frame subsequent strategic choices. Next the adaptive strategic alternatives define the scope of the organization. The market entry/exit alternatives carry out the adaptive strategies whereas competitive alternatives define the nature of the rivalry among similarly focused organizations. Because strategy development is a creative (and iterative) process, some combinations of strategies may be required to enable the organization to pursue its mission and achieve its vision.



Exhibit 6.1 The Process for Strategy Development

Step 1: Understand the Decision Logic of Strategy

Development

The decision logic of strategy formulation is illustrated in [Exhibit 6-2](#). Decisions concerning five categories of strategies – directional, adaptive, market entry/exit, competitive, and implementation – should generally be addressed sequentially with each decision more specifically defining the activities of the organization. Thus, the organization must first establish or reaffirm consensus on its mission, vision, values, and strategic goals (directional strategies). Next, the adaptive strategies must be agreed on and developed to accomplish the goals set forth by the directional strategies. *Adaptive strategies* are corporate-level decisions that specify the organization's scope and focus on expanding, reducing, or maintaining operations. Then strategists should discuss *market entry/exit strategies*, as they are the means to accomplish the adaptive strategies through purchase, cooperation, internal development, or market exit. Competitive strategies are generally independent of the adaptive and market entry/exit strategies as they are market- or service area-specific. *Competitive strategies* determine the organization's strategic posture and position *vis-à-vis* other organizations within the market. Finally, *implementation strategies* are directed toward value-adding service delivery strategies, value-adding support strategies, and unit action plans and must be developed to carry out competitive and market entry/exit strategies. The scope and role of the strategy formulation types are summarized in [Exhibit 6-3](#).

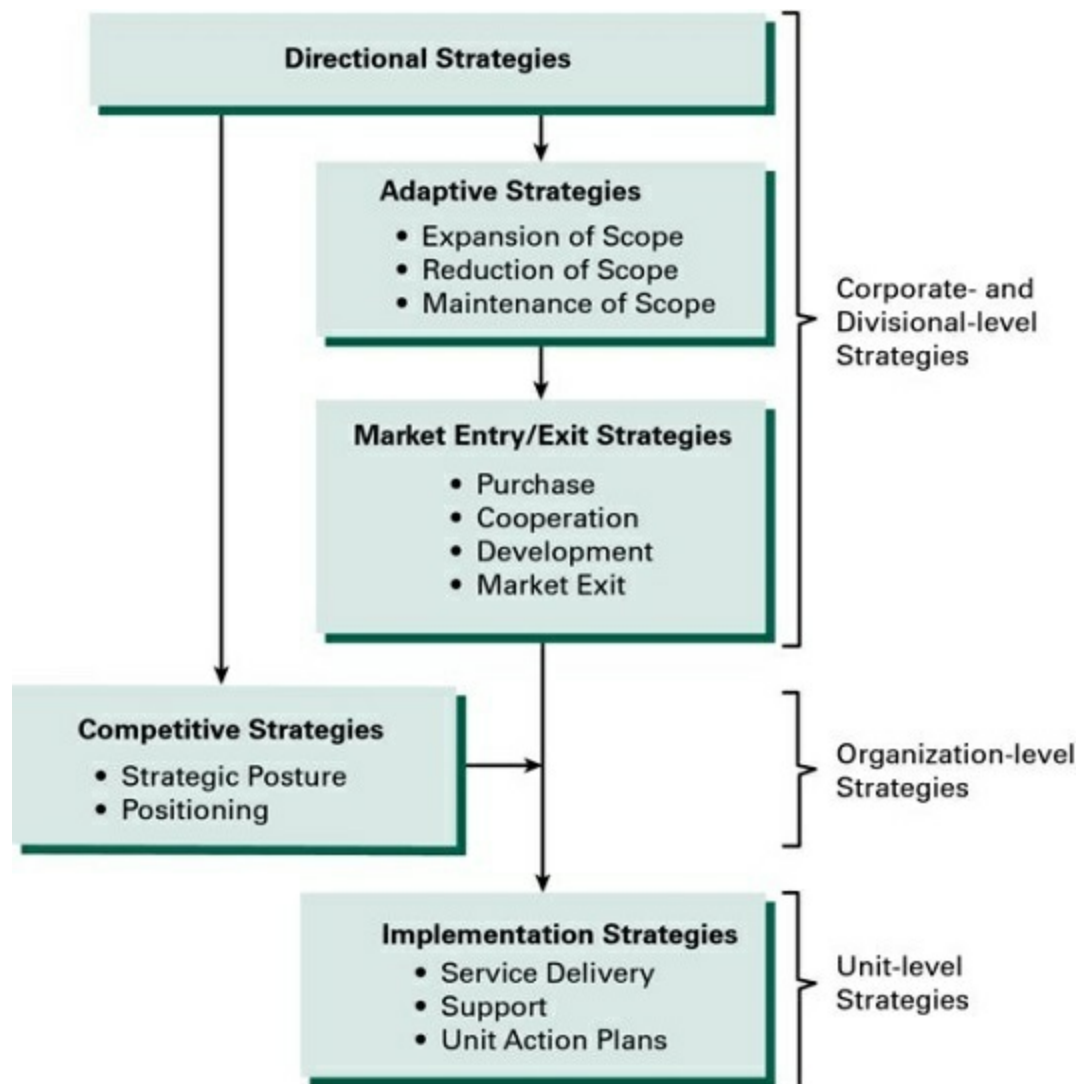


Exhibit 6.2 The Decision Logic of Strategy Formulation

Strategy	Scope and Role
Directional Strategies	The broadest strategies that set the fundamental direction of the organization by establishing a mission for the organization (Who are we?) and vision for the future (What should we be?). In addition, directional strategies specify the organization's values and its strategic goals.
Adaptive Strategies	These strategies are more specific than directional strategies and provide the primary methods for achieving the vision (adapting to the environment). These strategies determine the scope of the organization and specify how the organization will expand, reduce, or maintain scope.
Market Entry/Exit Strategies	These strategies provide the method of carrying out the adaptive strategies of expansion of scope and maintenance of scope strategies through purchase, cooperation, or internal development and reduction of scope through market exit.
Competitive	Two types of strategies: one determines an organization's

Strategies	strategic posture and one positions the organization <i>vis-à-vis</i> other organizations within the market. These strategies are market oriented and best articulate competitive advantage. When changes are not envisioned for adaptive or market entry/exit strategies, competitive strategies still may require changing.
Implementation Strategies	These strategies are the most specific and are directed toward value-added service delivery and the value-added support areas. In addition, individual organizational units develop objectives and action plans that support the market entry/exit strategies, competitive strategies, as well as the value-added service delivery and value-added support strategies.

Exhibit 6.3 Scope and Role of Strategy Types in Strategy Formulation

At each stage of the strategy formulation process, previous upstream decisions and the implications for subsequent downstream decisions must be considered. As leaders work through strategic choices, new insights and perspectives may emerge (strategic thinking) that suggest reconsideration of previous strategic decisions. Therefore, although the decision logic for strategic decisions is generally sequential, in practice it is very much an iterative process. Strategy includes a plurality of inputs, a multiplicity of options, and an ability to accommodate more than one possible outcome. For example, where mission and vision are ignored, or where no linkage occurs between vision and strategy, strategy has no measurable end objective. In these situations, strategy suffers from being a means without an end, an end in itself, or a means of achieving an operational end, rather than being a design or plan for achieving the organization's mission and vision.¹

Strategic decisions should be based on as much information and strategic thinking as possible. Strategic thinking occurs in situational analysis and strategy formulation, as well as when managing strategic momentum. Before the strategic plan is adopted, it is important to remember that organization-wide consensus and commitment to the strategies must be established and actively promoted if they are to be managed successfully (strategic momentum). The choice of a strategic alternative creates additional direction for an organization and subsequently shapes its internal systems (technology, information systems, culture, policies, skills, and so on). Strategic momentum is reinforced as managers understand, commit, and make decisions according to the strategy.

[Exhibit 6-4](#) presents a comprehensive strategic thinking map of the strategic alternatives available to health care organizations. This map not only identifies the alternatives but also the general sequential relationships among them. Using this organizing framework or decision logic keeps strategy formulation from becoming overwhelming and focuses strategic thinking. As strategic managers work through the strategic decisions, new understandings, insights, and strategies may (and in fact, should) emerge. Therefore, decision makers must work through the decision logic and back again, ensuring that all the proposed strategies make sense together. Strategic thinkers must always be able to see the

bigger picture. Decision makers should be prepared to adjust and refine earlier decisions in the decision logic as they make “downstream” decisions.

Directional Strategies	Adaptive Strategies	Market Entry/ Exit Strategies	Competitive Strategies
• Mission • Vision • Values • Goals	• Expansion of Scope - Diversification - Vertical Integration - Market Development - Product Development - Penetration • Reduction of Scope - Divestiture - Liquidation - Harvesting - Retrenchment • Maintenance of Scope - Enhancement - Status Quo	• Purchase - Acquisition - Licensing - Venture Capital Investment • Cooperation - Merger - Alliance - Joint Venture • Development - Internal Development - Internal Venture - Reconfigure the Value Chain • Market Exit - Fast/Slow - Partial/Complete	• Strategic Posture - Defender - Prospector - Analyzer - Reactor • Positioning – Marketwide - Cost Leader - Differential • Positioning – 1 Segment - Focus/Cost Leadership - Focus/Differentiation

Exhibit 6.4 Strategic Thinking Map – Hierarchy of Strategic Decisions and Alternatives

How-to formulas, techniques, or linear processes, of course, can never replace strategic thinking. Many of the greatest achievements in science, law, government, medicine, and other intellectual pursuits are dependent on the development of rational, logical thinkers; however, linear thinking can limit potential.² Leadership is essential to foster creativity and innovation and allow for the reinvention of the strategy formulation process. Strategy formulation involves managing dilemmas, tolerating ambiguity, coping with contradictions, and dealing with paradox.³ Often leaders must creatively resolve the tension between competing information and alternatives to generate new options and solutions.⁴ In addition, strategy development cannot ignore the entrepreneurial spirit, politics, ethical considerations, and culture in an organization. The strategy formulation decision logic discussed in this chapter provides a starting point. It should foster strategic thinking, not limit it. The map starts the decision

makers on their journey.

Step 2: Understand the Role of Directional Strategies

Chapter 5 explored mission, vision, values, and strategic goals and indicated that these elements are part of both situational analysis and strategy formulation. They are a part of situational analysis because they describe the current state of the organization and codify its basic beliefs and philosophy. In many ways, as discussed in Chapter 5, they provide an operational context for the organization and an ethical and moral framework. In addition, directional strategies are a part of strategy formulation because they set boundaries and indicate the broadest direction for the organization. The directional strategies should provide a sensible and realistic planning framework for the organization.

Because formulation of the mission, vision, values, and strategic goals provides fundamental direction for the organization, directional strategic decisions must be made first. Then the adaptive strategies mobilize organizational goals by specifying the type and scope of product/market expansion, reduction, or maintenance. The adaptive strategies form the core of strategy formulation and are most visible to those outside the organization. After the adaptive strategies have been selected, the directional strategies should be re-evaluated. Seeing the directional strategies (ends) and the adaptive strategies (means) together may suggest refinements to either or both. This broader perspective is essential in strategic thinking.

Step 3: Understand Adaptive Strategy Alternatives

From a practical standpoint, whether the organization should expand, reduce, or maintain scope is the first decision that must be made once the direction of the organization has been set (or reaffirmed). As shown in [Exhibit 6-5](#), several alternatives are available to expand, reduce, or maintain the scope of operations. These alternatives represent major strategic choices for the organization.

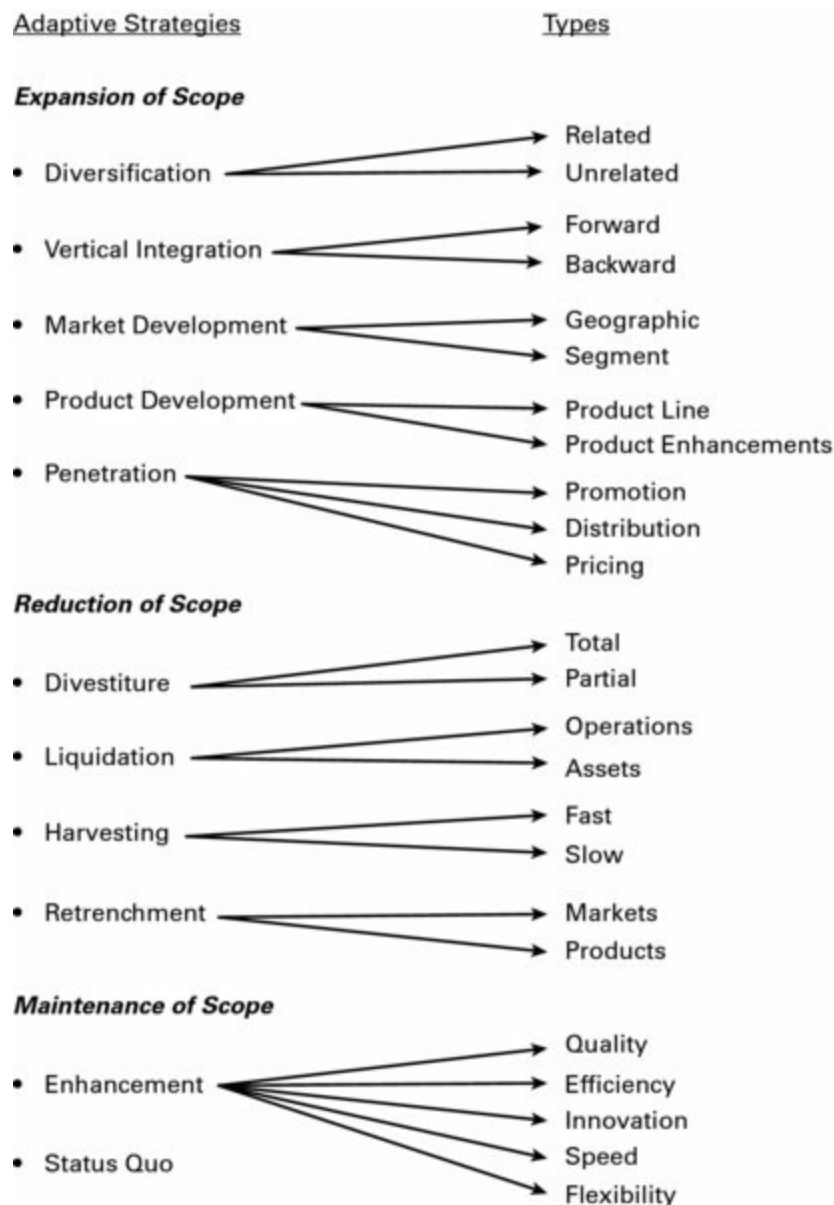


Exhibit 6.5 Strategic Thinking Map of Adaptive Strategic Alternatives

Expansion of Scope Strategies

If expansion is selected as the best way to perform the mission and realize the vision of the organization, several alternatives are available. The *expansion of*

scope strategies grow an organization and include:

- Diversification.
- Vertical integration.
- Market development.
- Product development.
- Penetration.

Diversification

Diversification is adding new related or unrelated products/services (businesses) outside the organization's core business(es). Diversification strategies, in many cases, are selected because markets have been identified outside the organization's core business that offer potential for substantial growth. Many hospitals have added hospice care as the increasing number of baby boomers are living longer and insurers (including Medicaid) began reimbursing for this type of care. Often, an organization that selects a diversification strategy is not achieving its growth or revenue goals within its current market, and these new markets provide an opportunity to achieve them. There are, of course, other reasons why organizations decide to diversify. For instance, health care organizations may identify opportunities for growth in less competitive or less regulated markets (such as medical office buildings, long-term care facilities, or outpatient care).

Diversification, at the level of the individual organization, is generally seen as a risky alternative because the organization is entering relatively unfamiliar markets or businesses. At the societal level it is sometimes thought of as a means of increasing the concentration of power among fewer firms and, again, is viewed as possessing certain dangers or risk.⁵ Organizations have found that the risk of diversification can be reduced if markets and products are selected that complement one another. Therefore, managers engaging in diversification seek synergy between corporate divisions or strategic business units (SBUs). Consider, for example, the discussion of Hill-Rom in Chapter 4. The core business of Hill-Rom is hospital beds and it dominates the market in this area. In recent years, however, the company has acquired Allen Medical (operating room beds), Liko (specialized products for safe lifting and transfer of patients), Aspen Medical (surgical blades and scalpels), Völker (long-term care beds), Trumpf Medical (advanced operating room products, lighting, surgical assistance systems), and Welch Allen (medical instruments). Note that these acquisitions are concentric in that they “revolve around” the core business of hospital beds. With these acquisitions Hill-Rom has taken on a risky but a highly diverse portfolio of medical products.

There are two types of diversification: related (concentric) and unrelated (conglomerate). [Exhibit 6-6](#) illustrates possible related and unrelated diversification strategies for one type of primary health care organization.

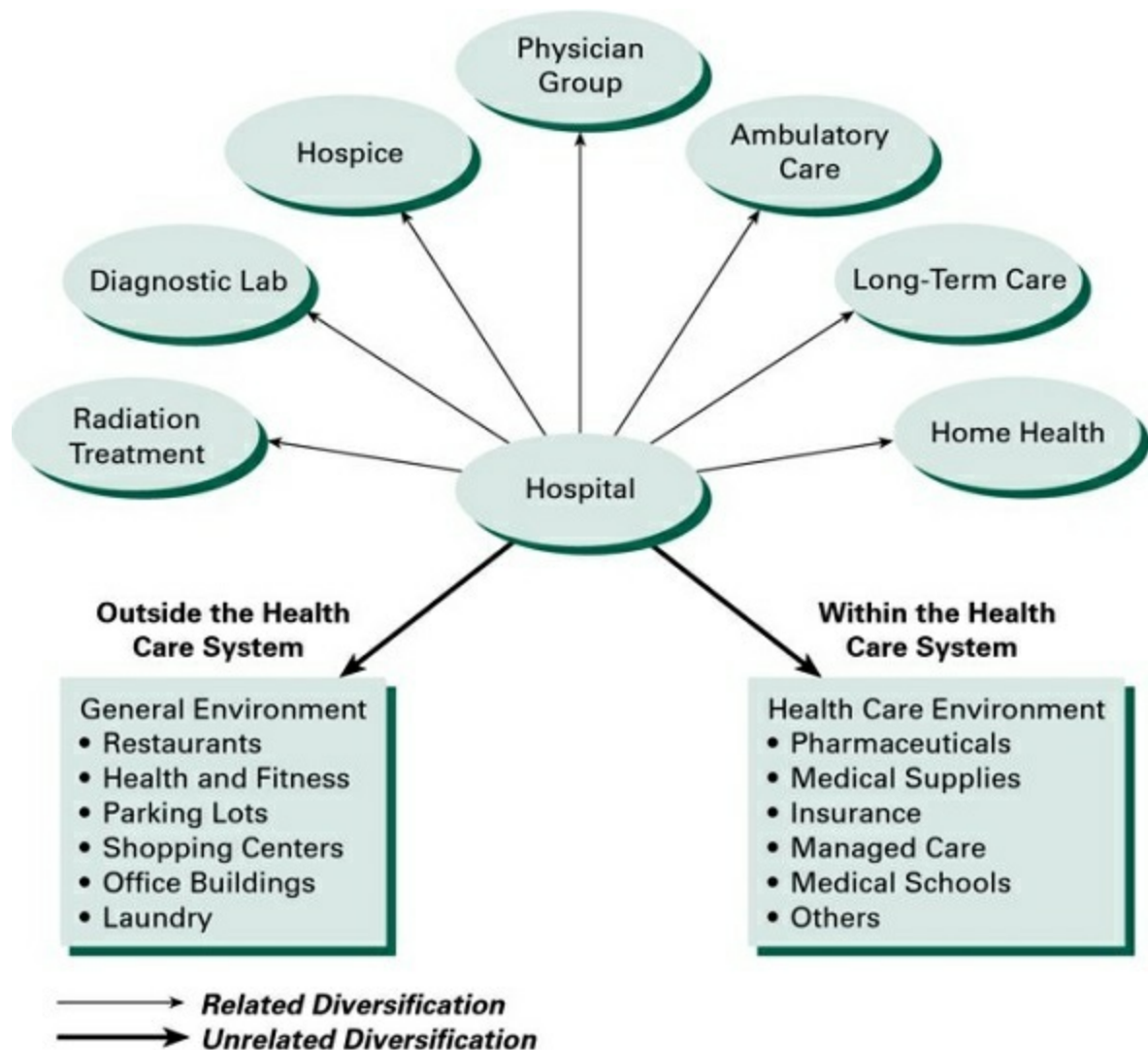


Exhibit 6.6 Related and Unrelated Diversification by a Primary Provider

Related diversification is adding new, similar products/services (businesses) that are outside the organization's core business. This form of diversification is sometimes called *concentric diversification* because the organization develops a "circle" of related businesses (products/services) and is illustrated by Hill-Rom's venture into a more diversified series of medical markets while focusing the diversification effort on a series of similar medical products (e.g. long-term care beds, patient mobility equipment, operating room beds, and so on).

The general assumption underlying related diversification is that the organization will be able to obtain some level of synergy (a complementary relationship where the total effect is greater than the sum of its parts) between the production/delivery, marketing, or technology of the core business and the new related product or service. This form of diversification has been characteristic of many firms in the pharmaceutical industry.⁶ For hospitals, the two primary reasons for diversifying are to introduce non-acute care or sub-acute care services that reduce hospital costs, or to offer a wider range of services to large employers and purchasing coalitions through capitated contracts.⁷ The movement of acute care hospitals into skilled nursing care is an

example of related diversification.

On the other hand, *unrelated diversification* is adding new unrelated products/services (businesses) unlike the organization's core business. This action creates a "portfolio" of separate products/services. Unrelated diversification, or *conglomerate diversification*, generally involves semi-autonomous divisions or strategic service units. An example of unrelated diversification would be a hospital diversifying into the operation of a restaurant, parking lot, or medical office building. In such a case, the new business is unrelated to the provision of health care although it may be complementary (synergistic) to the provision of health services.

Research on diversification indicates that financial performance increases as organizations shift from single-business strategies to related diversification, but performance decreases as organizations change from related diversification to unrelated diversification.⁸ Single-business organizations may suffer from limited economies of scope whereas organizations using related diversification can convert underutilized assets and achieve economies of scope by sharing resources and combining activities along the value chain. Unrelated diversification has been found to increase strain on top management in the areas of decision making, control, and governance. The stress increases in some cases because of the difficulties associated with integrating and managing diverse organizational cultures.⁹ In addition, unrelated diversification makes it difficult to share activities and transfer competencies between units; it has been particularly difficult in hospital diversification.¹⁰

Vertical Integration

A *vertical integration* strategy is a decision to grow along the channel of distribution or stages in the continuum of care of core operations. Thus, a health care organization may grow toward suppliers or toward patients. When an organization grows along the channel of distribution toward its suppliers or toward earlier stages on the continuum of care (upstream), it is called *backward vertical integration*. When an organization grows along the channel of distribution toward the consumer/patient or toward later stages in the continuum of care (downstream), it is called *forward vertical integration*.

A vertically integrated health care system offers a range of patient care and support services operated in a functionally unified manner. The expansion of services may be arranged around an acute care hospital and include pre-acute, acute, and post-acute services or be organized around specialized services related solely to long-term care, mental health care, or some other specialized area.¹¹ The purpose of vertical integration is to increase the comprehensiveness and continuity (or continuum) of care, while simultaneously controlling the channel of demand for health care services.¹²

One of the more familiar examples of vertical integration in health care has been the strategy of hospitals acquiring physician practices in a move to more effectively control the "patient flow." This move, as with many others, has produced varying results. Some have argued that tightly integrated relations

between physician practices and hospitals have resulted in higher hospital prices and spending.¹³

Vertical integration can reduce costs and thus enhance an organization's competitive position. Cost reductions may occur through lower supply costs and better integration of the "elements of production." With vertical integration, management can better ensure that supplies are of the appropriate quality and delivered at the right time. For instance, some hospitals have instituted technical educational programs because many health professionals (the major element of production in health care) are in critically short supply. However, in many cases it seems that managerial incentives to build market share is the primary motivation for vertical integration.¹⁴

Because a decision to vertically integrate further commits an organization to a particular product or market, management must believe in the long-term viability of the product/service and market. As a result, the opportunity costs of vertical integration must be weighed against the benefits of other strategic alternatives such as diversification or product development. Examples of vertical integration would be a hospital chain acquiring one of its major medical products suppliers (backward integration) or a drug manufacturer moving into drug distribution (forward integration).

Whether a strategic alternative is viewed as vertical integration or related diversification may depend on the objective or intent of the alternative. For instance, when the primary intent is to enter a new market to grow, the decision is to diversify. However, if the intent is to control the flow of patients to various units, the decision is to vertically integrate. Thus, a decision by an acute care hospital to acquire a skilled-nursing unit may be viewed as related diversification (entering a new growth market) or vertical integration (controlling downstream patient flow). Vertical integration is the fundamental adaptive strategy for developing integrated systems of care and is central to many health care organizations' strategies.

Numerous extensive health networks are the result of integration strategies and some observers expected that the Patient Protection and Affordable Care Act (ACA) would increase the movement to integrated health care systems.¹⁵ Although there is limited data to support or refute this suspicion, according to the American Hospital Association well over half of American hospitals may be affiliated with a system or network.¹⁶ The major reason that hospitals join networks and systems is to help secure needed resources (financial, human, information systems, and technologies), increase capabilities (management and marketing), and gain greater bargaining power with purchasers and health plans.¹⁷ However, it appears that the pace of integration has slowed. In fact there has been some degree of "disintegration," with health care systems divesting health plans, physician groups, home health care companies, skilled care services, or facilities and selling or closing hospitals.¹⁸ The reason for this divesting trend is related to research that suggests that integrated health care networks have little or no significant effect on the improvement of overall organizational efficiencies and profits.¹⁹

To increase the supply of patients to various health care units, several patterns of vertical integration may be identified.²⁰ In [Exhibit 6-7](#), an inpatient acute care facility is the strategic service unit or core technology that decides to vertically integrate. Example 1 represents a hospital (D) that is not vertically integrated. The hospital admits and discharges patients to and from other units outside the organization. Example 2 illustrates a totally integrated system in which integration occurs both upstream and downstream. In this case, patients flow through the system from one unit to the next, and upstream units are viewed as “feeder” units to downstream units.

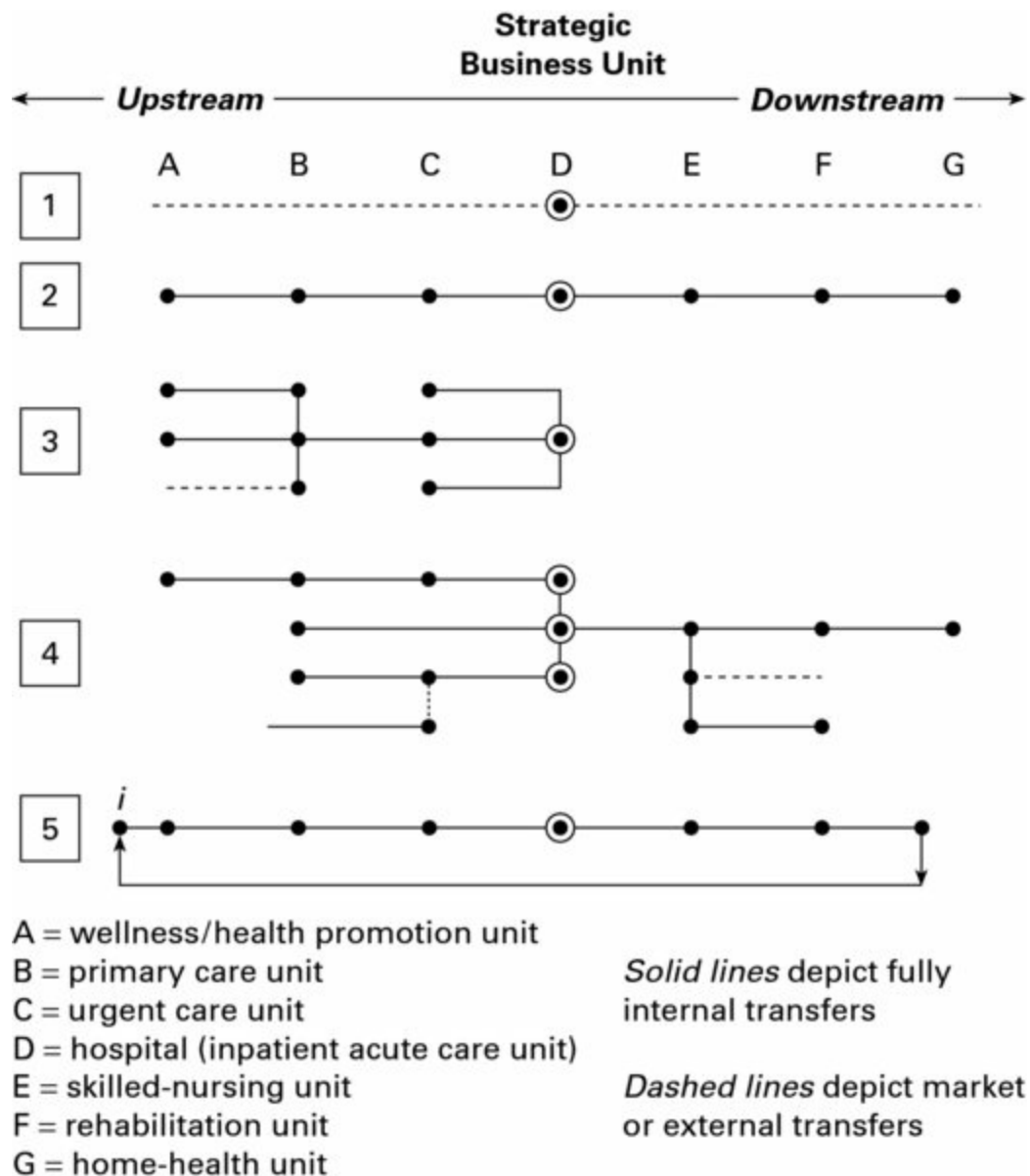


Exhibit 6.7 Patterns of Vertical Integration Among Health Care Organizations

Sources: Adapted in part from K. R. Harrigan, “Formulating Vertical Integration Strategies,” *Academy of Management Review* 9, no. 4 (1984), pp. 638–652. Reprinted by permission of Academy of Management. And adapted in part from Stephen S. Mick and Douglas A. Conrad, “The Decision to Integrate Vertically in Health Care Organizations,” *Hospital and Health Services Administration* 33, no. 3 (Fall 1988), p. 351. Reprinted by permission from Health Administration Press, Chicago.

Example 3 represents a hospital that has vertically integrated upstream. In

addition, more than one unit is involved at several stages of the integration. For instance, there are two wellness/health promotion units, three primary care units, and three urgent care units. The dashed line represents the receipt of patients via external or market transfers. Example 4 illustrates a multihospital system engaged in vertical integration. Three hospitals form the core of the system, which also contains three nursing homes, two rehab units, a home-health unit, three urgent care facilities, three primary care facilities, and a wellness center. It is important to note that simply adding members to create an integrated health system is not enough. Institutions must be truly integrated and create a “seamless” system of care to achieve the desired benefits for patients (effectiveness) and cost savings (efficiency).

Finally, some health care systems are closed systems with fixed patient populations entirely covered through prepayment. Thus, whereas in Example 2 the health care organization is vertically integrated, in Example 5 patients are a part of the closed system. This insurance function (letter *i* in the example) is shown as an additional unit.

Market Development

Market development is a divisional strategy used to enter new markets with the organization’s present products or services. Specifically, market development is a strategy designed to achieve greater volume, through geographic (service area) expansion or by targeting new market segments within the present geographic area (market niche strategies). Typically, market development is selected when the organization is fairly strong in the market (often with a differentiated product), the market is growing, and the prospects are good for long-term growth. A market development strategy is strongly supported by the marketing, financial, information systems, organizational, and human resources functions. An example of a market development strategy would be a chain of outpatient clinics opening a new clinic in a new geographic area (current products and services in a new market).

One type of market development is called horizontal integration. *Horizontal integration* is a method of obtaining growth across markets (in essence buying market share) by acquiring or affiliating with direct competitors rather than using internal operational/functional strategies to take market share from them. Many hospitals and medical practices engage in horizontal integration, creating multihospital systems. Such systems were expected to offer several advantages such as increased access to capital, reduction in duplication of services, economies of scale, improved productivity and operating efficiencies, access to management expertise, increased personnel benefits, improved patient access, improvement in quality, and increased bargaining power with insurers and suppliers. However, many of these benefits have not materialized and consolidation often raises prices with no measurable impact on quality – increasing scale without creating solutions.²¹

Another special type of market development is a market-driven or focused factory strategy. A *focused factory* in health care is an organization that provides comprehensive services across multiple markets (horizontal

integration) for one specific disease category such as cancer, diabetes, renal disease, asthma, or cardiac disease. The fundamental principle underlying a market-driven or focused factory strategy is that an organization that focuses on only one function is likely to perform better. Such focus allows an organization to achieve very high levels of effectiveness and efficiency. The shift includes:

... replacing giant providers and huge managed care networks, located in hard-to-reach sites with what I call “focused factories” (a nomenclature borrowed from the manufacturing sector) that provide convenient, specialized care for victims of a certain chronic disease, or for those who need a particular form of surgery, or for those who require a diagnosis, checkup, or treatment for a routine problem.²²

Focused factories become so effective (high quality, convenient, and so on) and efficient (less costly) that other providers are “forced” to use their services. Thus, these other providers can obtain higher-quality services at less cost by outsourcing to the focused factory. In turn, the focused factory commands a place in the payment systems. Focused factory tools for providers of health care services are outlined in Essentials for a Strategic Thinker 6–1 “What Is a Health Services Focused Factory?”

ESSENTIALS FOR A STRATEGIC THINKER 6–1

What Is a Health Services Focused Factory?



The health care providers who flourish in this market-driven environment will give customers the mastery and convenience as well as the focused, cost-effective services they want by following the rules of successful service entrepreneurs:

PAY ATTENTION TO THE CUSTOMER

Don't call them patients, don't fight their assertiveness, don't give them hype, give them real convenience and quality.

FOCUS, FOCUS, FOCUS

Throw out the general-purpose, everything-for-everybody model; *focus* on your strengths; design the system that will lower costs and optimize quality.

LEARN FROM THE ROCKETTES

Make sure that all the elements of your operating systems are integrated, resembling a well-choreographed dance, where disparate elements have been integrated into a harmonious whole.

RESIST THE EDIFICE COMPLEX

Bricks and mortar are distractions; fixed costs drag the enterprise down; many assets are really liabilities (money pits that consume your time and capital).

LOWER YOUR COSTS, DON'T RAISE YOUR PRICES

Successful enterprises succeed by achieving more output from every unit of input, not by raising prices; enterprises that lower their costs create sustainable competitive advantage.

USE TECHNOLOGY WISELY

Use technology to enhance the productivity of the health care process, not as a marketing tool.

DON'T LET THE DOGMA GRIND YOU DOWN

Be open to new and different ways of thinking; don't be a prisoner of your own thinking; obtain advice from the widest possible range of sources about what works and what doesn't.

BE ETHICAL

Don't seek competitive advantage in unethical ways such as discriminating against sick or poor people or by denying people the health care services they need.

BREADTH BEATS DEPTH

Don't fall for the lure of vertical integration; remember all the problems you have experienced in running just your corner of the health services world; a horizontally integrated chain of focused factories will amplify your strengths in each of the separate units that comprise the chain.

DON'T GET BIG FOR BIGNESS' SAKE

Don't think of horizontal integration as a way of blocking competitors; think of it as getting really good at what you do.

MEASURE RESULTS: YOUR OWN AND YOUR COMPETITORS'

What gets measured gets done; don't ignore results you don't like and don't bury the results in a file – use them actively in continually recreating your operations; don't believe your own press – you are at your most vulnerable when your measurement results are at their most flattering.

Source: Regina E. Herzlinger, *Market-Driven Health Care: Who Wins, Who Loses in the Transformation of America's Largest Service Industry* (Reading, MA: Addison-Wesley

In health care, focused factories have not escaped criticism. The success of some focused factories (cardiac surgery and treatment) led some states to propose legislation restricting them. The Federal Medicare Prescription Drug Improvement and Modernization Act became law in 2003. An important part of the law included a moratorium that limited physician investments in specialty hospitals. Specifically identified were cardiac, orthopedic, surgical, and “other” hospitals owned by physicians. These focused factories targeted profitable procedures from insured patients, requiring local not-for-profits to care for less profitable diseases/treatments without being able to offset the costs through the more profitable procedures being captured by focused factories. Therefore, many politicians are opposed to specialty hospitals and advocated for the federal legislation to become permanent.

Additionally, consternation has been expressed concerning whether health care-focused factories really reduce costs and in turn prices. Some experts suggest that price reductions are offset by the tendency of physicians with financial interest in the hospital to increase their volume with elective procedures. As for increasing quality, most experts agree that it is too early to judge. Some suggest that physicians referred easy cases to specialty hospitals and more complex patients to general hospitals, but there is no data to support that claim. Further, most experts agree that specialty hospitals initiated a “medical arms race” that might eventually drive up health care costs. The fear is that as general hospitals perceive the need to compete with the physician-owned specialty hospitals, they will develop dedicated centers as “hospitals-within-hospitals” or as freestanding facilities, forcing up overall costs.²³

Product Development

Product development is the introduction of new products/services to present markets (geographic and segments). Typically, product development takes the form of product enhancements and product line extension. Product development should not be confused with related diversification. Related diversification introduces a new product category (though it may be related to present operations), whereas product development may be viewed as refinements, complements, or natural extensions of present products. Product development strategies are common in large metropolitan areas where hospitals vie for increased market share within particular segments of the market, such as cancer treatment and open-heart surgery, and specialized women’s health clinics.

Penetration

An attempt to better serve current markets with current products or services is referred to as a market *penetration* strategy. Similar to market and product development, penetration strategies are used to increase volume and market share. A market penetration strategy is typically implemented by marketing activities such as promotional, distribution, and pricing strategies, and often

includes increasing advertising, offering sales promotions, increasing publicity efforts, or increasing the number of sales representatives.

Although still using their sales force to pursue expansion strategies, some pharmaceutical companies have recently moved toward e-detailing (electronic physician education concerning drugs) as a key component of their penetration strategies. The use of e-detailing by pharmaceutical companies is on the rise because physicians increasingly prefer to replace sales calls with other forms of communication and are accessing physician-only informational websites, and other interactive communication formats. For example, one study of physicians and other medical professionals found that when e-detailing was used in combination with occasional visits by professional service representatives the results were particularly effective. The argument was made that e-detailing and periodic, in-person visits are complementary in nature, less expensive, and that simultaneous use multiplied the effects of either approach on its own.²⁴

Reduction of Scope Strategies

Reduction of scope strategies decrease the size and reach of operations. Reduction strategies include:

- Divestiture.
- Liquidation.
- Harvesting.
- Retrenchment.

Divestiture

Divestiture is a reduction of scope strategy in which an operating strategic service unit (SSU) is sold off as a result of a decision to leave all or a portion of the market despite its current viability. Generally, the business to be divested has value and will continue to be operated by the purchasing organization.²⁵ For example, in 2016 Community Health Systems, Inc. (CHS) announced it was divesting its majority stake (80 percent) in its home health division to pay down debt. The strategic plan was for Almost Family, Inc. to purchase a majority interest and continue to operate the business.²⁶

The strategy of “unbundling” (divesting by a hospital of one or more of its services) has become common. Hospitals are carving out non-core services previously performed internally and divesting them. Typical services and products produced in a hospital that are not necessarily part of the core bundle of activities include laboratory, pharmacy, X-ray, physical therapy, occupational therapy, and dietary services. In addition, “hotel” services (laundry, housekeeping, and so on) formerly performed by hospitals are being contracted to outsiders. Even medical services in such specialty areas as ophthalmology are increasingly being performed outside the hospital in “surgicenters” and may be candidates for divestiture.

Divestiture decisions are made for a number of reasons. An organization may

need cash to fund more important operations for long-term growth or the division/SSU may not be achieving management's goals. In some cases health care organizations are divesting services that are too far from their core business or area of management expertise. For example, many multihospital systems have divested their HMO (purchased only a few years earlier) to concentrate on care delivery. A multihospital system purchasing a managed care organization actually represents unrelated diversification. Although the strategy appears logical and synergistic, managed care businesses are difficult to manage and there is little skill transfer from managing provider organizations. Moreover, research has shown that divestitures are more profitable when they are part of a carefully crafted strategy as compared to piecemeal sell-offs of various components of the business.²⁷

Liquidation

Liquidation is a reduction of scope strategy involving the termination of a unit through the sale of its assets. The assumption underlying a liquidation strategy is that the unit cannot be sold as a viable and ongoing operation. However, the assets of the organization (facilities, equipment, and so on) still have value and may be sold for other uses. Organizations may be partially or completely liquidated. Common reasons for pursuing a liquidation strategy include bankruptcy, the desire to dispose of non-productive assets, and the emergence of a new technology that results in a rapid decline in the use of the old technology.

One strategy of the MedCath Corporation illustrates an example of liquidation. On September 21, 2012 a Certificate of Dissolution was issued for MedCath Corporation. MedCath consisted of a series of hospitals that specialized in cardiovascular care. Its strategy was to operate these specialty hospitals in partnership with physician groups. Although the strategy was successful initially, the opposition of acute care hospitals resulted in a moratorium on specialty hospital development, which proved to be a mortal blow to the strategy and the company. MedCath's board of directors approved a "liquidating distribution" of assets to stockholders, removed its stock from trading on the NASDAQ stock exchange, and ceased operations.

On leaving a market, an aging hospital building may be sold for its property value or an alternative use. In a declining market, a liquidation strategy may be a long-term strategy to be carried out in an orderly manner over a period of years. Recently, many hospitals have been liquidating their emergency helicopter operations, which had historically been allowed to operate as loss leaders because they brought prestige and positive public relations to the hospital. However, because of increasing costs and limited reimbursements, many hospitals have shut down and liquidated such operations.

Harvesting

A *harvesting* strategy is a reduction of scope strategy to continue to operate a declining business and reap any remaining available profits while not investing additional resources. A harvesting strategy is selected when the market has

entered long-term decline. The reason underlying such a strategy is that the organization has a relatively strong market position but industry-wide revenues are expected to decline over the next several years. Therefore, the organization will “ride the decline,” allowing the business to generate as much cash as possible without further investment.

When implementing a harvesting strategy, the organization attempts to reap maximum short-term benefits before the product or service is eliminated. Such a strategy allows the organization an orderly exit from a declining segment of the market by planned downsizing. Harvesting has not been widely used in health care but will be more frequently encountered in the future as markets mature and organizations exit various segments. For instance, some regional hospitals that have developed rural hospital networks have experienced difficulty in maintaining their commitment to health care in small communities. The 20-bed hospitals frequently found in rural networks tend to struggle financially because of a lack of support from specialists and primary care physicians, an aging population, and flight of the young to urban areas. Twenty-bed rural hospitals are probably in a long-term decline with little hope for survival. On the other hand, 50-bed hospitals have managed to maintain or improve their financial position because of effective physician recruitment, good community image, and the continued viability of the communities themselves. Therefore, regional hospitals with rural networks may have to employ a harvesting strategy for the 20-bed hospitals while using market development or maintenance of scope strategies for the 50-bed and larger hospitals.

Retrenchment

A *retrenchment* strategy reduces the scope of operations, through redefining the target market, cutting geographic coverage, reducing the segments served, or reducing the product/service line. Typically a retrenchment strategy is a response to declining profitability, usually brought about by increasing costs. The market is still viewed as viable, and the organization’s products/services continue to have wide acceptance; however, costs are rising as a percentage of revenue, placing pressure on profitability. Retrenchment typically involves a redefinition of the target market and selective cost elimination or asset reduction. Retrenchment is directed toward reduction in personnel, the range of products/services, or the geographic market served and represents an effort to reduce the scope of operations.

Over time, organizations may find that they are overstaffed given the level of demand. As a result, their costs are higher than those of competitors. When market growth is anticipated, personnel are added to accommodate the growth, but during periods of decline, positions are seldom eliminated. A reduction in the staff members who have become superfluous or redundant is often central to a retrenchment strategy.

Similarly, in an attempt to “round out” the product or service line, products and services are added. Over time, these additional products/services may tend to add more costs than revenues. In many organizations, less than 20 percent of the products account for more than 80 percent of the revenue. In these

circumstances, retrenchment may be in order.

Finally, there are times when geographic growth is undertaken without regard for costs. Eventually, managers realize they are “spread too thin” to adequately serve the market. In addition, well-positioned competitors are able to provide quality products/services at lower costs because of their proximity. In this situation, geographic retrenchment (reducing the service area) is appropriate. In many cases, a retrenchment strategy is implemented after periods of aggressive market development or acquisition of competitors (horizontal integration).

Maintenance of Scope Strategies

Often organizations pursue a *maintenance of scope strategy* when management believes the past strategy has been appropriate and few changes are required in the target markets or the organization’s products/services. Maintenance of scope does not necessarily mean that the organization will do nothing; it means that management believes the organization is progressing appropriately. There are two maintenance of scope strategies: enhancement and status quo.

Enhancement

Enhancement seeks to improve operations within present product or service categories in various ways, such as by implementing quality programs, increasing flexibility, increasing efficiency, improving speed of delivery, and so on. When management believes that the organization is progressing toward its vision and goals but needs to “do things better,” an enhancement strategy may be used; neither expansion nor reduction of operations is appropriate but “something needs to be done.” Typically, enhancement strategies take the form of quality programs (continuous quality improvement or CQI, total quality management or TQM) directed toward improving organizational processes or cost-reduction programs designed to render the organization more efficient. In addition to quality and efficiency, enhancement strategies may be directed toward innovative management processes, speeding up the delivery of the products/services to the customer, and adding flexibility to the design of the products or services (marketwide customization). As discussed in Essentials for a Strategic Thinker 6–2, “What Is Health Information Technology (IT)?” the adoption of information technology may be an enhancement strategy that creates competitive advantage.

Many times after an expansion strategy, an organization engages in maintenance/enhancement strategies. Typically after an acquisition, organizations initiate enhancement strategies directed toward upgrading facilities, reducing purchasing costs, installing new computer systems, enhancing information systems, improving the ability to evaluate clinical results, reducing overhead costs, or improving quality.

Status Quo

A *status quo* strategy is a maintenance of scope strategy seeking to maintain relative market share within a market and retain services at their current level.

A status quo strategy is often based on the assumption that the market has matured and periods of high growth are over. In this situation, the organization has secured an acceptable market share that managers believe can be defended against competitors. In addition, a status quo strategy may be appropriate when an organization is in a period of “active waiting.” Active waiting is a temporary strategy for organizations operating in dramatically changing or volatile markets. During periods of active waiting, leaders must remain alert to market anomalies that signal potential threats and opportunities, build financial reserves, and prepare to make strategic changes.²⁸

ESSENTIALS FOR A STRATEGIC THINKER 6-2

What Is Health Information Technology (IT)?



Health IT is a broad term that refers to a wide range of technologies and applications designed to store, share, and/or analyze health information. Health IT includes electronic health records (EHRs), health information exchanges (HIEs), and many other technologies. Whereas EHRs are computerized versions of patient records that allow clinicians secured access to patient information (e.g. prior history, test results, medication information) and algorithms designed to assist clinicians to provide optimal care (e.g. dosing information, access to the newest medical guidelines), HIEs are the infrastructure that allow information from EHRs to be exchanged across different providers, settings of care, and time.

Ideally, health IT assists clinicians, managers, and public health officials to improve the quality of care, reduce inefficiencies, and lower health care costs. As such, federal policies have promoted the adoption and use of health IT by physicians, hospitals, and other providers. For example, the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 promoted the uptake of EHRs and HIEs by paying providers “bonus payments” for successfully installing, upgrading, or using health IT that met certain basic requirements.

Likewise, changes in reimbursement models by Medicare, Medicaid, and private insurance companies have also incentivized the use of health IT. Historically, most insurance companies reimbursed providers on a fee-for-service basis. That is, for a given clinical service, insurance companies would pay doctors and hospitals a predetermined fee on behalf of patients. Under this model, providers earned more if they provided a higher volume of services – and quality of care was not necessarily rewarded. As costs of care increased and quality concerns grew, new federal policies such as the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, introduced newer reimbursement models that sought to financially reward physicians and hospitals that provide the best care for the lowest costs.

Collectively, these new reimbursement models are known as value-based purchasing arrangements. Value-based (as opposed to volume-based) models promote the use of health IT because such technologies play a role in improving quality and efficiency.

Despite much national attention to health IT by insurance companies and providers, and despite substantial technological improvements to EHRs and HIEs, the U.S. health care system has not yet lived up to the full potential of health IT. In retrospect, whereas the HITECH Act may have spurred increased adoption of health IT, it may not have fostered an environment where health IT could be used innovatively. Moreover, many organizations struggled with the implementation process of health IT because the challenges with such wide-scale changes were underestimated. Lastly, despite improvements to commercially available health IT products, there is still a perception that the products available do not meet every organization's needs. As such, one can expect that health IT will continue to be tailored to individual organizational needs, and researchers will continue to find ways for health IT to be used more effectively to improve care, support population health, enable new analytics, and generally be a necessary ingredient of the modern U.S. health care system.

Source: Nir Menachemi, PhD Professor and Chair, Indiana University Richard M. Fairbanks School of Public Health, Affiliate Scientist, Regenstrief Institute, Inc.

In a status quo strategy, the goal is to maintain market share and keep services at their current level. Environmental influences affecting the products or services should be carefully analyzed to determine when significant change is imminent. Typically, organizations attempt a status quo strategy in some areas while engaging in market development, product development, or penetration in other areas to better utilize limited resources. For instance, a hospital may attempt to hold its market share (status quo) in slow-growth markets such as cardiac and pediatric services and attempt market development in higher-growth services such as intense, short-term rehabilitation care, renal dialysis, ophthalmology, or intravenous therapy.

In mature markets, industry consolidation occurs as firms attempt to add volume and reduce costs. Therefore, managers must be wary of the emergence of a single dominant competitor that has achieved a significant cost differential. A status quo strategy is appropriate when there are two or three dominant providers in a stable market segment because, in this situation, market development or product development may be quite difficult and extremely expensive.

A brief definition of the adaptive strategies and their rationales for selection are summarized in [Exhibit 6-8](#).

Adaptive Strategy	Definition	Rationale
Expansion of		

Scope		
Related Diversification	Adding new related product or service categories. Often requires the establishment of a new division.	• Pursuit of high-growth markets. • Entering less-regulated segments. • Not achieving current objectives. • Synergy is possible from new business. • Offset seasonal or cyclical influences.
Unrelated Diversification	Adding new unrelated product or service categories. Typically requires the establishment of a new division.	• Pursuit of high-growth markets. • Entering less-regulated segments. • Cannot achieve current objectives. • Current markets are saturated or in decline. • Organization has excess cash. • Antitrust regulations prohibit expansion in current industry. • Tax loss may be acquired.
Backward Vertical Integration	Adding new members along the distribution channel (toward a later stage) for present products and services or controlling the flow of patients from one institution to another.	• Control the flow of patients through the system. • Scarcity of raw materials or essential inventory/supplies. • Deliveries are unreliable.

		• Lack of materials or supplies will shut down operations. • Price or quality of materials or supplies variable. • Industry/market seen as profitable for long term.
Forward Vertical Integration	Adding new members along the distribution channel (toward an earlier stage) for present products and services or controlling the flow of patients from one institution to another.	• Control the flow of patients through the system. • Faster delivery required. • High level of coordination required between one stage and another – secure needed resources. • Industry/market seen as profitable for long term. • Gain bargaining power.
Market Development	Introducing present products or services into new geographic markets or to new segments within a present geographic market.	• New markets are available for present products. • Provide comprehensive services across the market (focus factory). • New markets may be served efficiently. • Expected high revenues. • Organization has cost leadership

		advantage. • Organization has differentiation advantage. • Current market is growing.
Product Development	Improving present products or services or extending the present product line.	• Currently in strong market but product is weak or product line incomplete. • Market tastes are changing. • Product technology is changing. • Maintenance or creation of differentiation advantage.
Penetration	Seeking to increase market share for present products or services in present markets through marketing efforts (promotion and price).	• Present market is growing. • Product/service innovation will extend product life cycle (PLC). • Expected revenues are high. • Organization has cost leadership advantage. • Organization has differentiation advantage.
Reduction of Scope		
Divestiture	Selling an operating unit or division to another organization. Typically, the unit will continue in operation.	• Industry in long-term decline. • Cash needed to enter new, higher-growth area.

		• Lack of expected synergy with core operation. • Required investment in new technology seen as too high. • Too much regulation. • Unbundling.
Liquidation	Selling all or part of the organization's assets (facilities, inventory, equipment, and so on) to obtain cash. The purchaser may use the assets in a variety of ways and businesses.	• Organization can no longer operate. • Bankruptcy. • Trim/reduce assets. • Superseded by new technology.
Harvesting	Products or services typically in late stages of the product life cycle (late maturity and decline) where industry-wide revenues are expected to decline. These products or services will ultimately be discontinued but may generate revenue for some time. Few new resources are allocated to these areas.	• Late maturity/decline of the product life cycle. • Consider divestiture or downsizing. • Short-term cash needed.
Retrenchment	Reducing the scope of operations, redefining the target market, cutting geographic coverage, reducing the segments served, or reducing the product line.	• Market has become too diverse. • Market is too geographically spread out. • Personnel costs are too high. • Too many products or services. • Marginal or non-productive facilities.

Maintenance of Scope		
Enhancement	Seeking to improve operations within present product or service categories through quality programs, increasing flexibility, increasing efficiency, speed of delivery, and so on.	• Organization has operational inefficiencies. • Need to lower costs. • Need to improve quality. • Improve internal processes.
Status Quo	Seeking to maintain relative market share within a market.	• Maintain market share position. • Maturity/late maturity stage of the product life cycle. • Product/market generating cash but has little potential for future growth. • Extremely competitive market.

Exhibit 6.8 Definition and Rationales of the Adaptive Strategies

Step 4: Understand Market Entry/Exit Strategy Alternatives

The expansion of scope adaptive strategies require entering or gaining access to a new market, while the maintenance of scope strategies may call for organizational improvements; therefore, it is likely that both strategies will require new resources. On the other hand, reduction of scope strategies may provide additional resources or free up committed resources. Thus, the next important decision that must be made for these strategies concerns how the organization will enter and develop a market or exit the market. Market entry strategies carry out the expansion and maintenance adaptive strategies through purchase, cooperation, or internal development. Reduction of scope strategies are carried out through market exit strategies.

There are three major methods to enter a market. As illustrated in [Exhibit 6-4](#), an organization can use its financial resources to purchase a stake in the new market, team with other organizations and use cooperation to enter a market, or use its own resources to develop its own products and services. It is important to understand that market entry strategies are not ends in themselves but serve a broader aim – supporting the expansion and maintenance of scope adaptive strategies. Any of the expansion and maintenance of scope strategies may be carried out using any of the market entry strategies but each one places different demands on the organization.

If a reduction of scope strategy is selected, the organization may choose to leave (exit) the market quickly or incrementally resulting in a partial withdrawal or a complete abandonment of the market. Similar to the market entry strategies, market exit strategies support a broader vision and may continue to require resources and careful management for a period of time before the strategy has been completed.

Purchase Strategies

A *purchase strategy* uses financial resources to enter a market quickly. There are three purchase market entry strategies: acquisition, licensing, and venture capital investment.

Acquisition

Acquisitions are entry strategies for expansion through the purchase of an existing organization, a unit of an organization, or a product/service. Thus, acquisition strategies may be used to carry out both corporate and divisional strategies such as diversification, vertical integration, market development, or product development. There are many reasons to purchase another organization, such as to obtain real estate or other facilities, to acquire brands, trademarks, or technology, and even to access employees. However, the most common reason is to acquire customers.²⁹ One form of acquisition is inversion which has been used as a tax reduction strategy as well as a market development

strategy. See Essentials for a Strategic Thinker 6–3, “What Is Inversion?”

The acquiring organization may integrate the operations of the newly acquired organization into its present operations or may run it as a separate business/service unit. Acquisitions offer a method for quickly entering a market, obtaining a technology, or gaining a needed channel member to improve or secure distribution. It is usually possible to assess the performance of an organization before purchase and thereby minimize the risks through careful analysis and selection. The “build internally” versus “acquire” decision is one where strategic leaders must determine whether the benefits of ownership justify the costs and whether the acquiring organization has the product and process knowledge to capitalize on an opportunity quickly. If the acquiring organization does not have the expertise or capability and there is an organization that provides a good strategic fit that does have such expertise then purchase may be warranted.³⁰ However, even a small acquired organization can be difficult to integrate into the existing culture and operations. Often it takes several years to “digest” an acquisition or to combine two organizational cultures.

ESSENTIALS FOR A STRATEGIC THINKER 6–3

What Is Inversion?



Inversion, also termed expatriation, results when a U.S.-based multinational company restructures and relocates the parent company to a low-tax country.¹ Inversions typically involve a U.S. company’s acquisition of a smaller corporation in a foreign country and the combined company moves its headquarters from the United States to the nation of the acquired firm. For example, in 2014, Mylan, Inc. of Pittsburgh acquired the European generic drug division of Abbott Laboratories and incorporated the resulting enterprise in the Netherlands. Mylan’s new enterprise will be managed by its executive team located in Pittsburgh; however, the company will be located in the Netherlands and will be a Dutch company.² The term “inversion” references the “upside-down” structure that results from the acquisition and headquarters relocation – the headquarters entity is smaller than the U.S.-based main entity.³

The strategic rationale for inversion usually focuses on reducing the corporate income tax burden of multinational companies.⁴ The United States uses a “world-wide” system of taxation in which both domestic and foreign income are combined for income tax reporting and, thus, may result in double taxation – first in the country of income origin and second in the United States.⁵ In the case of the Mylan–Abbott transaction, Mylan’s tax rate was reduced from 35 percent to 21 percent.⁶ In selecting an acquisition

target, U.S. companies are typically seeking suitable business locations in countries that use a regional taxation system where income is taxed only in the country where it originates.

Ireland, the UK, and the Netherlands have been prime locations for inverted multinationals because of: (1) business tax rates that are lower than U.S. rates, (2) flexibility in creating corporate governance models (the Netherlands), (3) common law legal framework (Ireland and the UK), (4) English-speaking (all three countries), and (5) offering market development opportunities in Europe (all three countries).⁷

The first inversion occurred in 1982 when McDermott International Inc., a construction company previously domiciled (headquartered and located) in Louisiana, moved its headquarters to Panama. In the health care system, inversion has been used mostly by pharmaceutical and medical device companies, such as Medtronic's move to Ireland, Convatec Healthcare's move to Luxembourg, Valeant Pharmaceuticals International's move to Canada, Jazz Pharmaceuticals' move to Ireland, Activas' move to Ireland, and Wright Medical Group's move to the Netherlands.⁸

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Source: Andrew C. Rucks, PhD, Professor, School of Public Health, University of Alabama at Birmingham.

Despite the difficulties of combining organizational cultures, the creation of

health systems with unified ownership has been an effective strategy. Health systems have been better able than health networks (looser contractually- or alliance-based strategies) to provide needed resources, competencies, and capabilities. Direct ownership of assets enables systems to achieve greater unity of purpose and develop more focused strategies, on average, than more decentralized networks. In addition, hospitals in health systems that have unified ownership generally have better financial performance than hospitals in contractually-based health networks.³¹

Much of the growth of for-profit hospital chains has been via a market development acquisition strategy also called horizontal integration (or buying market share). More specifically, horizontal integration is a type of market development – a method of obtaining growth across markets by acquiring or affiliating with direct competitors rather than using internal operational or functional strategies to gain/grow market share. Aggressive market development through acquisition of independent hospitals has been used to build the nation's largest private for-profit hospital chains. For example, in California the seven largest hospital systems control more than one-third of the hospitals and licensed beds in the state.³² Horizontal integration and vertical integration through acquisitions and alliances have been key entry strategies for initiating rapid market growth by health care organizations.

Licensing

Licensing is an agreement for rights to a technology, product, trademark, franchise, or exclusive geographic area (territory) developed by one organization and used by another for a fee. The da Vinci laser “knife” was licensed to surgeons. Acquiring a technology or product through licensing may be viewed as an alternative to acquiring a complete company. Licensing agreements obviate the need for costly and time-consuming product development and provide rapid access to proven technologies, generally with reduced financial and marketing risk to the organization. However, the licensee usually does not receive proprietary technology and is dependent on the licensor for support and upgrades. In addition, the upfront dollar costs may be high.

Another common form of licensing is a *franchise* – the granting of an exclusive territorial license assuring the licensee all rights that the licensor has with respect to a defined activity.³³ This practice is most commonly found in the field of trademark licensing. Franchisees benefit from exploitation of the goodwill, uniform format, and uniform quality standards symbolized by the franchisor's trademark. An example is the license agreement by and between Blue Cross and Blue Shield Association and the various regional Blue Cross and Blue Shield Plans. Blue Shield Plans are granted the right to use the Blue Cross and Blue Shield names and trademarks in the trade and corporate name and the right to use the licensed marks in the sale, marketing, and administration of health care plans and related services within a geographic area. In such agreements no other health insurance provider can encroach on the Plans' license under the Blue Cross and Blue Shield name within the stated territory.³⁴

Venture Capital Investment

A *venture capital investment* is a purchase strategy that provides capital to an organization with a developing technology, product, or market to participate (have a share) in its growth (profitability). Venture capital investments offer an opportunity to enter or “try out” a market while keeping risks low. Typically, venture capital investments are used to become involved in the growth and development of a small organization that has the potential to develop a new or innovative technology. By making minority investments in young and growing enterprises, organizations have an opportunity to become close to and – possibly later – enter into new technologies.³⁵

In addition, venture capital investments are a way for new health care organizations to grow. Venture capital investment in health care companies (including biotechnology, pharmaceuticals, medical devices, and health care delivery) in early 2012 fell to its lowest level since 2010; however, the number of deals remained relatively high. Venture capital investment in health care technology firms was strong throughout the decade of the 1990s but e-health (internet-related) companies began receiving a large share of health care venture capital beginning in 2000. During 2012 most of the venture capital investments were made in firms located in California and Massachusetts. By far the most investments were in mature companies rather than seed money for start-ups. Unlike the 1990s, 2010s venture capital investments involved firms in genomic research (Warp Drive Bio), non-invasive prenatal testing (Ariosa Diagnostics), radiation therapy (Mevion Medical Systems), and endoscopic surgery (Apollo Endosurgery).³⁶

Since 2012 venture capital investments in health care companies have reached almost \$150 billion and, for the first time in over a decade, accounted for a larger percentage of total venture capital than information technology. Juno Therapeutics, for example, did its initial public offering (IPO) less than a year after receiving its initial venture capital funding.³⁷ The *Wall Street Journal* reported that venture capital funding in health care companies rose 34 percent between 2014 and 2015 primarily in new disease treatment and other medical technologies.³⁸

Cooperation Strategies

Probably the most used – and certainly the most talked about – strategies of the late 1990s and early 2000s were cooperation strategies. A *cooperation strategy* occurs when organizations agree to work together to achieve a common goal through mergers, alliances, or joint ventures. Many organizations have carried out adaptive strategies – particularly diversification, vertical integration, product development, and market development strategies – through cooperation strategies.

Mergers

Mergers are similar to acquisitions. In a *merger*, however, the two organizations

combine through mutual agreement to form a single new organization, often with a new name. Mergers have been used most often in the health care segment to combine two similar organizations (horizontal integration) in an effort to gain greater efficiency in the delivery of health care services, reduction in duplication of services, improved geographic dispersion, increased service scope, restraint in pricing increases, and improved financial performance.³⁹ The expectation of increased merger activity has materialized, especially with regard to hospitals. Since 2009, for example, the number of hospital mergers per year has doubled from around 50 to over 100 per year.⁴⁰ Another area that has experienced a substantial amount of merger and acquisition activity is medical devices (pacemakers, surgical blades, catheters, and so on). According to PricewaterhouseCoopers, in the fourth quarter of 2012 alone medical device mergers and acquisitions amounted to \$3.4 billion.⁴¹ The other primary use of merger strategies (as well as acquisitions and alliances) in health care has been to create integrated delivery systems (vertical integration). There are four motives underlying such mergers:

1. Improve efficiency and effectiveness – by combining available resources and operations it is possible to exploit cost-reducing synergies and to take fuller advantage of risk-spreading managed care opportunities.
2. Enhance access – by providing a broader range of sophisticated programs and services and offering services at a greater number of sites, quality of patient care is improved.
3. Enhance financial position – by gaining market share, the sole or one of the dominant providers in the region's health delivery system is able to increase total revenue.
4. Overcome concerns about survival – by merging, a free-standing health care organization is better able to survive in an increasingly aggressive, market-driven environment where huge and powerful networks are experiencing cutbacks in managed care, Medicare, and Medicaid reimbursement.⁴²

Nevertheless, managing organizations that merge to create integrated systems has been difficult. There are several reasons why integrated health systems encounter significant obstacles in realizing the proposed benefits. The most frequently cited reasons relate to the difficulty of creating an effective strategic fit, giving away too much money and power with respect to governance to the local governing board, inability to achieve operating efficiencies, and experiencing difficulties in realigning resources.⁴³

As in acquisitions, a major difficulty in a merger is the integration of two separate organizational cultures. Mergers offer a more difficult challenge than acquisitions because a totally new organization must be forged. In an acquisition, the dominant culture remains and subsumes the other. In a merger, a totally new organizational culture (the way we do things) must be developed. Typically, there are significant changes in the organizational structure, governance, senior and middle management, service mix, product mix, and outside relationships. Therefore, merging two distinctly different corporate cultures requires a great deal of communication at all levels in the organization.

Medical staff and employees should engage in a reformulation of the mission, vision, and statement of the shared values of the new organization. Work groups must be formed to address how to effectively and efficiently meet the needs of patients. As well as communicating internally, external communications must be given top priority. Even with such efforts, truly merging the two organizational cultures into one generally takes years to complete.

Mergers and acquisitions and other forms of combination continue to be important market entry strategies for health care organizations. An environment conducive to large health care combinations, institutional coordination, demands for efficiency, and the continuum of care (seamless care) has fostered many of these mergers and acquisitions.

Alliances

Alliances are loosely coupled agreements between two or more organizations to achieve some long-term strategic purpose not possible by the organizations separately. Alliances include configurations such as federations, consortiums, networks, and systems.⁴⁴ Strategic alliances are cooperative contractual agreements that go beyond normal company-to-company dealings but fall short of merger or full partnership.⁴⁵ Alliances have been used to create health networks – loosely coupled or organized delivery systems. They are an attempt to strengthen the competitive position in a marketplace while maintaining the independence of the organizations involved. With all of the mergers, acquisitions, and alliances of hospitals, community blood centers are being affected as well. A new, larger hospital system with a larger footprint wants to know that blood will be available to meet all its needs. The result is aggressive merger or alliance activity among blood centers; more than two-thirds of independent blood centers in the United States are operating in the red in 2017 as is the American Red Cross. Many are entering mergers or alliances to survive.

Some research suggests that organizations that develop these cooperative relationships are likely to have similar status in the marketplace and have complementary resources, competencies, and capabilities.⁴⁶ Two organizations may establish an alliance when each one possesses strength in a different stage of the service category value chain – for example, when one organization has expertise in service delivery and another controls the distribution channel. As an illustration, it has been found that community hospitals have successfully used alliances to provide specific advantages for patients.⁴⁷ Further, organizations may form coalitions to defray costs and share risk when they undertake high-cost capital or development-intensive initiatives. Sometimes the resources available from an alliance partner can facilitate an organization's effort to alter its strategic position.⁴⁸ For instance, research indicates that biotechnology start-up organizations, in particular, could enhance their initial performance and strategic position by establishing upstream and downstream alliances.⁴⁹

In health care, the term “alliance” is sometimes used to refer to the voluntary organizations that hospitals join primarily to achieve economies of scale in purchasing. For some, this type of alliance provides the benefit of being part of a

large system, yet allows them to exist as free-standing, self-governing institutions. Examples of some major hospital alliances include Vizient (includes the former VHA, University Health Systems, Children's Hospital Association, and Novation), Premier, Intalere, and Health Trust. Note that purchasing alliances are a different type from those based on an expansion/cooperation strategy.

Although they are not mergers, strategic alliances have many of the same problems – previously unrelated cultures have to learn to cooperate rather than compete; numerous “sessions” are required to determine what will be shared and what is proprietary, and how to balance the two; and efforts must be made to maintain cooperation over time within such an informal cooperative effort. On the other hand, strategic alliances offer several opportunities, including shared learning, access to expertise not currently “owned” by the organization, strengthened market position, and direction of competitive efforts toward others instead of each other. In addition, one of the advantages of integrated networks and strategic alliances is the increased access to resources to obtain new technology or reduce the need to purchase duplicate equipment. Further, it has been suggested that these arrangements are promising mechanisms to reduce technology-driven health care cost inflation.⁵⁰ In some cases, an alliance can lead to a merger. For example, Breech Medical Center in Lebanon, Missouri moved its affiliation agreement with St. John's Health System of Springfield, Missouri to a full-asset merger over a several-year period (now St. John's Beech Regional Medical Center).

As the environment becomes more unpredictable, a number of health care providers have been seeking strategic alliances. Many primary providers have turned to alliances as vehicles for providing services, soliciting physician loyalty, and reducing investments in operations.⁵¹ Hospitals form alliances with physicians for several reasons. Alliances serve to contract with the growing number of HMOs, to pose a countervailing bargaining force for providers in the face of HMO consolidation, and to accompany hospital downsizing and restructuring efforts.⁵² However, strategic alliances between physicians and hospitals should be anchored in their common purpose – improving patient care. The physicians involved may not agree with the hospital in its management of facilities, staffing, and so forth. In addition, conflict may emerge as hospitals diversify into areas that compete more directly with the physicians' own clinics, such as ambulatory care centers, and diagnostic centers. Finally, although the hospital would prefer to have many qualified physicians admitted to the staff (who could refer more patients), allied physicians would prefer to limit credentialing of outside physicians (controlling competition).

Joint Ventures

When projects get too large, technology too expensive, internal resources, competencies, or capabilities too scarce, or the costs of failure too high for a single organization, joint ventures are often used.⁵³ A *joint venture* (JV) is a contractual agreement between two or more organizations to work together and combine resources to accomplish a designated task or project. A joint venture

may involve a pooling of assets or a combination of the specialized talents or skills of each organization. The four most common organizational forms used in health care joint ventures are:

1. Contractual agreements. Two or more organizations sign a contract agreeing to work together toward a specific objective.
2. Subsidiary corporations. A new corporation is formed (called an equity JV), usually to operate non-hospital activities.
3. Partnerships. A formal or informal arrangement in which two or more parties engage in activities of mutual benefit.
4. Not-for-profit title-holding corporations. Tax legislation enacted in 1986 allowed not-for-profit organizations to form tax-exempt title-holding corporations (providing significant benefits to health care organizations engaged in real estate ventures).⁵⁴

Because of the dynamism in the health care environment, hospitals engage in joint ventures to lower costs and to improve and expand services. Joint ventures can be an innovative way to generate revenues, supplement operations, and remain competitive.⁵⁵ Through the first half of the 2000s, the most common joint venture was between hospitals and physicians. Hospital/physician joint ventures are popular because they allow the hospital to pre-empt physicians as competitors and, at the same time, stabilize the hospital's referral base. Often joint ventures with hospitals increase physicians' profitability. Physicians enter joint ventures with hospitals to protect their incomes and autonomy, whereas hospitals are motivated to form joint ventures as a means of controlling medical care costs and gaining influence over physician utilization of hospital services. Changes in third-party payments have created competition based on price – joint ventures enable hospitals to reduce costs and compete more effectively.⁵⁶

Although there are benefits to creating joint ventures, they have their own unique set of challenges. These challenges revolve around strategy, governance, economic interdependencies, and organization. For example, the parent organizations may hold different strategic interests and maintaining strategic alignment across separate organizations with different goals, market pressures, and stakeholders can be difficult. In addition, sharing governance can complicate decision making, particularly with separate reporting systems and methods for measuring success. Further, problems develop in providing services, staffing, and other resources. Finally, building a cohesive, high-performing organization with a unique culture has proven difficult for many joint ventures.⁵⁷

Development Strategies

A *development* strategy is a decision to enter a new market using internal resources through internal development, internal ventures, or reconfiguring the value chain. Diversification and vertical integration through internal development or internal venture usually take considerably longer to achieve than through acquisition (although the costs may be lower). Reconfiguring the

value chain finds new ways to deliver value to customers and changes the “business model.”

Internal Development

Internal development uses existing organizational resources to create new products/services or enter new markets and may be most appropriate for products or services that are closely related to existing products/services. Internal development is common for growing organizations, particularly when they can exploit existing resources (especially financial), competencies, and capabilities (leveraging existing resources and other assets).

Internal Ventures

Internal ventures typically set up separate, relatively independent entities (businesses) within the organization to develop new products/services or to enter new markets. Internal ventures may be most appropriate for products or services that are unrelated to the current products or services.⁵⁸ For instance, internal ventures may be appropriate for developing vertically integrated systems. Thus, initial efforts by a hospital to develop home health care may be accomplished through an internal venture.

The number of health systems setting up their own venture funds has increased in recent years. Cedars-Sinai Health System set up a fund to help start-ups and had 500 applications for 11 open spots. Twenty percent of the most active investors over the past five years in the area of digital health have been corporate or strategic funds. Inova Health System established a \$100 million venture fund for personalized medicine investment. Providence Venture Fund has made seven internally financed investments since 2014.⁵⁹

In 2015 venture groups invested \$7.5 billion to fund start-ups, about 13 percent of all venture capital dollars. Of this amount, health care venture funds accounted for about 20 percent of the venture capital market and included some very familiar names such as Mayo Clinic Ventures, Partners Innovation Fund (Brigham and Women’s Hospital), and Flare Capital Partners (Cleveland Clinic). In total, more than 40 health care provider systems have started their own venture funds.⁶⁰

Reconfiguring the Value Chain

The value chain represents the fundamental way organizations create and deliver value to the customer. It represents the *business model*. The features of the model define the customer value proposition, cost/value formula, delivery mechanism, organization, processes, and so on.⁶¹ Dominant business models for product categories tend to emerge over time; however, an organization may *reconfigure the value chain* by changing the activities or sequence of activities it performs and therefore change how value is delivered to the customer – change the basic business model. Value chain reconfiguration requires rethinking the ways in which existing organizations serve customers. For the most part,

reconfiguration takes place in the service delivery components of the value chain (pre-service, service delivery, after-service) and thus is marketing and operations focused.

In many cases reconfiguring the value chain involves using new technology or organizations to perform activities in ways that were not possible in the past.⁶² For example, pharmaceutical companies might create a whole new way to provide value to physicians by using podcasts for physician education. As discussed in the Essentials for a Strategic Thinker 6–4, “What Are Health Care Platform Businesses?” platform technology offers great potential for reconfiguring the value chain in health care. Further, reconfigurations with the greatest potential for the development of a completely new business model in health care appear to be:

- New models applying a business model from another industry to health care.
- New models that are better tailored than the dominant models to meet customers’ personal and immediate needs.
- New models that reduce resource costs across partners.
- New models that share costly assets where sharing happens by means of two-sided online marketplaces (demand-side and supply-side) that unlock value for both sides through platform organizations.
- New models employing usage-based pricing.
- New models that improve collaboration with partners.⁶³

Market entry and penetration strategies coupled with reconfiguring the value chain can be powerful combinations for creating new business models and effectively entering the market. For example, when an organization bypasses brick-and-mortar outlets and sells its products through a website (penetration strategy – channel of distribution), it is reconfiguring the value chain.⁶⁴

ESSENTIALS FOR A STRATEGIC THINKER 6–4

What Are Health Care Platform Businesses?



One of the recent hallmarks of strategy for consumer-facing goods and services has been the rapid rise in platform businesses with their ability to dramatically outperform traditional producers. A platform business brings together supply and demand by providing a marketplace, or ecosystem, where producers and consumers can more effectively and efficiently interact. The platform does not control supply and demand, but does control the rules of exchange as well as how products or services are delivered or accessed (e.g. through a mobile phone). In contrast, traditional pipeline businesses focus on turning raw materials into products and tend

to compete on factors such as cost and quality. These businesses, such as WalMart or a traditional hospital system, implement the classic value-chain model to control resources, optimize internal processes to create strategic advantage, and focus primarily on the end user as the recipient of the value created.

In a sense, platform businesses have existed for a long time; for example, commercial malls bringing together customers and retailers. Recent advances in information technology have created the ability to build a much more efficient and scalable platform. Whether it is the Apple iPhone and its app store, the “sharing economy” in the form of Airbnb or Uber, or the “on demand” economy with such platforms as NetFlix, platform businesses introduce a fundamentally different way of delivering value than traditional pipeline producers. As a result, they have the potential to significantly disrupt traditional business. For example, Uber provides a platform for ride-sharing where producers (car owners) can find consumers (people wanting rides). Uber controls how the platform is accessed (e.g. through mobile devices) as well as the rules of how rides are delivered (e.g. pricing). The speed with which Uber has changed the face of global transportation demonstrates the potential of modern platform businesses.

Health care has many features that make platform businesses an effective and efficient business model; however, it has some unique features that make the entry of platforms difficult. Factors complicating the entry of platform businesses in health care are: (a) consumers of health care are not the sole “purchaser” of their care, and b) large fixed-cost assets such as hospitals are necessary for consumption of certain services such as MRIs. Yet, there are many health care services where platforms can better deliver services.

Companies such as Pack Health, a digital coaching platform, are using these concepts to connect individuals diagnosed with chronic conditions with suppliers of appropriate services for these conditions in a scalable fashion. In many cases, individuals with chronic conditions are motivated to be members of the platform because services are often difficult to obtain and coordinate and the services are subsidized by their employer, insurer, or a drug company. For example, individuals diagnosed with Type 2 diabetes have to change many aspects of their lives and consume unique goods and services to manage their disease. These services may include getting an annual eye and foot exam, signing up for an exercise program, shopping for healthy foods, and accessing medications. As part of platform services, an advisor is assigned to identify and coordinate appropriate services for the platform members (patients) considering their personal limitations and situations. On the supply side, the platform allows for the inclusion of a variety of service suppliers that pay to be a part of the platform and provide discounted services to platform members.

Source: Mazi Rasulnia, PhD, President, Pack Health.

Market Exit Strategies

The reduction of scope strategies of divestiture, liquidation, harvesting, and retrenchment may be implemented quickly or incrementally over a period of time. Additionally, these strategies may result in only a partial withdrawal from the market or a complete exit. Generally divestiture may be achieved fairly rapidly (or it may take some time if the price is too high or the organization does a poor job of marketing the unit to be divested) and represents a decision by the organization to “go in a different direction.” Similarly, liquidation can happen very quickly as it involves the sale of assets that have value to others (again, the process may take longer than expected if the value to others is not as great as the seller expects). Retrenchment generally is carried out quickly as it is often a cost saving effort in response to declining revenue or an over extension of organizational resources. Harvesting, on the other hand, is a decision to slowly leave the market primarily because the product category remains profitable, but is expected to decline or be replaced over time.

Divestiture and liquidation are generally decisions to completely leave the market. Harvesting and retrenchment are generally seen as decisions to partially leave the market. Reduction of scope strategies are relatively enduring and once they are implemented it is difficult to reverse the strategy or re-enter a market once exit is complete. A retrenchment strategy, although a partial market exit, may be the implementation of a redefinition of the target market(s) – reducing the number of market segments served allowing for market development in more attractive market segments – or the narrowing of the product line to focus on market development for key products or services. Both harvesting and retrenchment continue operations, at least temporarily, and require an implementation plan.

Market Entry/Exit Strategy Linkage

The definition, major advantages, and disadvantages of the market entry/exit strategies are summarized in [Exhibit 6-9](#). The adaptive and market entry/exit strategies work in tandem. They are the means for accomplishing the adaptive strategies. This relationship is demonstrated as organizations struggle with cost containment and their managed care strategies. Together the adaptive (scope of the organization) and market entry/exit strategies (means to achieve that scope) are shaping the health care landscape.

Market Entry Strategy	Definition	Major Advantages	Major Disadvantages
Purchase			
Acquisition	Strategy to grow through the purchase of an existing organization,	• Rapid market entry. • Image already established. • Performance known	• New business may be unfamiliar to parent. • Takes a long time

	unit of an organization, or a product/service.	before purchase.	to assimilate organization's culture. • New management team may be required. • High initial costs
Licensing	Acquiring or providing a valued asset (product, technology, market, equipment, etc.) through contract.	• Rapid access to proven technology. • Reduced financial exposure. • Access to brand name. • Exclusive territory.	• Not a substitute for internal technical competence. • Not proprietary technology. • Dependent on licensor. • Rules and regulations. • Ongoing expenses
Venture Capital Investment	Financial investment in an organization to participate in its growth or receipt of venture capital for start-up or expansion.	• Can provide window on new technology or market. • Lowered risk.	• Alone, unlikely to be a major stimulus of growth. • Extended time to profitability.
Cooperation			
Merger	Combining two (or more) organizations through mutual agreement to form a single new organization.	• Uses existing resources. • Retains existing markets and products. • Reduces competition.	• Takes a long time to merge cultures. • Merger match often difficult to find. • Big guppy eats little guppy.
Alliance	Formation of a formal partnership.	• Fills in product line gaps. • Creates efficiencies (e.g. bargaining power). • Reduces competition in	• Potential for conflict between members. • Limits potential

		weak markets. • Stabilizes referral base. • Shared risk.	markets/products. • Difficult to align resources. • Governance issues.
Joint Venture	Combination of the resources of two or more organizations to accomplish a designated task.	• Technological/marketing joint ventures can exploit small/large organizational synergies. • Spreads risks.	• Potential for conflict between partners (shared vs. proprietary). • Objectives of partners may not be compatible.
Development			
Internal Development	Products or services developed internally using the organization's own resources.	• Uses (leverages) existing resources. • Organization maintains a high level of control. • Presents image of developing (growth) organization.	• Time lag to break even. • Unfamiliarity with new markets. • Obtaining significant gain in market share against strong competitors may be difficult.
Internal Venture	Establishment of an independent entity within an organization to develop products or services.	• Uses existing resources. • May enable organization to retain a talented entrepreneur. • Isolates development from organization's bureaucracy.	• Mixed record of success. • Organization's internal climate (culture) often unsuitable.
Reconfigure the Value Chain	Changing the activities or sequence of activities in the value chain thereby changing how value is delivered to the customer.	• New approach may not be seen as a threat by existing competitors. • Captures a special niche of the market. • May create a low-cost business model.	• Not always possible. • Initially must focus on a niche rather than the entire market. • Must be first to recognize the new business model.

Fast	A decision to leave all or part of the market using divestiture, liquidation, or retrenchment.	• The organization can move on to more viable market/products. • Cash increase.	• Buyers may be difficult to identify. • May have to sell at a discount.
Slow	A decision to leave the market using harvesting.	• The organization reaps any remaining profitability from the product category.	• Some resource diverted to a declining product market. • Deterioration of customer service hastens the exit.
Partial	Serve fewer customers; reduce geographic areas served, or reduce the product line.	• Reduce costs while remaining in the product category accruing some profit. • May allow for market development in more attractive segments or products.	• Reduces market prestige; may be a problem if retrenching.
Complete	No longer attempting to satisfy any customers; geographic areas served and product lines eliminated.	• Allows management to refocus. • Resources may be used more effectively for more profitable products.	• No longer a player in a viable market. • Some disappointed loyal customers.

Exhibit 6.9 Definition, Advantages, and Disadvantages of Market Entry and Exit Strategies

Step 5: Understand Competitive Strategy Alternatives

Competitive strategies are largely independent of the adaptive and market entry/exit strategies as they concern the basis for competing in a market or service area. As shown in the decision logic in [Exhibit 6-2](#), for many organizations, where there is no significant change in scope suggested by the directional strategies, the development of competitive strategies follow and are driven by the directional strategies. In all cases, managers must decide the strategic posture of the organization and how the products and services will be positioned *vis-à-vis* those of competitors. Therefore, the results of competitor analysis and internal analysis play an important role in the selection of an organization's competitive strategies.

Strategic posture concerns the organization's fundamental behavior within the market – defending market position, prospecting for new products and markets, or balancing market defense with careful entry into selected new product areas and markets. In addition, an organization must consciously position its products and services within a market through one of the marketwide or market segment *positioning strategies* (generic strategies).

Strategic Posture

Organizations may be described by how they behave within their market segments or industry – their strategic posture. Research has shown that there are at least four typical strategic postures for organizations – defenders, prospectors, analyzers, and reactors. Defenders, prospectors, and analyzers are explicit strategies that result in a pattern of consistent and stable behavior within a market. Defender, prospector, or analyzer strategic postures may be appropriate for certain internal, market, and environmental conditions. Reactors, on the other hand, do not seem to have a strategy and may behave inconsistently; however, unless an organization exists in a protected environment, such as a monopolistic or highly regulated market segment, it may not be able to continue to behave as a reactor indefinitely.⁶⁵ Furthermore, an organization's strategic posture should not be left to chance. Health care organizations are able to change their strategic postures to match the demands of their environmental context and improve their performance.⁶⁶ Therefore, strategic decision makers should examine the current market behavior, explicitly delineate the appropriate organization strategic posture, and redirect resources and competencies needed to transform themselves into a better environmentally suited posture.

Defender Strategic Posture

Stability is the chief objective of a *defender strategic posture*. Managers using this strategy attempt to seal off a portion of the total market to create a stable domain. A defender posture focuses on a narrow market with a limited number of products or services and aggressively attempts to protect its market segment through pricing or differentiation strategies.

Defenders are organizations that engage in little search for additional opportunities for growth and seldom make adjustments in existing technologies, structures, or strategies. They devote primary attention to improving the efficiencies of existing operations. Thus, cost efficiency is central to the defender's success. In addition, defenders often engage in vertical integration to protect their market, control patient flow, and create stability. Defenders grow through penetration strategies and limited product development strategies.

Prospector Strategic Posture

Organizations adopting a *prospector strategic posture* frequently search for new market opportunities and regularly engage in experimentation and innovation. A prospector's major capability is that of finding and exploiting new products and market opportunities. As a result, the prospector's domain is usually broad and in a continuous state of development. Prospectors are typically in rapidly changing environments or service categories such as health care technology and frequently engage not only in diversification and product and market development expansion strategies but also divestment and

retrenchment strategies. One of the principal competitive advantages of a prospector strategic posture is that of creating change within the service category/service area. Many times these changes come about because of disruptive innovations as discussed in Essentials for a Strategic Thinker 6–5, “What Are Disruptive Innovations?”

ESSENTIALS FOR A STRATEGIC THINKER 6–5

What Are Disruptive Innovations?



Disruptive innovations change both the way firms operate and the underlying business models they use to compete. Most industries have experienced a steady stream of technological advances and process improvement activities that increase product quality or reduce cost. Such improvements are “sustaining innovations” that are necessary to meet customers’ ever-rising expectations, but they are not “disruptive” to the underlying business model. Disruptive innovations allow new competitors to enter the marketplace by undercutting incumbent firms’ product prices, service delivery modes, or both. In health care, there have been many sustained innovations, but relatively few disruptive innovations that have significantly changed the dominant organizational forms’ business models (such as medical groups and hospitals).¹

One example of a disruptive innovation in health care delivery is the introduction of freestanding ambulatory surgery centers (ASCs) in the mid-1970s.² The number and variety of services delivered by ASCs grew rapidly through 2005.³ The expansion was fueled in part by physicians’ desire to have an ownership stake in the facilities that delivered care and be more than just a member of the medical group. As with most disruptive innovations, ASCs were able to compete on price but struggled to demonstrate that outcome quality was comparable to traditional hospitals. Over time, ASCs were able to establish legitimacy by being a more efficient delivery mode and competing on quality with traditional hospitals. As often happens after a disruptive innovation takes hold, incumbent firms modify their business models to accommodate the new technology or process to compete. In 2017, most health care systems have established ASCs. Given the success of ASCs in improving quality, controlling cost, and increasing access to care, it begs the question: Why are there not more disruptive innovations in the health care sector?

There are three main reasons that the health care sector is resistant to disruptive innovations. First and foremost is the highly regulated nature of the industry. The health sector requires governmental permission to introduce new products or processes (see for example, Essentials for a Strategic Thinker 3–2: “What Is CON?”). The approval process creates a

significant barrier to new entrants and reduces the probability of disruptive innovations. A second factor that impedes innovation is the lack of consumer empowerment. Most disruptive innovations rely on consumers shopping for better prices on comparable goods. Such is not the case for most health care services because of the third-party payer system. Lastly, health care delivery is an integrated activity with providers referring patients to one another in a networked fashion. In effect, a new market entrant seeking to disrupt existing competitors would need consent from the competitors to gain access to consumers. Taken together, these factors impede the disruptive innovations needed to repair a health sector with unsustainable cost, quality, and access issues.

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Source: Eric W. Ford, PhD, MPH, Professor, School of Public Health, University of Alabama at Birmingham.

Analyzer Strategic Posture

The *analyzer strategic posture* is a combination of the prospector and defender strategic postures. The analyzer tries to balance stability and change through maintaining stable operations – typically in core businesses – but also searches for new opportunities to engage in market innovation in other areas. Characteristically they watch competitors and rapidly adopt those strategic ideas that appear to have the greatest potential. Analyzers tend to use penetration strategies in their stable core products and markets whereas related diversification, product development, and market development are used to enter new promising areas.

Reactor Strategic Posture

The defender, prospector, and analyzer postures are all proactive strategies. Those who are reactors may lack a strategy or plan or may be anticipating significant external changes or strategic moves by competitors. The *reactor strategic posture* may be the de facto result of a lack of strategy, leading to inconsistent and unstable responses to changes in the general environment, health care system, or the market segment and its competition. In such cases, reactors perceive opportunities and turbulence; but are uncertain or not able to

adapt effectively (severe limitation of financial resources may be a factor). Reactors lack consistent approaches to strategy and structure and make changes primarily in response to pressures in the environment, especially competitive pressures. On the other hand, a “wait and see” strategy may sometimes be appropriate, as a short-term strategy, but seldom works in today’s rapidly changing world in the longer term. Reasons that organizations become reactors include:

- Top management may not have clearly articulated the organization’s strategy.
- Management does not fully shape the organization’s structure and processes to fit a chosen strategy.
- Management tends to maintain the organization’s current strategy–structure relationship despite overwhelming changes in environmental conditions.⁶⁷
- The organization has consciously adopted a follower strategy.
- The organization anticipates a “game changing” external change or strategic move by competitors and is pausing to gather information prior to attempting a more effective strategic posture.

If the internal analysis reveals that the organization has been reactive without a clear strategy or that there is a mismatch between the strategy and implementation, changes will have to be made to move the organization toward a more effective strategic posture. There is some evidence that reactors may be able to hone their competencies and transform themselves into more viable strategic postures over time.⁶⁸

Understanding the organization’s preferred strategic posture and communicating it throughout the organization provides decision guidelines and will shape the culture of the organization. It is important that the strategic posture be consistent with the directional, adaptive, market entry/exit, and positioning strategies. The definition, major advantages, and disadvantages of the strategic posture strategies are summarized in [Exhibit 6-10](#).

Strategic Posture	Definition	Major Advantages	Major Disadvantages
Defender	Focus on a narrow market with limited number of products or services and aggressively attempt to keep others out of this segment through pricing or differentiation.	• Limited set of products and services. • Narrow market segment. • Stable environment. • Difficult for competitors to enter this	• Reliance on the success of narrow product line. • Must have long/sustaining product life cycles. • Market segment must be stable – slow change. • May be unable to

		segment.	respond to major market/industry shifts. • Difficult to enter new markets or technologies.
Prospector	Continuously seek out new products and new markets.	• Always involved in “cutting-edge” developments. • Organization shifts with changing environment. • Allows for a rapid response to a changing environment.	• Organization is in a constant state of change. • New products and markets always being developed. • Multiple technologies being employed, seldom able to achieve efficiency. • Tend to have lower profits because of continuous change. • Tend to overextend resources. • Tend to underutilize financial, human, and physical resources.
Analyzer	Balance defense in some markets with selectively entering a limited number of new markets or products.	• Allows for the maintenance of a core of stable traditional products and services. • Allows for high-risk products and services to be borne by prospectors.	• Difficult strategy to pursue. • Must respond quickly to follow lead of key prospectors while maintaining efficiency in core products/services. • Complex structure (matrix).

		• Lower investment in research and development.	• Management of both stable and dynamic products and markets. • Communication is often difficult. • Lack of consistent approaches to strategy and structure; make changes primarily in response to environmental pressures.
Reactor	React to the strategies of competitors; expects stability and does not like or want change.	• Little strategic planning required (monopolistic or highly regulated environment). • A follower or “wait and see” strategy allows for additional information on changing external conditions. • Comfortable with things as they are (until they are not).	• Inconsistency in response to environmental change. • Instability in organization. • Organization becomes both ineffective and inefficient. • No effective guide for decision making. • Follower strategy may be ineffective, especially with multiple products in later stages of the PLC.

Exhibit 6.10 Definition, Advantages, and Disadvantages of Strategic Postures

Positioning Strategies: Marketwide or Focus

Michael Porter, a well-known strategic management writer, proposes that an organization may serve the entire market using marketwide strategies or serve a particular segment of the market using focus strategies. Porter called these *generic strategies* because they were general strategies that any organization could use to position itself in the marketplace.⁶⁹ For both marketwide and market segment focus there are two fundamental positioning strategies – cost leadership and differentiation.⁷⁰

Marketwide strategies determine a product or service's place in the market *vis-à-vis* competitors and position the products/services of the organization to appeal to a broad audience (the entire market). For example, a community hospital may be positioned to serve all area residents – serve a broad market with a broad range of services. These products and services, therefore, are not tailored exclusively to the needs of any special segment of the population such as children or the aged. As shown in [Exhibit 6-11](#), marketwide positioning strategies can be based on differentiation or cost leadership. Thus, the community hospital may try to differentiate itself from other hospitals by emphasizing quality or convenience or may compete as a low-cost provider.

		Strategic Advantage	
		Uniqueness Perceived by the Customer	Low-Cost Position
Strategic Target	Marketwide (broad)	Differentiation	Overall Cost Leadership
	Particular Segment Only (narrow)	Differentiation/Focus	Cost/Focus

Exhibit 6.11 Porter's Matrix

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

Market segment strategies are directed toward the particular needs of a well-defined market segment, such as pediatric oncology or women's health, and often are called focus strategies. Thus, a *focus* strategy identifies a specific, well-defined "niche" in the total market that the organization will concentrate on or pursue. Because of its attributes, the product or service, or the organization itself, may appeal to a particular customer group (niche) within the market. Similar to marketwide strategies, focus strategies may be based on cost

leadership (cost/focus) or differentiation (differentiation/focus).

Because of the complexity of medicine and the entire health care system, focus strategies are quite common. Just as physicians have specialized, the institutions within the field have tended to focus on specialized segments. Examples of focus strategies are rehabilitation hospitals, psychiatric hospitals, ambulatory care centers, Alzheimer's centers, and so on. These specialty organizations may be further positioned based on cost leadership or differentiation. Each of the generic strategies results from an organization making consistent choices for product/services, markets (service areas), and distinctive competencies – choices that reinforce each other.

Cost Leadership

Cost leadership is a positioning strategy designed to gain an advantage over competitors by producing a product or providing a service at a lower cost. The product or service is often highly standardized to keep costs low. Cost leadership allows for more flexibility in pricing and relatively greater profit margins.

Cost leadership is based on economies of scale in operations, marketing, administration, and the use of the latest technology. Cost leadership may be used effectively as the generic strategy for any of the adaptive strategies and seems particularly applicable to the primary providers segment of the health care system. As Porter suggests:

Cost leadership requires aggressive construction of efficient-scale facilities, vigorous pursuit of cost reduction from experience, tight cost and overhead control, avoidance of marginal customer accounts, and cost minimization in areas such as R&D, service, sales force, advertising, and so on.⁷¹

To use cost leadership effectively, an organization must be able to develop a significant cost advantage and have a reasonably large market share; however, low cost is only an advantage if the organization in fact has the lowest cost and competitors know they cannot match it. Sustaining lowest cost is extremely difficult to achieve without extraordinary scale, market share advantages, or unique factor cost benefits.⁷² With an increase in value-based reimbursement, more availability of health outcomes information, consumers bearing a higher proportion of health care costs, and high deductible health plans opting for lower-cost narrowed networks that limit access to more expensive providers, low-cost/high-value strategies will continue to be viable.⁷³ As a result, low-cost, low-price strategies within the health care system are no longer perceived as necessarily meaning low quality.

A health care system segment where cost leadership is being used successfully is in the area of long-term care. Long-term care facilities are a “thin-margin business” in which profit margins range from approximately 1.2 percent to 1.7 percent. However, long-term care facilities that have been able to drive costs down while maintaining quality have enjoyed higher margins. In addition, many of these facilities have been upgraded to be more efficient and have instituted tight cost controls. Advertising has been used to keep occupancy above 95

percent, which is often required in the industry to be profitable.

Differentiation

Differentiation is a strategy to make the product/service not only different but also readily distinguishable from competitors' products/services. Thus, consumers see the service as unique among a group of similar competing services. Differentiation is of no benefit unless that difference is both valuable to buyers and capable of being sustained against competitors.⁷⁴

The product or service may be differentiated by emphasizing quality, a high level of service, ease of access, convenience, reputation, and so on. A number of ways to differentiate a product or service exist, however, the attributes that are to be viewed as different or unique must be valued by the consumer. Therefore, organizations using differentiation strategies rely on brand loyalty (reputation or image), distinctive products or services, and the lack of good substitutes.

The most common forms of differentiation in the health care system have been based on quality and image. Many acute care hospitals emphasize and promote quality care to differentiate themselves from other hospitals in their service area. Note, however, that consumers expect to receive high-quality care at every hospital, making quality a difficult differentiating factor. A "high-tech" image is another basis for differentiation among health care organizations. Affiliation with a medical school – which performs the most sophisticated procedures or uses the latest (often expensive) technology – may promote the image of "the best possible care." More recently, health care organizations are differentiating through providing consumers with more choices – when selecting health insurance products, choosing clinicians, and facilities where they receive care.⁷⁵ [Exhibit 6-12](#) presents the definition, advantages, and disadvantages of each of the positioning strategies.

Positioning Strategy	Definition	Major Advantages	Major Disadvantages
Cost Leadership	Low-cost/price strategy directed toward entire market.	• Provides clear competitive advantage. • Provides clear market position. • Provides opportunities to spend more than competition.	• Must obtain large volume. • Product/service must be standardized. • Product/service may be viewed as low quality. • Relatively easy to copy in the short run.
Differentiation	Development of unique	• Product/service viewed as	• Often difficult to adequately

	product/service features directed toward entire market.	unique. • Often viewed as high quality. • Greater control over pricing. • Difficult to copy.	differentiate product or service. • Product/service may be higher priced.
Focus – Cost Leadership	Low-cost/price strategy directed toward a particular market segment.	• Appeals to market segment seeking low price. • May develop good relations with market.	• Low quality may be associated with low price. • Expansion of market segment may be difficult.
Focus – Differentiation	Development of unique product/service features directed toward a particular market segment.	• Product/service may be customized to the special needs of the segment. • May develop close relationship with market segment.	• Market segment may remain small. • Price will probably be high.

Exhibit 6.12 Definition, Advantages, and Disadvantages of Positioning Strategies

Step 6: Understand Combination Strategies

Combination strategies are a number of different strategies used simultaneously to achieve goals/objectives for different products/services or service areas. Combination strategies are often used, especially in larger complex organizations, because no single strategy alone may be sufficient. In highly competitive markets, “...profitable growth comes when a company pushes out the boundaries of its core business into adjacent space.”²⁶ Several ways have been identified to grow into an adjacent space – expand along the external value chain (penetration), grow new products and services (product development), enter new geographies (market development), and address new customer segments (market development). Therefore, successful strategies often mix and match approaches, deploying strategies simultaneously or sequentially. For example, an organization may concurrently divest itself of one of its divisions and engage in market development in another. Perhaps the most frequent combination strategy for hospital-based systems has been vertical integration through acquisition and alliances combined with market development through acquisition (horizontal integration). The intent of these strategies has been to create regional, fully integrated systems with wide market coverage and a full range of services (often referred to as providing the continuum of care).

In addition to an organization using several different strategies at once, a strategy may have several sequential phases. It may be necessary to “string together” several strategic alternatives as phases to implement a broader strategic shift. In a two-phase strategy, for example, an organization may employ a retrenchment strategy in phase one and an enhancement strategy in phase two. As illustrated in [Exhibit 6-13](#), the strategic manager’s vision often extends through several strategic alternatives or phases. Such vision helps to provide long-term continuity for the entire management team. However, the strategic manager must be aware that, in a dynamic environment, circumstances may change and later phases may have to be modified or revised to meet the needs of the unique and changing situation. Strategic management is a continuous process of assessment and decision making.

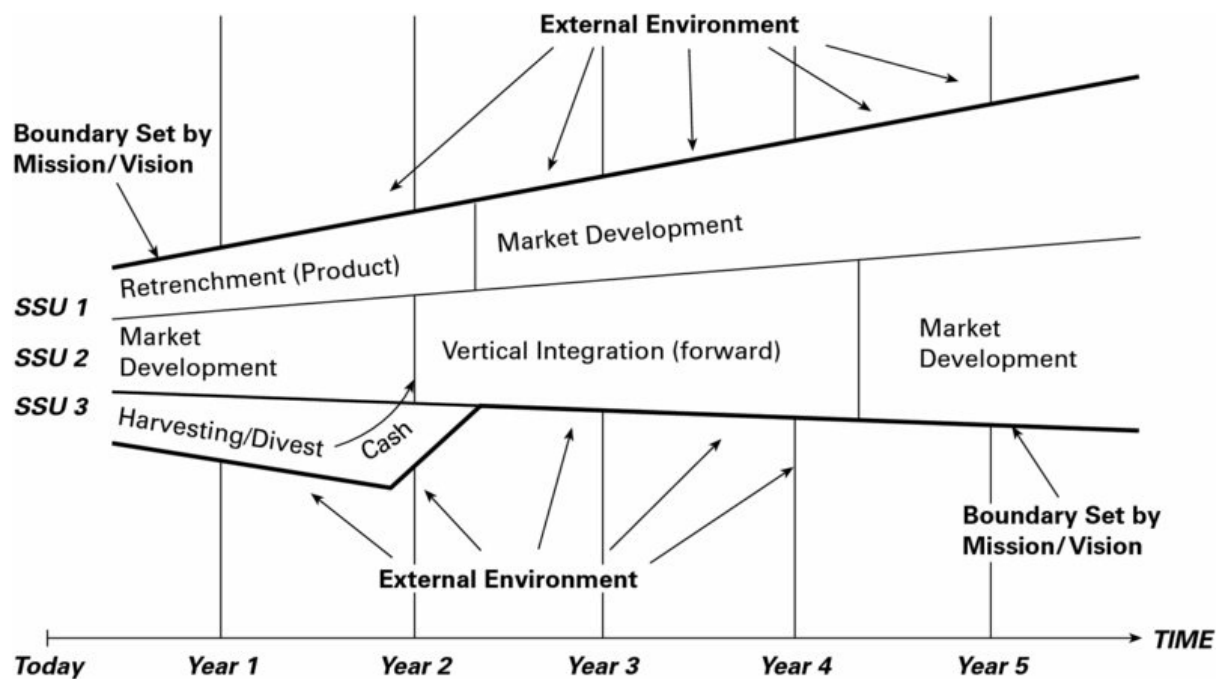


Exhibit 6.13 Vision of Combination Strategies

The decision logic for the formulation of the strategic plan was illustrated in [Exhibit 6-2](#). At this point, it would be useful to return to [Exhibit 6-1s](#) to [6-4](#) to review the complete strategy formulation process. After all the strategic alternatives have been considered, creation of a strategy map showing the desired directional, adaptive, market entry/exit, and competitive strategies together will help to ensure their consistency and fit. However, it is not enough to know the strategic logic and range of strategic alternatives. The strategic alternative (or set of alternatives) should be selected that best meets the requirements of the external environment, strengths and weaknesses of the organization, and the directional strategies. Chapter 7 will discuss methods for evaluating the strategic alternatives presented in this chapter and may lead to alterations or further refinements in strategy choice.

Chapter Summary

To understand the decisions that have to be made in strategy formulation, a strategic thinking map depicting a hierarchy of strategic alternatives is useful. There are several types of strategies, and several strategic alternatives within each type are available to health care organizations. In addition, there is a general sequential decision logic in the strategy formulation process. First, directional strategies must be articulated through the organization's mission, vision, values, and goals. Second, adaptive strategies are identified, evaluated, and selected. The adaptive strategies are central to strategy formulation and delineate how the organization will expand, reduce, or maintain the scope of operations. Expansion strategies include diversification, vertical integration, market development, product development, and penetration. Reduction strategies include divestiture, liquidation, harvesting, and retrenchment. Finally, maintenance of scope strategies include enhancement strategies and maintaining the status quo.

The third type of strategic decision concerns the market entry/exit strategies. Expansion and maintenance of scope strategies call for entering or gaining access to the desired market. Market entry strategies include acquisitions and mergers, internal development, internal ventures, reconfiguring the value chain, alliances and joint ventures, licensing, and venture capital investments. Any of the market entry strategies may be used to carry out an expansion or maintenance of scope adaptive strategy. Market exit may be quick or incremental or partial or complete depending upon the strategy and goals of the organization.

The fourth category of strategy includes the competitive strategies which are market-based strategies. Competitive strategies specify the strategic posture of the organization and position the products and services *vis-à-vis* competitors. The organization's strategic posture should be carefully considered by its leadership. Strategic posture specifies the organization/market relationship and provides decision and culture guidelines for management. Strategic postures that may be adopted by an organization include defender, analyzer, prospector, or reactor (although the latter usually indicates the lack of a strategy). In addition, positioning strategies (often called generic strategies) include cost leadership and differentiation, both of which can be applied as marketwide strategies or focus strategies (a market segment strategy). Each of the generic strategies places different demands on the organization and requires unique resources, competencies, and capabilities.

The strategy formulation decision logic provides a sequence for making the strategic decisions. However, the selected strategic alternatives must be viewed together to ensure their fit and consistency. In addition, it is unlikely that a single strategy will suffice for an organization. Several strategic alternatives may have to be adopted and used in combination. For instance, one service category may require market development whereas a different service category may require harvesting. One division may be a defender, positioned as a cost leader

and another may be a prospector, pursuing differentiation. Furthermore, several strategic alternatives may be seen as phases or sequences in a broader strategic shift. Chapter 7 presents several frameworks to help managers think about and evaluate strategic alternatives that are most appropriate given the organization's external environment, competitive advantages and disadvantages, and directional strategies.

Practical Lessons for Health Care Strategic Thinkers

1. There is a logical order to strategic decisions – directional, adaptive, market entry/exit, competitive, and implementation. These decisions range from very broad to very narrow. Planning logic (an analytical approach) suggests that making the broadest (directional strategies) first and working toward the most specific (implementation strategies) is best; however, strategy is rarely developed *de novo* for an organization. In reality strategic managers may begin by focusing on an alternative anywhere along the decision continuum and work for decision consistency both backward and forward along the continuum (an emergent approach). In the end, alternative decisions for each category must be made; strategic thinking helps one see the “big picture” and the implications of the series of decisions.
2. Unanticipated strategic opportunities and threats will no doubt present themselves. The hierarchy of strategic decisions can help determine the implications of these issues. Knowing the alternatives, the underlying rationale, and the implications provides insight into the next strategic move.
3. Organizations rarely have just one strategy; rather they have multiple strategies in various stages of implementation.

THE LANGUAGE OF STRATEGIC MANAGEMENT: KEY TERMS AND CONCEPTS

Acquisition
Adaptive Strategy
Alliance
Analyzer Strategic Posture
Backward Vertical Integration
Business Model
Combination Strategy
Competitive Strategy
Concentric Diversification
Conglomerate Diversification
Cooperation Strategy
Cost Leadership
Defender Strategic Posture
Development
Differentiation
Diversification
Divestiture
Enhancement
Expansion of Scope Strategy
Focus
Focused Factory
Forward Vertical Integration
Franchise
Generic Strategy
Harvesting
Horizontal Integration
Implementation Strategy
Internal Development
Internal Venture
Joint Venture

Licensing
Liquidation
Maintenance of Scope Strategy
Market Development
Market Entry/Exit Strategy
Marketwide Strategy
Merger
Penetration
Positioning Strategy
Product Development
Prospector Strategic Posture
Purchase Strategy
Reactor Strategic Posture
Reconfigure the Value Chain
Reduction of Scope Strategy
Related Diversification
Retrenchment
Status Quo
Strategic Posture
Strategy Formulation
Unrelated Diversification
Venture Capital Investment
Vertical Integration

Questions for Class Discussion

1. What four types of strategies make up the strategy formulation process? Describe the role each plays in developing a strategic plan.
2. Why are the directional strategies both a part of situational analysis and a part of strategy formulation?
3. How is strategy formulation related to situational analysis?
4. Name and describe the expansion, reduction, and maintenance of scope strategies. Which of the adaptive strategies are corporate and which are division level? Under what conditions may each be appropriate?
5. Explain how an understanding of an organization's strategic alternatives

provides structure for strategic thinking.

6. What is the difference between related diversification and product development? Provide examples of each.
7. What is a market-driven or focused factory strategy? Identify some organizations that have employed this type of market development strategy.
8. Many health care organizations have engaged in vertical and horizontal integration. What is the rationale for these strategies?
9. Describe vertical integration in terms of patient flow.
10. Explain the difference between an enhancement strategy and a status quo strategy.
11. How is market development different from product development? Penetration? Provide examples of each.
12. Compare and contrast a divestiture strategy with a liquidation strategy.
13. Which of the market entry strategies provides for the quickest entry into the market? The slowest?
14. What is strategic posture? How does a decision concerning the strategic posture help create decision guidelines for management and affect the organization's culture?
15. Explain Porter's generic strategies. How do they position the organization's products and services in the market?
16. How might a retrenchment strategy and a penetration strategy be linked together? What are some other logical combinations of strategies? How may a combination of strategies be related to vision?

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Chapter 7

Evaluation of Alternatives and Strategic Choice

“You can use all the quantitative data you can get but you still have to distrust it and use your own intelligence and judgment.”

—ALVIN TOFFLER, AMERICAN AUTHOR AND FUTURIST

Why Evaluation of Alternatives and Strategic Choice Are Important

The quote by Alvin Toffler is particularly relevant to those making strategic decisions. Quantitative as well as qualitative data help inform strategic decisions; however, the most important decisions made in organizations, the strategic choices, are fundamentally judgments – informed opinions about what the data actually means.

Toffler further suggests that although managers may collect and analyze all the data they can to support the decision-making process, they still have to question underlying assumptions, see the larger context, and use their best judgment. For instance, one set of statistical data can often be used to make a case for either side of an issue. Similarly, there really are no facts, just interpretations. The same set of “facts” may mean very different things depending on the interpretation – interpretation that is always colored by beliefs, values, and biases. Finally, by the time hard-data-driven information reaches the strategic decision maker, it is likely a day late and has been organized, summarized, sterilized, or otherwise manipulated by someone.

Many times a decision has to be made by the strategist despite a lack of data indicating that one alternative is clearly superior to another alternative. In these commonly occurring cases, no substitute exists that is better than using one’s intelligence, experience, and judgment. What will help strategic managers make improved judgments are innovative ways to organize the data so that it better reveals its implications and, thus, better informs judgment and opinion. Data organization may be accomplished by arranging information into tables and strategic “thinking maps.” These constructs aid strategic managers by enabling them to see relationships, discern trends, derive meaning from conflicting data, brainstorm alternatives, and so on. It is not so much the data itself that guides decisions, rather the organization and presentation of the data informs judgment.

Use concepts in this chapter to organize data and make judgments for better strategic choices!

Learning Objectives

After completing the chapter you will be able to:

1. Explain the rationale underlying the strategic thinking maps used to evaluate strategic alternatives.
2. Discuss the methods for the evaluation of adaptive strategic alternatives for a health care organization.

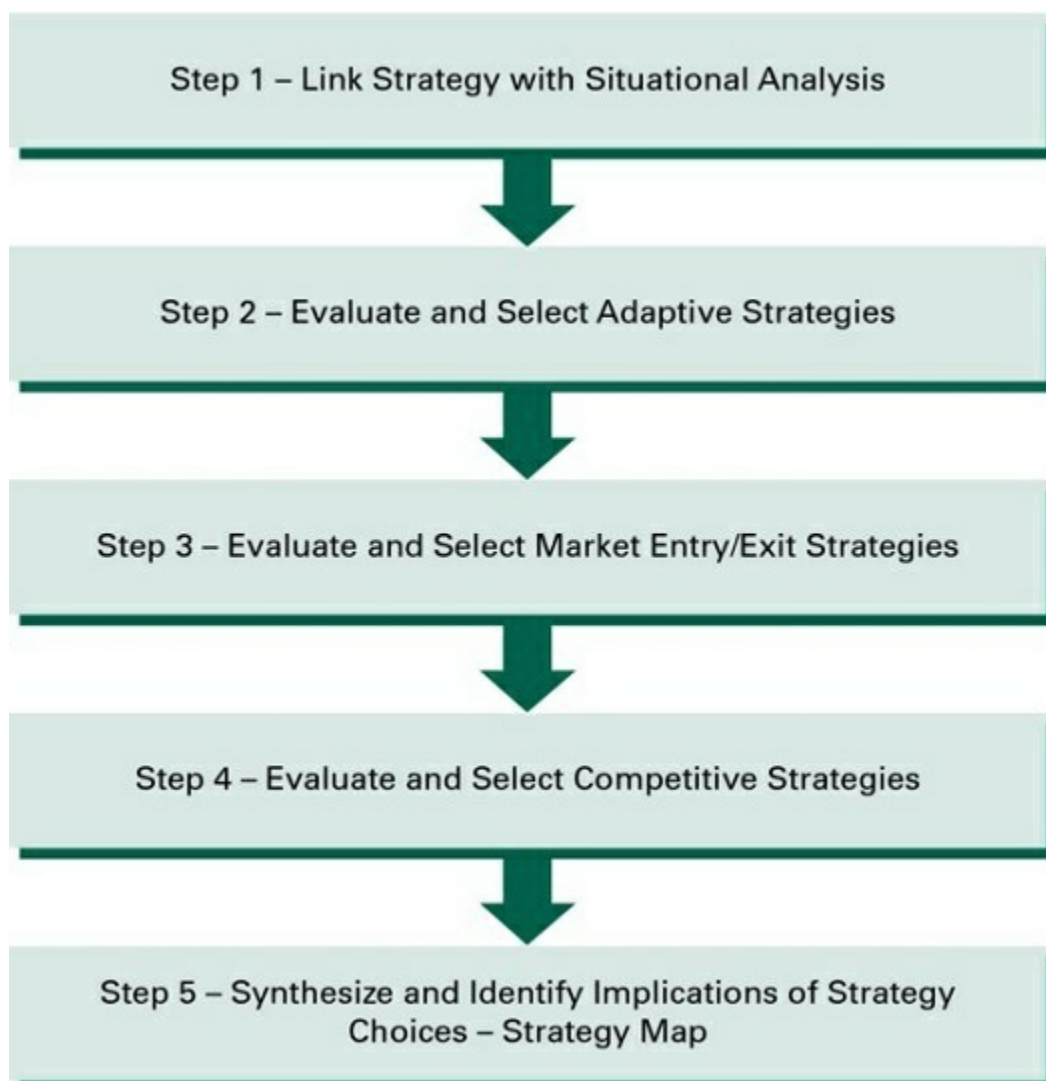
3. Discuss the external conditions and internal resources, competencies, and capabilities most suited for the market entry/exit strategic alternatives.
4. Discuss the external conditions and internal resources, competencies, and capabilities appropriate for the strategic posture and generic positioning alternatives.
5. Articulate the role of the service delivery and support strategies.

Strategic Management Competency

After completing this chapter you will be able to develop a comprehensive strategy for a health care organization.

A Process for the Evaluation of the Alternatives

Fundamental to strategic management is the need to change strategies over time.¹ There are several analytical frameworks or maps that may be used to guide strategic thinking concerning the appropriate strategic alternatives for an organization. These strategic thinking maps incorporate the results of external and internal analyses, as well as the directional strategies. Contemplative strategic thinking to understand the internal requirements and external conditions of strategic alternatives is essential to assure a coherent and integrated strategy. [Exhibit 7-1](#) provides an organized five-step process for using the analytical strategic thinking maps to develop a complete strategy for a health care organization.



[Exhibit 7.1](#) Process for Strategy Formulation

Although the evaluation of strategic thinking maps introduced in the process for strategy formulation fine-tunes the manager's perspective and organizes thinking, ultimately, the strategic manager must make the decision. Strategic

managers need to understand the risks, make judgments, and commit the organization to some course of action. Therefore, the analytical strategic thinking maps cannot be used to obtain “answers,” but they enable strategists to gain perspective and insight. Often no one right answer emerges. As management philosopher and author Peter Drucker has pointed out, “It is a choice between alternatives. It is rarely a choice between right and wrong. It is at best a choice between ‘almost right’ and ‘probably wrong’ – but much more often a choice between two courses of action neither of which is probably more nearly right than the other.”² Strategic thinking maps help to structure the thought processes of decision makers. It is important that managers think strategically and, almost as important, have some imagination and employ sound judgment. To have the proper perspective, strategic managers must be involved with customers, vendors, and employees in the organization, talking to people to gain a real feel for the culture, competitive advantage, and organizational opportunities and threats.

Step 1: Link Strategy with Situational Analysis

Situational analysis – external, service area competitor, and internal analyses, as well as the development of the directional strategies – provides a critical foundation for the development of strategy. Conclusions of these analyses are critical inputs to the analysis processes and must “drive” the strategy alternatives decisions. In fact, a final test of the strategic choices, as demonstrated by the checklist in [Exhibit 7-2](#), is that the strategies selected by an organization address external issues, draw on competitive advantages or fix competitive disadvantages, keep the organization within the parameters of the mission and values, move the organization toward the vision, and make progress toward achieving one or more of its strategic goals. This checklist procedure is a significant part of the strategic thinking process and helps to assure consistency of analysis and action. Each selected strategy should be tested against these questions. Strategies that do not have a “yes” in each column should be subject to additional scrutiny and justification.

Strategic Alternative	Addresses an External Issue?	Draws on a Competitive Advantage or Fixes a Competitive Disadvantage?	Fits with Mission, Values?	Moves the Organization Toward the Vision?	Achieves One or More Strategic Goals?
Strategy 1	Yes	Yes	Yes	Yes	Yes
Strategy 2	Yes	Yes	Yes	Yes	Yes
Strategy 3	Yes	Yes	Yes	Yes	Yes

Exhibit 7.2 Checklist for Linking Strategic Alternatives with Situational Analysis

Step 2: Evaluate and Select Adaptive Strategies

As discussed throughout Chapter 6, once the directional strategies have been developed, consideration is given to the adaptive strategies. The adaptive strategies are central to strategy formulation and are the broadest interpretation of the directional strategies. This level of strategic decision making specifies whether the organization wants to grow (expansion of scope), become smaller (reduction of scope), or remain about the same (maintenance of scope). Once the decision has been made to grow, reduce, or maintain scope, the methods to accomplish expansion, reduction, or maintenance of scope (diversification, divestiture, enhancement, and so on) must be formulated.

Re-evaluation of the adaptive strategies is an ongoing activity as new external forces emerge and provide fresh opportunities or threaten the viability of the current strategy. For example, Academic Health Centers (AHCs), although able to maintain their unique research focus for decades, have increasingly felt the pressures of change. AHCs, accustomed to having the most difficult cases referred to them for treatment, have not been a major part of “managed care” but rather dealt with these high-cost patients to further their unique mission. AHCs are preparing to deal with an array of complicated issues as they look to the future. Recently the Association of Academic Health Centers (AAHC) identified 10 “disrupters” its members must deal with in the future. These are: changing market forces, consumer empowerment, disease patterns, entrepreneurism, globalization, politics and policy, population demographics, science, societal needs and values, and technology.³

Several constructs help strategic managers to think about adaptive strategic decisions. As expressed previously, these constructs help to show relationships of the organization to its markets and competitors; they do not make the decision. However, some methods are available to evaluate the adaptive strategies including:

- SWOT Analysis – Strengths, Weaknesses, Opportunities, and Threats.
- External/Internal Strategy Matrix.
- Product Life Cycle (PLC) Analysis.
- Boston Consulting Group (BCG) Portfolio Analysis.
- Extended Portfolio Matrix Analysis.
- Strategic Position and Action Evaluation (SPACE).
- Program Evaluation.

SWOT: Strengths, Weaknesses, Opportunities, Threats Analysis

SWOT (strengths, weaknesses, opportunities, and threats) analysis has been popular as a way to display pertinent external issues and internal strengths and weaknesses. *SWOT analysis* is a systematic investigation to consider an organization’s internal (strengths and weaknesses) and external (opportunities and threats) issues and display them in a two-by-two matrix. SWOT is one of the most widely used strategic planning tools. One study noted that SWOT is a part of virtually every case analysis used in the teaching of strategic management

and business policy.⁴ A SWOT analysis is typically displayed as illustrated in [Exhibit 7-3](#) and developed in brainstorming sessions of participants familiar with the organization and its situation. SWOT analysis can provide an initial overview of an organization's external and internal situation.

Internal Analysis	Strengths	Weaknesses
	1.	1.
	2.	2.
	3.	3.
	4.	4.
	5.	5.
	6.	6.
	7.	7.
	8.	8.
External Analysis	Opportunities	Threats
	1.	1.
	2.	2.
	3.	3.
	4.	4.
	5.	5.
	6.	6.
	7.	7.
	8.	8.

Exhibit 7.3 SWOT Analysis

Methods for identifying an organization's opportunities and threats were discussed in Chapter 2, including trend identification and extrapolation, solicitation of expert opinion, dialectic inquiry, stakeholder analysis, scenario writing, and future studies. A method for determining organizational strengths and weaknesses was discussed in Chapter 4 and focused on identifying resources, competencies, and capabilities found in the organization's value chain.

A SWOT analysis is easy to develop; however, it does not provide much insight into what strategy decisions might result from the list of strengths, weaknesses, opportunities, and threats. It has even been suggested that in certain circumstances, such as moving from a deregulated to a highly regulated (or vice versa) health system, where the future is uncertain, SWOT may be less applicable.⁵ As discussed in Chapter 2, the designation of external issues as opportunities or threats is often arbitrary, and opportunities are commonly presented as strategic alternatives rather than independent external issues affecting the organization; however, those strategists that are able to identify true external opportunities (events/issues occurring in the external environment over which no one has control) prior to or earlier than others, have the possibility of seizing an issue and turning it into a competitive advantage. Additionally, it is important to note that external issues may be both opportunities and threats. Furthermore, SWOT analysis has no provision for

prioritizing or evaluating the internal strengths or weaknesses as being competitively relevant – competitive advantages or competitive disadvantages. As a result, SWOT analysis should only be used as an initial overview of the organization’s situation or to provide a foundation for more in-depth analysis.

External/Internal Strategy Matrix

Rather than just listing strengths, weaknesses, opportunities, and threats, decision makers should match the external issues identified in the general environment, health care system, and service area as discussed in Chapters 2 and 3 with long-term and short-term competitive advantages and disadvantages (discussed in Chapter 4). An *external/internal strategy matrix* juxtaposes external issues with internal competitive advantages and disadvantages. [Exhibit 7-4](#) shows such a strategic thinking map that is useful for matching external issues with internal competitive advantages and disadvantages. This approach, utilizing the complete results of a comprehensive external and internal analysis, better fosters strategic thinking concerning adaptive strategy alternatives.⁶

		EXTERNAL ISSUES		
		General Environmental Issues	Health Care System Issues	Service Area and Competitive Issues
		1. Population over 65 expanding 2. Economy continues to grow 3. Decreasing regulations of business	1. Declining reimbursements 2. Industry continues to grow 3. Lack of trained health care workers	1. Increasing number of competitors 2. CON required 3. Increasing number of retirees
INTERNAL ADVANTAGES & DISADVANTAGES	Long-Term Competitive Advantages	Strategies 1. Product Development – serving over 65 years of age market 2. Market Development – geographic expansion	Strategies 1. Enhancement – efficiency 2. Enhancement – increase training	Strategies 1. Penetration – increase advertising 2. Alliance with existing provider 3. Product Development – serving over 65 years of age market
	Short-Term Competitive Advantages	Strategies 1. 2. 3.	Strategies 1. 2. 3.	Strategies 1. 2. 3.
	Long-Term Competitive Disadvantages	Strategies 1. 2. 3.	Strategies 1. 2. 3.	Strategies 1. 2. 3.
	Short-Term Competitive Disadvantages	Strategies 1. 2. 3.	Strategies 1. 2. 3.	Strategies 1. 2. 3.

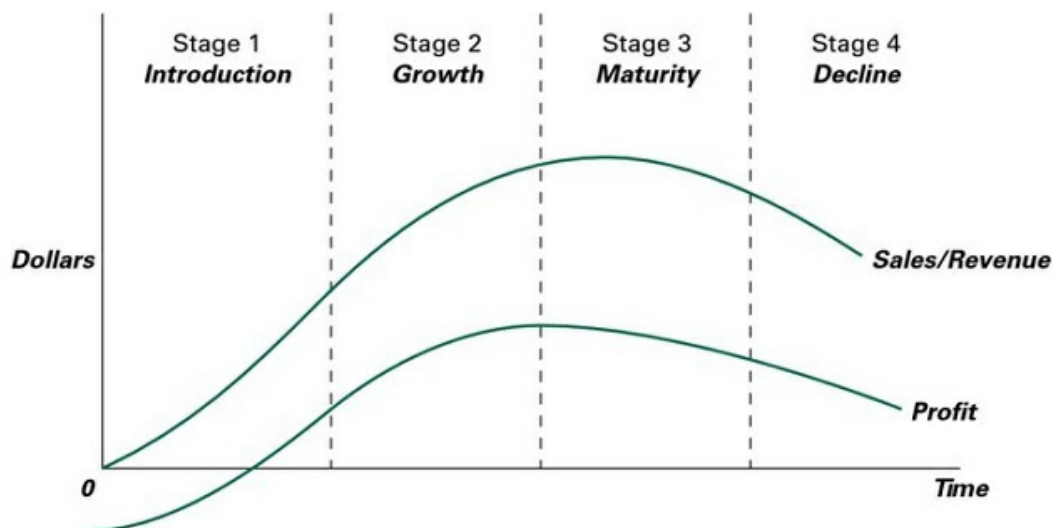
Exhibit 7.4 External/Internal Strategy Matrix

In the external/internal strategy matrix, adaptive strategic alternatives are suggested by the interactions of the seven sets of variables (long- and short-term competitive advantages, long- and short-term competitive disadvantages, and general, health care, and competitive issues). In this example, the primary focus is the adaptive strategic alternatives, but this analysis could also be applied to the development of any type of strategy. In practice, particularly in open discussion sessions, some of the alternatives developed through the strategy matrix may be adaptive, market entry/exit, competitive, or value-adding service delivery and support strategies.

The strategies developed by matching the long-term competitive advantages with the general environment, health care system, service area, and competitive issues represent the primary adaptive strategies of an organization. The long-term competitive advantages are valuable, rare among competitors, difficult to duplicate, and sustainable. The short-term competitive advantages may soon be duplicated, particularly if the service areas and competitors are undergoing change, but these advantages must be sustained for as long as possible. The long-term competitive disadvantages represent areas where internal “fix-it” strategies will have to be addressed because other organizations provide a competitive advantage that is valuable to stakeholders. The short-term competitive disadvantages are fixable but still represent a significant impediment to success. The long-term competitive advantage row as well as some key factors in the general environment, health care system and service area have been completed to illustrate the use of the external/internal strategy matrix (note that both the general environment and service area factors suggest product development serving those over 65 years of age).

Product Life Cycle Analysis

Product life cycle (PLC) analysis is a method, and typically a graphic representation, used to develop strategy alternatives based on the principle that all products/services progress through distinct stages of introduction, growth, maturity, and decline. These stages relate primarily to the changing nature of the marketplace, the product development process, and the types of demands made on management. Moreover, the nature of the product/service and industry may influence the life cycle stages. For example, in the medical technology industry innovation is strongly influenced by product/service life cycle stages. In addition, individual curves can be influenced by factors such as patent protection and barriers to entry.² In evaluating product life cycles, the evolution of service category sales and profits (or a surrogate for sales such as the number of subscribers, hospital visits, or competitors) is tracked over time. This evolution will have strategic implications for the organization. A typical PLC and the attributes of each stage are presented in [Exhibit 7-5](#).



PLC Stage Characteristics

	<i>Introduction</i>	<i>Growth</i>	<i>Maturity</i>	<i>Decline</i>
Sales/Revenue	Low	Rapid growth	Slow growth	Declining
Profits	Negative	Peak levels	High	Low
Competitors	Few	Growing	Many	Declining
Cost/Customer	High	Average	Low	Low
Capital Access	Venture	Equity/debt	Debt/internal	Minimal

Exhibit 7.5 The Product Life Cycle

Source: Adapted from Philip Kotler and Kevin Lane Keller, *Marketing Management*, 15th edn (New York: Simon & Schuster, 2016), p. 349. Reprinted by permission of Simon & Schuster.

Products and services have an introductory stage during which sales are increasing yet profits are negative. In this stage, there are few competitors (prospectors), prices are usually high, promotion is informative about the product category, and there are limited distribution outlets. In the growth stage, sales and profits are both increasing and, as a result, competing organizations enter the market (analyzers) to participate in the growth. During this stage, prices are still high but may begin to decline, promotion is directed toward specific brands, and there is rapid growth in the number of outlets.

The maturity stage of the PLC marks the end of rapid growth and the beginning of consolidation. In addition, market segmentation (defining narrower and narrower segments of the market) occurs. In this stage, prices have stabilized or declined, price promotion becomes common, distribution is widespread, and competitors are concerned with maintaining market share (defenders). In the decline stage, total revenues and profits for the product or service are declining and will likely continue to decline over the long term.

Tracking the enrollment of health maintenance organizations (HMOs) illustrates the PLC (see Essentials for a Strategic Thinker 7–1, “What Is Managed Care?” for an overview of managed care). HMOs had an extended introductory period. The first HMO prototype, the Ross-Loos Clinic in Los Angeles, became operational in 1929. Forty years later, in 1970, there were only 33, generally not-for-profit, HMOs in the United States serving approximately 3

million enrollees.⁸ The boost that pushed HMOs from introduction to growth included the passage of the Health Maintenance Organization and Resources Act of 1974. In addition to the federal funding for development and growth, HMOs sought additional capital in the early 1980s. One method to accomplish this was to convert from a not-for-profit to a for-profit HMO.

ESSENTIALS FOR A STRATEGIC THINKER 7-1

What Is Managed Care?



Managed care refers to health insurance plans or organizations that contract with doctors, hospitals, clinics, pharmacies, and other health care providers to control and efficiently manage the costs and quality of the health care of plan enrollees. The contracted providers (hospitals, physicians, and so on) are called the plan's network.¹ Managed care organizations control cost and quality by negotiating reimbursement rates and standards of care with network providers (often controlling where plan members may receive care) and sharing some costs (deductibles, copay, etc.) with members.

Most Americans who have health insurance are enrolled in one of several types of managed care health insurance plans. The most common types are Preferred Provider Organizations (PPOs), Health Maintenance Organizations (HMOs), and Point-of-Service Plans (POS). Over 60 percent of those in managed care plans are in PPOs and almost 36 percent are enrolled in HMOs.² Managed care plan enrollees are spread across commercial plans, Medicaid managed care plans, Medicare Advantage plans, and the military. The largest major national health plans are United Health Group, Anthem, Aetna, CIGNA HealthCare, Health Care Services Corporation, and Humana.³

Types of plans:

HMOs

Although there are several types of HMOs, the commonality among them is that HMOs are insurance companies and therefore “underwrite” the claims. Thus, they are ultimately responsible for the cost of covered medical care expenses provided to an enrollee.⁴ HMOs typically require a primary care physician (PCP) to manage the care of individual enrollees, including providing referrals to specialists within the HMO network when necessary. PCPs are typically internal medicine or family physicians operating practices as a part of the HMO network. Medical costs incurred by enrollees outside of the HMO's network are typically not covered.

PPOs

These organizations typically are not insurance companies and, therefore, do not underwrite the costs of care. Rather, PPOs are coordinating organizations primarily for employer-based health insurance. A PPO negotiates with providers to create a network of “preferred providers” that are willing to provide cost savings to members of the plan.⁵ These plans most often do not require a PCP to manage care and no referrals are required to see a specialist.

POSs

These plans have attributes of both HMOs and PPOs and usually provide wider provider choice options than HMOs (enrollees may seek care out-of-the-network); however, such plans frequently require more-out-of-pocket costs to the consumer for out-of-network services.⁶ Most often the plans require PCPs to manage care within the network; however, subscribers of the plan can choose to stay in the network or receive care out of the network with a PCP referral.

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[Exhibit 7-6](#) shows the national HMO enrollment from 1987 through 2016. The HMO enrollment growth stage extends through 1999 and then enters the mature stage. By the late 1990s, many urban markets experienced high managed care penetration, signifying local maturity. HMO consolidation in major markets continued and company strategies were typical of market maturity – price competition, extensive distribution development, aggressive promotion, and product differentiation. In addition, few new players were entering the market in these areas. Confusing the picture are the rural and non-urban markets that continue to adopt managed care very slowly because of a lack of economies of scale and an insufficient number of providers. In addition, few new players are entering the market in these areas. Overall enrollment

shows some growth. In fact by 2016 total HMO enrollment in the United States, according to the Kaiser Family Foundation, was just over 93.4 million indicating that the life cycle remains in the maturity stage, but the overall picture may hide two separate HMO life cycles that are in different stages – urban maturity, perhaps toward decline, along with rural/non-urban late-stage growth. Efforts to control costs have resulted in health insurers, particularly in the individual market, offering fewer preferred provider organization (PPO) plans and more HMO plans.

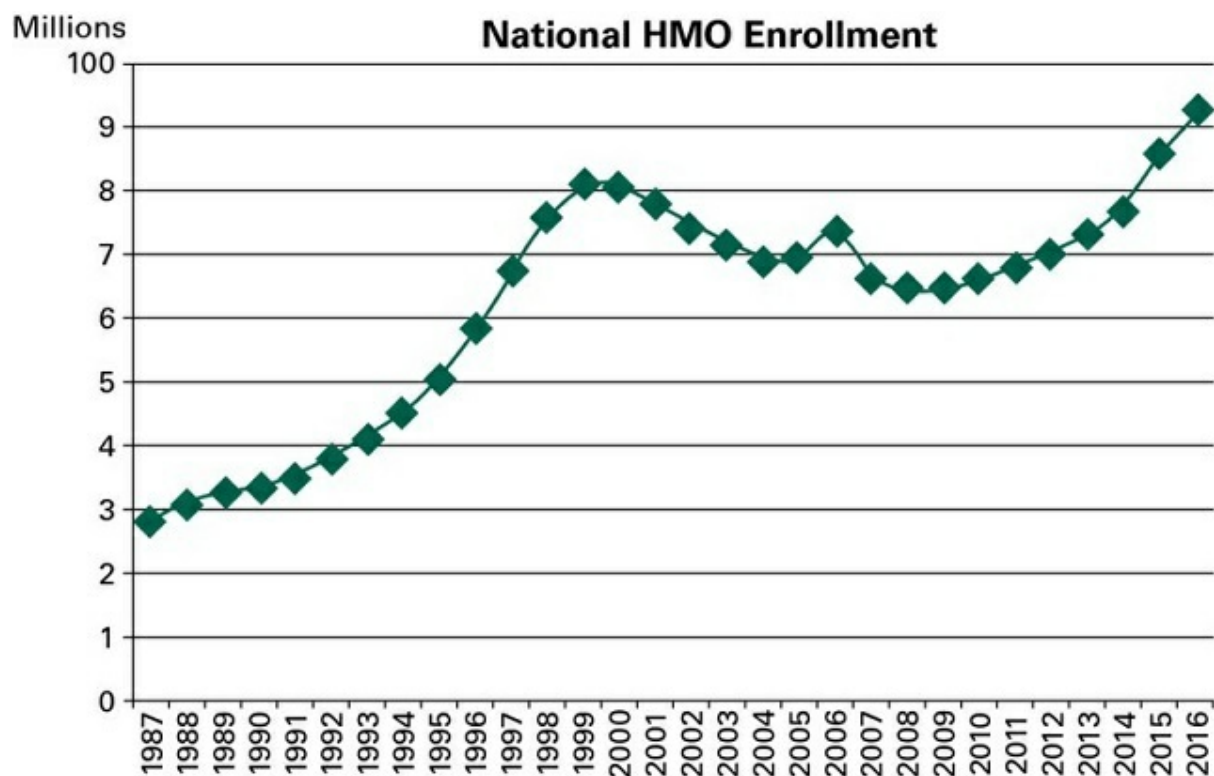


Exhibit 7.6 National HMO Enrollment

Source: MCOL Research compiled from historical Managed Care Fact Sheet National Managed Care Enrollment data for HMOs/.node/.blockUAT S 110—300x250(t,l)—Managed Care Executive/.

Despite its limitations, PLC analysis is a useful tool for strategic planning. It provides a framework for assessing existing activities as well as new products/services. The decomposition and critical review of market characteristics in conjunction with the PLC can serve as a guideline for strategy development. A PLC framework is particularly useful for product, marketing, and management strategies.

When considering new product/service lines, a PLC analysis can help answer questions not only about whether an activity is attractive for the organization, but also what might be the best market entry/exit strategy. Historically, hospitals have developed the businesses or services that they already offer. However, development makes sense only if the business is in introductory or growth stages of the life cycle. If the hospital chooses to enter a mature business, it is usually better to joint-venture the business with an experienced party or acquire an existing provider. Introducing new product variations during late maturity or decline carries great risk unless the variations are sufficiently

different such that an entirely new life cycle is created.

There are two important questions for strategy formulation when using product life cycles: “In what stage of the life cycle are the organization’s products and services?” and “How long are the stages (and the life cycle itself) likely to last?” To determine the stage of the PLC, management must use a great deal of judgment. Total service category revenues and profits may be monitored as an initial indicator. In addition, information obtained in external analysis concerning technological, social, political, regulatory, economic, and competitive change is valuable in assessing both the current stage and the expected length of the cycle.

The stage in the PLC for a product or service indicates a likely strategic response and the level of resources that might be committed. [Exhibit 7-7](#) shows logical strategic alternatives for each stage.

Stage 1: Introduction	Stage 2: Growth	Stage 3: Maturity	Stage 4: Decline
Market Development	Market Development	Market Development	Divestiture
Product Development	Product Development	Product Development	Liquidation
	Penetration	Penetration	Harvesting
	Vertical Integration	Enhancement	Unrelated Diversification
	Related Diversification	Status Quo	
		Retrenchment	
		Divestiture	
		Unrelated Diversification	

[Exhibit 7.7](#) Strategic Choices for Stages of the Product Life Cycle

The relevance of the strategies shown in [Exhibit 7-7](#) depends on management’s perception of the timing of the cycle. Products and services that management determines have lengthy stages (or a long PLC) will require dramatically different strategies from those that management concludes have short stages or a short PLC. For instance, extensive vertical integration may be justified in the growth stage and even in the mature stage of the PLC if the cycle is judged to be a long one. However, the investment in and commitment to the product required in vertical integration may not be justified when the PLC is viewed as being relatively short.

Portfolio Analysis

Strategic thinkers often think in portfolio terms because it is useful to have a

framework for analyzing the mix of products and services.⁹ As a result, portfolio analysis, popularized by the Boston Consulting Group (BCG), has become a fundamental tool for strategic analysis. Portfolio analysis allows for the assessment of the market position of the health care organization as a whole or its separate programs. As illustrated in [Exhibit 7-8](#), traditional *BCG portfolio analysis* is a graphic depiction and evaluation of an organization's products and services in terms of relative market share and market growth rate. The products and services may then be characterized as stars, cash cows, problem children, or dogs and strategic alternatives generated.

Stars

Products and services that fall in this quadrant (high market growth and high market share) represent the organization's best long-run opportunity for growth and profitability. These products and services are likely good investments and should be provided resources. Market development, product development, penetration, vertical integration, and related diversification are appropriate strategies for this quadrant.

Cash Cows

Products and services in this quadrant have low market growth (probably in maturity and decline stages of the PLC) but the organization has a high relative market share. These products and services should be maintained but should consume few new resources. For strong cash cows, appropriate strategies are status quo, enhancement, penetration, and related diversification. For weak cash cows, strategies may include retrenchment, harvesting, divestiture, and perhaps liquidation.

Problem Children

Problem children have a low relative market share position, yet compete in a high-growth market. Managers must decide whether to strengthen the products in this quadrant with increased investment through market development or product development or get out of the product/service category through harvesting, divestiture, or liquidation. A case may also be made for retrenchment into specialty niches.

Dogs

These products and services have a low relative market share position and compete in a slow- or no-growth market. These products and services should consume fewer and fewer of the organization's resources. Because of their weak position, the products or services in this quadrant are often liquidated or divested or the organization engages in dramatic retrenchment.

[Exhibit 7.8](#) BCG Portfolio Analysis

Relative market share may be thought of as the market share held by the largest rival organization compared with the market share held by others in the service category. Growth rate can be measured by the changes in level of gross revenues or by population or service utilization growth (such as admissions or inpatient days). Classification as high, medium, or low may be determined through comparison with national or regional health care growth figures, return on alternative investments, or the stage in the PLC.¹⁰

The evaluation of products and services in portfolio analysis can be a dynamic process and used for the long-run planning of service and product life cycles. Therefore, portfolio management might be concerned with several time horizons. Horizon 1 corresponds to managing the current fiscal reporting period, with short-term considerations. Horizon 2 might be concerned with ramping up the next generation of growth opportunities, and Horizon 3 with incubating new products and services that will sustain the organization far into the future. This time-horizon perspective is especially valuable for leaders trying to ensure that the organization will grow over the long term.¹¹ See Essentials for a Strategic Thinker 7–2, “What Are Red Ocean and Blue Ocean Strategies?” that helps explain market positioning.

Essentials for a Strategic Thinker 7–2

What Are Red Ocean and Blue Ocean Strategies?



“The only way to beat the competition is to stop trying to beat the competition.”¹ Red oceans are all the industries in existence today. The market space is known, the industry boundaries are defined, and the competitive rules are understood. “Products become commodities and cutthroat competition turns the red oceans bloody.”² Blue oceans, on the other hand, are defined by untapped market space and the opportunity for high growth and profits.

Organizations in red oceans try to beat the competition by building a defensible position in an existing industry. Creators of blue oceans engage in value innovation.³ These firms do not try to beat the competition but focus on creating leaps in value, thereby opening up new and uncontested market spaces.

There are three characteristics of a sound blue ocean strategy – focus, divergence, and a compelling tagline. First, strategies have focus and concentrate on a relatively few things that are done very well. Curves, a women’s fitness company, entered the red ocean of fitness companies by focusing on the most desirable aspects of traditional health clubs and home exercise programs. Next, competitors in red oceans react to rivals and lose their uniqueness. Curves differentiated its services by getting rid of special machines, juice bars, and saunas and arranged a limited number of simple-to-operate hydraulic machines in a circle to facilitate interactions among members, making the exercise experience fun. In blue oceans, organizations differentiate themselves from the average industry profile. Finally, a compelling and truthful tagline effectively communicates the value innovation of blue ocean firms.⁴ Curves’ tagline could be “for the price of a cup of coffee a day you can obtain the gift of health through proper exercise with friends.”

There is an interesting paradox in blue ocean strategies. The more successful a firm is in value innovation, the more likely other firms are to imitate it.⁵ The easier it is to imitate the blue ocean strategy, the less likely the strategy can be sustained; thus the blue ocean turns red. Blue ocean creators then become conventional competitors in a bloody sea or must innovate again. Consider for example, Pfizer's success with Viagra. Pfizer successfully reconstructed the market boundaries by shifting the focus from medical treatment to lifestyle enhancement. Pfizer was incredibly successful and today a plethora of FDA-approved erectile dysfunction products including Alprostadil, Caverject, CIALIS, Endex, LEVITRA, Muse, Sildenafil, Tadalafil, and Vardenafil are available.

Blue and red oceans have always coexisted and successful organizations learn to navigate both types of sea. The penchant to imitate, however, makes it necessary for organizations to understand competition in red oceans and how to create and sustain blue oceans. Much is known about how to navigate red oceans; much is to be learned about blue oceans.⁶

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3. Brian Leavy, "Value Pioneering – How to Discover Your Own 'Blue Ocean': Interview with W. Chan Kim and Renée Mauborgne," *Strategy & Leadership* 33, no. 6 (2005), pp. 13–21.
4. Kyle Bruce, "A Review of Blue Ocean Strategy: How to Create Uncontested Market Space and Make the Competition Irrelevant," *Journal of Management and Entrepreneurship* 10, no. 3 (2005), pp. 106–108.
5. John S. McClenahan, "Sailing the Ocean Blue," *Industry Week* 254, no. 3 (2005), pp. 20–21.
6. W. Chan Kim and Renée Mauborgne, "Value Innovation: A Leap into the Blue Ocean," *Journal of Business Strategy* 26, no. 4 (2005), pp. 22–29.

An example of portfolio analysis for a health care institution is illustrated in [Exhibit 7-9](#). Cash cow services, such as plastic surgery and substance abuse (lower left quadrant), have achieved high market share but the growth rate has slowed. These services should generate excess cash that may be used to develop stars and problem children services. Service lines in the upper left quadrant, such as women's services, geriatrics, cardiology, and so on, have high market growth and a relatively high market share (and most likely high profitability). These services are the most attractive for the institution and should be provided additional resources and encouraged to grow (and become cash cows). Services in the upper right quadrant (neurology/neurosurgery, GI/urology, emergency

services, and so on) over time will move into the stars quadrant or the dogs quadrant. Nurturing the services that will most likely move to the stars quadrant is important. Services such as psychiatry, vascular surgery, and pediatrics have low growth rates as well as a low relative market share (and most likely low profitability) and may be targets for reduction of scope strategies. Note however, that in health care some “dog” quadrant services may be slated for maintenance of scope or even expansion based on community needs.

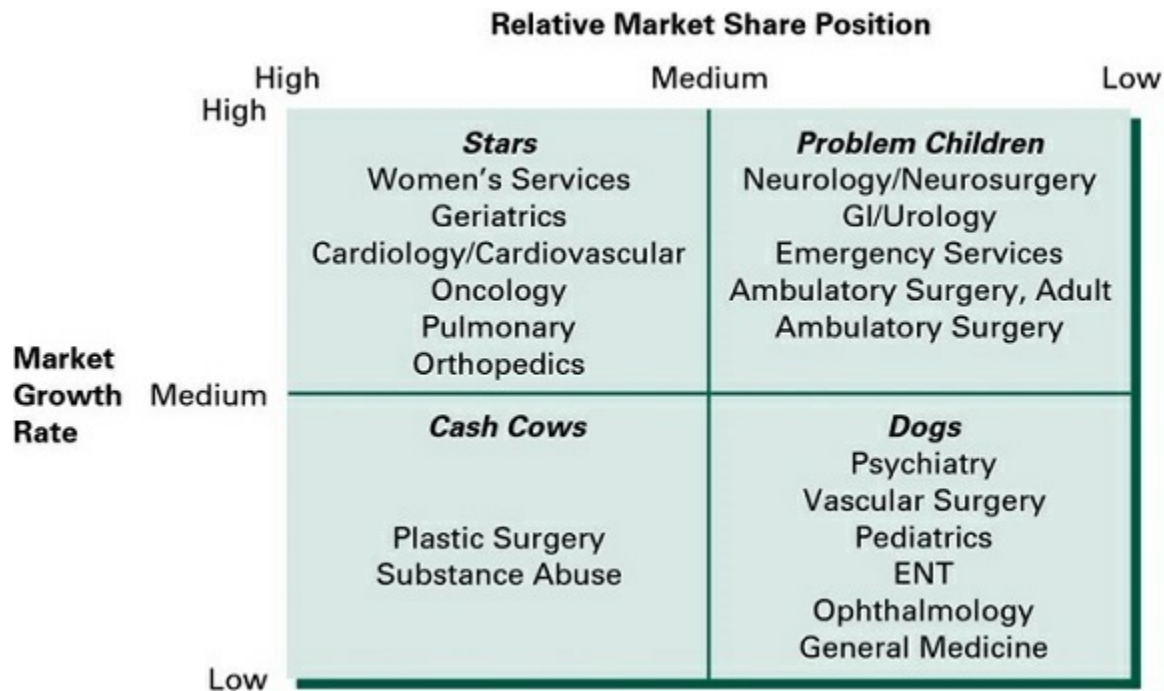


Exhibit 7.9 BCG Portfolio Analysis for a Health Care Institution

Source: Adapted from Doris C. Van Doren, Jane R. Durney, and Colleen M. Darby, “Key Decisions in Marketing Plan Formulation for Geriatric Services,” *Health Care Management Review* 18, no. 3, pp. 7–20. Copyright © 1993, Aspen Publishers, Inc. Adapted by permission.

Extended Portfolio Matrix Analysis

Although the BCG matrix may be used by health care organizations, portfolio analysis must be applied with care. For example, health care organizations typically have interdependent programs, such as orthopedics and pediatrics, which make a strategic service unit (SSU) difficult to define. Additionally, underlying the BCG matrix is an assumption that high market share means high profitability and that profits may be “milked” to benefit other programs with growth potential. In health care organizations, however, it is quite possible to have a high market share and no profit. For example, because of reimbursement restrictions, a high number of Medicaid patients may cause a physician practice to be unprofitable. Similarly, programs such as obstetrics, pediatrics, neonatal intensive care, and psychiatry may have high market share but be unprofitable for a hospital.¹²

The profitability issues suggest that portfolio analysis for health care organizations might better utilize an *extended portfolio matrix analysis* – an extension of the BCG Portfolio Matrix to account for profitability in situations

where high market share does not necessarily mean high profitability. The profitability dimension is measured by high or low profitability according to positive or negative cash flow or return on invested capital. The expanded matrix is presented in [Exhibit 7-10](#).

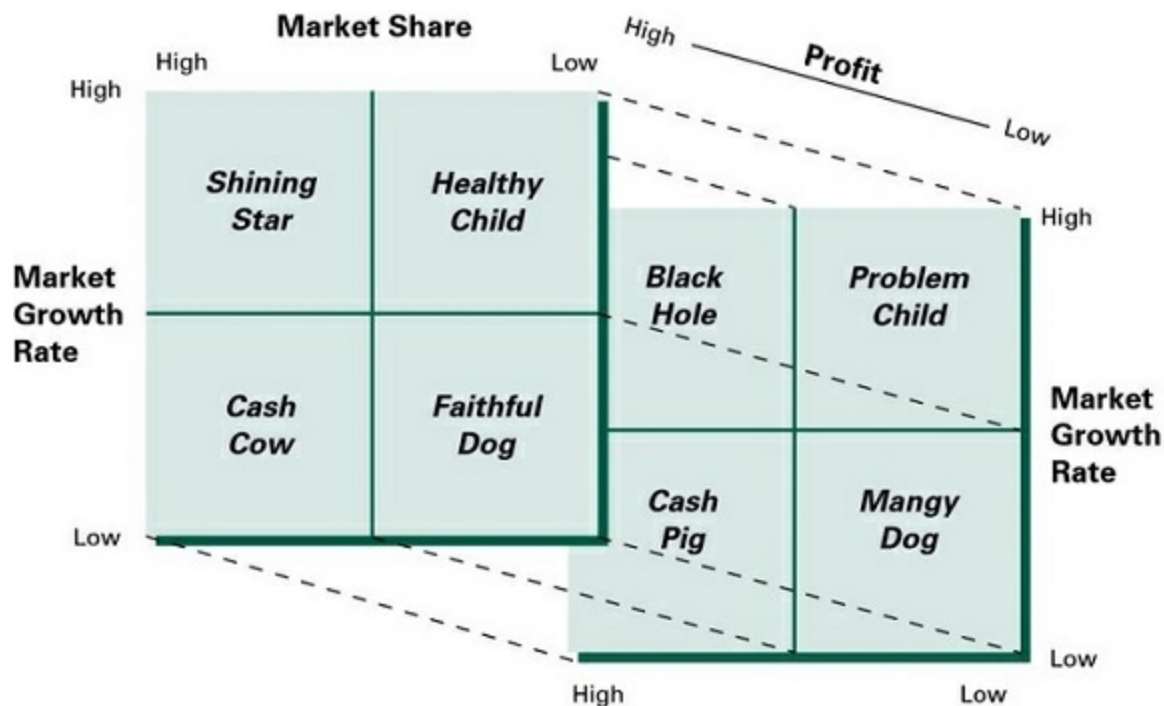


Exhibit 7.10 Extended Product Portfolio Matrix

Source: Adapted from Gary McCain, "Black Holes, Cash Pigs, and Other Hospital Portfolio Analysis Problems," *Journal of Health Care Marketing*, 7, no. 2 (June, 1987), p. 58. Reprinted by permission of the publisher, the American Marketing Association.

Shining stars have high market growth (typically in the early stages of the PLC), a high market share, and high profitability. This quadrant represents the best situation for a health care organization; however, it is likely that high profitability will attract competitors. Therefore, aggressive enhancement or product development will be required, yet market development may be difficult because of the already high market share. In addition, the organization will want to consider vertical integration and related diversification.

Cash cow products and services have low market growth but a high market share and high profitability. In this situation, the organization has a dominant position in the market (perhaps 100 percent – not uncommon in a given health care service area) and further growth is unlikely. Again, the high profitability may attract competition, and the organization may have to defend its market share. Thus, strategies should be directed toward maintaining market dominance through enhancement. If the PLC is viewed as being long, the organization may want to engage in vertical integration or related diversification.

Healthy children products and services have high market growth, a low market share, and high profitability. This quadrant demonstrates that there are situations in which it is possible to have a low share of the market and be profitable (at least in the short term or through segmentation). This situation is

potentially attractive to the organization, which may be able to move the product or service into the shining star and, ultimately, cash cow quadrant. These products and services will require investment to nurture them and gain relative market share. Strategies may include market development, product development, penetration, or vertical integration coupled with strong functional support.

For the faithful dog category, the products and services have low market growth and a low market share, but have been profitable. For example, many hospital services involve less-dominant units showing slow growth. However, if they are profitable, such units make a positive contribution to the overall health of the hospital and augment a full service line.¹³

For faithful dogs, managers must assess if increased market share will add to profitability. For instance, if profitable segments can be identified, it may be more advantageous to withdraw from broader markets, concentrate on a smaller segment, and maintain profitability. In such situations, a status quo or retrenchment strategy may be appropriate. If profitability is likely to decline over time, a harvesting or divestiture strategy may be best.

Black hole products and services have high growth and a high market share but low profitability. Not all high-growth, high-share programs are profitable in health care. For instance, costly technological equipment may make an organization the sole provider of a service whose high cost cannot be recovered from individual patients. However, such services may contribute to the overall image of the organization and increase the profitability of other services.

Nevertheless, having a high share for a service with low or negative profitability is quite disturbing. There must be a concentrated effort to reduce costs (enhancement strategy) or to add revenue without adding costs to such a program. "When circumstances prevent a service from generating most of its own cash inflow, it becomes a 'black hole' – a collapsed star sucking in light (profit or cash) – rather than shining and generating cash or profits."¹⁴

If a black hole product or service cannot be made into a shining star, it is likely to become a cash pig. Therefore, enhancement and retrenchment strategies may be most appropriate. In addition, action plan strategies should be employed to reduce costs and increase revenue.

Problem children are low-share, high-growth, and low-profitability products and services that present both challenges and problems. Some of the products and services represent future shining stars and cash cows, although others represent future black holes and mangy dogs. Management must decide which products and services to support and which to eliminate. For supported products, market development with strong financial commitment is appropriate. For products that management does not feel can become shining stars, divestiture and liquidation are most fitting.

Cash pig products and services have a high or dominant share, are experiencing low growth, and have low profitability. Health care cash pigs are likely to be those well-established SSUs with dominant shares that once were considered to be cash cows. Typically, they have well-entrenched advocates in the

organizational hierarchy who support their continuance.¹⁵

A possible solution to the cash pig problem is to cut costs and raise prices. Therefore, aggressive retrenchment may be required. This strategy may allow the organization to give up the market share to find smaller, more profitable segments and thus create a smaller cash cow.

Products and services with low growth, a low share, and poor profit (mangy dogs) have a debilitating effect on the organization and should be eliminated as soon as possible. In this situation, other providers appear to better serve the market. Probably the best strategy at this point is liquidation, as it will be difficult to find a buyer for products and services in this quadrant.

Strategic Position and Action Evaluation

Strategic position and action evaluation (SPACE), an extension of two-dimensional portfolio analysis (BCG), is used to determine the appropriate strategic profile of the organization. *SPACE analysis* is a method that includes a graphic depiction to indicate the applicability of strategic alternatives based on factors relating to the service category strength, environmental stability, the organization's relative competitive advantage, and the organization's financial strength. By using SPACE, the manager can incorporate a number of factors into the analysis and examine a particular strategic alternative from several perspectives.¹⁶

The SPACE chart and definitions of the four quadrants are shown in [Exhibit 7-11](#). Listed under each of the four dimensions are factors that individual numerical values ranging from 0 to 6 can be assigned. The numbers are then added together and divided by the number of factors to yield an average. The averages for environmental stability and competitive advantage each have the number 6 subtracted from them to produce a negative number. The average for each dimension is then plotted on the appropriate axis of the SPACE chart and connected to create a four-sided polygon. Factor scales for each dimension are presented in [Exhibit 7-12](#), which has been filled in for a regional hospital. The resulting shape of the polygon can be used to identify four strategic profiles – aggressive, competitive, conservative, and defensive. The quadrant with the largest area is the most appropriate general strategic position.

Aggressive Profile

Typical in an attractive service category with little turbulence in its environment. The organization enjoys a definite competitive advantage that can be protected with financial strength. The critical factor is the entry of new competitors. Organizations in this situation should take full advantage of opportunities, look for acquisition candidates in their own or related areas, increase market share, and concentrate resources on products having a definite competitive edge.

Competitive Profile

Typical in an attractive service category. The organization enjoys a competitive advantage in a relatively unstable environment. The critical factor is financial strength. Organizations in this situation should acquire

financial resources to increase marketing thrust, add to the sales force, extend or improve the product line, invest in productivity, reduce costs, protect competitive advantage in a declining market, and attempt to merge with a cash-rich organization.

Conservative Profile

Typical in a stable market with low growth. Here, the organization focuses on financial stability. The critical factor is product competitiveness. Organizations in this situation should prune the product line, reduce costs, focus on improving cash flow, protect competitive products, develop new products, and gain entry into more attractive markets.

Defensive Profile

Typical of an unattractive service category in which the organization lacks a competitive product and financial strength. The critical factor is competitiveness. Organizations in this situation should prepare to retreat from the market, discontinue marginally profitable products, aggressively reduce costs, cut capacity, and defer or minimize investments.

Source: Adapted from Alan J. Rowe, Richard O. Mason, Karl E. Dickel, and Neil H. Snyder, *Strategic Management: A Methodological Approach*, 4th edn (Reading, MA: Addison-Wesley Publishing, 1994), pp. 145–150. Reprinted by permission of Pearson Education Inc., Upper Saddle River, NJ.

Exhibit 7.11 Strategic Position and Action Evaluation (SPACE) Matrix

Factors Determining Environmental Stability

Technological changes	Many	0	1	2	3	4	5	6	Few
Rate of inflation	High	0	1	2	3	4	5	6	Low
Demand variability	Large	0	1	2	3	4	5	6	Small
Price range of competing products/services	Wide	0	1	2	3	4	5	6	Narrow
Barriers to entry into market	Few	0	1	2	3	4	5	6	Many
Competitive pressure	High	0	1	2	3	4	5	6	Low
Price elasticity of demand	Elastic	0	1	2	3	4	5	6	Inelastic
Other: _____	_____	0	1	2	3	4	5	6	_____

Average = $6 = -3.7$

Critical factors

Fairly turbulent environment; strong competition; many technological changes.

Comments

Necessary to maintain financial stability because of turbulence in the environment; demand in market segments relatively stable; protect market niche against competition.

Factors Determining Service Category Strength

Growth potential	Low	0	1	2	3	4	5	6	High
Profit potential	Low	0	1	2	3	4	5	6	High
Financial stability	Low	0	1	2	3	4	5	6	High
Technological know-how	Simple	0	1	2	3	4	5	6	Complex
Resource utilization	Inefficient	0	1	2	3	4	5	6	Efficient
Capital intensity	High	0	1	2	3	4	5	6	Low
Ease of entry into market	Easy	0	1	2	3	4	5	6	Difficult
Productivity, capacity utilization	Low	0	1	2	3	4	5	6	High
Other: <u>Flexibility, adaptability</u>	<u>Low</u>	0	1	2	3	4	5	6	<u>High</u>

Average = 3.7

Critical factors

Good growth and profit potential; strong competition.

Comments

Very attractive service category, but strong competition; degree of capital intensity increasing.

Factors Determining Competitive Advantage

Market share	Small	0	1	2	3	4	5	6	Large
Product quality	Inferior	0	1	2	3	4	5	6	Superior
Product life cycle	Late	0	1	2	3	4	5	6	Early
Product replacement cycle	Variable	0	1	2	3	4	5	6	Fixed
Customer/patient loyalty	Low	0	1	2	3	4	5	6	High
Competition's capacity utilization	Low	0	1	2	3	4	5	6	High
Technological know-how	Low	0	1	2	3	4	5	6	High
Vertical integration	Low	0	1	2	3	4	5	6	High
Other: _____	_____	0	1	2	3	4	5	6	_____

Average - 6 = -2.4

Critical factors

Market share low; product/service quality very good.

Comments

The organization still enjoys slight competitive advantage because of quality and customer loyalty; can be expected to diminish, however, because of improving performance of competitive organizations.

Factors Determining Financial Strength

Return on investment	Low	0	1	2	3	4	5	6	High
Leverage	Imbalanced	0	1	2	3	4	5	6	Balanced
Liquidity	Imbalanced	0	1	2	3	4	5	6	Balanced
Capital required/capital available	High	0	1	2	3	4	5	6	Low
Cash flow	Low	0	1	2	3	4	5	6	High
Ease of exit from market	Difficult	0	1	2	3	4	5	6	Easy
Risk involved in business	Much	0	1	2	3	4	5	6	Little
Other: <u>Inventory turnover</u>	<u>Slow</u>	0	1	2	3	4	5	6	<u>Fast</u>

Average = 1.6

Critical factors

Very little liquidity; too much debt.

Comments

Financial position very weak; cash inflow has to be increased in order to improve liquidity; outside financing difficult because of high leverage.

Source: Adapted from Alan J. Rowe, Richard O. Mason, Karl E. Dickel, and Neil H. Snyder, *Strategic Management: A Methodological Approach*, 4th edn (Reading, MA: Addison-Wesley Publishing, 1994), pp. 148–149. Reprinted by permission of Pearson Education Inc., Upper Saddle River, NJ.

Exhibit 7.12 Strategic Position and Action Evaluation Factors for a California-based Regional Hospital

The factor scales shown in [Exhibit 7-12](#) are for a California-based regional hospital system specializing in health services for the elderly and chemically dependent. This hospital system is operating in a fairly turbulent environment with many competitive pressures and many technological changes (environmental stability axis).

Despite the turbulent environment, the hospital's service category segments show good growth potential that attracts strong competition. Increasing competition requires increased investment in new facilities and technology. The hospital still has a competitive advantage (as seen on the competitive advantage axis) derived from early entry into the market and it has been able to retain

customer loyalty because of high-quality service. However, the hospital's financial position (as seen on the financial strength axis) is weak because it financed new facilities through a substantial amount of debt. Its liquidity position has eroded and cash flow continues to be a problem.

Which of the adaptive strategic alternatives is most appropriate for this regional system? The dimensions for this organization are plotted on the SPACE matrix shown in [Exhibit 7-13](#), demonstrating that the hospital is competing fairly well in an unstable but attractive service category segment. This organization cannot be too aggressive because it has few financial resources and the environment is a bit unstable. Therefore, it should adopt a competitive profile.

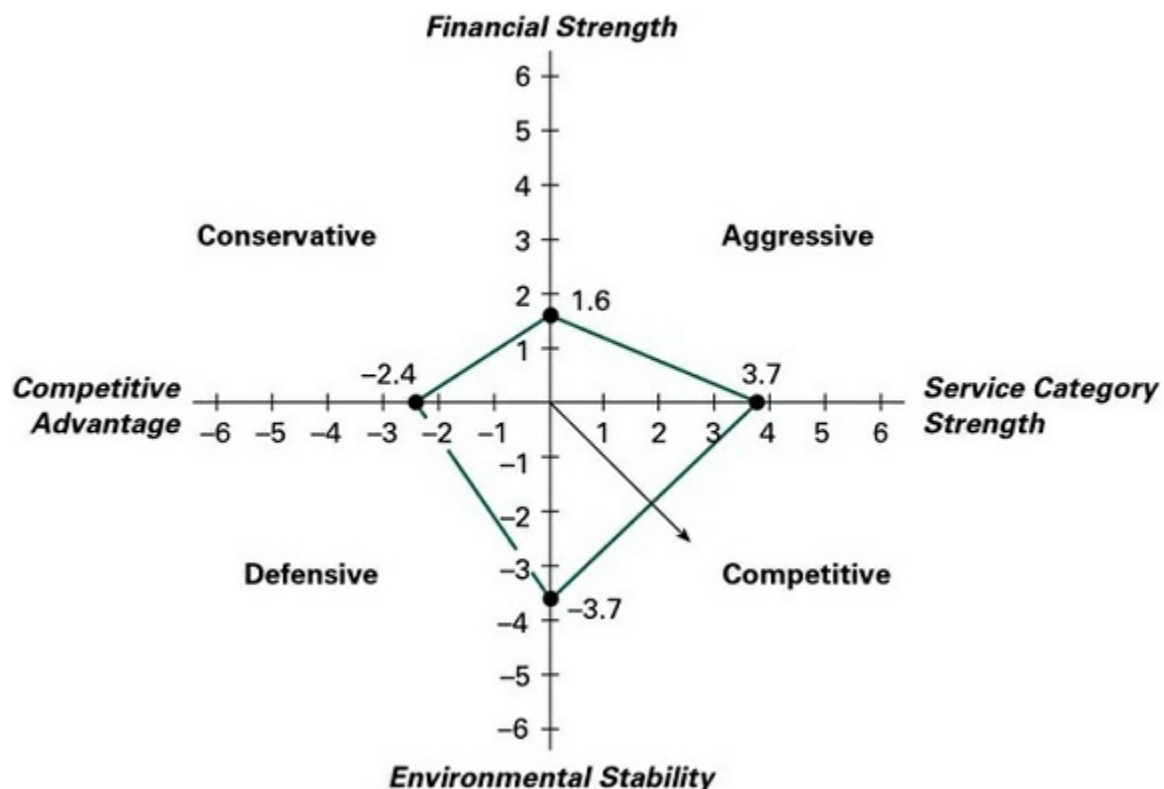


Exhibit 7.13 SPACE Profile for a California-based Regional Hospital System Specializing in Elderly and Chemically Dependent Care

The SPACE chart is a summary display; each factor should be analyzed individually as well. In particular, factors with very high or very low scores should receive special attention.¹⁷ [Exhibit 7-14](#) examines various strategic profiles that may be obtained in a SPACE analysis; [Exhibit 7-15](#) shows the adaptive alternatives for each strategic profile. The SPACE plot for the regional hospital system resulted in a competitive profile. Accordingly, the most appropriate strategic alternatives are penetration, market development, product development, status quo, or enhancement, with the most likely being enhancement. The hospital should continue to differentiate itself, but must rectify its financial position because an unstable environment may place unanticipated demands on the organization that will require an additional infusion of capital. In light of its financial problems, the hospital may have to pursue its goals (for example, market development) through a cooperation market entry strategy. A cooperation strategy – joining a network – may be

important in a situation where health care systems, continuums, and referral networks are the key to market development and penetration. In the end, the adaptive and market entry/exit strategic decisions are inextricably linked.

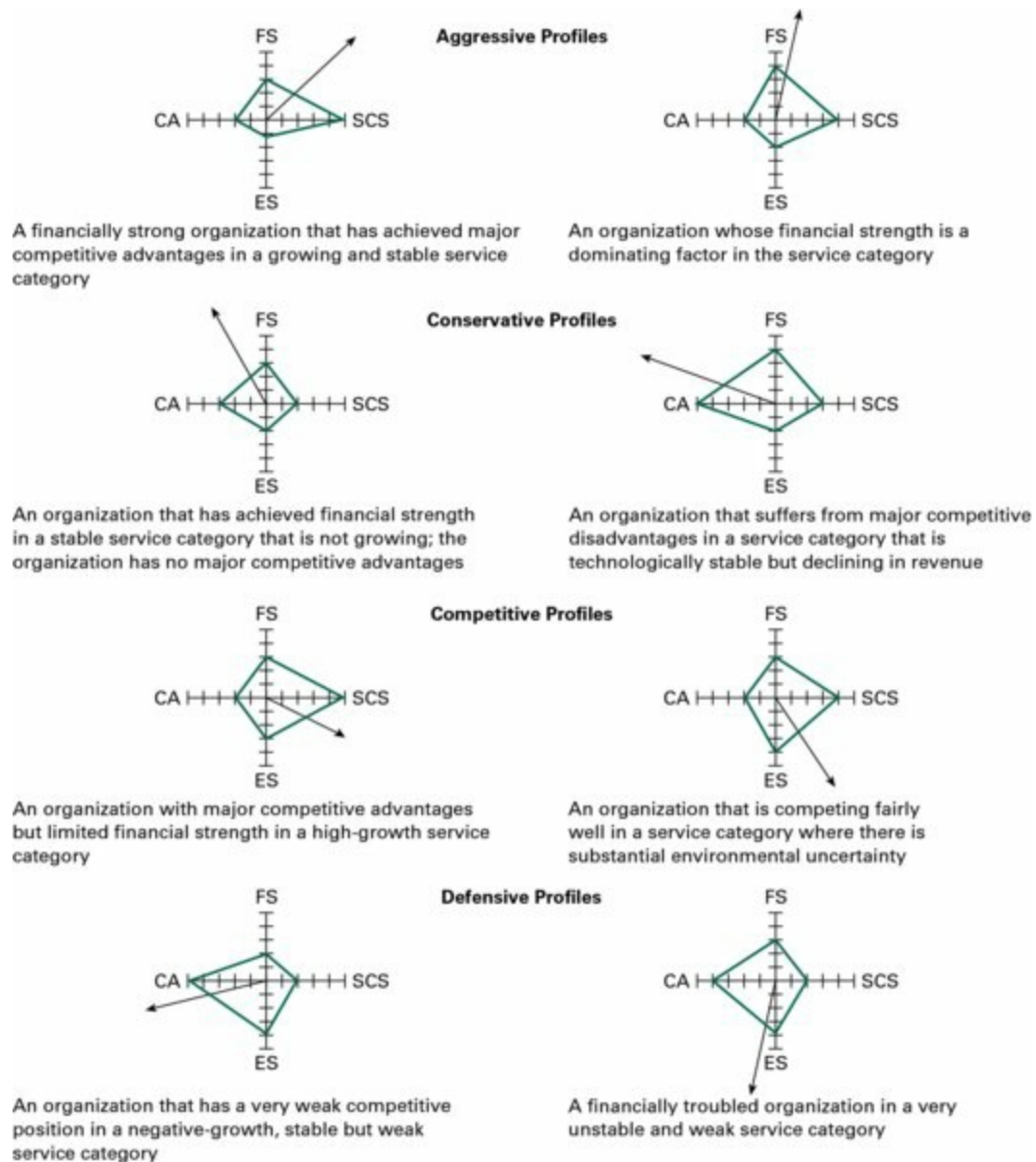


Exhibit 7.14 Space Strategy Profiles

Source: Adapted from Fred R. David, *Strategic Management*, 2nd edn (Columbus, OH: Merrill Publishing Co., 1989), p. 216.

Conservative • Status Quo • Unrelated Diversification • Harvesting	Aggressive • Related Diversification • Market Development • Product Development • Vertical Integration
Defensive • Divestiture • Liquidation • Retrenchment	Competitive • Penetration • Enhancement • Product Development • Market Development • Status Quo

Exhibit 7.15 Strategic Alternatives for SPACE Quadrants

Program Evaluation

Program evaluation is an analysis method used particularly by not-for-profit and public organizations for assessing their portfolio of programs and developing strategic alternatives in situations where market share, service category strength, and competitive advantage are not relevant. Program evaluation is particularly useful for state- or federally-funded institutions, such as state and county public health departments, state mental health departments, Medicaid agencies, community health centers, and public community hospitals. Despite the fact that these organizations are public and not-for-profit, they should develop explicit strategies and evaluate the adaptive strategic alternatives open to them. Although the internal/external strategy matrix and a form of portfolio analysis may be used to evaluate public health programs,¹⁸ evaluation methods that consider increasing revenue and market share may be inappropriate or difficult to use.

Public and not-for-profit institutions typically maintain a number of programs funded through such sources as state appropriations, federal grants, private donations, fee-for-service, and so on. In a public health department, such programs might include HIV/AIDS education, disease surveillance, disease control, immunizations, food sanitation inspection, on-site sewage inspection, and many more. Usually, these programs have been initiated to fill a health care need within the community that has not been addressed through the private sector. These “health care gaps” have occurred because of federal or state

requirements for coordination and control of community health and because of the large number of individuals without adequate health care insurance or means to pay for services.

Within the context provided by an understanding of the external environment, internal systems, and directional strategies, these not-for-profit institutions must chart a future through a set of externally and internally funded programs. The set of programs maintained and emphasized by the organization constitutes its adaptive strategy. The degree to which they are changed (expansion of scope, reduction of scope, maintenance of scope) represents a modification of the adaptive strategy. The fundamental question is, “Does our current set of programs effectively and efficiently fulfill the mission and vision for the future?” This question may be addressed through a process of program evaluation. Two program evaluation methods that have been used successfully are needs/capacity assessment and program priority setting.

A *needs/capacity assessment* is an evaluation method for developing strategy alternatives for not-for-profit and public organizations based on community need and the organization’s capacity to deliver programs that meet the need. The set of programs in not-for-profit organizations are determined by the community, although some programs may be mandated by law, such as disease control, disease surveillance, and the maintenance of vital records (birth and death records). However, the assumption is that the legislation is a result of an important need and, typically, the mandate is supported by non-discretionary or categorical funding (funding that may be used for only one specific purpose as required by law). Therefore, in developing a strategy for a public health organization or not-for-profit organization serving the community, a needs/capacity assessment must be undertaken – community needs must be assessed *vis-à-vis* the organization’s ability (capacity) to address those needs.

Community need is one dimension for determining the strategy for a not-for-profit organization’s programs based on (1) clear community requirements (environmental, sanitation, disease control, and so on) and personal health care (primary care) gaps; (2) the degree to which other institutions (private and public) fill the identified health care gaps; and (3) public/community health objectives. Many not-for-profit institutions enter the health care market to provide services to those who otherwise would be left out of the system. Despite efforts to reform health care, these gaps are likely to remain for some time. Health care gaps are identified through community involvement, political pressure, and community assessments such as those carried out by the Centers for Disease Control and Prevention (CDC). These gaps exist because there are too few private or public institutions positioned to fill the need. Where existing institutions are willing and able to fill these gaps, public and not-for-profit organizations should probably resist entering the market. In addition, public and community health objectives must be considered when developing strategy. National, state, and community objectives such as the Healthy People 2020 and Healthy People 2030 objectives should be included as part of a community needs assessment.¹⁹

Organizational capacity is one dimension for determining the strategy for a not-for-profit organization’s programs based on its ability to initiate, maintain,

and enhance its programs. Organizational capacity is comprised of (1) funding to support programs, (2) other organizational resources and skills, and (3) the program's fit with the mission and vision of the organization. Availability of funding is an important part of organizational capacity. Many programs are supported with categorical funding and accompanying mandates (program requirements dictated by a higher authority, usually federal or state government). Often, however, local funds supplement federal- and state-funded programs. For other programs, only community funding is available. Thus, funding availability is a major consideration in developing strategy for public and not-for-profit organizations. In addition, the organization must have the skills, resources, facilities, management, and so on to initiate and effectively administer the program. Finally, program strategy will be dependent upon the program's fit with the organization's mission and vision for the future. Programs outside the mission and vision should be viewed as luxuries, superfluous, or wasteful. Similar needs assessment methodologies have been used extensively by public and not-for-profit organizations (see Essentials for a Strategic Thinker 7–3, “What Is Needs Assessment?”).

Essentials for a Strategic Thinker 7–3

What Is Needs Assessment?



Needs assessment is a systematic process for identifying gaps between two conditions: the current state of “what is” (real) and the desired state of “what should be” (ideal). Needs assessment is not intended to generate solutions; but rather, to assess the discrepancy between these two conditions. Conducting a needs assessment allows an organization to identify and prioritize needs; determine criteria for solutions; make data-informed decisions regarding human, financial, and other resources; and implement actions to improve programs, services, or organizational structure and operations.¹

For example, if administrators at a local health clinic observe an increase in demand for patient access based on the health-seeking behaviors of a specific target population, the clinic may conduct a needs assessment to determine the number of patients served (actual) as compared to patient demand for services (ideal). In doing so, these administrators may discover that the clinic's current capacity is 500 patients while patient demand for services is 1,000.

This example demonstrates that there is gap between “what is” and “what should be.” In other words, a discrepancy exists. When discrepancies are detected, organizational leaders may seek to identify the root cause(s) of this gap to craft effective and data-informed solutions. If there is little to no discrepancy, organizations may choose to direct resources to other

priorities.

The needs assessment process is typically conducted in phases during which data are collected, analyzed, summarized, and presented as a list of identified needs. Common data collection tools for conducting a needs assessment include surveys, focus groups, key informant interviews, document analysis, and observations. Irrespective of method, information is gathered from key stakeholders and others who have knowledge or experience with the issue. Decision-makers may then consider each need in the organization's context to prioritize issues for planning interventions.

In addition to assessing expressed needs based on supply and demand, as demonstrated in the previous clinic example, needs assessments can be used to identify other discrepancies between real and ideal states. For example, needs assessment can be used to evaluate:

- Prescribed or normative needs based on a target as defined by an expert.
- Relative needs between two groups in which differences are compared to one another.
- Perceived needs as defined by a specific group.
- Extrapolated needs or formula-driven estimates based on a standard.²

Rather than adopting an ill-fitting solution to a poorly defined problem, a rigorous needs assessment empowers organizational leaders to be thoughtful and strategic about how and when to deploy specific resources to address needs that are prioritized as the most important.

REFERENCES

1. J. W. Altschuld and D. D. Kumar, *Needs Assessment: An Overview* (Thousand Oaks, CA: SAGE, 2010).
2. M. J. Harris, *Evaluating Public and Community Health Programs* (San Francisco, CA: Jossey Bass, 2010).

Source: Matthew Fifolt, PhD, Assistant Professor, Department of Health Care Organization and Policy, School of Public Health, University of Alabama at Birmingham and Julie Preskitt, PhD, Associate Professor, Department of Health Care Organization and Policy, School of Public Health, University of Alabama at Birmingham.

[Exhibit 7-16](#) presents the adaptive strategic alternatives indicated for public organizations as they assess community needs and the organization's capacity to fill them. Where the community need is assessed as high (significant health care gaps, few or no other institutions addressing the need, and the program is one of the community's objectives) and the organization's capacity is assessed as high (adequate funding, appropriate skills and resources, and fit with mission/vision), then the organization should adopt one of the expansion of scope adaptive strategies (upper left quadrant). Appropriate strategies might include vertical integration, related diversification, product development, market development, and penetration. When the community need assessment is

low (no real need, the need has abated, the need is now being addressed by another institution, or the need does not fit with community objectives) but organization capacity is high (adequate funding, appropriate skills and resources, and fit with mission/vision), there should be an orderly redistribution of resources, suggesting reduction and maintenance of scope adaptive strategies (lower left quadrant). Reduction of scope strategies should be given priority as the community need diminishes; however, phasing out a program may take some time or, alternatively, the uncertainty concerning the changing community needs may dictate maintenance in the short term. Appropriate adaptive strategies might include related diversification, retrenchment, harvesting, and status quo.

		Organizational Capacity	
		<i>High</i>	<i>Low</i>
Community Need	<i>High</i>	Expansion of Scope • Vertical Integration • Related Diversification • Product Development • Market Development • Penetration	Maintenance/Reduction of Scope • Enhancement • Status Quo • Retrenchment • Harvesting
	<i>Low</i>	Reduction/Maintenance of Scope • Related Diversification • Retrenchment • Harvesting • Status Quo	Reduction of Scope • Liquidation • Harvesting • Divestiture • Retrenchment

Exhibit 7.16 Public Health and Not-for-Profit Adaptive Strategic Decisions

Where community needs have been assessed as low (no real need, the need has abated, the need is now being addressed by another institution, or the need does not fit with community objectives) and the organization has few financial or other resources to commit to programs (low organization capacity), one of the reduction of scope adaptive strategies should be adopted (lower right quadrant). These strategies include liquidation, harvesting, divestiture, and retrenchment. When community needs have been assessed as high but organizational capacity is low, maintenance and reduction of scope strategies are appropriate (upper right quadrant). Maintenance of scope strategies should be given priority because of the high community need; however, if resources dwindle or funding is reduced, reduction of scope may be required. Appropriate adaptive strategic alternatives include enhancement or status quo (maintenance of scope) and

retrenchment or harvesting (reduction of scope). As resources become available, and organizational capacity increases, programs in this quadrant will move to the upper left quadrant, enabling more aggressive (expansion) strategies to be selected.

The second method of developing adaptive strategies for not-for-profit or public programs involves ranking programs and setting priorities. *Program priority setting* is another analysis method used by not-for-profit and public organizations for developing strategies that involves rank ordering programs when all programs are considered important but resources are limited. As the demand for health services has increased and the resources available for service delivery has contracted, evidence-based priority setting methods that are transparent and inclusive have been developed and improved. A study of five Primary Care Trusts in England demonstrated the difficulty in achieving the dual goals of priority setting effectiveness and information accessibility, and consequently transparency, among the decision makers.²⁰ Other studies have demonstrated how different issues fail to reach the actual decision makers in priority setting activities. The result is often skepticism regarding the objectivity of program priority setting.²¹

Program priority setting is significant because community needs (both the need itself and the severity of the need) are constantly changing and organizational resources, in terms of funding and organization capacity, are almost always limited. Invariably, more programs have a higher community need than resources are available. Therefore, the most important programs (and perhaps those with categorical funding) may be expanded or maintained. The organization must have an understanding of which programs are the most important, which should be provided incremental funding, and which should be the first to be scaled back if funding is reduced or eliminated.

The nature and emphasis on programs is the central part of strategy formulation in many public and not-for-profit organizations. However, a problem in ranking these programs is that typically all of them are viewed as “very important” or “essential.” This is particularly true when using Likert or semantic differential scales to evaluate the programs. Therefore, it is necessary to develop evaluation methods that further differentiate the programs. One method that can be used is to list all the programs of the agency or clinic, each on a separate sheet of paper posted in different areas of the room. Then using different colors or types of sticker, one for each of the adaptive strategies – expand the scope, reduce the scope, and maintain the scope – each member of the management team is asked to sort the organization’s programs into categories – those that should be expanded, those that should be reduced, or those to remain the same – based on the perceived importance of each to the organization’s mission and vision. The group may agree on several programs. Discussions can then be focused on those programs where there is disagreement. After points have been raised and discussed, the programs can be ranked again, hopefully leading to greater consensus from the group.

The Q-sort method provides a more formal method of differentiating the importance of programs and setting priorities and can be used to prioritize a

variety of issues.²² *Q-sort* is a ranking procedure that forces choices along a continuum in situations where the difference between the choices may be quite small. The *program Q-sort evaluation* is a forced-choice ranking procedure for differentiating and reaching consensus on the importance of programs/issues and setting priorities. It is particularly useful when experts differ on what makes one choice preferable over another. By ranking the choices using a *Q-sort* procedure, participants see where there is wide consensus (for whatever reasons used by the experts) and have an opportunity to discuss the choices for which there is disagreement (and, hopefully, reach greater consensus).

Q-sort is part of the *Q-methodology*, a set of philosophical, psychological, statistical, and psychometric ideas oriented to research on the individual. *Q-sort evaluation* helps overcome the problem of all programs being ranked as very important by forcing a ranking based on some set of assumptions.²³ Once *Q-sort* has rank-ordered a series of objects (programs), numerals may be assigned to subsets of the objects for statistical purposes. *Q-sort* focuses on sorting decks of cards (in this case each card representing a program) and displaying the correlations among the responses of different individuals to the *Q-sorts*.

For ranking an organization's programs, only the first step in using the *Q-methodology* is used – the *Q-sort*. In the *Q-sort* procedure, each member of the management team is asked to sort the organization's programs into categories based on their perceived importance to the organization's mission and vision. To facilitate the task, the programs are printed on small cards that may be arranged (sorted) on a table. To force ranking of programs, managers are asked to arrange the programs in piles from most important to least important. The best approach is that the number of categories be limited to nine and the number of programs to be assigned to each category be determined in such a manner as to ensure a normal distribution.²⁴ Therefore, if a public health department had 49 separate programs that management wished to rank (culled from a larger list of programs), they may be sorted as shown in [Exhibit 7-17](#). Notice that to create a normal distribution (or quasi-normal), 5 percent of the programs are placed in the first pile or group, 7.5 percent in the second group, 12.5 percent in the third, and so on. In this case, there are two programs in the first group, four programs in the second group, six in the third, and so on.

				Cancer Prevention 4.88				
			Seafood Sanitation 6.11	Lodging/Jails Inspection 4.88	Microbiology 4.44			
			Infection Control 5.77	Injury Prevention 4.77	Home Health 4.22			
		Immunization 6.99	Health Education 5.66	Disaster Preparedness 4.77	Quality Assurance 4.11	Administrative Support 3.99		
		Tuberculosis Control 6.88	Family Planning 5.66	Public Health Nursing 4.75	Primary-Care Support 4.11	Vector Control 3.99		
	Sewage Regulation 7.22	Licensure and Certification 6.77	Child Health 5.55	Lead Assessment 4.62	School Health Education 4.0	Dental Health 3.87	Medicaid Waiver 3.33	
	STD Control 7.22	Newborn Screening 6.62	Emergency Medicine 5.50	HMO Regulation 4.55	WIC 4.0	Diabetes 3.77	Swimming Pools 3.11	
Food Sanitation 8.0	Milk Sanitation 7.0	Health Statistics 6.44	Radiation Control 5.44	Hypertension 4.55	Vital Records 4.0	Indoor Air Quality 3.66	Adolescent Health 2.66	Hearing Aid Regulation 1.88
Epidemiology 8.0	HIV/AIDS Planning and Control 7.0	Solid Waste 6.33	Maternity 5.22	Mycobacteriology 4.55	Serology 4.0	Public Health Social Work 3.44	Plumbing Inspection 2.55	Animal Control 1.44
Most Important 5%	Next Most Important 7.5%	Next Most Important 12.5%	Next Most Important 15%	Next Most Important 20%	Next Most Important 15%	Next Most Important 12.5%	Next Most Important 7.5%	Next Most Important 5%

Exhibit 7.17 Department of Public Health Q-Sort Results*

*Program name and mean score in each box.

Depending on the group in which it is placed, each program is assigned a score ranging from 1 to 9, where 1 is for the lowest- and 9 is for the highest-ranked programs. The score indicates an individual's perception of that program's importance to the mission and vision of the organization. A program profile is developed by averaging individual members' scores for each program.

Based on the results of the Q-sort, programs may be designated for expansion, reduction, or maintenance of scope. For the public health programs in [Exhibit 7-17](#), food sanitation and epidemiology, sewage planning and operation, sexually transmitted disease (STD) control, and so on, might be earmarked for expansion. Cancer prevention, lodging/jail inspection, injury prevention, and so on might be slated for maintenance of scope, whereas plumbing inspection, hearing aid dealer board regulation, and animal control may be marked for reduction.

The Q-sort procedure works well when incorporating several different sets of strategic assumptions or scenarios. For example, the programs may be sorted several times, each based on a different scenario. Then the group can determine which of the scenarios is most likely and make decisions accordingly.

Priority setting is likely to increase in importance for health care organizations as the demand for services continues to increase and resources become even more scarce. Priority setting, by its nature, appears threatening especially to those whose programs are judged to be of a lower priority. For this reason transparency and communication from upper leadership are critical elements in

any effective priority setting process.²⁵

Step 3: Evaluate and Select Market Entry/Exit Strategies

Once expansion of scope or maintenance of scope through enhancement adaptive strategies are selected, one or more of the market entry strategies must be used to break into or capture more of the market. All of the expansion adaptive strategies require some activity to reach more consumers with the products and services. Similarly, enhancement strategies indicate that the organization must improve what it is already doing, which requires market entry analysis. Reduction of scope and market exit strategies are directed toward offering fewer products and services and markets and may require identifying buyers, closing facilities, reducing the product line, internal cost cutting issues, and managing declining demand.

The market entry strategies include acquisition, licensing, venture capital investment, merger, alliance, joint venture, internal development, internal venture, and reconfiguring the value chain. Although any one (or several) of these strategies may be used to enter the market, acquisitions, mergers, and alliances have received most of the media attention over the past decade. Acquisition is the principal purchase strategy and mergers and alliances are the principal cooperation strategies. Market exit strategies are methods to either rapidly or slowly, partially or completely leave markets and similar to market entry, divestiture (the other side of acquisition) has most obviously shaped the health care landscape.

The specific market entry/exit strategy considered to be appropriate depends on (1) the external conditions; (2) the pertinent internal strengths and weaknesses based on the organization's resources, competencies, and capabilities; and (3) the goals of the organization. Each of these three areas should be scrupulously evaluated.

External Conditions

The first consideration in the selection of the market entry/exit strategy is the evaluation of the external situation. A review of the external issues and supporting documentation (see Chapters 2 and 3) should provide information to determine which of the market entry/exit strategies is most appropriate. [Exhibit 7-18](#) provides a list of representative external conditions appropriate for each of the market entry/exit strategies.

Market Entry Strategy	Appropriate External Conditions
Acquisition	• Growing market. • Early stage of the product life cycle or extended maturity stage. • Attractive acquisition candidate. • High-volume economies of scale (horizontal

	integration). • Distribution economies of scale (vertical integration).
Licensing	• High capital investment to enter market. • High immediate demand for product/service. • Early stages of the product life cycle.
Venture Capital Investment	• Rapidly changing technology. • Product/service in the early development stage.
Merger	• Attractive merger candidate (synergistic effect). • High level of resources required to compete.
Alliance	• Alliance partner has complementary resources, competencies, capabilities. • Alliance partner has similar status. • Market demands complete line of products/services. • Market is weak and continuum of services is desirable. • Mature stage of product life cycle.
Joint Venture	• High capital requirements to obtain necessary skills/expertise. • Extended learning curve to ensure necessary expertise.
Internal Development	• High level of product control (quality) required. • Early stages of the product life cycle.
Internal Venture	• Product/service development stage. • Rapid development/market entry required. • New technical, marketing, production approach required.
Reconfiguring the Value Chain	• Competition dominated by a few traditional providers. • Specialized market niche identified. • New technology, marketing, production approach required.

Market Exit Strategy	Appropriate External Conditions
Fast	• Declining market – late stages of the product life cycle. • Available buyers for the business or assets. • High level of resource required to compete. • Liquidate before others recognize the change in the market.
Slow	• Late stages of the product life cycle. • Extended product life cycle, as others leave, greater share possible. • Product category likely to remain profitable for near future.
Partial	• Specialized market segments provide opportunities to redefine the market. • Extended product life cycle.
Complete	• End or decline stage of the product life cycle. • External change renders product category obsolete.

Exhibit 7.18 External Conditions Appropriate for Market Entry/Exit Strategies

Resources, Competencies, and Capabilities

As illustrated in [Exhibit 7-19](#), each market entry/exit strategy requires somewhat different resources, competencies, and capabilities. Before selecting the appropriate market entry or exit strategy, a review of the internal competitively relevant strengths and weaknesses should be undertaken (see Chapter 4). A market entry/exit strategy might be selected if the required skills and resources, competencies, and capabilities (competitive advantages) are possessed by the organization. On the other hand, if they are not present, another alternative should be selected or a combination strategy of two or more phases should be adopted. The first phase would be directed at correcting the weakness (competitive disadvantage) that is prohibiting selection of the desired strategy, and the second phase would be the initiation of the desired market entry/exit strategy. In some cases a total redesign, or *re-engineering*, of a process may be required before a strategy can be implemented (see Essentials for a Strategic Thinker 7-4, “What Is Re-engineering?”).

Market Entry	Appropriate Resources, Competencies, and Capabilities (Strengths or Weaknesses) Affecting

Strategy	Choice
Acquisition	• Financial resources. • Capability to manage new products and markets. • Capability to merge organizational cultures/structures. • Rightsizing capability for combined organization.
Licensing	• Financial resources (to pay licensing fees). • Support organization to carry out license. • Capability to integrate new product/market into the present organization.
Venture Capital Investment	• Capital to invest in speculative projects. • Capability to evaluate and select opportunities with a high degree of success.
Merger	• Management willing to relinquish or share control. • Rightsizing capacity. • Complementary service/product line. • Capability to merge organizational cultures/structures.
Alliance	• Lack of competitive skills/facilities/expertise. • Desire to create vertically integrated system. • Need to control patient flow. • Capability to coordinate boards. • Willing to relinquish some control.
Joint Venture	• Lack of a distinctive competency. • Additional resources/capabilities are required. • Not enough time to develop internal resources, competencies, or capabilities. • Venture is far removed from core competency. • Lack required skills and expertise.
Internal Development	• Technical expertise. • Marketing competency. • Operational capacity. • Research and development capability.

	• Strong functional organization. • Product/service management expertise. • Financial resources.
Internal Venture	• Financial resources. • Entrepreneurial organization. • Capability to isolate venture from the rest of the organization. • Technical expertise. • Marketing competency. • Operational capacity.
Reconfiguring the Value Chain	• New technology available. • Entrepreneurial organization. • Capability to rearrange value chain. • Capability to adapt business model.
Market Exit Strategy	Appropriate Resources, Competencies, and Capabilities (Strengths or Weaknesses)
Fast	• Significant drain on resources. • Decision to focus on other market segments. • Lack of management expertise in the product category.
Slow	• Product category remains profitable. • Decision to focus on other segments or to trim product line. • Capability to manage decline.
Partial	• Specialized market segments provide opportunities to redefine the market. • Prolong product life cycle. • Managing sales decline by ramping production as competitors leave the market; shutting down operations when too many customers leave the market.
Complete	• No resources to support product category or market. • Lack of marketing expertise in the segment. • Giving up on success (profitability) with the product category.

Exhibit 7.19 Appropriate Internal Resources, Competencies, and Capabilities for the Market Entry/Exit Strategies

Organizational Goals

Along with the internal and external factors, organizational goals play an important role in evaluating the appropriate market entry/exit strategies. As shown in [Exhibit 7-20](#), internal development, internal ventures, and reconfiguring the value chain offer the greatest degree of control over the design, production, operations, marketing, and so on of the product or service. On the other hand, licensing, acquisition, mergers, and venture capital investment offer the quickest market entry but control over design, production, marketing, and so on is low in the short term (in the longer term the organization may take complete control). Alliances and joint ventures offer relatively quick entry with some degree of control. The trade-off between speed of entering the market and organizational control over the product or service must be assessed by management in light of organizational goals.

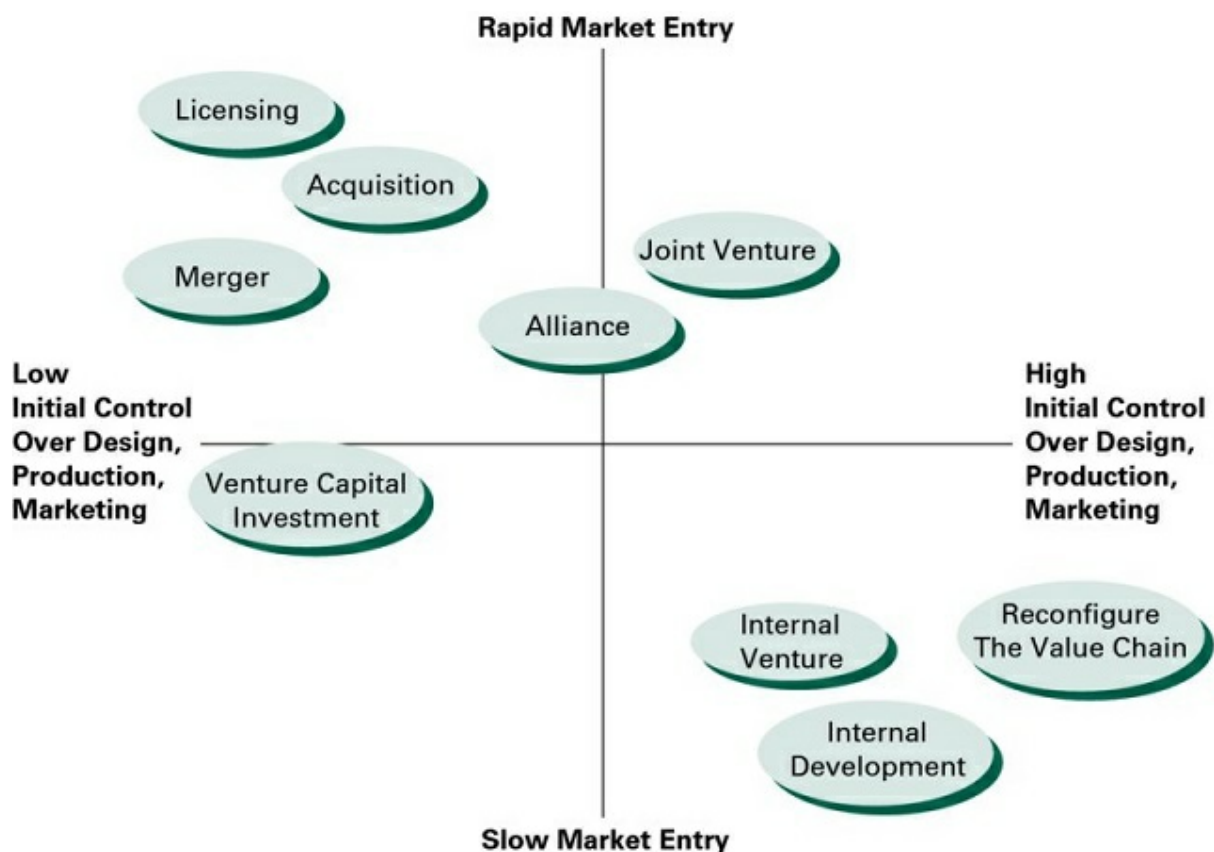


Exhibit 7.20 Market Entry Strategies and Organizational Goals

Similarly, speed of exiting the market can be an important strategic decision. If financial resources are limited, selling all or part of the business or retrenchment may generate cash or substantially reduce costs and be the difference in survival or failure. Harvesting, while a slow exit from the market, allows for the generation of revenue without new investments and may continue for a number of years.

Essentials for a Strategic Thinker 7-4



What Is Re-engineering?

Re-engineering has been used as part of strategic planning to help organizations rethink the way processes are managed in organizations. Many health care organizations are using re-engineering to cut across departmental lines to completely redesign a process. Its founders and leading proponents, Michael Hammer and James Champy, define re-engineering as “the fundamental rethinking and radical redesign of process to achieve dramatic improvements in critical, contemporary measures of performance, such as cost, quality, service, and speed.” Key words in this definition are radical and process.

Re-engineering goes beyond quality improvement programs that seek marginal improvements. It asks a team to “start over” and completely and radically redesign a process. It does not mean tinkering with what already exists or making incremental changes that leave basic structures intact. It ignores what is and concentrates on what should be. The clean sheet of paper, the breaking of assumptions, the throw-it-all-out-and-start-again flavor of re-engineering has captured and excited the imagination of managers across all industries. Radical redesign requires creativity and a willingness to try new things, questions the legitimacy of all tasks and procedures, challenges all assumptions, breaks all the rules possible, and draws upon customer desires and needs.

The process is an end-to-end set of activities that together create value for a customer. Many organizations have become so specialized that few people understand the complete process. In the past, organizations have focused on improving the performance of individual tasks in separate functional units rather than on complete processes that typically cut across many functions. Everyone was watching out for task performance, but no one was watching to see whether all the tasks together produced the intended results of creating value for the customer. Dramatic improvements can be achieved only by improving the performance of the entire process.

To be successful, management must be willing to destroy old ways of doing things and start anew. Many changes take place in an organization or unit when re-engineering is initiated:

- Work units change – from functional departments to process teams.
- Jobs change – from simple tasks to multidimensional work.
- People’s roles change – from controlled to empowered.
- Job preparation changes – from training to education.
- The focus of performance measures and compensation change – from activity to results.

- Advancement criteria change – from performance to ability.
- Attitudes change – from protective to productive.
- Managers change – from supervisors to coaches.
- Organizational structure changes – from hierarchical to flat.
- Executives change – from scorekeepers to leaders.

Michael Hammer identified seven principles for organizational re-engineering:

1. Organize around outcomes, not tasks. By focusing on the desired outcome, people consider new ways to accomplish the work.
2. People who use the output should perform the process.
3. Include information processing in the “real” work that produces useful information.
4. Treat geographically dispersed resources as if they were centralized.
5. Link parallel activities rather than integrate them. By coordinating similar kinds of work while it is in process rather than after completion, better cooperation can be fostered and the process accelerated.
6. Let “doers” be self-managing. By putting decisions where the work is performed and building in controls, organizations can eliminate layers of managers.
7. Capture information once and at its source.

SOURCES

Michael Hammer and James Champy, *Reengineering the Corporation: A Manifesto for Business Revolution* (New York: HarperBusiness, 1994).

Michael Hammer, *Beyond Reengineering: How the Process-Centered Organization Is Changing Our Work and Lives* (New York: HarperBusiness, 1996).

Michael Hammer, “Reengineering Work: Don’t Automate, Obliterate,” *Harvard Business Review* 68, no. 4 (July–August, 1990), pp. 104–112.

Step 4: Evaluate and Select Competitive Strategies

After the market entry/exit strategies have been selected, the strategic posture must be specified and the products/services positioned within the market using the generic strategies of cost leadership, differentiation, or focus. All the adaptive strategies (expansion, reduction, and maintenance of scope) require explicit strategic posture and positioning strategies.

Strategic Posture

Strategic posture concerns the relationship between the organization and the market and describes the pattern of strategic behavior. Strategic postures include defender, prospector, analyzer, and reactor. Any of these may be suitable, subject to: the external situation; the changing nature of the market; competition; the resources, competencies, and capabilities (competitive advantages) of the organization; and its vision and values. It is important to make sure the strategic posture is linked to and fits the adaptive and market entry/exit strategies.

External conditions are very important in the selection of strategic posture. Defender strategies tend to be successful when the external environment is relatively stable (change is slow and reasonably predictable). In such situations competitive rivalry is low and the barriers to entering the market are high. Indeed, the cost-efficiency strategy of the defender tends to push entry barriers even higher. Because defender organizations focus on a narrow product line, the strategy works best when relatively extended PLCs are expected. In addition, long PLCs enable the organization to commit to vertical integration, develop cost efficiency, and create routine processes. Defender strategies are most effective in the mature stage of the PLC. The risks associated with the defender posture are that the PLC will be dramatically shortened by external change (new technology, for instance) or that a competitor can somehow unexpectedly take away market share.

Prospectors operate well in rapidly changing, turbulent environments. In these situations change is coming so rapidly that there are few rewards for efficiency. Rather, the ability to incorporate the latest technology, feature, or design will reap the greatest rewards. In addition, prospectors are successful by utilizing a technology across several markets (prospecting in new high-growth markets). Products are usually in the introductory and early growth stages of the PLC and the cycle tends to be relatively short. As a result, entry barriers may be low and the intensity of rivalry typically is low (there is room for everybody). As products or services mature, prospector organizations move on to new products and services, typically in introductory stages of the PLC. Prospectors divest their maturing products and services to successful defender organizations that are consolidating.

Analyzers operate well in conditions where there is moderate external change with some product categories that are quite stable and some that are changing. Competitive rivalry tends to be relatively high and these organizations cannot afford to ignore new product developments, markets, or product categories. PLCs for their stable products are moderately long but there are periodic innovations and disruptions. Therefore, these organizations must enter new markets and product areas. Analyzers typically do not enter the market in the introductory stage of the PLC. Instead, they carefully watch product and market developments (the prospectors) and enter the most promising ones in the early growth stage of the product life cycle (using one of the market entry strategies). Analyzers attempt to maintain balance with both mature- and growth-stage products or services and markets.

Reactors tend to exit in protected or monopolistic markets or are legislatively restricted from moving into new markets or offering new products. Like

defenders, reactors often focus on efficiency rather than external changes. In addition, for products and markets in the decline stage of the product life cycle, a reactor strategy may be part of a harvesting strategy or a prelude to divestiture or liquidation.

The external conditions appropriate for each of the strategic postures are summarized in [Exhibit 7-21](#).

Posture Strategy	Appropriate External Conditions
Defender	• Stable external environments. • Predictable political/regulatory change. • Slow technological and competitive change. • Products or services in mature stage of PLC. • Relatively extended PLCs. • High barriers to entry.
Prospector	• Turbulent environment. • Rapid technological, political/regulatory, economic change. • Introduction and early growth stages of PLC. • Technology may be employed across markets. • Low intensity of competitive rivalry. • Numerous market and product opportunities. • Fairly low barriers to market entry.
Analyzer	• Moderately changing environment. • Technological, regulatory, economic, social, or competitive changes open new opportunities. • Some competitive rivalry in old and new markets. • Some stable products and markets. • Some new market and product opportunities. • Growth and mature stage of PLC for existing products. • Growth stage of PLC for new products.
Reactor	• Monopolistic or highly regulated market. • Decline stage of PLC. • Legislative restrictions to growth. • New emerging technological change.

- Political/legislative uncertainty.
- “Game changing” moves by competitors.

Exhibit 7.21 External Conditions Appropriate for Strategic Postures

As shown in [Exhibit 7-22](#), there are certain strengths (or weaknesses) associated with each of the strategic postures. For the defender posture the organization must be able to develop a core technology and be very cost efficient. Defender organizations try to drive costs down through vertical integration, specialization of labor, a well-defined organization structure, centralized control and standardization, and cost reduction while maintaining quality. Prospectors, on the other hand, are continuously moving in and out of products and markets looking for high growth. Therefore, they need organization structures, systems, and procedures that are flexible. Prospectors rely on decentralized control. These types of organizations do not concentrate on developing efficiency but, rather, focus on the development and early adoption of new products and services. Analyzers attempt to balance defender strategies in stable markets with some prospecting in selected developing markets. Managing these organizations is often difficult because they must mix high levels of standardization and routinization with flexibility and adaptability. Reactors tend to be reactors because of weaknesses or have adopted a strategy to leave the market.

Posture Strategy	Appropriate Resources, Competencies, and Capabilities (Strengths or Weaknesses)
Defender	• Capability to develop a single core technology. • Capability to be very cost efficient. • Capability to protect market from competitors. • Capacity to engage in vertical integration strategy. • Management emphasis on centralized control/stability. • Structure characterized by division of labor. • Well-defined hierarchical communications channels. • Cost control expertise. • Well-defined procedures and methods. • High degree of formalization, centralization (where a single central group/person, typically top management, makes key decisions for the entire organization).
Prospector	• Capability to adjust organization to a variety of external forces. • Technological and administrative flexibility. • Capability and competency to develop and use new technologies. • Capability to deploy and coordinate resources among numerous

	decentralized units. • Decentralized planning and control (where key organizational decisions are distributed throughout the organization closer to the customer). • Flexible structure. • Marketing plus research and development expertise. • Low degree of formalization (few well-defined procedures and methods).
Analyzer	• Capability to mix high levels of standardization and routinization of core products/markets with flexibility and adaptation for new products/markets. • Capability to utilize structure to accommodate both stable and dynamic areas of operation. • Capability to utilize many different management skills. • Effective lateral and vertical communication channels. • Effective strategy and planning team.
Reactor	• Lack of finances. • Lack of technical expertise. • Lack of management skill. • Lack of new product/service development and marketing skills. • Long-term strategy to leave the market.

Exhibit 7.22 Appropriate Internal Resources, Competencies, and Capabilities for Strategic Postures

Positioning Strategies

As discussed in Chapter 6, products/services may be positioned marketwide or for a particular market segment. Cost leadership and differentiation are used as marketwide strategies or they are used to focus on a specific segment of the market.

Presence in a market requires that the products and services be positioned *vis-à-vis* competing products and services. Similar to the other strategy types, positioning depends upon the strengths and weaknesses (competitive advantages and disadvantages) of the organization and the issues externally in the service area. In other words, how a product or service is positioned depends on the organization's competitive situation. Therefore, the positioning strategies must be selected on the basis of resources, competencies, and capabilities (competitive relevant strengths), as well as external risks. For example, it would be difficult for an urban public community hospital dependent on limited

county funding to be positioned as the high-technology hospital in the region (differentiation strategy). Conversely, a well-funded hospital using the latest technology is unlikely to be positioned as the cost leader.

Each of the generic positioning strategies has its own external risks that must be evaluated by the organization (see [Exhibit 7-23](#)). Perhaps the biggest risk for cost leadership is technological change. Technological change in processes may allow competitors to achieve cost advantages. Technological change in products/services may result in differentiation, making the cost leader's product less desirable.

Generic Strategy	External Risks
Cost Leadership	• Technological change that nullifies past investments or learning. • Low-cost learning by industry newcomers or followers, through imitation or through their ability to invest in state-of-the-art facilities. • Inability to see required product or market changes because of the attention placed on cost. • Inflation in costs that narrow the organization's ability to maintain sufficient price differential to offset competitors' brand images or other approaches to differentiation.
Differentiation	• The cost differential between low-cost competitors and the differentiated firm is too great for differentiation to hold brand loyalty; buyers sacrifice some of the features, services, or image possessed by the differentiated organization for larger cost savings. • Buyers' need for the differentiating factor diminishes, which can occur as buyers become more sophisticated. • Imitation narrows perceived differentiation, a common occurrence as the industry matures.
Focus	• Cost differential between broad-range competitors and the focused organization widens to eliminate the cost advantages of serving a narrow target or to offset the differentiation achieved by focus. • Differences in desired products or services between the strategic target and the market as a whole narrows. • Competitors find submarkets within the strategic target and out focus the focuser. • Focuser grows the market to a sufficient size that it becomes attractive to competitors that previously ignored

it.

Source: Adapted from Michael E. Porter, *Competitive Strategy: Techniques for Analyzing Industries and Competitors* (1980), pp. 40–41. Copyright © 1980, 1998 by the Free Press. All rights reserved. Adapted by permission of Simon & Schuster Adult Publishing Group.

Exhibit 7.23 External Risks Associated with Positioning Strategies

The most significant risks for the organization that chooses a differentiation strategy are that emphasis on differentiation pushes costs too high for the market or that the market fails to see, understand, or appreciate the differentiation. In addition, there are risks for the organization adopting a focus strategy. Often, the focusing organization is dependent on a small segment that may diminish in size, or purchasers may turn to the broader market for products or services. Movement toward marketwide products and services will occur if the differences in cost or differentiation become blurred.

[Exhibit 7-24](#) presents the appropriate internal strengths for each of the positioning strategies. For an organization to use a cost leadership strategy, it must have or develop the ability to achieve a real cost advantage (not price) through state-of-the-art equipment and facilities and low-cost operations. This competitive advantage must be maintained through tight controls and emphasis on economies of scale.

Generic Strategy	Resources and Competencies	Organizational Capabilities
Cost leadership	• Sustained capital investment and access to capital. • Process engineering skills. • Intense supervision of labor. • Products and services that are simple to produce in volume. • Low-cost delivery system.	• Tight cost control. • Frequent, detailed control reports. • Structured organization and responsibilities. • Incentives based on meeting strict quantitative targets.
Differentiation	• Strong marketing abilities. • Product/service engineering. • Creative flair. • Capability and competency in basic research. • Reputation for quality or technological leadership.	• Strong coordination among functions in R&D, product/service development, and marketing. • Subjective measurement and incentives instead of quantitative measures. • Amenities to attract highly skilled labor, scientists, or

	• Long tradition in the industry or unique combination of skills. • Strong cooperation from channels.	creative people.
Focus	• Combination of the preceding competencies and resources directed at a particular strategic target.	• Combination of the preceding organizational requirements directed at a particular strategic target.

Source: Michael E. Porter, *Competitive Strategy: Techniques for Analyzing Industries and Competitors* (1980), pp. 40–41. Copyright © 1980, 1998 by the Free Press. All rights reserved. Adapted by permission of Simon & Schuster Adult Publishing Group.

Exhibit 7.24 Appropriate Internal Resources, Competencies, and Capabilities for the Positioning Strategies

Differentiation requires the ability to distinguish the product or service from other competitors. Typically, this requires technical expertise, strong marketing, a high level of skill, and an emphasis on product development. A focus strategy is directed toward a particular segment of the market; however, either cost leadership or differentiation may be used. Therefore, the appropriate competencies are the same for either market segment or marketwide strategies. It is important that organizations adopting a focus strategy closely monitor their market so that specialized needs may be fully addressed and changes in the segment carefully tracked. Otherwise, changes in the market may negate the differentiation or cost leadership. Often benchmarking (see Essentials for a Strategic Thinker 7–5, “What Is Benchmarking?”) can be used to assess current internal strengths for successfully implementing strategies.

Essentials for a Strategic Thinker 7–5

What Is Benchmarking?



Benchmarking is a management process of comparing an organization against a set of its peers or top performers on critical metrics for success. Benchmarking is generally considered to be part of an organization’s “learning” or continuous improvement efforts. In a sense, benchmarking is similar to “taking a picture” of one’s organization and comparing it with pictures of other organizations. Some organizations simply identify a peer organization and try to emulate it; however, a better approach is to view benchmarking as an ongoing, long-lived process for senior management that is designed to gather and disseminate both process and performance information throughout an organization.

The benchmarking process begins with the identification of a set of peers. The peers should be organizations that are similar, but not necessarily identical, to the organization and should operate on a scale that will not distort the understandings. The peers should not be direct competitors because of the collaborative nature of the process that will ensue. For example, a large health care system might use a telecommunications company as a benchmarking peer or a multifacility nursing home might seek a hotel chain.

Senior management of the peer organizations should be contacted to initiate a dialog. The initiator of the benchmarking process is seeking a group of senior managers with whom every intimate detail concerning the strategies of the organizations may be shared. In other words, the initiator should describe the desire to share strategies, financial data, personnel data, and so on, as though the benchmarking participants were part of the senior management team of each organization. The number of participants in a benchmarking group probably should be limited to seven or fewer to allow all participants equal opportunities to participate and gain from the experience.

Once a set of willing participants has been recruited, an initial meeting should be scheduled for the purpose of establishing protocol – a set of ground rules for the operation of the benchmarking group. Although there is no well-established standard for such a protocol, it should focus on creating an atmosphere in which full disclosure and frank discussion is facilitated. The meeting can be held at the location of one of the participants or it can be at a neutral site. Ground rules should deal with frequency of meetings, confidentiality, format of the meetings, processes for establishing the agenda for subsequent meetings, and the process of choosing the locations for meetings.

It may be useful to hire a professional facilitator for the first meeting and to determine whether such a person would be helpful in further meetings of the group. Each participant should leave the first meeting with the agenda for the second meeting and a set of work assignments to be completed by the next meeting. Work assignments might include detailed descriptions of the handling of customer complaints, how supplies are inventoried, how customer billing is processed, or other activities identified as worthy of discussion by the group. At each meeting, detailed minutes (perhaps a transcript) should be taken, produced, and distributed to the participants in a timely manner. The purpose of the minutes is to formalize the process and to minimize misunderstandings that may arise from failed memories.

The formal agenda for subsequent meetings should include reports from each of the participants. The frequency of meetings should be such that they impact the practices and procedures of the participants. For the most positive impact, meetings should occur at least on a quarterly basis.

The benchmarking process is not completed when the meetings end. The lessons learned and the insight gained must be shared with subordinates. Participants in the benchmarking process should schedule regular meetings

with subordinates for dissemination of information. In other words, the lessons should be shared widely within the organization to gain the greatest impact.

Source: Andrew C. Rucks, PhD, School of Public Health, University of Alabama at Birmingham.

Step 5: Synthesize and Identify Implications of Strategy Choices – Strategy Map

After all the strategy formulation decisions have been made, they should be evaluated in combination to ensure that they are logical and fit together. As suggested at the beginning of this Chapter and illustrated in [Exhibit 7-2](#), the strategies selected must address an external issue, draw on an internal and competitively relevant strength or fix a competitively relevant weakness, maintain the organizational mission, move the organization toward the vision, and make progress toward achieving one or more of the organization's goals. Each strategy should be checked to determine if it meets these criteria.

The strategies of the organization can be mapped and the interdependence of strategies evaluated in concert for consistency and compatibility. Evaluating all the strategic decisions together provides the “big picture” of where the organization is going and helps to determine whether the vision is truly being achieved. In the process of evaluating the strategic map, adjustments may be made and the strategies reconsidered. For example, a vertical integration adaptive strategy and a prospector strategic posture may not work together well. Similarly, a product development or diversification adaptive strategy through an internal development market entry strategy may be inconsistent with an analyzer strategic posture. In addition, the map provides useful shorthand for communicating and discussing the strategy of the organization.

Strategy Map: An Example

A strategy map for a long-term care organization is shown in [Exhibit 7-25](#). This long-term care organization has been a free-standing, independent institution providing assisted living services for some time. However, because of the growth of integrated health systems in the area, the organization's leadership has decided that it needs to be part of a system to provide a steady referral base. Therefore, vertical integration as an adaptive strategy was selected. To accomplish the vertical integration strategy, management decided to develop an alliance with a nearby local hospital. The strategic posture is one of aggressively defending the organization's traditional market (private pay and long-term care insurance), but management is willing to enter new products and markets if the viability seems reasonable (analyzer). In addition, management has selected market development directed toward entering into the Medicare segment of the market and has decided that the organization has the internal resources to accomplish Medicare certification. Furthermore, product development has been

selected and management is planning to add an independent living facility on the organization's campus to complement the current assisted living and nursing facilities. The product development strategy will be accomplished through a joint venture with a regional hotel chain. The organization's leadership believes the market and product development strategies are consistent with their analyzer strategic posture. The organization plans on developing an extensive advertising campaign (penetration strategy) aimed at communicating its highly effective differentiation strategy based on quality, high level of service, and caring. Additionally, the organization has committed to install a sophisticated information system including bedside terminals to further differentiate itself from its competition.

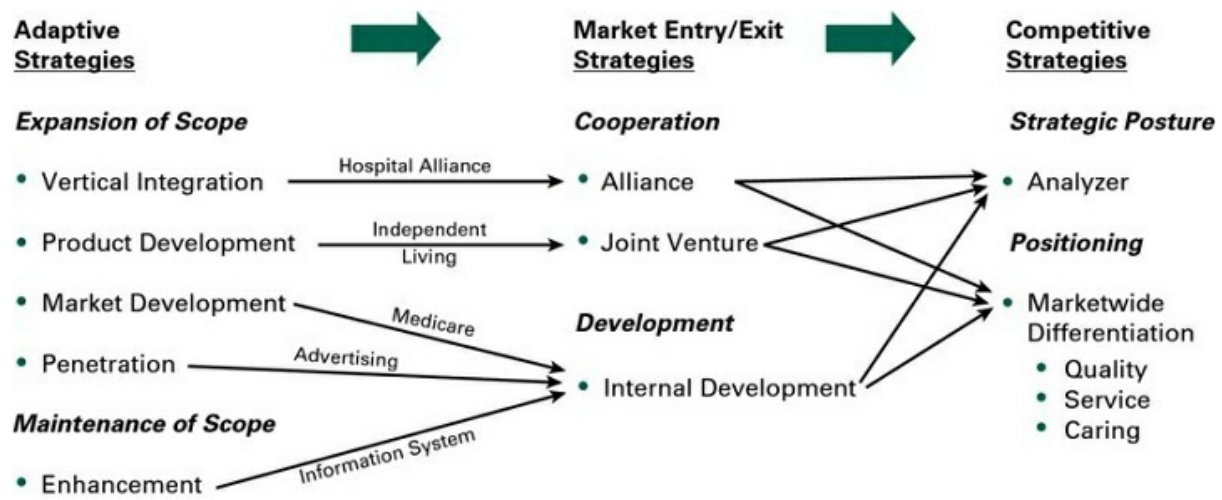


Exhibit 7.25 Map of Selected Strategies for a Long-Term Care Organization

Such a strategy map provides a broad overview of the organization's direction and a basis for the development of effective implementation strategies to carry out the organization's overall strategy. These maps need not be complicated. Indeed, at this level, simple is better. In stable markets, strategic managers can rely on complicated strategies built on detailed predictions of the future; however, in complicated, fast-moving markets where significant growth can occur, unpredictability reigns. When "business" becomes complicated, strategy should be simple.²⁶

Strategic Momentum: Adaptive, Market Entry/Exit, and Competitive Strategies

Managing strategic momentum at this level is not a matter of keeping the organization on track: rather, it entails deciding if a completely new track or approach is warranted. Managers must decide if conditions require a change in the organization's fundamental strategies. Authors of *Strategic Control*, Lorange, Morton, and Ghoshal have called this decision "managing the strategic leap." They suggest:

Here the challenge is to reset the trajectory of the strategy as well as to decide on the relative levels of thrust and momentum for the new strategic direction. The critical underlying assumptions that underpin the strategy are no longer viable, and the rules that govern the strategy must be redefined. This situation involves a mental leap to define the new rules and to cope with any emerging new environmental factors. Such a recalibrating of strategy requires a personal liberation from traditional thinking, an ability to change one's mindset and confront the challenge of creating advantage out of discontinuity. The question now is how to achieve a quantum leap in one's strategy to capitalize on emerging environmental turbulence. One must proceed by redefining the rules rather than by clinging to the unrealistic hope that the old rules are still valid.²⁷

Changes in one organization's adaptive strategy create significant changes for other organizations, especially those in the same strategic group. Such dramatic change is relatively rare in stable environments but somewhat more frequent in dynamic environments. Signals that the basic strategy for the organization needs to be changed must be carefully monitored because the change will have serious long-term consequences. The questions presented in [Exhibit 7-26](#) are helpful in surfacing such signals, and they provide a starting point for discussion of the appropriateness of the organization's adaptive strategy. The assumption underlying [Exhibit 7-26](#) is that the mission, vision, values, and goals are still appropriate but that the organization's adaptive strategy should be questioned.

1. Are all the important assumptions on which the strategy is based realistic (external systems, competitive service areas, internal systems)?
2. Has the strategy been tested with appropriate strategic thinking tools?
3. Have the major stakeholders both inside and outside the organization that will be most influential in ensuring the success of the strategy been identified and evaluated?
4. If the adaptive strategy is to fill a currently unfilled niche in the market, has the organization investigated whether the niche will remain open long enough to return the capital investment?
5. Has the adaptive strategy been tested with appropriate financial analysis, such as return on investment and the organization's ability and willingness

to bear the risks?

6. Is the payback period acceptable in light of potential external change?
7. Does the strategy take the organization too far from its current products and markets?
8. Is the adaptive strategy appropriate for the organization's present and prospective position in the market?

Exhibit 7.26 Managing Strategic Momentum – Adaptive Strategies

Changes in market entry/exit strategies represent a “new way of doing business” for an organization. For example, developing alliances as a means of accomplishing market development is quite different from an internal development strategy and changes the entire orientation of the organization. Evaluation of the effectiveness of the market entry/exit strategies provides insight into how well the adaptive strategies are being carried out in the marketplace (see [Exhibit 7-27](#)). Similarly, a change in an organization's strategic posture or positioning represents a revolutionary change. For example, moving from a differentiation strategy to cost leadership initiates substantial change throughout the organization. The adaptive strategies and market entry/exit strategies may be appropriate, but if the product or service does not have the appropriate strategic posture or is not positioned effectively, the organization may not achieve its goals (see [Exhibit 7-28](#)).

1. Is the market entry/exit strategy the most appropriate way to achieve the mission, vision, and goals of the organization?
2. Is the market entry/exit strategy consonant with the values of the organization?
3. Is the market entry/exit strategy the best way to accomplish the adaptive strategy?
4. Is the market entry/exit strategy compatible with the adaptive strategy?
5. Does management understand the unique requirements of the market entry/exit strategy (purchase, cooperation, development, market exit)?
6. Does management understand the important market forces?
7. Have adequate financial resources been allocated to enter the market?
8. Does the selection of the market entry/exit strategy affect the ability of the organization to effectively position its products/services in the market?
9. Does the market entry/exit strategy place unusual strains on any of the functional areas?
10. Have new stakeholder relationships developed as a result of the market entry/exit strategy (customers, vendors, channel institutions, and so on)?
11. Has the relationship between the desire and need for rapid market entry or exit been properly analyzed?
12. Has the relationship between the desire and need for control over the

products and services been achieved?

3. Have the trade-offs between costs and control been properly analyzed?

Exhibit 7.27 Managing Strategic Momentum – Market Entry/Exit Strategies

Strategic Posture

1. Is the strategic posture sustainable?
2. Have there been external developments (technological, social, regulatory, economic, or competitive) that have shortened product life cycles of important products/services?
3. Are there new market opportunities or challenges that suggest the organization should move more toward a prospector posture? Analyzer posture? Defender posture?
4. Has the organization developed the right mix of centralization and decentralization of decision making for the selected strategic posture?
5. Is the level of standardization and administrative flexibility appropriate for the strategic posture?
6. Is the level and type of communication appropriate for the strategic posture?
7. Is the strategic posture appropriate given the barriers to market entry/exit?
8. Has the level of vertical integration been appropriate for the strategic posture?
9. Has the organization been caught by surprise too often?
10. Does the organization need to evolve its strategic posture?
11. Are the overall strategy, strategic posture, and value-adding strategies compatible?

Positioning

1. Is the product/service positioning credible to the customer?
2. Can the organization use one of the other generic positioning strategies?
3. Is the positioning strategy appropriate considering the external opportunities and threats?
4. Will competitors allow the selected positioning?
5. Is the positioning strategy best suited to capitalize on the organization's strengths and minimize its weaknesses?
6. Is the positioning of the organization's products/services unique in the marketplace?
7. Is the positioning strategy defensible against new players trying to position themselves in a similar fashion?
8. Does the positioning strategy provide the appropriate image for the organization?

9. Is the positioning strategy sustainable?
10. Is the appropriate distribution channel being used?
11. Is the current promotional strategy appropriate?
12. Is the pricing strategy appropriate?

Exhibit 7.28 Managing Strategic Momentum – Competitive Strategies

Chapter Summary

Several strategic alternatives are available to health care organizations. To initiate strategic thinking and planning, it is important that the organization has a process in place for understanding the internal systems, external conditions, and methods for evaluating strategic alternatives. There are several methods for deciding which of the adaptive strategic alternatives is most appropriate for an organization, including SWOT analysis, external/internal strategy matrix, product life cycle (PLC) analysis, portfolio analyses (BCG and extended), strategic position and action evaluation (SPACE) analysis, and program evaluation. Using these methods, managers can classify internal and external factors to gain perspective concerning which adaptive strategic alternative or combination of alternatives is most appropriate.

Once the most appropriate adaptive strategy (or combination of adaptive strategies) has been determined, a market entry/exit strategy must be selected. Expansion and maintenance of scope strategies are initiated through one or more of the market entry strategies. Entry strategies include acquisition, licensing, venture capital investment, merger, alliance, joint venture, internal development, internal venture, and reconfiguration of the value chain. The organization's internal resources, competencies, and capabilities (competitively relevant strengths), the external conditions, and the organization's objectives will determine which of these strategies is most appropriate. If market exit is selected, it must be determined if the exit will occur fast or slowly and if the market exit will be partial or complete. Divestiture, liquidation, and retrenchment can happen very quickly while harvesting usually occurs over a number of years. Divestiture and liquidation are generally decisions to completely leave the market. Harvesting and retrenchment are seen as decisions to partially exit the market.

After the market entry/exit strategy has been selected, competitive strategies, which include strategic posture and positioning strategies, should be evaluated and selected. Strategic postures include defender, prospector, and analyzer strategies. Positioning strategies include marketwide or focus strategies of cost leadership or differentiation. The external conditions and internal resources, capabilities, and competencies influence strategic posture and positioning strategies. Therefore, the most appropriate strategic posture and positioning strategy may be selected through an evaluation of the internal skills and resources of the organization and the external conditions.

Chapters 8 through 10 discuss implementation strategies. Chapter 8 will address strategy implementation through value-adding service delivery strategies.

Practical Lessons for Health Care Strategic Thinkers

1. The strategy analysis methods are tools to help strategic managers generate strategic alternatives and evaluate the appropriateness of strategies given the organization's external conditions and internal strengths and weaknesses.
2. Use several strategic thinking tools (analyses) to surface different perspectives and insights.
3. Remember there are no definitive answers to strategic decisions; only informed judgment.
4. Evaluation of strategic alternatives requires organization and structured thinking.

THE LANGUAGE OF STRATEGIC MANAGEMENT: KEY TERMS AND CONCEPTS

BCG Portfolio Analysis
Benchmarking
Community Need
Extended Portfolio Matrix Analysis
External/Internal Strategy Matrix
Needs/Capacity Assessment
Organizational Capacity
Product Life Cycle (PLC) Analysis
Program Evaluation
Program Priority Setting
Program Q-Sort Evaluation
Q-sort
Re-engineering
SPACE Analysis
SWOT Analysis

Questions for Class Discussion

1. Why is the traditional SWOT Analysis a good place to begin? What are the problems with using SWOT?
2. Explain the rationale underlying the external/internal strategy matrix.
3. Describe the product life cycle. How is it useful for thinking about the adaptive strategy of a health care organization?
4. Why is the length of the product life cycle important for strategy formulation?
5. What adaptive strategic alternatives are indicated for each stage of the product life cycle?
6. Is BCG portfolio analysis useful for developing adaptive strategic alternatives for health care organizations?
7. Explain the rationale for expanding the traditional BCG portfolio matrix.
8. Identify appropriate adaptive strategic alternatives for each quadrant in the expanded portfolio matrix.
9. Explain the strategic position and action evaluation (SPACE) matrix. How many adaptive strategic alternatives can be developed using SPACE?
10. Why should program evaluation be used for public health and not-for-profit institutions in the development of adaptive strategies?
11. What are the critical factors for determining the importance of programs within a not-for-profit organization?
12. Why should public health and not-for-profit organizations set priorities for programs?
13. Describe program Q-sort. Why would an organization use Q-sort?
14. How are market entry/exit strategies evaluated? What role do speed of market entry/exit and control over the product or service play in the market entry/exit decision?
15. How are the strategic postures and the product life cycle related?
16. How many positioning strategic alternatives be evaluated?
17. Do health care organizations change directional and adaptive strategies often?
18. How can “doing the strategy” (managing the strategic momentum) provide information about changing the strategy?
19. As managers learn by doing, what strategies are most likely to change: adaptive, market entry/exit, or competitive?

Notes

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Chapter 8

Value-Adding Service Delivery Strategies

“An organization’s ability to learn, and translate that learning into action rapidly, is the ultimate competitive advantage.”

—JACK WELCH, AMERICAN BUSINESS EXECUTIVE AND AUTHOR

Why Value-Adding Service Delivery Strategies Are Important

As concluded by Jack Welch, an organization's ability to learn and take action quickly is a leadership and management capability that may, in itself, create an advantage for organizations. The primary value for customers is created in service delivery – without an effective product or service strategy that satisfies customers over time, there are no customers. Service delivery is the “face” of the health care organization – the point of intersection between the customer and the organization.

Three things must happen to have effective service delivery. First, service delivery managers must translate the broader organization-wide strategies into sound implementation plans. The service delivery function is largely responsible for achieving the organization's strategy and, in doing so, providing a level of value to customers. A poor alignment of the service delivery strategy to the overall strategy, or poor implementation of the service delivery strategy, will render the organization's overall strategy ineffectual. The value-adding service delivery strategies are the means to accomplish organizational ends.

Second, clear, unambiguous service delivery strategies must be developed and managed, reflecting what the organization is able to do. An over-ambitious service delivery strategy that outstrips the organization's resources, competencies, or capabilities is useless. Service delivery strategies draw on the organization's strengths, although on occasion they may be attempting to negate a weakness.

Third, it is the organization's ability to learn (or re-learn) that may make the biggest difference. Strategies do not always work as planned and most of the time managers learn by doing. Strategic managers must be willing to forego service delivery strategies that are not working and learn from them. A strategy that draws upon the organization's strengths, fixes weaknesses, and encourages learning along the way creates momentum for the organization.

Use the concepts in this chapter to develop effective value-adding service delivery strategies!

Learning Objectives

After completing the chapter you will be able to:

1. Explain how the service delivery portion of the value chain is key in the implementation of strategy.
2. Discuss the service delivery strategies.
3. Describe the decision logic for developing implementation strategies.

4. Link the results of internal analysis and the development of service delivery implementation strategies.
5. Explain how the pre-service, point-of-service, and after-service strategies of an organization are the means to achieve directional, adaptive, market entry/exit, and competitive strategies.
6. Demonstrate how competitive advantage may be created inside the organization through implementation of the service delivery strategies.
7. Explain how the service delivery strategies may be used to strengthen competitive advantages and improve competitive disadvantages.

Strategic Management Competency

After completing this chapter you will be able to create effective service delivery strategies for a health care organization.

Implementation Strategies

Once consensus has been reached regarding the directional, adaptive, market entry/exit, and competitive strategies, planning for implementation strategies commences. Further strategic thinking is required to determine how to achieve the goals previously decided during strategy formulation. A leader can announce a strategy, but that strategy will only be realized if it is in line with the pattern of resource allocation decisions made at every level of the organization.¹ Without a clear process for implementation, considerable overlap and confusion regarding specific guidelines for translating strategies into management practice remain. As introduced in Chapter 1 (refer to Exhibit 1–1), the implementation strategies include two different sets of value-adding strategies: value-adding service delivery strategies and value-adding support strategies. In addition, planning strategy implementation includes setting organizational unit objectives, developing plans, assigning responsibilities, and agreeing on budgets that, in concert, translate the organization's overall strategy into specific action plans.

Strategies Based on the Value Chain

Chapter 4 presented strategic thinking maps for evaluating the strengths and weaknesses of the organization. This approach focused on evaluating those components of the organization that create value and, ultimately, competitive advantage – the value chain (see [Exhibit 8-1](#)). Recall that the upper portion of the value chain focuses explicitly on the primary activities of the organization – the delivery of services. The lower portion of the value chain contains the value-adding support activities that include the organization's culture, structure, and strategic resources. The components depicted in the value chain are the principal means of creating value for the organization and developing competitive advantages.² These activities are major elements of strategy implementation and are shaped by strategic thinking and strategic planning.



Exhibit 8.1 The Value Chain

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

Remember that service delivery strategies and support strategies are not separate but, rather, interact and complement each other. The organization's culture, structure, and strategic resources are an inherent part of the pre-service, point-of-service, and after-service activities. Thus, a change in the culture of the organization – human competencies – is reflected in service delivery. Further, an enhanced information system – a resource – can benefit all aspects of service delivery as well as other strategic resources. Focusing on adding value and results in health has been a theme for a number of years and the Essentials for a Strategic Thinker 8–1, “What Is Value-Based Reimbursement?” examines reimbursement models to encourage moving from volume to value. This chapter examines the service delivery strategies and the process for developing service delivery implementation strategies. Chapter 9 discusses the support strategies and the associated process for developing support implementation strategies.

ESSENTIALS FOR A STRATEGIC THINKER 8–1

What Is Value-Based Reimbursement?



Value-based reimbursement is a health insurance system that pays providers based on the value of care they deliver rather than on the number of visits and tests they order – thus paying for value rather than volume. Value is typically determined by the overall health of a defined population.

This payment system is designed to spur the development of care systems oriented toward outcomes rather than activity.

Under traditional fee for service (FFS) models, providers are reimbursed for activity – treatments, procedures, hospitalizations, visits, encounters, consultations, and so on. Therefore, total reimbursement rises as the number of activities increases. At issue in FFS is whether the economic incentives encourage overtreatment.

Capitation is a well-known alternative reimbursement method, itself controversial. Under a capitated system, providers receive a set, periodic payment for each patient in a population. The sum of the payments received by the providers to care for this population produces a pool of revenue. All activity to render care is a cost. At issue in capitation is whether it encourages undertreatment, since the economic incentives are to perform less activity to avoid expenses and increase income.

Both of these models rely on economic incentives, assuming a direct correspondence between ordering care and the economic benefit of doing so. Thus gaining more or less income influences decision behavior (such as when a surgeon prescribes surgery, or an internist orders a follow-up exam) that enables them to directly and personally gain from that order. Equally true is that much economic activity occurs within health care that is ordered without prospect of personal economic gain. Examples include: an emergency physician admitting a patient to the hospital or ordering a follow-up test; a primary care physician prescribing a drug; an internist referring to a specialist or admitting a patient to the hospital. All the same, each of these actions becomes the basis for payment. They increase the total cost of health care. Payers – insurers, government, and consumers – are paying for the volume of activity.

Some value-based reimbursement resembles capitation because it is population-based rather than activity-based; however, this type of reimbursement differs from capitation chiefly because of incentives to attain specific population health measures. Such measures might include A1C (a marker for diabetes), blood pressure, cholesterol, and body mass index (BMI, a measure of obesity). If the population, as a whole, reaches the performance targets additional payments are earned.

Other value-based models “bundle” an array of related treatments and procedures into a single, flat-rate payment. An example is joint replacement that involves several providers and suppliers; a bundled payment goes to one entity that divides it among those who participated in the care. By organizing the reimbursement in this fashion, the goal is that the model of care will follow in alignment and become more efficient, standardized, evidence-based, and consistent.

Essential for the strategist is to: (1) have a belief about whether and how economic flows shape – or do not shape – behavior of people and organizations; (2) recognize that in the past, the rewards were for doing more under FFS and less under capitation; (3) understand that under value-based systems, the rewards – it is hoped – are for doing those things that

add value, for example, reduce morbidity in the population; (4) acknowledge that value-based systems depart significantly from past systems – they are unprecedented and largely unproven and arguably the largest change to health care reimbursement ever attempted; and (5) strategists must know the markets in which they operate. Right now, all of these systems – fee for service, capitation, and value-based – operate in the market, making it enormously complicated.

Source: Christopher E. Press, MBA, FACHE, Assistant Professor (adjunct), Rollins School of Public Health, Emory University and Partner, Morgan Healthcare Consulting, LLC.

Decision Logic for the Value-Adding Service Delivery Strategies

A planning logic for developing implementation strategies is illustrated in [Exhibit 8-2](#). Market entry/exit and competitive strategies provide the most direct input into the development of the implementation strategies. The *value-adding service delivery strategies* specify the pre-service activities, point-of-service configurations and processes, and after-service activities required by the strategies developed during strategy formulation. These strategies must be coordinated and consistent.

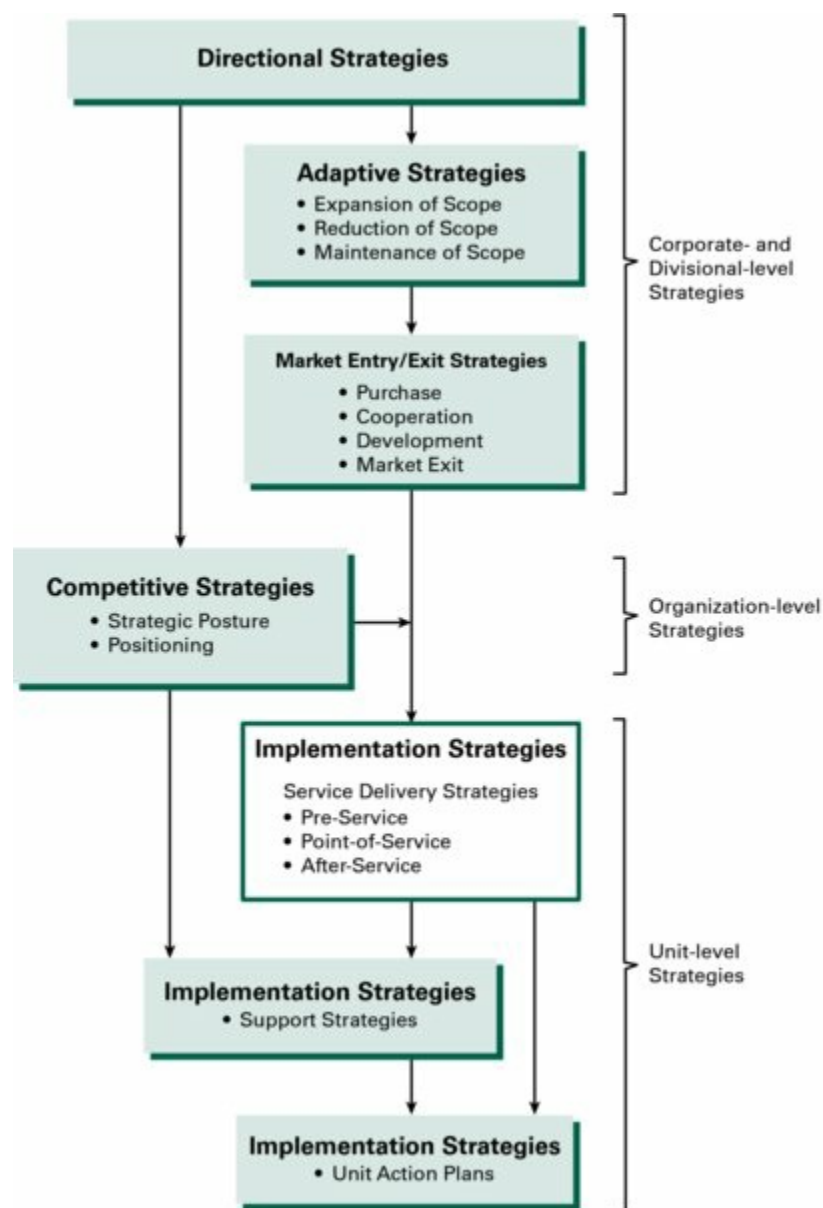


Exhibit 8.2 Decision Logic for Developing Value-Adding Service Delivery Strategies

The *value-adding support strategies* create and shape the working environment and behavioral norms, reporting relationships and structure, as well as information flows, financial needs, and human resource requirements for carrying out the selected strategies. Organizations that do not have the appropriate culture, structure, or strategic resources cannot implement effective plans. Finally, unit action plans link the individual organizational units to the overall strategy. Units are typically functional, such as operations (e.g. surgical units, Alzheimer's units, well-baby care), marketing, finance, human resources, and so on.

The value-adding service delivery strategies must be developed first, followed by the support strategies and unit action plans. The value-adding service delivery strategies are planned first because service delivery is the central activity of the organization and is the principal way of delivering value to the customer. The support strategies and action plans must facilitate the accomplishment of the service delivery strategies.

Process for Developing Service Delivery Strategies

A six-step process for developing service delivery strategies based on the decision logic for the development of value-adding strategies is presented in [Exhibit 8-3](#). For each component of service delivery – pre-service, point-of-service, and after-service – the demands of the selected strategies must be determined and matched to the strengths and weaknesses (competitive advantages and disadvantages) of the organization identified in internal analysis to determine whether the service delivery needs to be changed to accomplish the selected strategies.

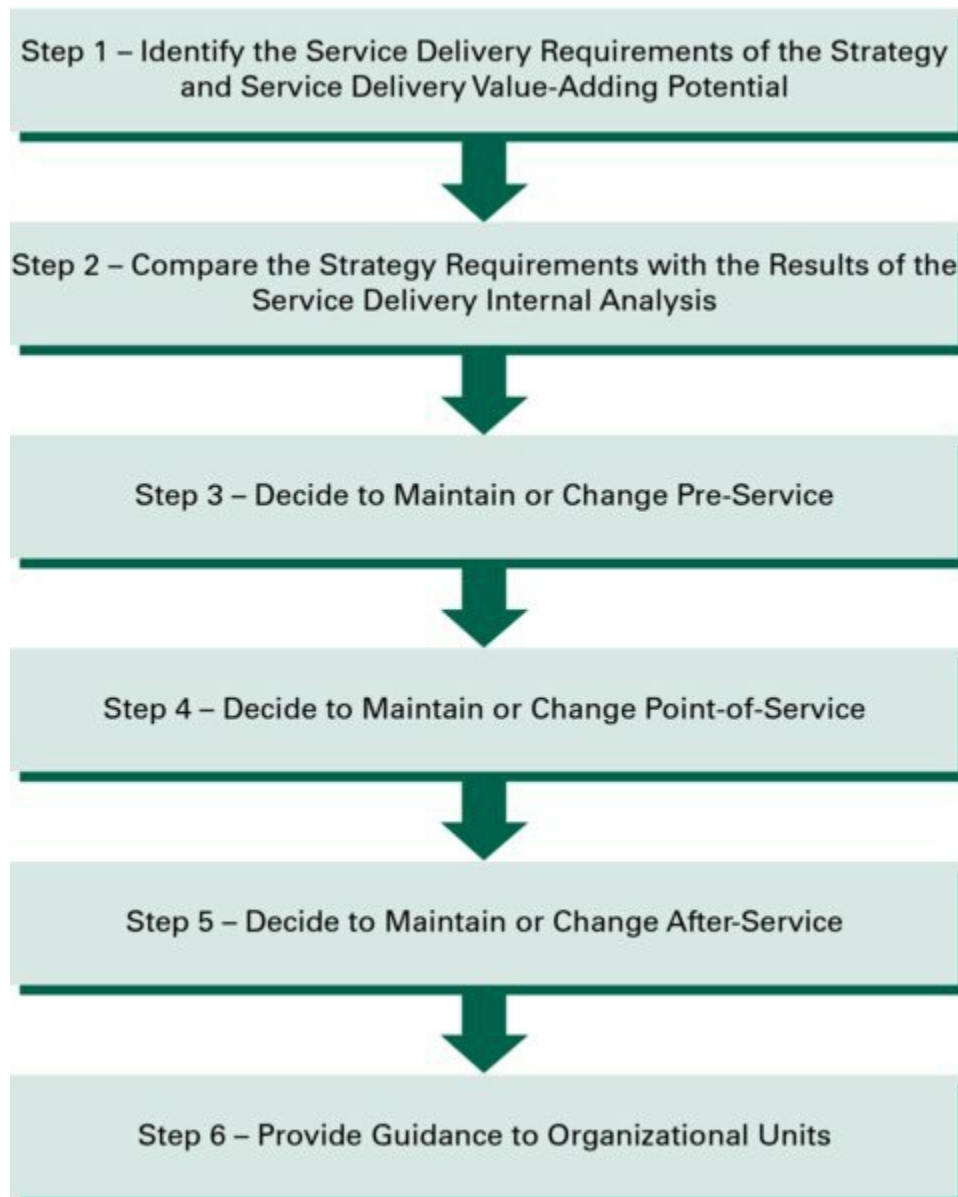


Exhibit 8.3 Process for Developing Service Delivery Strategies

As shown in [Exhibit 8-3](#), the final step in the process for the service delivery strategies is providing guidance to the organizational units. Although steps 1–5

are critically important, time-intensive, and demanding, the success of the strategies hinges on the guidance delivered by leadership. The directions given can bolster and motivate employees, or render them frustrated, confused, and unenthusiastic regarding any proposed changes. For best results, leaders need to carefully consider the content of their guidance, their plan for delivery, and how to work through possible opposition.

Step 1: Identify the Service Delivery Requirements of the Strategy and Service Delivery Value-Adding Potential

Each of the strategic decisions (directional, adaptive, market entry/exit, and competitive) made to this point moves the organization closer to accomplishing its mission and vision and at the same time makes special demands on the organization that require explicit action. The requirements of directional, adaptive, market entry/exit, and competitive strategies have been discussed in Chapters 5 through 7. The general resource, competency, and capability requirements of the market entry/exit strategies are presented in Exhibit 7–19, the requirements for the posture competitive strategies are outlined in Exhibit 7–22, and the requirements for the positioning competitive strategies are shown in Exhibit 7–24; however, each situation will be different and the demands on service delivery will be unique to that situation. For example, strategic managers may assess that a merger will initiate a new model of service delivery. Prospecting for new areas of growth may require additional market research and a differentiation strategy may require an emphasis on building point-of-service quality and reputation.

Strategic thinking – awareness, anticipation, analysis, interpretation, synthesis, and reflection – will be required to customize service delivery to the demands of the strategy. Strategic leaders may be required to reinvent service delivery to align with strategy or incremental changes may be required to maintain competitiveness.

The Value-Adding Service Delivery Strategies Potential

Value-adding service delivery strategies are critical to the success of the organization because they are the principal methods for carrying out the strategy and creating value. Therefore, explicit strategies must be developed for each type. The components must be coordinated and work in concert. It is the role of strategic managers responsible for developing and managing the strategic plan to ensure the compatibility of pre-service, point-of-service, and after-service strategies. A review of the value-adding service delivery strategies demonstrates their potential for contribution to the organization's broader strategies and goals.

Pre-Service Delivery Strategies

Pre-service is a key area in the value chain where value can be created for the customer/patient before the service is actually delivered. Pre-service activities

include marketing, target marketing, branding, pricing, distribution/logistics, and promotion. A pre-service strategy entails the planning and activities that enable the organization to determine its customers and the services that will be offered to them as they enter the system. Marketing is central in developing pre-service strategies. Pre-service marketing involves market and marketing research that enables the organization to determine the appropriate customer (target market), design services that will satisfy that customer, build recognition for the service through branding, price the service at a level that is acceptable to the customer while allowing the organization to survive, and offer the service where the customer wants it or is able to obtain it.

Market and Marketing Research

Market research is data gathering about the marketplace (potential customers) including demographics, geographics, psychographics, and benefits sought, that is combined with segmentation to identify the organization's best customer. Market research aids in identifying the *target market* (the market or market segment believed to be an organization's best customers and around which all marketing activities focus) and must be done in conjunction with identifying the services the organization will deliver. For example, a group of physicians in a medical clinic has internal resources, competencies, and capabilities to provide care. If all the physicians are board certified in plastic surgery, the group could decide to provide comprehensive care including reconstructive and cosmetic surgery, or the physicians could decide to focus only on cosmetic surgery "to the stars" with extreme confidentiality in a remote but very comfortable location. The target market has to want or need the services and the organization must have or develop or purchase the appropriate resources, competencies, and capabilities to provide the services.

Beyond information concerning potential customers, marketing research provides information concerning desired attributes for the product or service, appropriate price, the most convenient place desired by customers to obtain the product or service, and type of promotional activity to best inform potential customers (the four Ps of marketing: product, price, place, and promotion). Therefore, once the internal assessment has highlighted the organization's competitively relevant strengths and weaknesses, the external analysis has identified the issues in the marketplace, and the organization has identified the strategies it wants to pursue, pre-service strategies attempt to identify the specific target market and define the services to be offered. Marketing research may uncover a ready market of potential customers for alternative types of services, for example, telehealth and telemonitoring (see Essentials for a Strategic Thinker 8–2, "What Are Telehealth and Telemonitoring?").

ESSENTIALS FOR A STRATEGIC THINKER 8–2

What Are Telehealth and Telemonitoring?



The Centers for Medicare and Medicaid Services define telehealth as remote health care delivery via monitoring. Telehealth is specifically defined as phone monitoring of the implementation of scheduled and prescribed encounters. Telemonitoring relates to the collection and transmission of vital signs and clinical data through electronic information-processing technologies. Quality improvement organizations have been particularly supportive of home health agencies in implementing telehealth tools to reduce acute care and hospitalization. Using these techniques, a health care provider is able to stay in contact with patients, monitor via telephone the extent to which recommendations are being followed, and track compliance rates. These techniques support the assumption that proactively reaching out to patients with chronic diseases will encourage them to change unhealthy behaviors and adopt more healthy lifestyles.

In many cases patients make poor decisions about their personal health because of a lack of information. The ability to accurately access a patient's condition via telemonitoring makes it possible to intervene when appropriate and provide equally important education regarding healthy living in a manner that is more convenient for both patient and provider.

Research has shown that the primary advantage of telemonitoring is the increased patient compliance. Often, changes in a patient's condition can be detected at or before the onset of a serious event in much the same way as nurses monitor patients in an inpatient setting. Of course, real-time monitoring of data, direct patient feedback, and high levels of provider/patient interaction depend on digital proficiency on the part of both parties as well as effective multimodal communication.

Home patient monitoring assumes two things: (1) the rise of the responsible patient who can self-manage her/his long-term medical condition and (2) availability of mobile devices as effective go-betweens for clinicians and patients. For example, telemonitoring of congestive heart failure patients has been shown to be successful in reducing hospitalizations and trips to the emergency department.

Telemonitoring enables patients to have more choices about how and when to react to changes in medical conditions before a genuine emergency occurs. Regardless of where a patient may be, wireless monitoring supports a more mobile lifestyle. Providers have made effective use of digital monitoring in home health by reducing the frequency of nursing visits, thereby reducing the cost of home health care. Because health care costs are growing so rapidly, the telehealth equipment market is growing as well. Many experts see great promise in the ability of telehealth to decrease the cost of health care delivery and possibly improve quality as compliance rates increase. There is little debate that telemonitoring has improved and will continue to improve the quality of life for a large numbers of patients worldwide.

REFERENCE

“Research and Markets: Tele-Health Monitoring: Market Shares, Strategies, and Forecasts Worldwide, 2011–2017,” *Telemedicine Business Week* (June 29, 2011), pp. 82–83.

Identifying the Health Care Customer – Target Market

Research has shown that as customers participate more actively in the purchasing experience, their positivity increases, and as positivity increases so does the perception of service quality.³ In health care, however, two major issues are noteworthy. First, many patients, as consumers, have been reluctant to participate in the purchasing decision; they want to rely on their doctor to tell them what is wrong and what to do to fix it. Second, and more challenging for health care marketers, is the sheer number of very diverse customers to satisfy – physicians, health care consumers (patients) and their friends and families, other health care organizations, third-party payers, and more. In addition, there are multiple service categories that consumers may utilize over their lifetime – long-term care, emergency medicine, oncology, dermatology, pediatrics, and so on – that determine who potential customers will be. Furthermore, within these specializations are consumers with varying degrees of health and wellness resulting in differing needs, wants, and desires.

Segmentation is the process of identifying groups within a market and determining the distinct characteristics of the various groups to select one or more as the target market – that segment of the population that the organization will focus its efforts to satisfy. Several groups may be targeted, but each one requires different marketing activities to achieve customer satisfaction. In addition, for health care sometimes a choice does not exist, as when a person shows up at an emergency room, the law requires that he or she be treated and the patient may be unconscious and taken to the nearest ER (which might not be the preferred one). [Exhibit 8-4](#) illustrates the many customers for a hospital and the segments a physician (one of the hospital’s customers) may consider. The process of segmentation for a general medical practice service category would be more challenging than for an oncology (cancer) practice, which is more specialized; however, many segments can be identified among cancer patients – those with leukemia, skin cancer, lung cancer, and so on. Specialization of the hospital, nursing home, or physician’s practice could be a first step in the segmentation process, but other demographic, psychographic, and geographic factors must be considered as well.

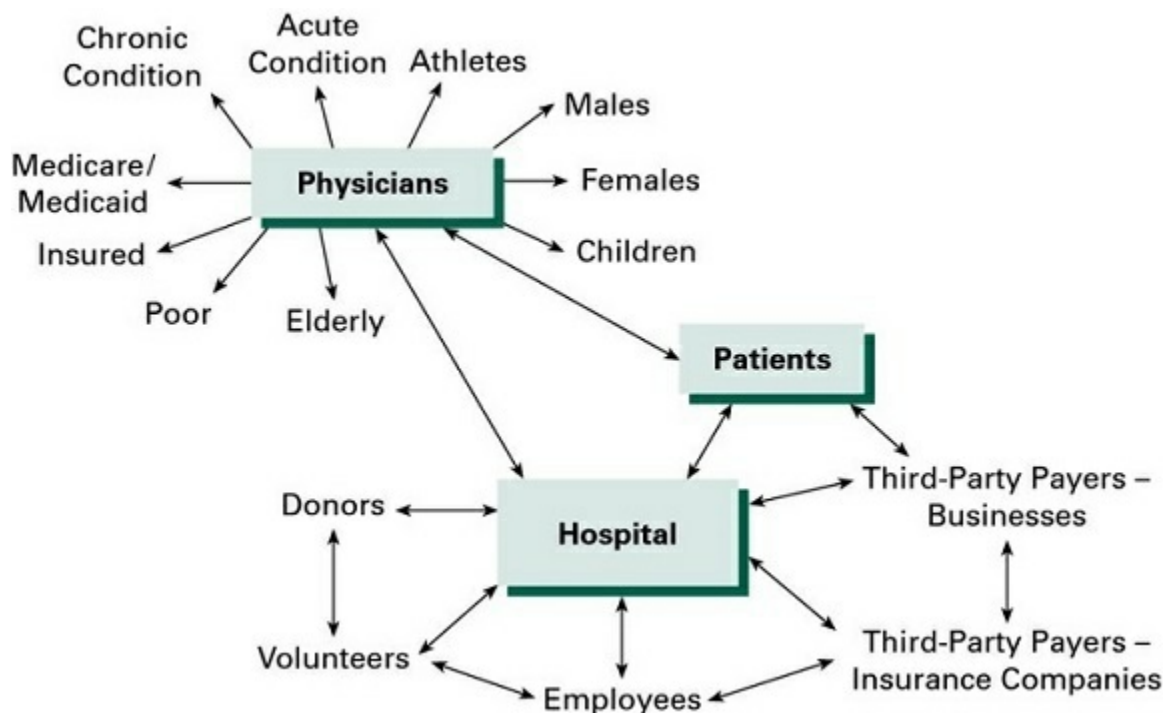


Exhibit 8.4 Determining the Health Care Customer

Physicians are a major target for marketing efforts because they recommend other health care providers for their patients. Estimates are that physicians control 80 percent of health care costs, as they prescribe pharmaceuticals and medical equipment, and determine hospitalization, diagnostic, and surgical procedures. Physicians are an important customer base for hospitals because almost all patients are admitted by physicians who have staff privileges at the hospital. If physicians choose not to admit patients to a given hospital, the hospital will have no patients.

The patients themselves are customers. However, the buyer–seller relationship of traditional exchange processes has to be modified in much of health care because the patient has a professional dependency on the doctor. Many patients and their families have limited knowledge of medical terminology, or the complexity of medical diagnosis or care, nor can they accurately evaluate the medical care provided. An excellent oncologist may provide outstanding care to a lung cancer patient who smoked three packs of cigarettes a day. When the patient dies many family members want to blame the physician or the hospital, not their loved one. The same difficulty arises for obstetricians (physicians who deliver babies). Excellent care may have been provided, but a mother who smoked heavily or engaged in drug use may increase birth defects.

At one time, patients would never have questioned their doctor’s choice of hospital. Today, a patient’s choice is more frequently determined by health insurance. In a study of pregnant women (who have enough time to actually plan for a hospital admission), 98 percent said a very important factor in choosing a hospital was acceptance of her health insurance. A hospital that was “recommended by my doctor” had 64 percent agreement of being very important and a hospital that received high ratings for its “quality of maternity care” received 59 percent agreement.⁴ A 2017 study found that 73.2 percent of

pregnant women chose their obstetrician/midwife first before their choice of hospital, and over half (55% percent) did not believe their choice of hospital would affect their likelihood of having a cesarean section. In addition, most respondents understood that quality of care varied across hospitals; however, only about a third felt that specific quality measures (maternal birth trauma rates, obstetrical infection rate, neonatal trauma rate, episiotomy, and hospital infection rate) were medium/high priority. At issue appears to be that women view the quality of their prenatal care as more important, not quality metrics reported at the hospital level; they do not believe that a hospital's quality scores influence the care they will receive. "Presentations of hospital quality data should more clearly convey how hospital-level characteristics can affect women's experiences including the fact that their chosen obstetrician/midwife may not deliver their baby."⁵

A plethora of quality scores have been generated for hospitals including The Joint Commission that accredits in part on the basis of performance on measures of quality; Centers for Medicare and Medicaid (CMS) that uses 123 different metrics to produce "Hospital Compare" for the public to access; the National Committee for Quality Assurance (NCQA) that offers HEDIS (Healthcare Effectiveness Data and Information Set) scores; the National Quality Forum (NQF); the Agency for Healthcare Research and Quality (AHRQ) that serves as a clearinghouse for quality measures; Utilization Review Accreditation Commission (URAC); plus several not-for-profit and for-profit organizations including The Leapfrog Group (set up by business organizations and consultants with the goal to save lives by reducing medical errors, injuries, accidents, and infections ranking hospitals on the basis of safety); Truven Health Analytics' Top 100 Hospitals (part of IBM Watson Health) to rank health systems based on inpatient outcomes, process of care, extended outcomes, efficiency, and patient experience; Healthgrades' Top 100 hospitals claiming these hospitals have a 27 percent lower risk of patients dying than patients in other hospitals not making the list (23 states did not place a single hospital on its Top 100 Hospitals list in 2017); and *US News & World Report's* listing of top hospitals by 16 specialties, such as cardiology, cancer, gynecology, geriatrics, etc. while its Honor Roll recognizes the top 20 hospitals with the most rankings in the various specialties (the Mayo Clinic was at the top, nationally ranked in 15 of 16 adult specialties and eight of ten pediatric specialties).

The University of Michigan's Center for Healthcare Research & Transformation developed a research brief that concluded: "hospital rankings, ostensibly designed to enlighten health care consumers, have morphed into a confusing array of metrics and methodologies that are now largely ignored outside of hospitals' executive suites and doctors' lounges." Nine prominent rankings were studied and in 2012, 37 percent of hospitals were ranked on one of the nine hospital ranking systems. In 2015, 53 percent of Michigan hospitals received a high rank on one of nine hospital ranking systems, but only 22.5 percent received a high rank on at least two ranking systems.⁶

Third-party payers (insurance companies and employers) are also customers. These companies must be satisfied that the health care provider is efficiently treating patients or they will use their substantial financial influence to dictate

that patients go elsewhere. Considerable insight concerning third-party payers can be gained through quality monitoring organizations.

The National Committee for Quality Assurance (NCQA) is an independent, not-for-profit organization started by a number of large employers in 1991 with a mission to “improve health care quality everywhere.” NCQA defines quality health care as “the extent to which patients get the care they need in a manner that most effectively protects their health.” Three different methods are used to assess quality: (1) Voluntary accreditation (currently about 43 percent of the U.S. population is covered by accredited health plans); (2) Healthcare Effectiveness Data and Information Set (HEDIS), a tool used to measure performance in key areas such as immunizations and mammograms; and (3) A comprehensive member satisfaction survey. NCQA maintains an up-to-date website available to consumers and employers to determine whether they want to use a specific plan. Because of NCQA’s success in the private sector it has expanded to the public sector as well – Medicaid and Medicare HEDIS are being used in various states, as well as “dual eligible” consumers (those covered under both Medicare and Medicaid) in 2017.⁷ The rate of change in health care is rapid and, therefore, health care employees must be ready to adopt new ways of doing things even if they feel threatened by the change. Often changing conditions require that value and quality have to be viewed in entirely new ways.

To Brand or Not to Brand Services

A *brand* is a name created for a product, service, or idea. It provides identification and a guarantee of a certain consistent quality. A brand is intangible – it is simply a set of promises. It implies trust, consistency, and a defined set of expectations.⁸ A brand is a means to set customers’ expectations (assurances of quality) and reduce their risks. A brand name can be protected through legal registration; then no other organization in the same industry can use it or something close to it (although how close is often challenged in court). A brand has other dimensions that differentiate it in some way from other products designed to satisfy the same need.⁹ Those dimensions may include packaging, service, advertising, customer advice, financing, delivery arrangements, warehousing, the customer’s feelings and perceptions about the product attributes and how it performs, and the brand name (how it makes them feel, what it stands for, and how they feel about the company that produces/sells the brand).

The strongest brands have a unique position in the mind of buyers. Mayo Clinic, MD Anderson, and Johns Hopkins are examples of brands that have value for customers. Every person who has contact with a patient at these clinics represents the brand. If housekeeping is poorly performed, it hurts the brand; if admitting is repetitious and slow, it hurts the brand; if clinical care is done less thoroughly than customers expect, it hurts the brand. Thus, it is critical that every member of the organization realizes that the brand is owned and should be managed by every single employee.

To develop a good branding strategy, answers to three questions have to be understood:

1. Why do consumers choose one brand over another?
2. How does our brand stack up against competition?
3. What possibilities exist for potential brand growth and expansion?

Customers evaluate every service experience by dividing perceived quality by price to arrive at a sense of value. It may not be a perfect method, or very accurate, but it is real as far as that consumer is concerned. For services, the brand is more important than for tangible products; especially because if performance falls short, the service brand's image and positioning deteriorate rapidly.¹⁰

Much branding activity in health care has centered on promoting and creating identities for health care systems. However, customers are not interested in abstract systems, but rather the physicians and nurses who care for them in a hospital that they are familiar with and perhaps have preferred for decades. Although preference for a new brand can be built over time, in most cases it is less expensive and more effective to leverage and extend the existing brand name.

A brand may be used to develop *brand equity*, a different construct than brand familiarity (I know the brand), or brand loyalty (I buy only this brand), or commitment (I support this brand). Brand equity is a perceptual predisposition to support a brand based on stored knowledge; it represents the biased behavior a consumer has for a branded product versus an unbranded equivalent. A consumer may think highly of the Mayo Clinic, may speak about its quality, but may never visit it; however, having heard and read about its philosophy, its great work over its long history, and admiring it as an organization, that consumer has an image in mind that leads to high brand equity.¹¹

Marketers cannot simply create brand equity; it is earned through the marketing mix variables. Product, price, place, and promotion are the basic building blocks of brand equity and are under a company's control, enabling marketers to grow brand equity through marketing activities.

Brand image includes perceptions related to the object and brand attitude is an evaluation of the object.¹² Creating/managing positive brand attitude is one of the brand associations that synergistically creates brand image. "Brand associations should be conveyed consistently across all marketing and communication efforts if the desired image is to be realized."¹³ Research has shown that different brand images significantly affect the brand equity measures of purchase intentions and willingness to pay premium prices.¹⁴ In one study, perceived quality was the major contributor to brand equity; however, brand quality alone will not contribute substantially to brand equity without an appealing brand image.¹⁵

Using original, creative, and different advertising strategies, health care organizations can develop greater brand awareness and positive perceptions of their brands – or can damage the brand. The CEO who approved his hospital's advertising agency recommended tagline of "We Cheat Death!" lost his job. Individuals' attitudes toward the advertisements play a key role in brand

awareness, influencing perceived quality, and brand associations.¹⁶

Monetary promotions (reduced prices, price discounts, coupons) have a negative influence on perceived quality as they appear to draw focus to internal reference prices and create a negative influence on perceived quality of the brand. On the other hand, non-monetary promotions (gifts, premiums) help develop brand equity.¹⁷

To increase brand equity, the organization should build brand awareness as a means to anchor various associations the consumer has about a brand. Brand associations, acquired through the firm's marketing mix activities or product use, contribute to and ultimately define the brand's image to the customer. Then, to increase loyalty, managers should focus on associations. Associations that are unique, strong, and favorable should create a positive brand image which when processed by consumers will bias consumer brand behavior toward brand equity.¹⁸

Brand equity entails favorable predispositions that may or may not necessarily result in repeat buying behavior (or any buying behavior).¹⁹ A perfectly healthy recreational athlete may not visit renowned orthopedic surgeon Dr. James Andrews but be well aware of his reputation for repairing injuries for professional athletes. Dr. Andrews has brand equity developed through the recreational athlete and many others who would want Dr. Andrews to do their surgery if they needed it. The athlete may review advertisements and absorb the content of articles written about the successful surgeries performed by Dr. Andrews on high-profile college and professional athletes. Brand equity is being built.

Another benefit of brand equity occurs when a health care organization has service failure. The brand equity effect is identified as a prevailing advantage that spans the entire failure and recovery sequence. Customers exposed to a failure incident appear to be more satisfied and more willing to repurchase high-equity brands than low-equity brands.²⁰ This is an important finding because it indicates that the advantages of high brand equity theoretically can apply to all failures, not just those for which recovery is attempted. In health care, patients do not always complain when they perceive a service failure and the organization does not realize that it should be engaging in service failure recovery actions. Patients who have high brand equity for the physician, nurse, clinic, or hospital may "counter-argue" negative information about a favored brand believing that the failure is a departure from the norm and unlikely to recur.

Although high-equity brands have an overall advantage throughout the failure situation, customers view high-equity brand failures as particularly disappointing; thus satisfaction and behavioral intentions for high-equity brands decline at a faster rate (immediately after the time of failure), but the disappointment can be reversed with carefully planned recovery strategies. In health care that includes: quick acknowledgment of the failure, a sincere apology, and restitution of some sort. Although death is often viewed by the family as a service failure, better education from a caring physician about a

disease or condition and involvement of the family in the care decisions may aid in understanding that all living things die at some point.

Pre-Service Pricing Decisions

Some say that health care in the United States is delivered behind “secure walls of a fortress where information on pricing is kept out of public view.”²¹ Pricing health care is extremely difficult because it is a service that consumers would rather not have to purchase. Consumer perceptions of “high price equals high quality and low price means low quality” and “you get what you pay for” operate in health care, yet most consumers do not have the ability to judge quality. In addition, consumers rarely know upfront pricing and payment must be made regardless of outcomes; together, these factors make price and quality comparisons difficult. Further, in many instances third-party payers separate consumers from the actual costs of care. Finally, health care providers have a great deal of difficulty determining their costs and then deciding on a price given the variability of the human condition. Does each appendectomy cost the same for the hospital or the surgeon? Given the numerous complications that may occur, the answer is generally “No, costs are not the same,” yet how many patients actually have complications?

The prospective payment system (PPS or fee-for-service) was easy for providers to implement; however it ballooned U.S. health care spending. The cost-plus-based system has proven to be no better. The value-based system is unknown. Competitive negotiations with third-party payers looking for lower prices have led some health care providers to prices that are too low, thereby threatening the provider’s long-term viability; many hospitals have closed. Government reductions in payments for Medicare and Medicaid patients have resulted in reimbursements that are frequently below the cost of providing care. Thus, some providers have opted not to serve Medicare or Medicaid patients.

In health care, low-price strategies must be selected carefully because few people want to think that they are receiving “cheap” care (because of the association between “cheap” and “poor quality”). Although cost leadership strategies are generally associated with having low costs that can be translated into low prices, a high-price strategy can effectively position an organization as a high-quality health care provider; however, the consumer must perceive that the benefits (esthetically pleasing surroundings, attentive care, latest technology, and so on) are worth the high price.

Based on the services offered, the ability of the consumer to pay, and the cost to deliver the service, the health care organization determines a price. No magic formulas exist to determine prices and some government mandates (about serving every patient that shows up at the emergency room door regardless of the ability to pay, for example) make pricing an even more challenging task.

One way that prices have been lowered for patients, employers, and insurers, is the site of care. Rather than high-acuity institutional settings, patients are moving from inpatient hospital departments to outpatient hospital departments, from hospital-based to free-standing surgery centers, from free-standing centers to physicians’ offices, and from the physician’s office to the

patient's home.

A new component of health insurance design being used in California is reference pricing that motivates the patient to select low-price and low-acuity care settings.²² Reference pricing is an attempt to change the system by restructuring the incentives (referred to as “choice architecture”). The combination of low consumer price-sensitivity (resulting from generous insurance coverage) and high provider power (resulting from market consolidation) has weakened the pricing clout of managed care plans.²³ As patients are being required to pay a greater portion of their health care costs, reference pricing attempts to return some of the choice to patients. Employers or insurers establish a maximum contribution toward payment for a service, product, or episode of care, selecting some midpoint in the distribution of prices in each local market.²⁴ Then employees have a choice. If they choose a physician or health care institution that charges less than the reference price, they receive full coverage (after meeting their co-pay requirements). If they choose a provider that is higher than the reference price they have to pay the difference. Patients who need to use a high-priced provider because of specific medical conditions or live in remote geographical areas are typically exempted.²⁵

Reference pricing has been applied to joint replacement, colonoscopy, cataract surgery, and testing (laboratory and imaging). It works for services where quality is relatively standardized (such as diagnostic imaging) or can be relatively easily compared (as in joint replacement). Employers and insurers understand that it is unreasonable to expect patients to select providers based on price when quality is variable and unmeasured, or when the patient does not have the knowledge to evaluate complex treatments because of disease severity. The approach requires that information be available to consumers. The California Public Employees' Retirement System (CalPERS) provides a list of low-price, high-quality hospitals for enrollees.²⁶

Reference pricing is possible for a wide variety of health care needs, but not all of them. One study identified those health care procedures that are most suitable for reference pricing as: non-emergency procedures that are scheduled in advance, that take place in markets with multiple providers, and for which some quality metrics are available to patients.²⁷ Included in their definition were 73 high-volume inpatient services (based on Medicare diagnosis-related groups) and 90 percent of the most common services. They estimated that these shoppable services and procedures accounted for one-third of total spending for the non-elderly commercially insured population and could reduce spending for this population by approximately 8 percent.

Another approach to more manageable prices for patients is direct primary care – a service where customers have access to a variety of unlimited services for a “modest” flat fee rather than being billed *à la carte* for every office visit and test. Direct primary care offices generally do not accept insurance and patients can consult with their doctor or nurse practitioner as often as they want; the average fee is \$77.38 per month.²⁸ That can be contrasted with “concierge” medical practices at an average of \$182.76 per month (but the concierge practices generally do bill insurance for their services). The concierge model is more to

ensure access as the practice limits patient loads to ensure adequate time and availability for each patient.

Seattle-based Qliance, a pioneer in the direct primary care model (founded in 2007), charged \$100 per month and claimed Qliance patients had medical claims that were 20 percent lower than other patients because they went to the emergency room less often, were hospitalized less frequently, and saw fewer specialists.²⁹ Some health care experts were concerned that the business model encouraged the “worried well” to visit more often than needed. Those experts might have been right; as of June 15, 2017, Qliance announced it was closing five locations in the Seattle area. According to the CEO, “the general market is reluctant to pay what it takes for primary care to flourish.” One location remains open to provide occupational health for Seattle fire-fighters.

Pre-Service Distribution/Logistics

The location of the health care provider will impact the number of people who seek its services. A location that is attractive because of its proximity to patients’ homes and work is a valuable asset, especially if other health care providers cannot duplicate the location. Because people do not want to travel great distances for most health care, demographic studies of population are an important part of choosing a location for a facility. Satellite offices and hospital branches have become increasingly important as busy patients value convenience. Although satellite offices/hospitals do not typically cut costs for the organization, they do cut costs for the patient, which can lead to an increased market share and improved efficiency for the health care provider.

Some hospitals are finding it worthwhile to establish education centers in shopping malls. Other health care organizations have established limited primary care facilities in grocery stores. Furthermore, many hospitals have established urgent care centers in multiple locations throughout a city; extended hours and a known “brand” name from the local hospital are appealing to consumers. Urgent care facilities have been used to draw people away from using the hospital emergency room, a costly place to deliver primary care. According to the American Academy of Urgent Care Medicine, although the number of hospitals and emergency rooms have been decreasing over the past decade, the number of emergency room visits has increased significantly. It was estimated that between 14 to 27 percent of ER visits could be handled in urgent care centers or retail clinics at a cost savings of about \$4.4 billion. In response, by 2016 over 9,000 walk-in, stand-alone urgent care centers operated in the United States with 50 to 100 new clinics opening every year.³⁰

Mobile units are another method of achieving the optimum in health care delivery. Long practiced by the Red Cross to gain more blood donations, other institutions have increased movable equipment to be closer to patients (such as mobile mammography units to increase women’s use of this excellent but expensive tool).³¹

Pre-Service Promotion

Promotion includes: advertising; public relations events (baby birthday parties, health fairs, cancer survivor celebrations, and so on); personal selling; sales promotion (contests, participation in trade shows, and others); and direct marketing (websites, direct mail, social media marketing, and so on). The promotional elements work in combination to be able to communicate a message to various consumers and stakeholders of health care organizations. For example, hospitals have learned that increased amounts of advertising alone will not fill more beds, and that great advertising might set customer expectations higher than the organization can deliver. Advertising works best when there is an identified product or service that meets consumers' needs. Branding helps consumers to know the service to seek and reminds them where they can obtain health care when they have a need for it.

Personal selling has been used more extensively in health care as various organizations compete to be the provider of choice in managed care plans and physicians are recruited to hospital systems. Direct marketing through social media provides another touch point for consumers to interact with a health care provider and each other to share experiences – good and bad. Many potential consumers will check for “reviews” and find them a credible tool for information, especially millennials who have in 2017 surpassed baby-boomers in numbers and some of whom are beginning to have children. Having a baby is often the first time a woman has chosen her own physician and hospital; experiences are shared with family and friends, often on social media.

WebMD is the most popular website for consumers to gather health care information (80 million unique monthly visitors), followed by the National Institutes of Health (55 million unique monthly visitors). Yahoo Health ranks third (50.5 million unique visitors), the Mayo Clinic ranks fourth (30 million unique visitors), and MedicineNet ranks fifth (25.5 million unique visitors).³²

Physicians are using websites as well. Most MDs do not use a search engine (i.e. Google), but prefer targeted sites. Uptodate (www.uptodate.com) is used by 10.8 percent of MD study participants, Medscape (www.medscape.com) used by 8.4 percent, WebMD (www.webmd.com) used by 5.5 percent, MDconsult (www.mdconsult.com) used by 4.7 percent, and Emedicine (www.emedicine.com) used by 2.9 percent. More than one quarter (27.3%) of the physicians surveyed indicated their on-site preferred source of medical information was research databases that provided access to medical journal publications. Specifically, 19.7 percent use Pubmed (www.pubmed.org), 3.9 percent use Ovid, and 3.7 percent use Medline as their primary web source for online medical information gathering. A minority of physicians identified various sites dedicated to their specialized area, with no site representing more than 2.9 percent of the sample. Finally, a small percentage (3.1%) used medical website portals such as Mercmedicus (www.mercmedicus.com) as their preferred means to gather medical information.³³

Point-of-Service Delivery Strategies

Point-of-service is a key area in the value chain where the service is actually delivered and value can be created for the customer/patient through clinical

operations and marketing. *Point-of-service strategy* is a transformational process that incorporates an organization's resources, competencies, and capabilities – its assets – into value-adding service delivery.

Health care was a cottage industry for centuries. Specialization and cost pressures have taken health care from being totally customized for the individual patient in his or her home to an attempt to treat patients more similarly so as to develop economies of scale. Placing people in hospitals, outcomes measures, formularies, and so on, focus on treating patients more alike – the industrialization of health care. Most Americans and their physicians do not like it. Moreover, the system has become so complex and technical that it is difficult for providers to communicate effectively with patients. The best service delivery differs for each organization depending on its broader strategies.

Clinical Operations

The appropriate model of health care delivery is based to a great degree on the care required. If health care were divided into three sectors – acute illnesses with quick recovery, significant illnesses (chronic but manageable), and catastrophic illnesses – each accounts for approximately one-third of the health care dollar in America. However, the latter two represent 10 percent of the population. In other words, 90 percent of the population represents short-term treatable illnesses where the volume is high, but costs are low per episode and copayments and deductibles have a measurable impact. Technology can improve efficiencies in this sector. For significant and catastrophic illnesses, health care providers can increase efficiencies through understanding the choice of processes and selecting the one most suitable for patients' care (mass customization).³⁴ Clinical pathways have been used to create operational efficiencies as well as to increase the quality of care (see Essentials for a Strategic Thinker 8–3, “What Are Clinical Pathways?”).

ESSENTIALS FOR A STRATEGIC THINKER 8–3

What Are Clinical Pathways?



Health care organizations are increasingly being asked (sometimes required) to reduce costs and simultaneously increase quality. For almost two decades, clinical pathways have been used as a tool for optimizing health care resources and enhancing quality of care. Clinical pathway analysis applies critical-path methods used in industrial process control to clinical processes. These methods can lead to optimal interdisciplinary patient care. Clinical pathways involve all health care professionals – physicians, nurses, social workers, pharmacists, and so on. A clinical pathway can be thought of as a visualization of the patient's health care

process and a multifaceted, resource-intensive process, involving all concerned parties. Because health care is a knowledge-intensive industry, any attempt to reduce costs and increase quality will require effective knowledge management across a diversity of disciplines, interdisciplinary teamwork, and management of the culture.

The sharing and integrating of the knowledge and skills of diverse professionals are important to the implementation of successful health care processes using clinical pathways. Knowledge management is a business concept that can facilitate the application of clinical pathways because it relates to an organization's ability to acquire and disseminate new and existing knowledge. One theory of knowledge management that relates well to health care is the "community of practice." Communities of practice galvanize knowledge sharing and adaptation to change and are defined as groups of people bound together by shared experience and a passion for joint enterprise. It is a cross-functional group brought together to capture and spread ideas and know-how. The disadvantage of communities of practice is that the knowledge shared is often informal in nature. Clinical pathways are developed informally through the cooperative efforts of physicians, nurses, and other professionals to improve the quality of services delivered and value of the patient, yet formally captured pathways are designed using clinical guidelines based on evidence-based management and visualized knowledge.

Additionally, pathways benefit from effective interdisciplinary teamwork that brings different professional points of view to bear on a patient's problem(s); however, simply combining points of view may not be sufficient to ensure integrative knowledge. Integrative knowledge sharing among knowledge workers is a capability critical for the application of new knowledge to health care phenomena and may be the basis for competitive advantage.

One of the major barriers to effective teamwork in health care is poor communication among diverse health care professionals. Physicians and nurses have major differences in cultures and experiences. Physicians stop in periodically to see patients in the hospital, whereas nurses maintain quantitative and qualitative data about the patient on a consistent basis. Physicians are trained to take control and issue orders; nurses to carry out orders; however, nurses can point out those qualitative factors observed (patient is depressed) that may interfere with recovery. Miscommunication is especially likely to arise in emergency situations where events are unpredictable and a high level of cooperation among professionals is mandatory.

For effective clinical pathways, health care professionals have to understand and appreciate differences in cultures and the results these differences have on the attitudes of colleagues. Most culture is based on context-specific knowledge unique to each profession. Sharing of different knowledge is important for the continuous implementation of knowledge management in health care organizations. Clinical pathways promote communication among health care professionals because they express clearly that tacit

knowledge is a part of all health care processes.

REFERENCE

Tomoyoshi Yamazaki, Mitsuru Ikeda, and Katsuhiro Umemoto, “Enhancement of Healthcare Quality Using Clinical-Pathways Activities,” *VINE* 41, no. 1 (2011), pp. 63–71.

Other value-adding clinical operations activities often concern mass customization, quality of operations, and process innovation. *Mass customization* is the modification of the attributes or characteristics of a widely available product or service to better meet the particular needs of individual customers. Mass customization may be the way to capture the customer-friendly benefits of long-term physician–patient relationships, plus the cost-careful benefits of capitation, to increase the chances of organizational survival in today’s health care market. It can be accomplished by a “series of modular approaches to prevention and care, highly articulated, and well supported by information technology”³⁵ (see [Exhibit 8-5](#)).

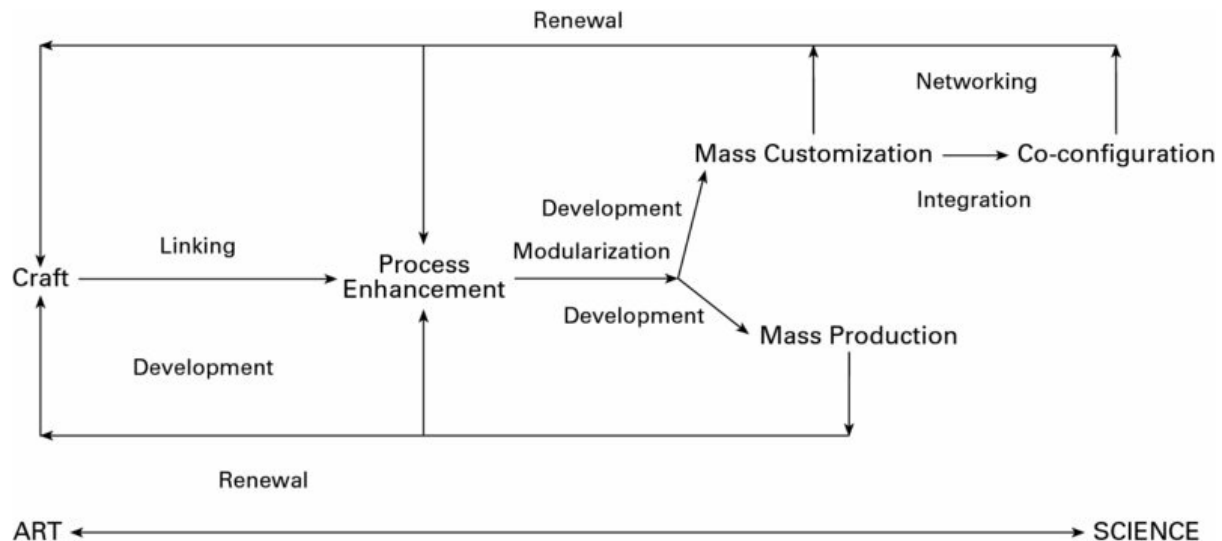


Exhibit 8.5 Increasing Quality through Mass Customization

Source: Reprinted from C. P. McLaughlin and A. D. Kaluzny, *Defining Quality Improvement, Continuous Quality Improvement in Health Care*, 3rd edn (Sudbury, MA: Jones and Bartlett Publishers, 2006), p. 17. Reprinted with permission www.jbpub.com.

Mass customization is a pathway that is best suited to the production of satisfied health care customers at low or reasonable relative costs. Best practices are more widely shared today and many are known to the health care organization from the collection of data within its own operations. The best practices are applied by a configurator (the health care professional) to meet the needs of the individual patient. Mass customization represents a process that simulates craft (the art of medicine), but is also science-based. Once scientific information about a health care process accumulates, it moves from the craft stage to “enhancement” where the process is studied and refined further to shift to mass customization. Once the approach is codified and volume is high (and patients will accept the level of impersonal delivery), then the organization can develop a

series of modular approaches that breaks up the work into units that are interchangeable on demand. However, at a practical level, “it takes hard science to legitimize the conformance of providers to make such a system work.”³⁶ Co-configuration is optimal because the patient is linked into the network and customer intelligence is accessed as readily as the physician’s (configurator’s).

Pathways represent the best known way to treat the patient; however, the path still has to be applied to the individual patient’s background, medical history, health status, and so on.³⁷ Recognizing that people are different, this “synchronization of the implementation of the modules” or co-configuration, must be determined by the providers.³⁸

Mass customization requires that a sufficient number of people have the same disease or diagnosis. For example, Medco Health Solutions (which was acquired by Express Scripts Holding Company in 2012) effectively created mass customization through segmentation based on pharmacy benefit plans for private and public employers. The mass customization “digs down” another level to differentiate clinical needs among people in a single disease category (diabetes) that is large enough to warrant separate contact but not too small to present an administrative burden. In these cases true customization is not cost justified, but “one-size fits all” programs are not effective either. Mass customization falls somewhere in between and prevents therapy gaps within categories, such as the gap between diabetics who have only a few health problems and those who require frequent medical attention.³⁹

Maintaining and incrementally improving the quality of clinical operations can be a source of competitive advantage for a health care organization. Trust in the health care system has diminished because of reports in the media about managed care’s failures as well as the Institute of Medicine’s study indicating that as many as 98,000 deaths per year are because of medical errors (the third leading cause of death in the United States).⁴⁰ Research in *The BMJ* highlighted the fact that cause of death is based on ICD codes and no such code exists for medical error. Thus, medical error is not going to make it to the Centers for Disease Control and Prevention’s list of the most common causes of death in the United States that guides national research priorities for the year.⁴¹ The greatest opportunity a health care organization has to rebuild confidence is the day-to-day interaction between caregivers and patients.⁴² Every person in a health care organization has some responsibility for its image.

Historically, hospitals have concentrated on meeting the expectations of physicians; more recently, third-party payers have become a concern. In the past, the structure of the health care system enabled it to circumvent a customer orientation that most other segments in the services industry have had to adopt.⁴³ Various external changes are creating the need for health care to be more responsive to the wants, needs, expectations, and requirements of patients for information, convenience, and personal control.⁴⁴ Recently, attempts have been made to rank health care organizations on the basis of clinical quality. However, rankings are difficult because there is a lack of agreement over the assumptions underlying the ranking attributes, and some of the implications

may be misleading. Continuous Quality Improvement (CQI) programs have been utilized extensively in health care organizations for greater patient outcomes (see Essentials for a Strategic Thinker 8–4, “What Is Continuous Improvement?”).

ESSENTIALS FOR A STRATEGIC THINKER 8–4

What Is Continuous Improvement?



Continuous improvement (continuous quality improvement or CQI or *kaizen* in Japanese) refers to a process and ongoing effort to achieve better results through incremental changes that enhance efficiency. Continuous improvement was essentially the starting point in health care for what later broadened into the “Quality Movement” and eventually spawned other patient safety initiatives. However, some initial uncertainty in both industry and health care concerned the exact meaning and implications of the term “quality.” For example, some of the early quality improvement academic centers, such as the University of Tennessee’s Institute for Productivity Through Quality and Wisconsin’s Center for Quality and Productivity Improvement, emphasized the efficiency/productivity aspects of quality improvement rather than a more holistic approach that is emphasized today.

A milestone event in health care quality improvement initiatives took place in 1990 with the publication of *Curing Health Care: New Strategies for Quality Improvement*.¹ The senior author was Donald Berwick, a physician who is now regarded as the chief advocate of health care quality. The book reviewed the theory and rationale for CQI and presented the methods by which systematic improvements could be realized. The template for improvement was the scientific method, presented as the Plan–Do–Check–Act cycle or some variant. Data-based decision making was *de rigueur* and various tools were adopted or created for the gathering and analysis of data, such as the Pareto diagram, the cause and effect diagram, and control charts. The book’s goal was to demonstrate the applicability of “industrial” quality methods to health care, and included several detailed, successful case studies.

As a health care example, consider a medical procedure that requires a twelve-hour fast, yet 20 percent of patients neglect to fast. The time spent by both the provider and the patient in scheduling and preparing for the appointment has been wasted, and the process must be repeated. If better patient communications could reduce the percentage of people failing to fast, providers would spend less time on “rework and scrap,” thus becoming more productive.

A second example concerns central line-associated bloodstream infections

(CLABI). These infections are not uncommon, especially in the ICUs of a hospital. CLABIs have a significant mortality risk (15–20 percent), are expensive to treat, and add several days to the patient's length of stay (LOS). Fortunately, improvement projects were undertaken by Peter Pronovost (Johns Hopkins) and Richard Shannon (University of Pennsylvania) that drastically reduced the infection rate. These process accomplishments were realized without increased ICU staffing or capital investments, and have been successfully replicated by other hospitals.

The quality of care and patient safety will, no doubt, continue to be important issues in all health care settings for the foreseeable future. There continues to be more focus on prevention strategies and care improvement using evidence-based guidelines by health care decision makers at all levels. These strategies are important because “[a]s medical science and technology have advanced at a rapid pace, the health care delivery system has floundered in its ability to provide consistently high quality care to all.”²

REFERENCE

1. Donald M. Berwick, A. Blanton Godfrey, and Jane Roessner, *Curing Health Care* (San Francisco, CA: Jossey-Bass, 1990).
2. www.who.int/management/quality/assurance/QualityCare_B.Def.pdf (accessed July 2017).

Source: Joseph G. Van Matre, Professor, Collat School of Business, University of Alabama at Birmingham.

The National Committee for Quality Assurance (NCQA) developed by large employers provides the HEDIS database (introduced earlier in the chapter) to compare individual managed care health plans. The intent was to create a database that the participants (consumers or employers) could use to compare the performance of their health plans against other health plans on a consistently measured set of criteria to then be reported to consumers.

Neither the Joint Commission (JC) nor the HEDIS data can be correlated with *Consumer Report* satisfaction studies. The fact that mammograms are done (a HEDIS measure) does not mean women are happy with the way they are done (a measure of patient satisfaction). Health care providers are more responsive to patients at Lakeland Regional Medical Center, a large multiservice facility in Florida. Lakeland Regional discovered during a planning retreat that the time allocated to coordination and scheduling of procedures was almost the same as the time spent in providing services. Red tape and increasingly specialized jobs made relatively simple procedures seem overly complex to the patients. In addition, customers had to repeat the same information to a variety of staff. A patient might come into contact with as many as 60 different employees.⁴⁵ The quality of clinical care received by patients was not perceived to be as good as it actually was because of the way care was delivered (see [Exhibit 8-6](#)).

Trustees, administrators, and medical and nursing leaders should ask themselves the following key questions to determine whether their

organization's environment places patients and families first:

- Do the hospital's vision, mission, and philosophy of care statements reflect the principles of family-centered care?
- Are the vision, mission, and philosophy communicated clearly throughout the hospital, to patients and families as well as others in the community?
- Do patients and families serve as advisers to the hospital? In what ways are the patients and families involved in the orientation and education of employees? In the design planning process?
- Are hospital policies, programs, and staff practices consistent with the view that families are allies and important to patient well-being?
- What systems are in place to ensure that patients and families have access to complete, unbiased, and useful information?
- Does the hospital's human resources system support the practice of family-centered care?
- In academic medical centers, how do the education programs prepare students and professionals in training for family-centered practice?

Source: Institute for Family-Centered Care, Bethesda, Maryland.

Exhibit 8.6 Key Questions for Determining Patient- and Family-Oriented Care

Labor-intensive services are difficult to automate, but not impossible. For example, blood pressure checks have been automated. Additionally, a finger stick for routine blood work could be done by a machine; but would the public accept a machine instead of a nurse? In a different but important service industry, many bankers held on to their beliefs that consumers would want to talk to a real person when cashing checks or depositing money; however, those banks that were the first to automate with teller machines have been very profitable. Similar results may be achieved in health care.

Just focusing on quality or marketing alone may not be enough – a real emphasis on clinical process innovation may be required to achieve significant competitive advantage. Robert A. McDonald, retired Chairman, President, and CEO of Procter and Gamble, stated: “Promotions may win quarters, innovation wins decades.”⁴⁶ *Clinical process innovation* (or CPI) is defined as “the generation, acceptance, and implementation of new ideas, tools, and/or support systems aimed at improving clinical processes and, ultimately, patient care.”⁴⁷ It differs from continuous quality improvement (CQI) in that CQI focuses on improving existing clinical processes for performance improvement. CPI is a contextual and critical appraisal of current clinical processes to identify opportunities for more effectively providing care. As Michael Hammer, author and management consultant, explains:

Operational innovation should not be confused with operational improvement or operational excellence. Those terms refer to achieving high performance via existing modes of operation ... Operational innovation means coming up with entirely new ways of filling orders, developing

products, providing customer service, or doing any other activity that an enterprise performs.⁴⁸

In recent years a considerable amount of interest has developed in operational innovation in the clinical setting. A body of research has investigated the relationship between innovation and quality, improvements related to information technology innovations, and a variety of other areas.⁴⁹

A more radical form of innovation in clinical services is *disruptive innovation*.⁵⁰ Disruptive innovations do not target process improvement but are ideas and actions that disrupt the status quo and are so fundamental they displace market leaders by creating new markets and value networks. For example, personal interaction between provider and patient has long been the conventional medical care model. In recent years asynchronous interactions made possible by technologically advanced information systems has made telemedicine and e-Health potentially disruptive approaches to health care⁵¹ (see Essentials for a Strategic Thinker 6–5, “What are Disruptive Innovations?”).

It is important for providers to recognize that consumers who want more control over their health care will seek it through consumer advocacy groups, increased competition, and unprecedented access to information. If customers do not receive the care they want, they will change to another provider. Physicians have to be willing to listen to patients talk about other treatments and how alternative therapies might blend with more traditional medicine to improve health.⁵² Consumers who use alternative therapies are typically middle- to upper-class, well-educated people with good jobs and money to spend on whatever they believe to be important for their health care.⁵³

Marketing

Physicians are an integral part of the health care system. As such, hospitals and health systems have tried a variety of models to incorporate physicians into the new systems. Perhaps that is because of a lack of focus on the physician–patient relationship. As a patient satisfaction survey concluded: “A renewed patient focus is not only the best way to serve our customers and patients, it is also a business imperative for any organization that wishes to survive into the next era of health care.”⁵⁴ Examples of strategies in which physicians and health systems can work together to achieve patient goals include redesigning service lines around enhancing the patient experience rather than around financial aspects of delivery of care; multispecialty physician care teams based on consumers’ needs; physician outreach programs to determine ways that physicians believe patient care can better be delivered; increasing physician–patient communications since physicians are frustrated by the lack of time they can spend with patients; and agreeing on measurements for success.

Health care providers must understand their current situation in the market. How well are they satisfying the various customers they currently serve? Are competitors better at meeting customer needs? What new needs will occur in the near future that should be in the planning stages today? Frequently, the necessary information is not available, and marketing research must be

conducted to understand patient satisfaction, medical staff satisfaction, competitive offerings, and so on. Therefore, it is necessary to collect data from patients and staff who do not use (or occasionally use) the facility as well as current users.

After-Service Strategies

After-service is a key area in the value chain where value can be added for the customer/patient through follow-up (both clinical and marketing) after the service has been delivered. They are sometimes referred to as “back-office strategies” and are often the final impression (contact) that a customer has with the health care organization.

Follow-Up Activities

Follow-up is a process of checking with the consumer/patient concerning the quality, effectiveness, and satisfaction with the point-of-service encounter. For example, follow-up might be calling to inquire after the health of a child who was seen in the ER; such nurturing attention would spotlight a pediatrician as “caring and concerned” and endear him or her to any parent. Calling after outpatient surgery to ask if everything is going as expected or whether additional prescriptions are needed is simply good clinical follow-up (and can save pain, complications, and an unscheduled office visit). Follow-up calls say to customers “we care” and may avoid unnecessary anxiety.

Marketing follow-up activities include patient satisfaction studies to determine from a patient’s perspective how he or she was treated. All health care providers should be doing follow-up surveys with their customers. The feedback gathered offers greater insight if responses are conducted several days after the health care encounter as bias may occur with on-site collection of data.

Patient Satisfaction Strategy Maps (PSSM) can be used for strategic planning and implementation as well as for measuring patient satisfaction by a variety of health care providers from independent physician practices to large hospitals.⁵⁵ PSSM is a framework that links overall patient satisfaction to its antecedents and outcomes (see [Exhibit 8-7](#)). Satisfied customers may become loyal customers who are more likely to re-patronize and recommend the organization; are less likely to switch (despite inducements from competitors); buy more, and more often; as well as try new products/services. Over time, an organization with relatively more satisfied customers experiences a cycle of positive financial performance as the organization lowers its cost to acquire new customers and positive word-of-mouth is shared.⁵⁶

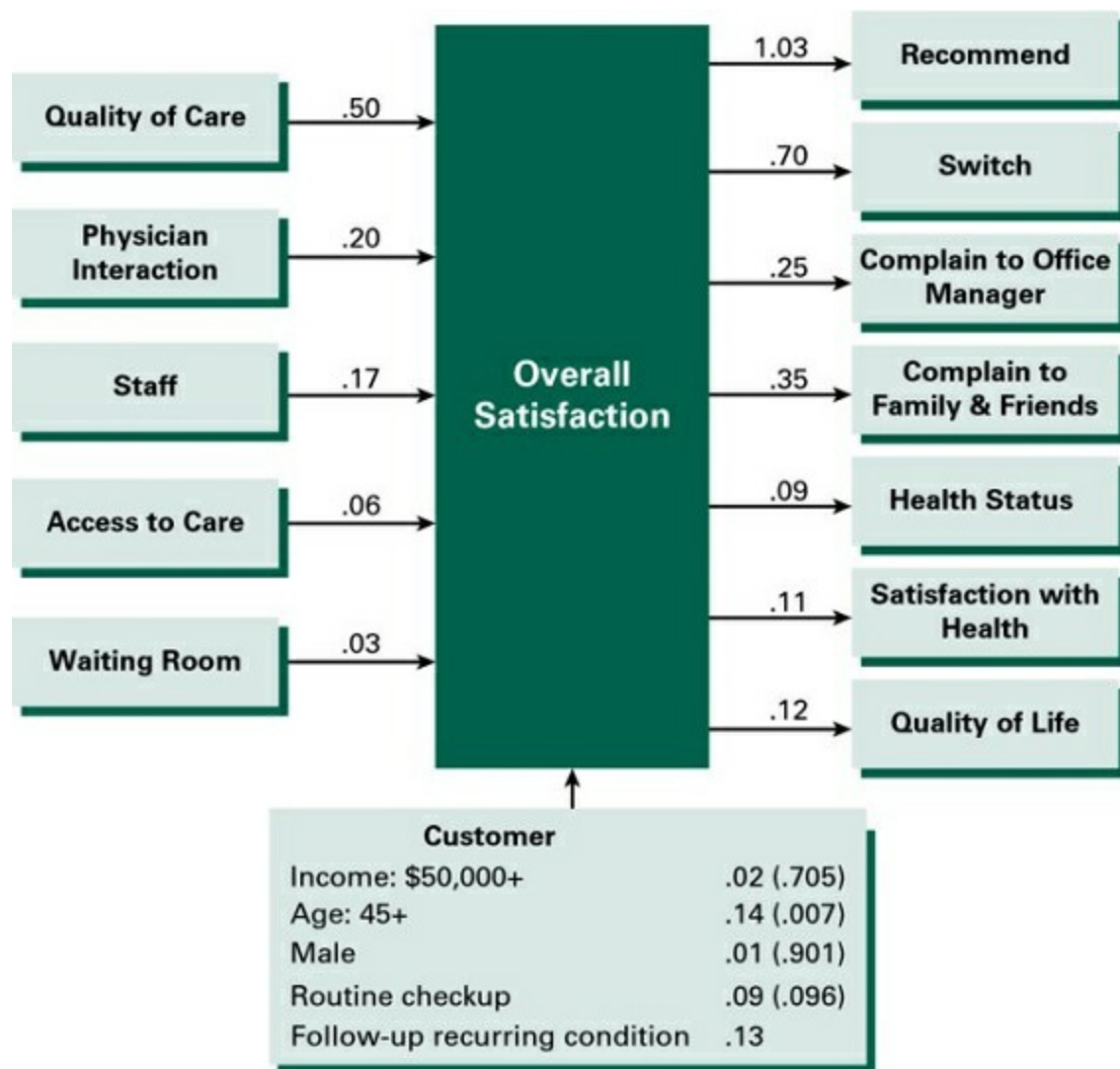


Exhibit 8.7 Patient Satisfaction Strategy Map

Survey-based measures of patient satisfaction have been associated with key outcomes.⁵⁷ A 2014 study by the Veteran's Administration analyzed care at 913 clinics; the 77 clinics in the top decile exhibited significantly higher patient satisfaction, lower hospitalization rates for ambulatory care-sensitive conditions, and lower ER use. Another 2014 hospital study found higher patient satisfaction to be associated with lower mortality rates for patients undergoing surgical procedures.⁵⁸ In a 2015 study, patient satisfaction was associated with shorter lengths of stay following major surgery, lower readmission rates, and lower mortality rates.⁵⁹ Finally in a 2016 study, patients with acute coronary syndrome that had higher patient satisfaction were associated with a lower risk of cardiac ER visits and cardiac hospitalization.

These studies strongly support the conclusion that patient satisfaction ratings are associated with key consequences: quality of care, clinical outcomes, and malpractice risk. Reassuringly, these beneficial consequences of patient satisfaction have been established in large-scale studies encompassing thousands of patients and providers assessing different conditions, across different institutions and hospital systems, and using varied and different

measures of patient satisfaction.⁶⁰

Rather than ad hoc studies, PSSM uses a structured survey that provides reliable, valid, and comparable data across service units, enabling patient satisfaction to be a useful metric for evaluating and assessing downstream consequences such as quality of care, clinical outcomes, and malpractice risk.⁶¹ PSSM breaks down the various strategic areas and attributes that comprise a patient's overall satisfaction. Using a primary care practice to illustrate, PSSM generates insights concerning the specific strategic areas that drive patient satisfaction. The general logic of PSSM, as shown in [Exhibit 8-8](#), highlights patient satisfaction as the focus because its downstream consequences include a patient's likelihood of recommending, switching, or complaining behavior. The antecedents (upstream) of patient satisfaction are organized into five strategic areas: quality of care, physician interaction, staff, access to care, and waiting room.⁶²

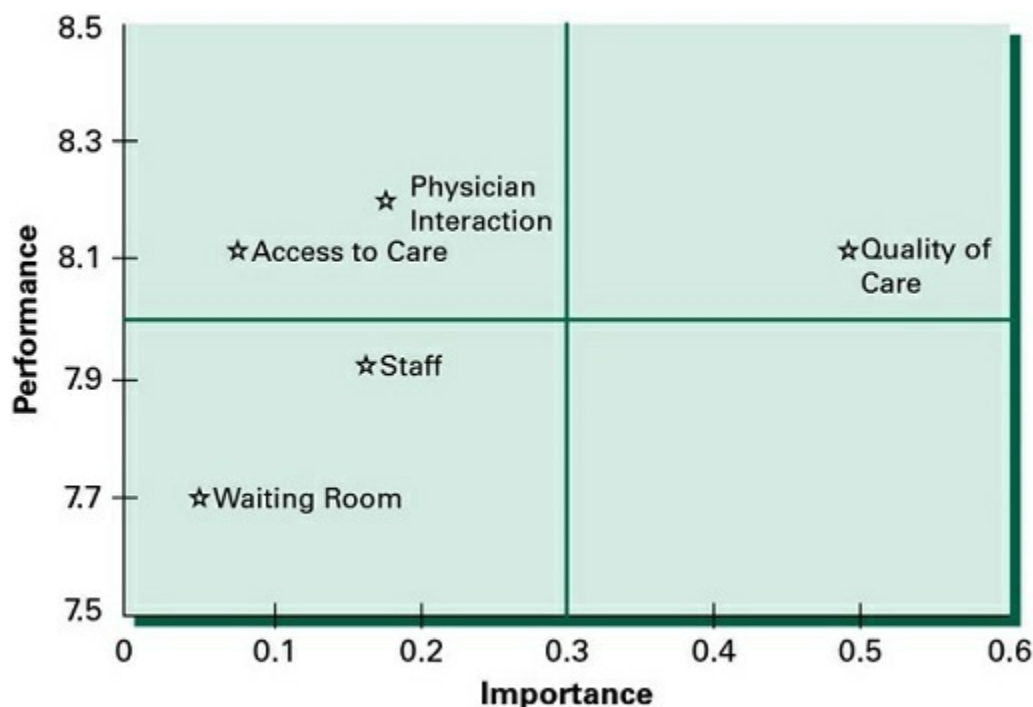


Exhibit 8.8 Importance–Performance Analysis for a Primary Care Medical Practice

Source: Vikas Mittal and C. Frennea, “Customer Satisfaction: A Strategic Review and Guidelines for Managers,” *MSI Fast Forward Series*, Marketing Science Institute, Cambridge, MA, 2010.

The magnitude of the strategic area with the highest association with overall patient satisfaction is referred to as the importance weight; importance weights help prioritize strategic areas for further action.⁶³ The area with the highest importance weight for this primary care practice is quality of care at .50 (top left in Exhibit 8-7). The performance level for each strategic area is determined from patient satisfaction scores, rated from 10 = extremely satisfied to 0 = extremely dissatisfied on the specific attributes that comprise quality of care. Located on a grid that positions quality of care in the high performance, high importance quadrant in [Exhibit 8-8](#), it represents a competitive advantage that

needs to be maintained.⁶⁴ On the other hand, waiting room has lower performance but is not considered very important by patients and is an area simply to be monitored.

Weighted by performance and importance, the ten individual items evaluated by patients that constitute quality of care include from highest ranked to lowest ranked: (1) Explanation of condition, (2) Quality of advice, (3) Treatment explanation, (4) Prescription explanation, (5) Assistant's quality of care, (6) Correct diagnosis, (7) Exam thoroughness, (8) Treatment thoroughness, (9) Performed all needed tests, and (10) Time spent with the patient.⁶⁵ The practice should focus on the top three as improving them will likely improve the patient's perception of quality care. Training physicians concerning lay language to explain the condition or establishing protocols that can be covered with the patient may improve the perception of quality care. Exam thoroughness or treatment thoroughness are much less likely levers for improving quality of care.⁶⁶

Once the analysis has been performed for each attribute of the five categories on the left of the Patient Satisfaction Strategy Map (see Exhibit 8–7), the items on the right side of the model are able to be determined. Of key strategic importance are those who recommend (word-of-mouth – WOM) and share information – in essence aiding the physician clinic's marketing efforts. If a patient is interested in switching, he or she might be retained with service recovery activities to avoid the last two positions on the right side of the model. Complaining to the office manager still might be able to be turned around; however, complaining to family and friends is difficult to overcome (negative WOM is powerful).⁶⁷

PSSM is comprehensive and integrated; enables a narrowed strategic focus; is flexible and adaptive to changes across organizational units, over time; is quantifiable and measurable; provides for benchmarking; may be used for financial and non-financial planning; offers predictive ability; and is based on multiple data sources. The end user is the beginning for patient satisfaction strategy mapping and its effective implementation appears to be a significant aid in determining specific strategies to increase customer satisfaction and the positive benefits that satisfied patients experience.

Studies of patient satisfaction cannot be merely looked at, plotted as to movement up or down, and put on a shelf. The information gathered needs to be analyzed to learn what customers expect, what the organization is able or willing to do to meet the expectations (its capabilities), and how to manage the expectations the organization is not willing or able to meet.⁶⁸ For example, shortening the time for test results may not be possible because of the time it takes to do the test properly. However, patient expectations can be managed by explaining the length of time it takes to do the test and making the information available as soon as possible on a secure website – if the patient wants the information this way – or an immediate call from the physician's office, or at a minimum providing a consumer hot line to call.

Health care purchasing decisions are often made through a third-party payer

with little or no consumer input; eventually, such a lack of information exchange creates distance in the relationship between the provider and the consumer of health care. In 2012 consumers were spending more out-of-pocket for copays and a higher percentage of the cost of care, yet were not aware of how their money was being used. Pressed for time, they become frustrated if they feel their time is being wasted, as when they have an appointment and sit for an hour waiting for an X-ray or to see a physician. Today, consumers have the knowledge to take their business elsewhere. Despite all the studies that have been done, quality improvement has not lived up to expectations. To achieve satisfaction, customers must be satisfied throughout the value chain, from pre-service activities to after-service activities. The problem has been that the studies were not designed with minimal standards of conceptual or methodological rigor; nor were they designed to facilitate quality improvement.⁶⁹ In 2017 reimbursements are becoming more value-based and since customer satisfaction is part of determining value, development of patient surveys are being offered by many marketing research companies.

Billing Activities

There is more to the patient's determination of the value and quality of the total health care experience than the success or failure of the medical procedure or clinical service itself. Richard L. Clarke, former CEO and President of Health Financial Management Association (HFMA) stated: "The best care, and great customer service provided during the patient's hospital encounter can be destroyed quickly by confusing, complicated, or incorrect billing afterwards."⁷⁰ Hospital *billing activities* that irritate customers most include:

- Confusion about what the patient's insurance company has paid.
- Confusion about the balance the patient owes the hospital once the insurance company pays its share.
- Use of medical terminology that the patient does not understand.
- Sending a bill to the patient before the insurance company has processed the patient's claims.
- Inability to determine exactly what services the hospital has provided and what the patient is being charged for a service.⁷¹

Greenwich Hospital's convoluted billing statement was reported in the *New York Times* when a freelance writer tried to figure out what he owed the hospital after his stay. His very public discussion of the problems with billing began a major change for the hospital. Having undergone the process, Greenwich recommends that when a health care organization realizes that its billing statement needs revision, the task should not be delegated to staff. Rather, a task force of actual customers, physicians, information systems personnel, clinical employees, and billing personnel should be assigned the task of making the bill understandable. Greenwich followed this format and the redesigned billing process reduced consumer complaints from about 30 per week to five per week and, interestingly, there was a reduction in accounts receivable and bad

debt because people understood their bill and paid it.⁷²

When customers call in with questions about their bill, the manner in which calls are handled is critically important. More than likely someone has to stop with data entry or analysis of data input to answer a patient's question. If answering customers' questions is not a priority, customers will know; moreover, costs are associated with doing things incorrectly. Consider a hospital or nursing home billing statement that contains errors. Not only is there the cost of finding the error, addressing the complaint, and redoing the statement, but there is an additional cost of losing a positive consumer attitude – and, perhaps, a patient who decides to go elsewhere.

Follow-On Activities

Follow-on is the provision of additional services after the initial point-of-service delivery. It is almost always preferable to have services recovery occur during services delivery rather than waiting to engage in services recovery at a later time. However, health care managers are not always aware of the failure until follow-on activities are undertaken.

After a patient has been seen by a physician or is leaving the hospital after surgery, there is likely a need for further services: a child with an ear infection has to return in 10 days for another check-up to make sure the infection is no longer present; after hip surgery a patient may need to be relocated to a rehabilitation facility to learn to walk again. These additional services are called follow-on value-adding service activities. A new parent with a child's first ear infection may have no idea about returning. An unexpected broken hip, surgery, and then the need for additional care is not something most families research until it happens. If the health care provider has thought through the follow-on care and provides literature, assistance with placement in another facility, and so on, consumers will leave with a more favorable attitude about the experience.

After a doctor's visit, can the patient easily find the appointment desk? Is the employee that handles follow-on appointments knowledgeable concerning the length of time it will take for a patient's next visit? Do these employees know that they represent the entire organization to the patient? Customer capital is the value of customer relationships and the value those relationships contribute to future growth prospects. Customer capital includes an organization's customer base, customer relationships, customer potential, and brand recognition. Although the specifics vary by industry, it has long been understood that it costs more to gain a new customer than it takes to retain a customer. Given that this is true, it is logical to assume that the customer franchise is an asset of real worth. Establishing lifetime relationships with customers is the focus of the smart 21st-century organization because it leads to competitive advantage.⁷³ Follow-on activities can cement or destroy a good customer relationship.

To achieve high levels of patient satisfaction, Baptist Hospital in Pensacola, Florida felt that it needed to become the employer of choice.⁷⁴ Its strategy included monitoring employee satisfaction as well as customer satisfaction.

Managers' performance is measured in five areas – customer service, quality (length of stay), expense management, employee turnover, and growth – and compensation is linked to accomplishing objectives. Patient portals have been shown to improve patient satisfaction as well as access to personal records and providers (see Essentials for a Strategic Thinker 8–5, “What Are Patient Portals?”).

ESSENTIALS FOR A STRATEGIC THINKER 8–5

What Are Patient Portals?



Patient portals are secure online applications (apps) that allow patients to access their personal health information with the ability to communicate with their health care providers from anywhere with internet access at any time using an account with a protected username and password.¹ The original intent behind patient portals was to increase provider and administrative productivity and efficiency, raise patient satisfaction, boost patient participation in medical decisions, and ultimately improve patient outcomes. Commonly coordinated through the health care provider's website, patient portals may also function as modules of the provider's electronic medical record (EMR) system or electronic health record (EHR) system. Vendors offer patient portals as modular parts of EHR systems or as stand-alone products that work with any EHR.

Patient portals can be used to provide educational materials to patients and their families, remind patients of appointments, encourage patients to engage in preventive and chronic care, renew medication prescriptions, pay bills, review test results, and schedule new appointments. Health care providers can use patient portals to achieve several important goals at once: improving productivity, efficiency, and customer satisfaction as well as demonstrating “meaningful use” of health care technology to receive federal incentives.

Potential drawbacks to patient portals include security concerns, difficulty registering in the system, and only being able to use one portal per provider (which can be inconvenient for patients with multiple providers). Maintaining engagement between patient and provider can also be more difficult, as some patients and providers are more comfortable with internet-based communication than others. Providers' best interest requires that they consider, establish, and clarify expectations regarding the expected content of responses. In addition, expected response time (all inquiries will receive a response the day they are received) and billing issues associated with time spent responding to patients electronically need to be tracked.

Research on patient portals has associated them with medication adherence, disease awareness, self-management of disease, a decrease in

office visits, an increase in preventative medicine, an increase in extended office visits (at the patient's request for additional information), and some evidence of improved health outcomes.^{2,3}

REFERENCES

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2. C. S. Kruse, K. Bolton, and G. Freriks, "The Effect of Patient Portals on Quality Outcomes and Its Implications to Meaningful Use: A Systematic Review," *Journal of Medical Internet Research* 7, no. 2, (2015). www.1e44.doi: 10.2196/jmir.3171.
3. T. Garrido, B. Raymond, and B. Wheatley, "Lessons from More Than a Decade in Patient Portals," *Health Affairs 2016 Blog*. Retrieved from: <http://healthaffairs.org/blog/2016/04/07/lessons-from-more-than-a-decade-in-patient-portals/>.

Source: Lauren Wallace MPH, MPA, DrPH Candidate, University of Alabama at Birmingham.

Step 2: Compare the Strategy Requirements with the Results of the Service Delivery Internal Analysis

Each area of the value chain was evaluated during internal analysis (Chapter 4) and the conclusions were used during strategy formulation. Based on the results of the comparison of the current situation and what strategic managers want the organization to be (the demands of the strategy), value chain components may need to be maintained or changed to carry out the strategy.

A decision table is shown in [Exhibit 8-9](#). As suggested by the table, for each component of the value chain, a strategic decision must be made (maintain or change) and general direction provided to the organizational units as to how that decision is to be accomplished. [Exhibit 8-9](#) enables organization of the strategic thinking necessary to decide to maintain or change pre-service, point-of-service, or after-service. Later, more specific organizational unit strategies (action plans) that carry out the value-adding strategies will be developed.

Value-Adding Service Delivery Strategies	Results of Internal Analysis	Requirements of Selected Strategies	Comparison of Strategy Requirements and Internal Analysis	Maintain or Change
Pre-service Market/marketing research Target market				

Branding Pricing				
Distribution/logistics Promotion				
Point-of-service Clinical operations Marketing				
After-service Follow-up activities Billing Follow-on activities				

Exhibit 8.9 Strategic Thinking Map for Developing Value-Adding Service Delivery Strategies

Implementation of a strategy is often the most difficult part of strategic management. New strategies may call for changes in service delivery, marketing, organizational structure, or strategic resources. Such changes typically require new systems and new ways of doing things. Therefore, successful change in the value-adding strategies requires leaders to establish a sense of urgency for change and to clearly articulate the connections between the new changes and the success of the selected strategies.⁷⁵

Step 3: Decide to Maintain or Change Pre-Service Delivery

A pre-service strategy is the development of an implementation plan to maintain or change pre-service activities by comparing the results of the internal analysis with the requirements of the broader organizational strategies. It is important that service characteristics and the target market are appropriate for the selected strategy. In addition, the price, brand, promotional activities, and logistics for services must contribute to the accomplishment of the directional, adaptive, market entry, and competitive strategies. The services delivery activities were assessed and classified as competitive advantages or competitive disadvantages in the internal analysis phase of situational analysis. As shown in [Exhibit 8-9](#), the attributes of the current pre-service activities must be compared with the service characteristics, target market, price, brand, promotional activities, and service logistics that are required by the strategy. Results of this assessment will determine whether the strategic managers need to create implementation strategies to maintain or change the pre-service activities.

Maintain Pre-Service Activities

When the requirements of the strategy match the current pre-service strengths and needs of the customers, strategic managers should focus on maintaining the

strengths, giving particular attention to the areas that have created competitive advantage. For example, if during internal analysis a brand name was evaluated as a strength having high value (H), was rare (Y), was difficult to imitate (D), and was sustainable (Y), resulting in HYDY, maintaining the effectiveness of the brand name is particularly important. Allowing such a strength to weaken may lead to the loss of an important competitive advantage. Similarly, maintaining a strong brand name would be important when strong brand names are common (not rare) among competitors (HNDY). In this situation, strong brands have likely become a threshold condition for success. Therefore, in maintaining pre-service activities, strategic managers should:

- Engage in periodic customer focus groups and market research to understand the wants, needs, and desires of the organization's target markets and whether they are or are not being satisfied.
- Monitor the demographic, psychographic, and health status characteristics of the service area (with particular attention to trends in the target markets).
- Continually communicate to physicians, patients, third-party payers, and others concerning the type and range of services offered, pricing, and branding.
- Monitor promotional effectiveness.
- Monitor customer ease of system entry (logistics).

Change Pre-Service Activities

Pre-service activity changes can be difficult and may require considerable market research as well as promotion. In internal analysis, if the requirements of the strategy call for different services, a different or additional target market, changes in pricing, branding, or promotional activities, change strategies should be initiated. In addition, where significant competitive disadvantages have resulted because of ineffective pre-service activities, it is likely that change strategies will be required. For example, if the promotional strategy was viewed in internal analysis as a weakness, of high value, the weakness is common among competitors, difficult to correct, and competitors can sustain their advantage (HYDY), change strategies should be implemented specifically where competitors may act to develop an effective promotional strategy and achieve a significant competitive advantage. Similarly, if an organization has a weak promotional strategy and other organizations have effective promotions that are difficult to imitate and can be sustained (HNDY), strategic managers will need to explore changes that could lead to improvements. Strategic managers who want to transform pre-service activities should:

- Modify the service attributes to better match the expectations of the target market.
- Train employees to better provide the new services.
- Redefine the target market to match the changing demographic, psychographic, and health status characteristics of the service area.
- Provide price discounts or price categories among members of the target

market.

- Change the balance among advertising, personal selling, and direct marketing (one-to-one marketing).
- Brand individual products (as opposed to the organization's name as the brand).
- Redesign accommodations, dining experience, parking lots, and signage.

Step 4: Decide to Maintain or Change Point-of-Service

A point-of-service strategy is the development of an implementation plan to maintain or change point-of-service activities by comparing the results of the internal analysis with the requirements of the selected broader organizational strategies. Each strategic alternative selected by an organization may affect the point-of-service delivery strategy. However, as discussed previously, central to point-of-service delivery are issues such as quality, efficiency/speed, innovation, and flexibility (mass customization) of the service. Most organizations are constantly trying to improve point-of-service delivery – employing an adaptive/enhancement strategy.

Maintain Point-of-Service Activities

When the requirements of the selected strategy match the characteristics of the current point-of-service delivery, strategic managers should develop strategies to maintain the current strengths of the organization's resources, competencies, and capabilities. As with the pre-service activities, particular attention should be given to those point-of-service delivery areas that have created competitive advantage. In maintaining point-of-service delivery activities strategic managers should:

- Monitor service quality through asking customers (physicians, patients, payers, others) if there is a way the experience could be improved – as they are the ones receiving the service, recommending the service, or serving as an intermediary.
- Monitor clinical (patient) and organizational (financial) outcomes.
- Institute quality programs in key service areas.
- Benchmark other organizations' processes (see Essentials for a Strategic Thinker 7-5).
- Measure the organization's efficiency (personnel, assets, costs) against peer organizations and industry standards.
- Revise rules and regulations that limit process innovation.
- Continue to communicate and emphasize the individuality of customers.

Change Point-of-Service Activities

If the requirements of the strategy indicate that the present point-of-service

delivery processes should be reorganized, then explicit strategies must be implemented. In addition, if internal analysis indicates that the point-of-service delivery process is a weakness (resulting in competitive disadvantages) or the requirements of the strategy call for new standards of quality, efficiency, or innovation, change strategies should be initiated. Strategic managers who want to change clinical point-of-service activities should consider involving a team of appropriate leadership across disciplines to:

- Institute a quality improvement program for service delivery.
- Re-engineer critical service delivery activities.
- Provide quality enhancement training for service delivery personnel.
- Institute a cost-cutting program.
- Provide incentives for efficiency suggestions.
- Reduce rules and regulations that limit innovation.
- Provide savings or revenue sharing with employees to encourage innovations.

To change marketing point-of-service activities, strategic managers should:

- Target unserved consumers.
- Increase market penetration activities.
- Serve new markets with existing products (market development).
- Offer new products for current consumers (product development).
- Improve differentiation among services offered.

Step 5: Decide to Maintain or Change After-Service

An after-service strategy is the development of an implementation strategy to maintain or change post-service delivery activities by comparing the results of the internal analysis with the requirements of the selected broader organizational strategies. As with pre-service and point-of-service activities, after-service activities must contribute to the accomplishment of the selected strategy. These operations and marketing activities may be quite important in implementing an effective strategy. Follow-up, billing, and follow-on activities humanize the services, reduce hassles and frustration, and provide for continued care. Such activities often make the difference between a positive and negative health care experience and can differentiate the service and create competitive advantage.

Effective after-service activities are typically of high value, often rare, fairly easy to develop, and are sustainable. These activities can be the source of at least short-term competitive advantage. However, these areas are often ignored by many health care organizations; therefore the organizations that effectively undertake them may create a long-term advantage.⁷⁶ Careful attention should be given to understanding the after-service requirements of the selected strategy and then strategic managers must decide if the activities should be maintained

or changed.

Maintain After-Service Activities

When the requirements of the selected strategy match the characteristics of the current after-service activities, strategic managers should develop strategies to maintain the current after-service strengths of the organization through its resources, competencies, and capabilities. Likewise, these after-service activities that have resulted in a competitive advantage should be protected and maintained. In maintaining after-service activities, strategic managers should continue to:

- Emphasize and train employees on communication and etiquette.
- Emphasize patient satisfaction.
- Improve the “readability” of billing statements.
- Stress the importance of correct billing statements and ensure their accuracy.
- Develop relationships in the referral network to facilitate follow-on activities.

Change After-Service Activities

If the requirements of the strategy indicate that the present after-service activities should be changed, then explicit strategies must be implemented. In addition, if internal analysis has indicated that follow-up, billing, or follow-on is a weakness resulting in competitive disadvantage, change strategies should be developed. Strategic managers who want to change after-service activities should:

- Make follow-up an explicit part of patient (customer) care.
- Determine the preferred method for follow-up phone call (home, work, cell) or email.
- Keep a log of patient follow-up as a part of the patient/customer record.
- Train employees on communication and etiquette.
- Emphasize customer satisfaction at staff meetings.
- Redesign the billing statement with the assistance of a variety of stakeholders (including patients), and define complicated medical terms.
- Inform customers about billing procedures.
- Clear any confusion about billing charges and which charges are to be paid by insurance.
- Continue to improve relationships with payers.
- Develop more and better relationships with referral organizations.
- Develop a list of options for patients who need follow-on referral, explaining the characteristics and pricing of each.

Step 6: Provide Guidance to Organizational Units

Value-adding service delivery strategies translate the directional, adaptive, market entry, and competitive strategies into action. As a critical component of the value chain, value-adding service delivery strategies, coupled with value-adding support strategies, set the stage for maintaining strategic momentum through the action plans and control of the strategies.

No position of leadership lasts forever. Every health care organization that succeeds at differentiation serves as a model for new competitors.⁷⁷ The dynamic health care market and ever-changing technology mean that no competitive advantage can be sustained in the long run without a great deal of thought and effort. To further complicate the strategic process, the long run itself is becoming shorter as the rate of change becomes increasingly more rapid.

In conjunction with external analysis, service area competitor analysis, and internal analysis, value-adding service delivery strategies attempt to reposition the health care organization to create new competitive advantages. Although maps may be created for development of value-adding service delivery strategies (see [Exhibit 8-10](#) for an example), using a compass to creatively develop new strategies for pre-service, point-of-service, and after-service delivery can rejuvenate or achieve competitive advantage.

Adaptive strategy: Vertical integration – enter into a system of care. *Market entry:* with a hospital to assure a referral network. *Strategic posture:* Move from defense posture. *Positioning strategy:* Differentiation based on quality, upscale image.

	Characteristics/Attributes			
Value-Adding Service Delivery Strategies	Results of Internal Analysis	Service Delivery Requirements of Selected Strategies	Comparison: Strategy Requirements – Internal Analysis Results	Eval Mai
Pre-service • Market/marketing research • Target market • Services offered/branding • Pricing • Promotion • Distribution/logistics	Target market: upscale families, private pay. Prestige pricing in this step-down facility that offers long-term care and skilled nursing. Word-of-mouth is relied on as well as the publicity about	Become Medicare and Medicaid qualified to meet hospital's needs. Intensify branding efforts to combat new competition. Maintain upscale	Fairly good match. Expansion of the target market may impact upscale image. Word-of-mouth promotion not sufficient to develop brand	

	the CEO's mother residing there. Excellent location – upscale neighborhood with excellent shopping and recreation nearby.	appearance, caring staff. Add new services to be “full-service.”	awareness. Maintaining the current competitive advantage will be challenging with an expanded target market.
Point-of-service Service delivery	Patients/families indicate care delivery is outstanding. Facility is clean, does not smell like a nursing home. Food is tasty and nutritious – like home cooked. Families do not want to move the loved one if other problems associated with aging occur.	Expand services: Alzheimer's care, senior day care, rehabilitation.	Fairly good match. Services differentiation strategy requires improved information system to track care. Enhancement strategy requires process innovation while maintaining caring environment, cleanliness, great food. Product development appears attractive.

After-service • Follow-up activities • Billing • Follow-on activities	“No need” for patient/family satisfaction studies. Billing process: give an accumulated bill to a family member when they stop in for a visit. If the patient needs care from a specialist, referrals are prompt, transportation arranged.	Satisfaction studies to track improvements. Billing procedure to provide consistent revenue stream.	Not a good match. Information systems upgrade needed to match the hospital’s system for timely, accurate billing to increase customer satisfaction. Expanded target market requires careful tracking to maintain image.	

Exhibit 8.10 Exhibit Strategic Thinking Map for Value-Adding Service Delivery Strategies for a Skilled Nursing Facility

Strategic Momentum: Service Delivery Strategies

Just as the success of the directional, adaptive, market entry/exit, and competitive strategies of the organization must be evaluated as an ongoing part of managing the strategy, the service delivery strategies often must be adjusted as managers learn by doing. This type of change represents an evolutionary alteration – a strategic adjustment. Referred to as managing the strategic momentum, “[t]he basic continuity of the business is still credible, and one can hence speak of an extrapolation of the given strategy, even though a lot of operational changes may be taking place. The challenge here is to manage the buffeting of the given strategy and to maintain the strategy on course.”⁷⁸

In the end, it is implementation that has to be effective and efficient. Changes in the “way we do things” represent evolutionary change. Each of the value-adding strategies – service delivery and support – should be examined separately to determine whether management has correctly defined the role of these strategies in supporting the organization’s overall strategy. Strategic managers must determine whether the service delivery, support strategies, and action plans are well integrated and support one another. The questions presented in [Exhibit 8-11](#) provide an evaluation of the effectiveness of the service delivery strategies.

1. Have the pre-service activities provided customers with need-satisfying services?
2. Have the pre-service activities provided the right price, the appropriate information to current and potential customers, as well as convenient locations?
3. Are the pre-service logistics appropriate for the service?
4. Are the point-of-service activities sensitive to changing customer needs?
5. Are the point-of-service activities efficient? Effective?
6. Has the quality of the services changed?
7. Has the organization innovated delivery of its services?
8. Is the delivery of services flexible (can accommodate special customer needs)?
9. Is there proper follow-up with customers?
10. Is the billing system timely, accurate, and user-friendly?
11. Are the follow-on strategies appropriate?

Exhibit 8.11 Strategic Thinking Map for Evaluating Service Delivery Strategies

The logic underlying these questions is that the organization’s strategy is fundamentally sound but the organization’s performance in carrying out service delivery may not be as effective or efficient as it could be. Adding value is an ongoing process and requires the value-adding support strategies to be in

concert with the value-adding service delivery strategies. The value-adding support strategies are discussed in Chapter 9.

Chapter Summary

Because of the competition and complexity in the market, health care providers must add value to survive. The value chain consists of value-adding service delivery strategies that are primarily operations (clinical) and marketing oriented as well as value-adding support strategies that include organizational culture, organizational structure, and strategic resources.

The directional, adaptive, market entry, and positioning strategies are implemented through value-adding service delivery, including pre-service, point-of-service, and after-service strategies. Pre-service activities include market research to understand the customer and marketing research to understand the customer's reactions to the organization's marketing efforts. A variety of health care customers, including physicians, patients, third-party payers, volunteers, employees, and so on must be considered. Patients have to be admitted to a hospital by a physician; third-party payers influence physician choice, length of stay, and so on; volunteers and employees may also be patients; government entities interpret the need for additional health care subsidies from the public. In addition, pre-service includes segmentation to select the target market and determination of the services that will satisfy the target market. Further, decisions have to be made concerning branding as well as pricing, promotion, and distribution/logistics.

Point-of-service delivery is oriented around patient care and delivery – clinical and marketing activities. Marketers study the customer and market to suggest the manner of care delivery, while clinical personnel deliver care. Properly implemented mass customization is a way to deliver efficient and effective care.

After-service activities include both clinical (next appointments, further services) and marketing (determining how to satisfy customers through new products/services that are needed) as follow-up activities. Staff could make clinical calls to inquire how the patient is doing and whether additional medication is needed. Marketing follow-up is generally in the form of patient satisfaction studies. Billing is another important after-service activity, as it is the time when the consumer decides whether value has been received. Follow-on activities include nursing home care arrangements after hospitalization, arranging home care, and other similar activities. Chapter 9 examines implementation strategies for the lower portion of the value chain – the value-adding support strategies.

Practical Lessons for Health Care Strategic Thinkers

1. Service delivery is the only thing consumers experience; therefore value that is important to them must be created.
2. In health care, quality has to be perceived or the rest of the factors in service delivery will not matter.
3. The more ways in which an organization can deliver real value, the greater the customers' loyalty as well as higher returns.
4. Adding value to service delivery has to be at the heart of an effective service delivery strategy.

THE LANGUAGE OF STRATEGIC MANAGEMENT: KEY TERMS AND CONCEPTS

After-Service Strategy
Billing Activities
Brand
Brand Equity
Clinical Process Innovation
Disruptive Innovation
Follow-On
Follow-Up
Kaizen
Market/Marketing Research
Mass Customization
Point-of-Service Strategy
Pre-Service Strategy
Target Market
Value-Adding Service Delivery Strategies
Value-Adding Support Strategies

Questions for Class Discussion

1. Explain the linkage between internal analysis and the value-adding service delivery and support strategies. How are the value-adding strategies linked with action plans?
2. Explain the difference between pre-service, point-of-service, and after-service activities. What elements are central to each? Provide an example of how an organization might create a competitive advantage in each of these areas.
3. For a health care organization, explain why pre-service, point-of-service, and after-service activities are fundamentally marketing and clinical in nature.
4. Pre-service, point-of-service, and after-service are different for health care than for producing and distributing a tangible product. Explain some of these differences.

5. Discuss the various ways that health care providers can define the market they want to serve.
6. What role does marketing play in the implementation of adaptive strategies for expansion? Is marketing ever involved in reduction of scope strategies?
7. Does marketing have a role to play in the market entry strategies?
8. What is mass customization? In what circumstance does mass customization become useful?
9. What is “evolutionary” strategic change?

Notes

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Chapter 9

Value-Adding Support Strategies

“The value chain disaggregates a firm into its strategically relevant activities in order to understand the behavior of costs and the existing and potential sources of differentiation.”

—MICHAEL PORTER, STRATEGY AUTHOR AND PROFESSOR

Why Value-Adding Support Strategies Are Important

As advanced by Michael Porter, the value chain may be used to identify and analyze the strategically relevant activities that create value and ultimately competitive advantage for an organization. Strategically relevant value-adding support activities include the organization's culture, organizational structure, and strategic resources (financial resources, human resources, information systems resources, and strategic technologies resources). In a similar manner to service delivery, the support strategies must be linked to demands of the overall strategy and the organization's strengths and weaknesses. Developing strategies for the strategically relevant support activities is crucial because of the ways these activities add value and differentiate the organization. The support activities may be less visible than service delivery activities, yet are profoundly important.

Ideology or culture is at the center of determining the ability of an organization to support service delivery and the overall organizational strategy. The organization's culture is not separate from the organization but inherent to it. In addition, an organization's culture infuses life into the organization's structure as well as into the strategic resources. If the organizational culture is adaptive, it can respond to the periodic changes that must be made in all elements of the value chain that enable the organization to remain relevant.

The organization's structure is critical to accomplishing the strategy – structure should probably follow strategy. Whether the organization structure will be flat or tall; whether the organization will make decisions centrally or will decentralize decision making, will be tied not only to the organization's strategy but also to its culture. Therefore, the organization's structure is dependent on the culture.

Further, culture infuses life into the strategic resources – the strategically relevant support activities that make the service delivery and broader organizational strategies possible. Without the right people, adequate financial resources, a strategic information system, and appropriate technology, service delivery will be hampered and the overall strategy will not be accomplished. Pulling these strategic resources together is essential for successful implementation of the strategic plan.

Developing effective value-adding support strategies is aided by processes and guidelines that determine whether the support functions need to remain the same or change to meet the demands of the strategy and align with the organization's strengths. Proper translation of the strategy, an adaptive culture, and the appropriate strategic resources are necessary for a successful organizational strategy.

Use the concepts in this chapter to develop effective value-adding support strategies for a health care organization!

Learning Objectives

After completing the chapter you will be able to:

1. Explain why the value-adding support strategies are important elements in the implementation of strategy.
2. Align the value-adding support strategies to ensure they point the organization toward achieving its mission, vision, and goals.
3. Link the results of internal analysis of the support activities to the implementation of value-adding support strategies.
4. Demonstrate how the culture, structure, and strategic resources of an organization must be explicitly linked to directional, adaptive, market entry/exit, and competitive strategies, as well as the value-adding service delivery strategies.
5. Discuss how the value-adding support strategies may be used to create or solidify competitive advantages and strengthen weaknesses to overcome competitive disadvantages.
6. Explain how the value-adding support strategies provide guidance for the development of organizational objectives and action plans.

Strategic Management Competency

After completing this chapter you will be able to create effective value-adding support strategies for a health care organization.

Implementing Support Strategies

As indicated in Chapter 8, implementation strategies take a decidedly internal focus. Effective and efficient operations make strategies work. Along with the pre-service, point-of-service, and after-service strategies, the value-adding support strategies should be developed and specified. Similar to the service delivery strategies, the *value-adding support strategies* are implementation strategies directed toward accomplishment of all the other strategies including the directional, adaptive, market entry/exit, competitive, and service delivery strategies.

Unfortunately, as with service delivery strategies, value-adding support strategies may not succeed because of a lack of proper implementation. Three pillars of effective execution are necessary for successful implementation of strategies – direction, structure, and people.¹ *Direction* involves stepping down the strategic plan to the specifics of getting things done. *Structure* is the organization of the processes necessary to accomplish the strategy and *people* means that the organization must have the engaged individuals required to make strategy happen. For organizations to reach ambitious strategies, they must thoughtfully and purposefully manage the way the strategy is implemented.²

Similar to service delivery, the value chain provides a strategic thinking map of the support activities that create value for the organization and may be a source of competitive advantage or disadvantage. The value-adding support strategies are based on the elements of the lower portion of the value chain and are the means for accomplishing the decisions made in strategy formulation (see [Exhibit 9-1](#)). Once the support strategies are determined, more specific action plans may be developed (see Chapter 10).



Exhibit 9.1 The Value Chain

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

Decision Logic for the Value-Adding Support Strategies

Once the service delivery strategies (the primary value-adding activities) are formulated, support strategies that provide the appropriate organizational context and resources to carry out the organization's strategy are needed. As illustrated in [Exhibit 9-2](#), the support strategies are dependent primarily on the organization's market entry/exit strategies (which achieve the adaptive strategies), competitive strategies (strategic posture and positioning), and the service delivery strategies. The success of these strategies may be dependent on the effectiveness of the organization's culture, structure, or strategic resources. For example, an acquisition or merger market entry strategy may require the combining of two very different organization cultures. Similarly the demands of a differentiation positioning strategy may require additional technical, human, or financial resources. Additionally, changes in the service delivery strategy will likely initiate culture and structure modifications.

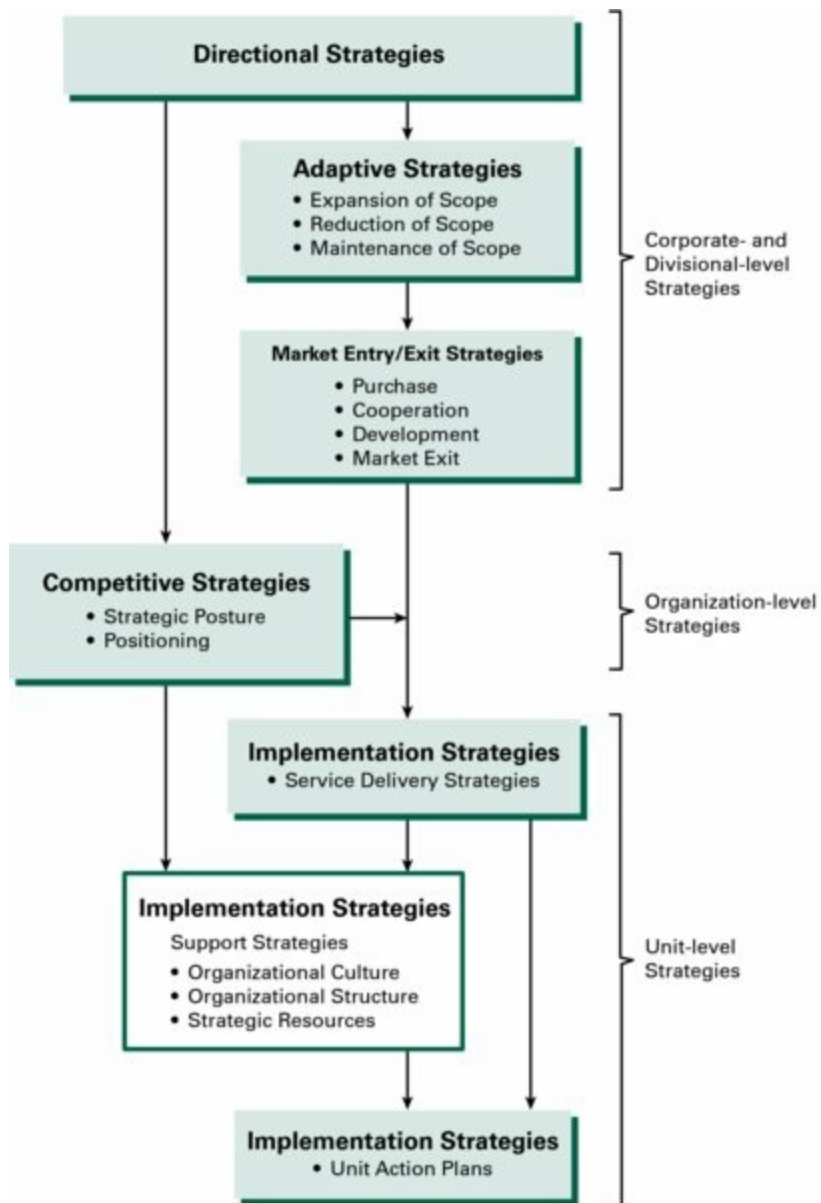


Exhibit 9.2 Decision Logic for Developing Support Strategies

Process for Developing Support Strategies

Just as a step-wise process was helpful in developing the broader strategies and service delivery strategies, a similar process for formulating the support strategies is presented in [Exhibit 9-3](#). For each of support activities – culture, structure, and strategic resources – the demands of the broader strategies (market entry/exit, competitive strategies, and service delivery strategies) must be matched to the results of the internal analysis to determine if the support strategies need to be maintained or changed to accomplish the selected strategies. Once the strategy is determined, guidance can be provided to the organizational units.



[Exhibit 9.3](#) Process for Developing Support Strategies

Step 1: Identify the Support Requirements of the Strategy and Support Value-Adding Potential

The appropriate directional, adaptive, market entry/exit, and competitive strategies have been discussed in Chapters 5 through 7. As illustrated in [Exhibit 9-2](#) the market entry/exit, competitive, and service delivery strategies place the greatest demands on the support strategies. The value-chain support strategies must aid in the accomplishment of these strategies. Although the requirements of the market entry/exit, competitive, and service delivery strategies will be unique to each particular situation and organization, general internal resource, competency, and capability requirements for the market entry/exit strategies were presented in Exhibit 7–19, for the posture strategies in Exhibit 7–22, and for the positioning strategies in Exhibit 7–24. Using these tables can stimulate strategic thinking for most any organization. For example, an internal venture market entry strategy will require financial resources, an entrepreneurial culture, and marketing expertise. A defender strategy will require development of a single core technology, cost efficiency, and management emphasis on centralized control and stability. Further, a cost leadership strategy will require investments in efficiency, process engineering skills, focus on minimizing labor costs, and so on. Finally, there may be additional requirements of the support activities depending upon the adopted service delivery strategies.

Importantly, strategic managers must think through how the support strategies are able to assist in carrying out the broader organizational strategies. Unfortunately, no formula or template exists for determining strategy requirements; each organization, service category, and service area has its own particular considerations. Focused strategic thinking will be needed to work out a plan, then learning what works – and what does not – as the plan unfolds, will be essential.

Value-Adding Support Strategies Potential

The lower portion of the value chain provides direction for the development of the value-adding support strategies and includes the organization's culture, structure, and strategic resources. More specifically, the support strategies concern areas such as the behavioral norms, organization structure and flexibility, human resources, finance, information systems, and technology, and play a major role in the implementation of the organization's overall strategy. Each area adds value in the organization. Thus, strategies are required to maintain or enhance the organization's competitive advantages and to strengthen competitive disadvantages. Increasingly, health care managers are trying to implement evidence-based management practices to improve the organization's culture, structure, and strategic resources (see Essentials for a Strategic Thinker 9–1, "What Is Evidence-Based Management?").

ESSENTIALS FOR A STRATEGIC THINKER 9–1

What Is Evidence-Based Management?



Evidence-based management (EBMgt or EBM) is an emerging philosophy of management that employs current best management practices that have been tested in real-world organizational settings and are supported by data documenting their effectiveness or efficiency. The approach involves hypothesis development and testing, documentation of results, and the synthesis of best management practices. Spurring this movement is the belief that when managers act on better logic and the best available evidence, their organizations will fare better than organizations not using best practices.¹ Evidence-based management uses a systems approach to identify components of a management problem and to identify sound evidence supporting a solution. This approach can be particularly helpful when conducting external analysis during strategic planning. Both external and internal analyses require the collection and analysis of data, and can benefit from the incorporation of best practices (including thinking through future implications of current trends, etc.). Once a part of the culture, managers can practice evidence-based management systematically so that it becomes second nature.

Evidence-based management has its origins in evidence-based medicine. In an attempt to rely less on traditional, more subjective, practices, evidence-based medicine focuses on the development of medical best practices using data from well-designed empirical research concerning the outcomes of medical procedures, drugs, and practices. An emphasis on evidence-based medicine helped to generate the field of medical decision making and outcomes research.

Much of the activity of developing evidence of effective management begins with organizational experiments and is a matter of developing management practices, putting those practices in place, measuring the practices' effectiveness against objectives, and redesigning best practices based on results. Thus, the evidence in evidence-based management comes largely from scientific research, but internal business information and even professional experience can count as evidence as well.²

Management professors and authors, Jeffrey Pfeffer and Robert Sutton conclude:

As with medicine, management is and will likely always be a craft that can be learned only through practice and experience. Yet we believe that managers (like doctors) can practice their craft more effectively if they are routinely guided by the best logic and evidence – and if they relentlessly seek new knowledge and insight, from both inside and outside their companies, to keep updating their assumptions, knowledge, and skills. We aren't there yet, but we are getting closer. The managers and companies that come closest already enjoy a pronounced competitive advantage.¹

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As with the service delivery strategies, value-adding support strategies must be consciously aligned. Strategic managers should take care to ensure that the support strategies are consistent and compatible with each other and that they contribute to the accomplishment of the organization's overall strategy. Therefore, the support strategies for each area cannot be developed or evaluated in isolation. It is the strategic manager's responsibility to make decisions concerning each support strategy and ensure that these elements are coordinated to help achieve the overall strategy of the organization. Strategic thinking, strategic planning, and managing strategic momentum are central to this process. A brief review of value-chain support strategies demonstrates their potential for achieving organizational goals and strategies.

Organizational Culture Strategies

Organizational culture is unique and exerts a powerful influence on how people function and act as a key factor in how well the organization performs. Studies have demonstrated that in addition to strategy, execution, and structure, the proper culture is imperative for organizations that outperform their industry peers.³ Moreover, effective culture has been shown to vary significantly from industry to industry.⁴ Successful strategic managers understand the importance of organizational culture and that shaping organizational culture is an essential part of leadership.⁵ Therefore, strategic leaders implementing strategy must effectively integrate operational changes, as well as cultural changes, into the fabric of the organizations they lead.⁶ In the case of health care delivery, cultural factors such as excellence in health care delivery, ethical values, involvement, professionalism, value for money, cost of care, commitment to quality, strategic thinking, plus diversity and inclusion are important determinants of the quality of care⁷ (see Essentials for a Strategic Thinker, 9–2, "What Are Diversity and Inclusion?").

ESSENTIALS FOR A STRATEGIC THINKER 9–2

What Are Diversity and Inclusion?



Diversity and inclusion are often used interchangeably, but these terms are not synonymous. Diversity is the breadth of lived experiences by people

from different backgrounds. These different backgrounds may relate to identities such as race, ethnicity, age, gender, gender identity, sexual orientation, disability, social class, religion, political identity, and national origin. Whereas diversity recognizes the differences among people, inclusion goes beyond recognition and focuses on valuing these differences. It is the intentional engagement of people from different backgrounds that fosters inclusion. As consultant, Vernā Myers, masterfully states: “Diversity is being invited to the party; inclusion is being asked to dance.”¹

Diversity is typically measured by reviewing data on the number of people from different backgrounds within an organization. For example, organizations may review annual data regarding the recruitment, interviewing, and hiring of women and individuals from historically underrepresented groups. These efforts to collect and monitor data are necessary; however, diversity in numbers is just the first step. It is not sufficient to increase the numerical representation of people from different backgrounds, without also developing an organizational culture that values the lived experiences of every individual. The intentional engagement of people from diverse backgrounds is needed to create and cultivate an inclusive culture.

For diversity and inclusion, the adage “every organization is perfectly designed to get the results that it is getting” is poignant, yet real. A diverse and inclusive culture will not occur by happenstance. Organizations that make little to no progress in the areas of diversity and inclusion seek members who will acclimate to the existing culture and make a good “fit.” In contrast, organizations that make diversity and inclusion a priority seek a cultural environment that is welcoming to members from different backgrounds. For the latter, “fit” is no longer about whether the individual will conform to the current environment, but about how the individual will enrich the current environment. Initial assessments of whether an organizational culture embodies diversity and inclusion may examine:

- Do the vision, mission and values of the organization embrace diversity and inclusion?
- Do the organization’s structure, function, and processes denote a diverse and inclusive culture?
- Does the organization foster a sense of belonging for each individual?

The responsibility for ensuring a diverse and inclusive culture belongs to each member of the organization – not just to those individuals who are the focus of targeted diversity efforts (e.g. women, minority groups). Leaders must lead to create a culture in which diversity and inclusion are ingrained in the foundation of the organization. Diversity without inclusion or inclusion without diversity will not work. Both diversity and inclusion are critical for meaningful change to ensure all people and their unique identities and contributions are recognized and valued.²

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Source: April P. Carson, PhD, MSPH, FAHA, Associate Professor and Director of Office of Diversity, Equity and Inclusion, School of Public Health, University of Alabama at Birmingham.

In some situations culture may be more important than strategy, as an organization can copy a strategy, but replicating culture is much more difficult.⁸ Strategy implementation is most likely to be successful when the culture of the organization is appreciated and considered. Indeed, culture should serve strategy.⁹ A cognitive culture, as well as an underlying emotional culture, are operating in organizations. The *cognitive culture* is made up of its stated intellectual values, norms, artifacts, and assumptions that serve as a guide for behavior and might include such values as customer focus, teamwork, and quality.¹⁰ The cognitive cultural values are typically promoted and documented in an organization’s strategy and provide meaningful behavioral guidance.

The cognitive culture is shaped by strategic managers largely through the directional strategies and the organizational systems, practices, and processes. The cognitive assumptions, values, and behavioral norms set the tone for how employees think and behave and persists over time even when the membership of the organization changes.¹¹ *Cognitive assumptions* include a common understanding of “who we are” (mission) and “what we are trying to accomplish” (vision and strategic goals) and the belief in the values of the organization. *Cognitive values* represent the understanding of “the way we do things” and reflect the organization’s shared values. The cognitive behavioral expectations or *behavioral norms* are common understandings among the members of a group or organization concerning appropriate ways to act and interact.

The *emotional culture* is reflected in the *shared values*, norms, artifacts, and *shared assumptions* and reflect how people feel in the workplace; it is manifest as emotions such as happiness, sadness, fear, joy, caring, indifference, and so on.¹² People in organizations are socialized by the organization through the cognitive culture, but also have a self with capacities for self-reflection and purposeful action.¹³ Most leaders are focused on the cognitive culture; however, the emotional culture influences commitment, decision making, teamwork, burnout, turnover, absenteeism, and work quality.¹⁴ People’s emotions are drivers of organizational processes.¹⁵ For instance, in health care the emotional culture may deliver a callous and indifferent care rather than compassionate care that would support the strategy.

The attitudes and behaviors of management of the organization largely set the tone for the emotional culture. A positive attitude and optimism demonstrated

by management can go a long way in creating a positive emotional culture. In addition, encouraging creativity and innovation, joy and fun, and instilling pride in quality work further shape a positive emotional culture and tend to be contagious in organizations. Furthermore, a caring and kind emotional culture will foster organizational loyalty.

Strategic managers must focus on both the cognitive and emotional cultures to successfully shape and create an adaptive organizational culture. The current culture may already be supportive of strategic efforts and, thus, there is no requirement to dramatically change the culture. In this case, maintaining cognitive culture and nurturing the emotional culture may be all that is necessary. On the other hand, the cognitive or emotional culture may not support required strategic changes. If this situation occurs, the implementation process may require a change in and management of the stated values of the cognitive culture, and active management of the emotional culture, to encourage people to experience the emotions valued by the organization. Although culture change is difficult, it is often an important factor in moving the organization toward realizing its vision.

Organizational Structure Strategies

Similar to culture, the organizational structure must facilitate rather than impede the implementation of the overall strategy. “Whenever the executives responsible for the firm fail to create the offices and structure necessary to bring together effectively the several administrative offices into a unified whole, they fail to carry out one of their most basic economic roles.”¹⁶ The relationship among strategy, structure, and performance continues to be a topic of great interest and receives much attention.¹⁷ A long-standing, although not universally accepted, tradition in strategy research, known as configuration theory, argues that in specific cases (e.g. industries, locations, and so on) certain organizational structures are more effective in accomplishing the mission than others.¹⁸ This view has been confirmed in a number of settings and reinforces configuration theory.¹⁹

Once the directional, market entry/exit, competitive, and service delivery strategies have been developed, management must determine what organizational structure will best facilitate the strategy. This strategic thinking activity matches the requirements of strategy with the advantages and disadvantages of various organizational structural options. In addition, it should be acknowledged that an organization’s current organizational structure might limit the strategic options or at least their initiation in the short run. Over time, the structure can be changed to meet the needs of the proposed strategy. At some point, the strategist must decide if the present structure should be maintained or changed. This decision must be carefully made to facilitate the accomplishment of the long-term strategy and not merely capitalize on a few profitable activities in the short term.²⁰

Organizational hierarchy remains the basic structure of most large organizations.²¹ Organizations, whether loosely coupled, networked, or

divisionalized, are no more than modifications of the same basic design and hierarchies remain the best available mechanism for doing complex work.²² There are three fundamental organizational hierarchical designs that form the basic building blocks for organizations:

1. Functional structure.
2. Divisional structure (strategic business or service units).
3. Matrix structure.

Functional Structure

A *functional structure* is an organization structure based on the primary activities or processes required for producing the product/service of the organization. Functional structures organize activities around the mission-critical activities or processes of the organization and are the most prevalent structures for single product/service and narrowly focused organizations. A functional structure might include departments such as clinical operations, marketing, finance, information systems, and so on. However, activities will vary from one organization to another. Often parts of an organization are structured around processes. For example, in health care organizations, clinical operations are mission critical and the clinical function may be at the center of a functional structure. The clinic may then be organized around separate clinical processes such as registration, testing, examination, lab, and so on.

A functional structure builds a high degree of specialization and expertise within the functions or processes and can foster efficiency, particularly when tasks are routine and repetitive (such as in clinics). Moreover, in this type of organizational structure, control of strategic decisions is highly centralized. However, functional structures sometimes foster “silo thinking,” slowing down decision making and inhibiting horizontal communication. As a result, it becomes a major task of strategic management to keep functional managers focused on the broader mission and the organization’s vision (beyond their own functions) and to ensure coordination and communication across the functions. [Exhibit 9-4](#) illustrates a functional organizational structure for clinical operations (organized around processes) and summarizes the advantages and disadvantages of functional structures.



Exhibit 9.4 Functional Structure Combined with Process Structure

Divisional Structure

A *divisional structure* is developed on the basis of the organization's products/services, geographic markets, or customers (semi-autonomous business or service units). Divisional structures are common in organizations that have grown through diversification, vertical integration, and aggressive market or product development. As organizations grow and become more diverse, divisional structures are used to break the organization down into more manageable and focused parts. Therefore, a divisional structure creates several smaller, more focused, semi-autonomous strategic business/service units (SBUs/SSUs).

Structures with geographic divisions allow each division to tailor strategy and differentiate products/services based on the unique needs or characteristics of the geographic area or market. Local responsiveness will usually result in enhanced performance because communication and coordination with a target market will be improved. When organizations have multiple unique products/services, a divisional structure that places organizational emphasis on these products/services may be most appropriate. This structure gives product division managers authority and responsibility to formulate and implement a product/service strategy. In addition, the structure allows functional areas to specialize around each product/service, thus increasing coordination and communication. Divisions based on products/services increase the focus on products, markets, and quick response to change.

Divisional structures are not without problems. Divisional structures make it difficult to maintain a consistent image or reputation, add layers of management because of duplicate services and functions, and require carefully developed policy guidelines for the SBU/SSU. In addition, divisional structures may create competition for resources among the divisions. [Exhibit 9-5](#)

illustrates an organizational structure with product divisions (organized geographically) and summarizes the advantages and disadvantages of divisional structures.

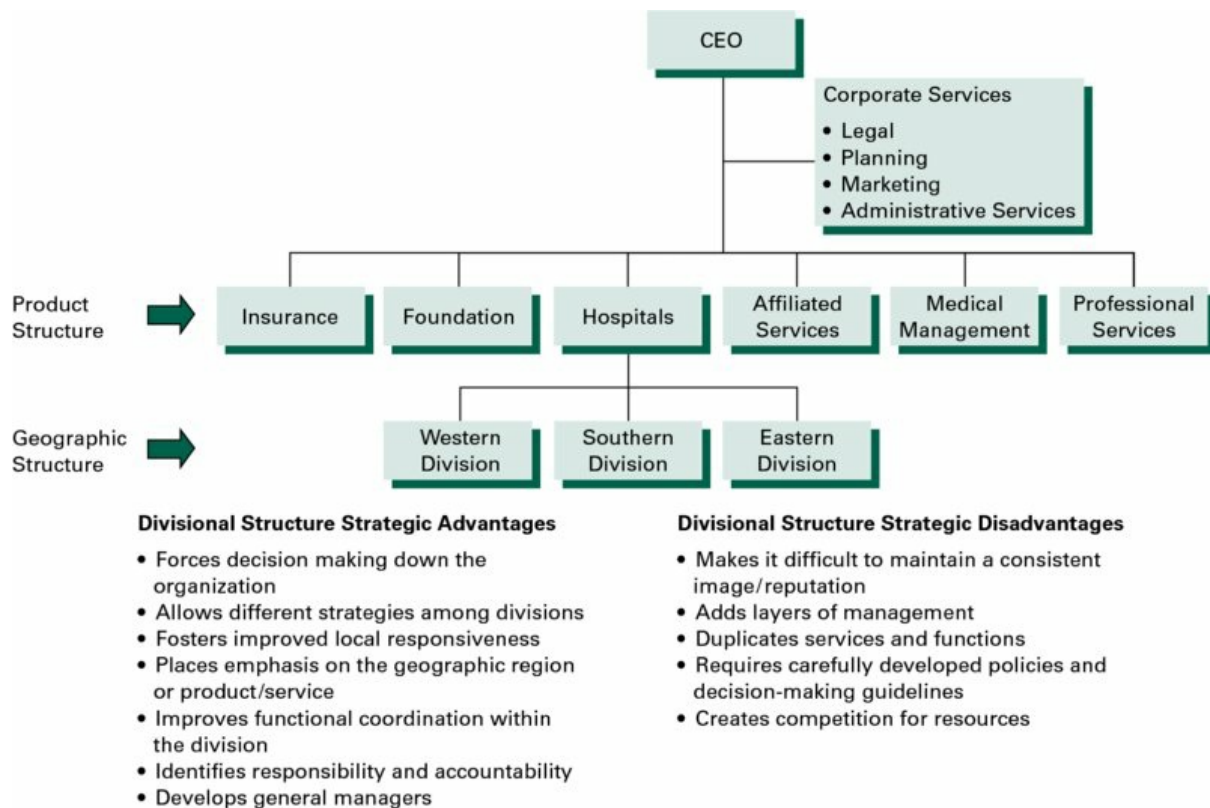


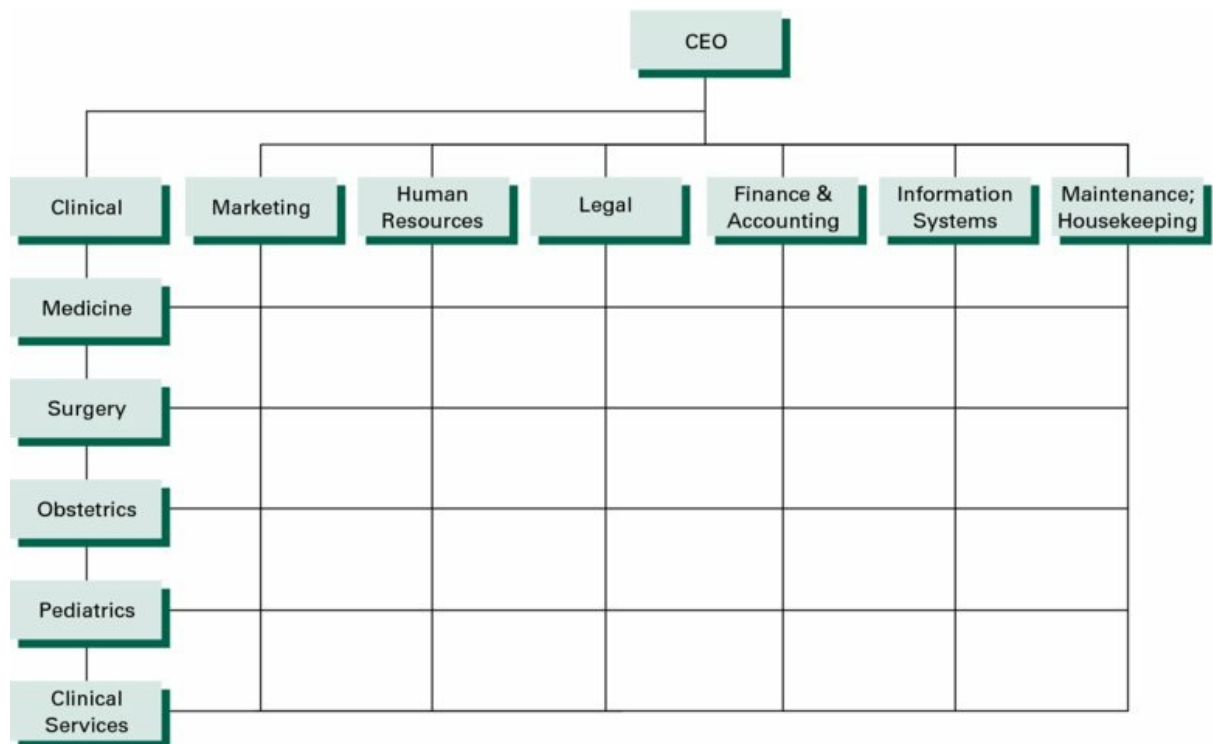
Exhibit 9.5 Divisional Structure – Product with Geographic Divisions

Matrix Structure

A *matrix structure* is an organization structure based on the organization's projects or programs where centralized functional specialists interact with and provide services to project or program teams. A matrix structure may be most appropriate when organizations have numerous products or projects that draw on common functional expertise. The fundamental rationale underlying a matrix structure is to organize around problems to be solved rather than functions or products or geography. Matrix organizations develop expertise and allow product areas or projects to use that expertise as needed. Therefore, in this structure, functional specialists may work on a number of different projects and with a number of project managers over time. Matrix structures foster creativity and innovation in the organization; therefore, the structure is particularly effective for rapid product development and can accommodate a wide variety of product or project activities.

Matrix structures are difficult to manage – no one disputes that fact. The structure violates the “unity of command” (a person reports to only one boss) principle and, as a result, employees are often confused on priorities and “who is the boss.” Therefore, this type of structure requires a great deal of coordination and communication, plus some degree of negotiation and shared responsibility between project managers and functional managers. [Exhibit 9-6](#) illustrates a

matrix structure, summarizing the advantages and disadvantages.



Matrix Structure Strategic Advantages

- Develops functional expertise
- Allows for a variety of product/project developments
- Allows for the efficient use of functional expertise
- Encourages rapid product development
- Fosters creativity and innovation

Matrix Structure Strategic Disadvantages

- Causes difficulties in management
- Violates the unity of command principle
- Creates coordination and communications problems
- Requires negotiation and shared responsibility
- Allows for confusion on priorities

Exhibit 9.6 Matrix Structure

Combination Structures and Teams

Determining the most effective basic structure to carry out the strategy is critical for all organizations; however, health care organizations are rarely organized using just a single structural building block. Rather, health care organizations commonly find it necessary to create combination structures to mix and often supplement the basic design. *Combination structures* use more than one type of organizing approach. For example, functional organizations are often supplemented with cross-functional teams to improve coordination and communication. Furthermore, geographic divisions may be organized around functions or products. Product divisions may have geographic divisions as well as functional components. Organizational structure should enable the strategy; managers should select the most appropriate set of organizational structure building blocks.

Although the organizational structure building blocks set the basic design of the organization, seldom are they adequate for carrying out the strategy and work of the organization. Therefore, most organizations modify their basic structure with some type of coordinating structures. These coordinating structures are sometimes referred to as the *collateral organization* – a system of teams, task

forces, committees, and ad hoc groups that supplement the basic organization structure and are used to bring different perspectives to the table for discussion and resolution. No organization can function for long without an effective collateral organization.²³ Collateral structures include:

Project and product teams

Created to undertake well-focused projects (typically short term) or to develop new products.

Cross-functional task forces

Created to bring together specialists from several functional areas and address threats or opportunities. Typically, task forces take on a major project such as reorganization or the building of new facilities.

Venture teams

Created outside the normal organizational structure, they are not bound by the normal “rules” of the organization. Because they develop new products or processes, the creation of venture teams is sometimes called “intrapreneuring.”

Re-engineering teams

Created to evaluate and reconfigure an organizational process (such as service delivery). Such teams are asked to disregard the current way of doing things and to redesign a process from scratch.

Executive and standing committees

Created to make organization-wide decisions. Executive and standing committees provide wide representation for key decisions and facilitate communication of the organization’s direction and strategy implementation.

Greater diversity in the composition and function of teams is occurring than in the past. For example, team members may be dispersed in different locations, interact only electronically, and membership adjustments may be quite dramatic.²⁴ Therefore, it is important that both traditional teams and virtual teams have strong cultures motivated by a clear and motivating direction, the right mix of members, support from the organization’s leadership, and a sense of identity – common understandings concerning the mission and values of the team.²⁵ Where a sense of identity and common understandings exists, self-managed teams may be utilized. Self-managed teams eliminate organizational hierarchy; leadership, authority, accountability, goal setting, and decision making are dispersed throughout the team. Self-managed teams are often called holacracies, pods, circles, or organic organizations, and foster flexibility, adaptability, engagement, and productivity.²⁶

Strategic Resources Strategies

Effective development and use of key organizational resources are critical in carrying out the selected strategies. *Strategic resources* (resources, competencies, and capabilities) include financial, human, information systems, and technological assets of the organization.

Financial Resources

The financial resources of the organization are evaluated during internal analysis and contribute to strategy formulation. Therefore, to this point the financial resources have provided a framework for developing a realistic strategy. Once the strategy has been selected, finance becomes a way to implement the strategy. All organizational strategies have financial implications and most will require an assessment of needed capital and a method to access capital. In addition, strategies require an understanding of the relationship between the organization's business model, reimbursement methods, and the mission.²⁷ Expansion, reduction, or maintenance of scope adaptive strategies will require a financial implementation strategy.

Expansion and maintenance of scope strategies frequently make it necessary for health care organizations to enter the capital market or make arrangements to borrow money from one or more financial institutions. Expansion of scope, such as market development, may be realized through acquisition of a competitor (horizontal integration) and involve hundreds of millions of dollars. In addition, expansion carried out through cooperation strategies may require additional financial resources. Joint ventures are often financed by attracting other individuals, such as physicians, to invest in promising ideas or equipment along with the hospital. Similarly, maintenance of scope strategies directed toward enhancement of facilities, equipment, quality of services, and so on will often require new capital and operating funds. An organization may have to acquire new property and relocate in its efforts to change the image held by physicians who might join its staff and the patients who might use its facilities. New technology may be demanded as well for this change in image or for significant improvement of services.

Reduction of scope strategies require equally challenging financial decision making. Divestiture, liquidation, harvesting, and, in some cases, retrenchment all convert financial resources, at least temporarily, into cash or near cash assets. An inflow of cash forces strategic managers to consider alternatives for the funds to ensure that they are appropriately invested until they are needed for other uses. Reduction of scope requires careful re-evaluation and possible redirection of financial resources. For example, a hospital experiencing financial distress, after careful analysis, might decide that its emergency room is too expensive to continue to operate in view of limited demand by the community. The high level of specialized staffing for around-the-clock operations is a financial burden that cannot be justified economically. The decision to close the emergency room would temporarily free financial resources that could be allocated to more profitable areas and relieve some of the cost pressure on the

hospital.

In developing financial strategies to carry out the organization's overall strategy, two issues typically predominate – increasing financial resources (equity and debt capital acquisition in addition to fund raising) and better management of the organization's current financial resources including cash flow management, budgeting, and financial planning. Financial leasing as a financing alternative is examined in Essentials for a Strategic Thinker 9–3, “What is Financial Leasing?” In addition, analysis of accounting and financial issues, as well as interpretation and analysis of balance sheet and income statement issues, are reviewed in this textbook in Resource 2 – Health Care Organization Accounting, Finance, and Performance Analysis.

ESSENTIALS FOR A STRATEGIC THINKER 9–3

What is Financial Leasing?



The delivery of health care is typically capital-intensive with extensive investments in equipment and real estate. Capital intensity motivates health care organizations to seek access to all forms of financing. In addition to equity and debt financing, it is a common practice for health care organizations to enter into lease arrangements for facilities and equipment.¹ In other words, health care organizations use leases to finance assets that would otherwise be financed by equity or debt. A lease is “an agreement conveying the right to use property, plant, or equipment (land and/or depreciable assets) usually for a stated period of time.”² In a lease arrangement, the organization with the right to use an asset is known as the “lessee” and the organization actually owning the asset is the “lessor.” Long-life assets present two forms of risk: (1) ownership risk – obsolescence or default on debt and (2) operating risk – inefficient or ineffective use of the asset resulting in financial losses. In buy-and-use, the buyer is exposed to both ownership and operating risks. Lease arrangements, on the other hand, separate the risks such that the lessee bears only the operating risk and the lessor bears the ownership risk.³

Leasing is often an attractive financing alternative for a health care organization to: (1) avoid technological obsolescence – with frequent changes in technology, lessees are able to upgrade as needed; (2) improve maintenance – lessors usually include expert maintenance with a lease and incur the cost of training and equipping maintenance personnel; (3) off-set project-life uncertainty – leases often include cancellation clauses useful for lessees with uncertainty about the length of time an asset will be needed, lessors accept such clauses because they are in a good position to remarket the asset; (4) maintain credit availability – it is often possible for a lessee to obtain larger amounts of financing for a longer period of time in a lease financing versus a loan financing for an asset; and (5) preserve liquidity –

by leasing an organization avoids a potential large cash outlay frequently required in a purchase.^{4,5}

Some health care organizations have used long-term leases as a form of “off-balance sheet financing,” a situation where the value of the lease is not reported on the balance sheet, thus, the organization gains access to high-value assets without having to record a debt (long-term leases are reported in the debt portion of the balance sheet).⁶ The use of off-balance sheet finances permits organizations to portray their financial health as being better than it is in reality – through a lower debt ratio. In 2019, new accounting rules are to be implemented that significantly curtail the practice of off-balance sheet financing.⁷ Under these accounting rules, the value of the leases must be placed on the balance sheet. The impact of this change for health care organizations is that some organizations may be reporting more debt on their balance sheets making future debt financing costlier. For the most part, cash flow will be unaffected by the change in requirement since lease payments will be treated in much the same way as interest payments.⁸

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Source: Andrew C. Rucks, PhD, School of Public Health, University of Alabama at Birmingham.

Human Resources

Successfully implemented strategy is inextricably connected with having committed, high-performing employees.²⁸ It takes strong leadership and a positive organizational culture to keep employees motivated and productive. Motivated employees are the key to any strategy; however, human resource requirements of the selected strategies will vary considerably depending on whether the organization is expanding, reducing, or maintaining scope. For example, expansion strategies, such as related diversification, will make it necessary to recruit new personnel with skills and talents similar to those already in the organization. On the other hand, unrelated diversification or backward/forward vertical integration will create the need for human resources with skills and talents quite different from those presently employed. The necessity of recruiting, hiring, and leading individuals with different skills and talents is a major reason that these strategies are “riskier” than related diversification. Any one of these strategies requires the merger of organizational cultures, presenting yet another human resources challenge.

Diversification and integration are two very different strategic choices, but they require similar types of organizational and human resources management responses. When diversification or integration is selected as a strategic alternative, organizational size and diversity may increase, along with the demand for more specialized human resources management services.

Although the problems are difficult and demanding, expansion is always more fun to manage than maturity and decline. During maturity, the emphasis is on efficiency. Human resources management practices must be constantly refined and improved to ensure that things are done in the best way at the least cost. However, organizations do not always successfully manage maturity, hence markets erode and even disappear. Therefore, the strategic health care manager needs to understand how to manage organizational and human resources during market contraction.

Reduction of scope involves different human resources management skills. Incentives must be devised to encourage employees to find other jobs or to retire earlier than anticipated. For some, layoffs may be necessary, and the organization will be forced to determine its responsibility in assisting displaced employees to find alternative employment opportunities. At times, health care organizations may assist employees by retraining them for different tasks that will be needed as reduction of scope takes place.

In Chapter 6, several reduction strategies, such as divestiture and liquidation, were discussed. Although terms such as “divestiture” and “liquidation” imply financial actions, they have important human resource implications in the form

of restructuring and reorganizing, early retirements, layoffs, and so on.

The benefits of systematically managing the human resources dimension under expansion and reduction strategies are somewhat obvious. The need for carefully managing maintenance of scope strategies is equally important, if not as obvious. Maintenance strategies almost always require training and development activities. Enhancement strategies, through total quality management programs, involve significant commitments to continuous learning on the part of the individual and the organization. Status quo requires the challenging task of keeping people motivated in the face of career plateaus.

When an organization reaches a point in its life cycle where it is no longer growing, it must work extremely hard to keep from contracting. Strategic decision makers may adopt a conservative strategy, such as managing the steady state or status quo. As was noted in Chapter 6, the assumption underlying this strategy is that the expansion phase of the organization's evolution is over, maturity has been achieved, and acceptable market shares have been attained. The organization attempts to replace personnel with employees of similar skills and training, and works to keep existing personnel up-to-date and technologically prepared to perform their jobs at high levels of effectiveness.

Maintaining scope can present an opportunity to enhance current levels of operation. This stage of organizational development can be thought of as a temporary "breather," allowing preparation to commence for the next period of growth. Or, decision makers may simply think of maintaining scope in a dynamic sense and recognize that they must work hard just to hold their current position. In this case, they may choose to enhance their facilities, improve the quality of their services, increase the speed with which they respond to patients and make decisions, and create new and better ways of doing things. Human resource strategies are important to support any attempt at enhancement because ultimately it is the employees that must promote quality, innovate, and work faster if things are to improve.²⁹

Information Resources

Information systems (IS) are an essential competitive resource for health care organizations and are critical in supporting strategic decision making, administrative operations, and patient care in an increasingly information-intensive industry. Although much attention has been focused on the competitive nature of sophisticated information technology, health information systems are no less important in the public sector.³⁰ Information systems in health care may be divided into four general categories: clinical, management, strategic decision support, and electronic networking and e-health applications.³¹ Competitive advantage may be created in each of these areas, and strategic managers should therefore play a key decision-making role in defining and shaping these systems. Such systems draw on both internal data from clinical and administrative systems in the organization and external data on community health, market demography, and activities of competitors.³² To meet strategic objectives and develop high-priority applications, the health care organization must make decisions about hardware configurations

(architecture), network communications, degree of centralization or decentralization of computing facilities, and types of computer software required to support the network.³³ One type of health information system, the electronic health record, may be used effectively to create competitive advantage (see Essentials for a Strategic Thinker 9–4, “What Is an Electronic Health Record?”).

ESSENTIALS FOR A STRATEGIC THINKER 9–4

What Is an Electronic Health Record?



The electronic health record (EHR) is a digital version of a patient’s medical chart and other important information designed to improve care communication and coordination.¹ EHRs are designed to be a secure information platform where patients, providers, and other stakeholders are able to: (1) post and retrieve relevant data; (2) access evidenced-based decision support tools; and (3) streamline activities to improve care processes. In the United States, efforts in the ambulatory and inpatient environments to implement EHRs that meet these design aims have been underway for many years.²

When EHRs were first developed in the early 1990s, they were primarily used to document clinical encounters by an individual provider. Despite this limited scope, the EHR’s potential benefits were quickly recognized by the Institute of Medicine (IOM) that issued a report calling for a “paperless” care environment within ten years.³ In particular, the IOM realized that through progressive innovations, the EHR would become a technology platform linking a wide variety of hardware and clinical data sources. The EHR’s potential to promote care quality improvement and operational efficiency was slowed by providers’ concerns about the system’s costs and potential disruptions to workflows.

Providers’ slow uptake of EHRs may have continued except for passage of the Health Information Technology for Economic and Clinical Health Act in 2009.⁴ The law stipulated that most doctor’s offices and hospitals should implement progressively more sophisticated EHR technologies in stages. The Meaningful Use program, as it came to be known, accelerated EHR adoption in both the ambulatory and inpatient settings. Nearly every U.S. hospital has at least a basic EHR capable of capturing clinical data from providers. Moreover, the benefits to care quality and improved efficiency associated with EHR use are beginning to become apparent. As a result, many U.S. health systems are implementing EHR platforms with increased capabilities as a means of creating a sustained competitive advantage.

Early adopters of EHR platforms have a first-mover advantage that is difficult for others to overcome in the near-term. The reason for the

advantage is that EHRs require lower-level, basic functionalities be in place before higher order clinical applications can be effectively integrated into the system.⁵ Hence, EHR platforms follow a path dependent model of technology innovation and diffusion with early adopters able to stay ahead of the competition. In addition, EHR's technological advantages enable hospitals to deliver higher quality care and avoid unnecessary costs. Because EHR platforms become more robust as the network of providers and systems feeding into it grows, the potential competitive advantage increases as well. Moreover, having a robust EHR provides the information needed to meet reporting requirements contained in many of the rewards and incentive programs being created by insurers.

Public and private insurers are creating new reimbursement plans designed to increase care quality while simultaneously reducing costs. Value-based purchasing or VBP plans rely heavily on doctors and hospitals tracking care processes and health outcomes. The amount of care-process details needed to achieve reward thresholds of most VBP plans, necessitates the use of advanced EHR capabilities. Therefore, having a fully-functioning EHR will gradually transform from a competitive advantage to a business sustainability requirement – as has happened with technological advances in many other sectors throughout history.

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Source: Eric W. Ford, PhD, MPH, Professor, School of Public Health, University of Alabama at Birmingham.

A *strategic information system* (SIS), sometimes referred to as a *decision support system*, takes vast quantities of unorganized data and converts them

into useful information to enable managers to make better decisions. Such information systems involve organizing the data, selecting the models that will be used to analyze the data, and interpreting the output; nevertheless, it is not sufficient simply to provide the reports to the strategist. Sometimes there is a need to interpret and clarify the data relative to the assumptions that were used. Because decision support systems attempt to investigate future activities, the assumptions are critical. The organization that can design a SIS that is pertinent, relatively accurate, and timely will have developed a competitive advantage. “Inappropriate use and interpretation of decision support models can be dangerous, but appropriate use of these models can be a powerful tool in the hands of an informed decision maker.”³⁴ Geographic Information Systems (GISs) are increasingly being used in health care to provide decision support (see Essentials for a Strategic Thinker 9–5, “What Is a Geographic Information System?”).

ESSENTIALS FOR A STRATEGIC THINKER 9–5

What Is a Geographic Information System?



A geographic information system (GIS) is computer software used for the collection, storage, management, analysis, and visualization of data. That data has associated location information such as latitude and longitude or a physical address that can be translated into geographic coordinates and mapped to a physical location. Maps created using GIS help individuals and organizations integrate, aggregate, and interpret data elements by organizing related data and using location as the unifying common denominator.

Using maps to display health care data can aid in understanding and interpreting patterns, trends, and interrelationships of complex data. For example, GIS data can be used to track the influence of vaccination policy on the distribution of disease, identify high-risk populations with special health care needs, track the effects of health care resources on health outcomes, as well as monitor diseases or track medical mistakes across organizations. In addition, GIS makes it possible to aggregate and track information at the individual patient level within an individual health care institution, a health care system, or across a community, state, or region through information contained in electronic health records (EHRs).

GIS has been evolving and its use in health care has been expanding as its applications have become better understood. For example, GIS is now being used by health care professionals to manage supply chain networks, identify new service locations, understand specific population health needs, understand the health care access needs of different patient populations, track assets within an organization, and track health service utilization.

Combining and layering datasets can yield even more information. For example, a data layer of hospital locations that contains each hospital's capacity and trauma level combined with a data layer of the state's highways plus a layer of population density, results in a map that paints a more robust picture of the health care landscape. Additional analysis using spatial statistics (statistics that incorporate the spatial relationships between data) creates an even more detailed picture identifying counties in need of additional hospital resources (quantifying that need based on drive times and incorporating predictive modeling of projected population growth).

Similarly, GIS is being used to add context and meaning by adding a geospatial component to current in-house datasets. For example, the Northern California Kaiser Permanente health system has used the spatial statistical capabilities of GIS and vaccination data from members' EHRs to identify significant clusters or "hotspots" of children considered to be underimmunized for childhood illnesses, which can be associated with increased risk to the insurer's members and the community at large. By identifying these areas, public health officials and health care providers can efficiently target additional educational efforts and interventions in the locations most impacted.¹

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Source: Ariann Nassal, MFA, Evaluation and Assessment Unit, School of Public Health, University of Alabama at Birmingham.

Administrative information systems support financial information systems, human resources systems, payroll, billing, purchasing, materials and facilities management, outpatient clinic scheduling, office automation, and so on (other than direct patient care). Clinical information systems support patient care and include computerized patient records systems, automated medical instrumentation, patient monitoring systems, nursing information systems, laboratory information systems, pharmacy information systems, clinical decision support systems, and information systems that support clinical research and education. Most information systems in the health care system focus on the financial and administrative aspects of the practice of medicine and much less on the clinical decision making.³⁵ However, clinical information systems are growing in importance, creating significant competitive advantage through increased efficiency and effectiveness in patient care. Basic clinical information systems provide a "dictionary" of health problems for clinicians or display background information on specific patients. More sophisticated systems, often referred to as expert or knowledge-based systems, can actively assist clinicians in the decision-making process.³⁶ Such functions include:

- Assistance with diagnosing a patient's condition.

- Assistance in determining proper drug dosage.
- Reminders to administer preventive services to patients at specific times.
- Assistance in carrying out diagnostic or therapeutic procedures, such as recommending specific treatments, reminders to perform procedures, alerts regarding potential adverse events, feedback based on previous orders, and prompts for testing or treatment options.³⁷

In today's information-intense environment, seamless integration and information sharing are becoming increasingly important. Most health care organizations interchange electronic data within their own organizations as well as with other organizations for insurance billing and claims processing, accessing clinical information from regional and national databases, online purchasing, and communications between affiliated providers.³⁸ Telemedicine is a part of such systems and has the potential to create additional competitive advantage for health care organizations. Newer technologies include the use of mobile technologies for improving pharmacy utilization.³⁹ Perhaps equally important is the fact that although there are still some resisters, most of the evaluations of the use of health information systems have been positive.⁴⁰

Strategic Technologies

The technologies selected by the organization are dictated by the chosen strategies. Broadly, *strategic technologies* concern the type of facilities, type and sophistication of equipment, and management of technology employed within the organization. Each of these activities is critical to the successful implementation of the organization's strategy.

Facilities is the broad term used to delineate the physical environment of the health care organization. It is the "shell" in which health care is delivered. It generally includes such diverse areas as design and construction of new facilities and renovation of older facilities, key equipment, clinical engineering, environmental services, safety and security, materials management, and food service. Each component affects the health care organization's ability to implement its strategy.

Facilities management is an area of increasing concern to strategic managers of health care organizations for a variety of reasons. One of the most important is changing technology that has fostered tremendous growth in the number and kind of alternative delivery systems requiring different strategies for success. Free-standing outpatient clinics, ambulatory (same-day) surgery centers, diagnostic and imaging centers, and others, are challenging traditional inpatient health care delivery. To survive, hospitals have expanded vertically and horizontally to diversify into these new delivery systems; however, each type is subject to different regulatory guidelines as well as entirely different design needs for buildings – a challenge for the facilities manager.

A variety of components should be considered in the design of a health care facility: medical technology, the full range of medical procedures from routine exams to complicated life-saving activities, medical staff, sanitation, prevention

of injury, economics, patients, and visitors. From the patients' perspective, the facility includes "curb appeal," ease of access to the main entrance, ease of parking, ease of wayfinding (finding the department, room, diagnostic area, or other area where the patient is expected), comfort, and convenience. Designing the facility with the human experience in mind recognizes that people's perceptions of health care are multidimensional; the facility helps them to define the care they receive. Sending a "we care" message cannot stop with the staff but must be designed into the facility itself.⁴¹

When the health care organization decides on a high-tech, high-touch, or some other strategy, the facility provides the first impression. The design, layout, color scheme, and so on should reflect the desired image to improve the implementation of the strategy. "Unlike the quality of medical care, health facility design is something that can readily be understood and judged, for better or worse, by the public."⁴²

Closely associated with facilities is the choice of the type and sophistication of equipment and effective management of technology; these are integral parts of strategic management and should be approached in a systematic way. Because health care technology changes rapidly, is costly, and often requires changes in the facility, it must be assessed and planned for carefully to reach its greatest potential. Physicians generally want the latest technology – using the "latest" equipment or newest procedure earns prestige with colleagues and patients and may save more lives or prevent discomfort. The decision concerning the use of the latest technology must fit with the strategy (differentiation based on high-technology image).

Another consideration concerning technology is determining how rapidly a new technology will supplant an older one. New technologies that are not dependent on co-innovations and new infrastructure will be adopted much faster than new technologies that require new supporting infrastructure complements.⁴³ Where there is substantial commitment to an old technology or the supporting infrastructure can be improved, change to a new technology might come very slowly.⁴⁴ Therefore, adopting a new technology too soon may create a competitive disadvantage just as adopting too late might.

Technology decisions involve technology assessment, planning, acquisition, and management.⁴⁵ Strategists advocate that a committee assess requests for new and emerging technology alongside the capital budget requests for new and replacement technology. The committee should report to senior management and should set mission-based, strategic priorities for new, emerging, and replacement technologies. Many hospitals do not incorporate into the budget the costs of redesign and "space" for new technology; nor do they investigate ways to reduce maintenance, insurance, and outside service contract costs. The planning process has to take into account what the competition is planning to acquire in terms of new and emerging technology as well as assessing the services offered by competitors.

Clinical engineering (sometimes called biomedical engineering) is a relatively new area in most health care organizations. Its responsibilities include: applying

engineering technology to diagnostic and treatment devices used by health care facilities through testing, maintaining, and repairing equipment; training; consultation with clinical staff concerning the capabilities, efficiencies, and accuracy of the equipment; environmental testing; and incident and recall investigations that involve diagnostic or treatment equipment. The number and sophistication of technologies within health care institutions has increased significantly over time. Because of the expertise required for such a large variety of equipment, some health care organizations use outside service contracts for some or all of their technological equipment.

Step 2: Compare the Strategy Requirements with the Results of the Support Activities Internal Analysis

Each value chain support area was evaluated in situational analysis (Chapter 4) and the conclusions were used in strategy formulation. As with the value-adding service delivery strategies, the results of the internal analysis identify the competitively relevant strengths and weaknesses for the support activities. Depending on the results of this comparison, the support areas may need to be maintained or changed to carry out the selected strategy.

A strategic thinking map depicting this rationale in the form of a table is shown in [Exhibit 9-7](#). The table organizes strategic thinking about what elements of the support strategies may need to be maintained or changed to meet the needs of the selected strategies.

Value-Adding Support Strategies	Results of Internal Analysis	Requirements of Selected Strategies	Comparison of Strategy Requirements and Internal Analysis	Maintain or Change
Organizational Culture Shared Assumptions Shared Values Behavioral Norms				
Organizational Structure Functional Divisional Matrix				
Strategic				

Resources				
Financial				
Human Resources				
Information Systems				
Technology				

Exhibit 9.7 Strategic Thinking Map for Developing Value-Adding Support Strategies

Step 3: Decide to Maintain or Change Organizational Culture

Mission, vision, values, and strategic goals (discussed in Chapter 5) provide an explicit linkage between strategy and culture. Just as these directional strategies were a major input to the selection of the adaptive, market entry/exit, and competitive strategies, they play a major role in shaping the appropriate organizational culture. How the organization defines itself, what it wants to be, how it accomplishes its tasks, and what it wants to achieve, shape the culture of the organization. The directional strategies can be powerful forces in maintaining or changing the culture. Similarly, management's attitudes, style, and behaviors shape the organizational culture and play a major part in creating a positive and adaptive culture.

Strategic managers must decide whether the organizational culture can help achieve the strategy. Therefore, they must assess what cognitive and emotional assumptions, values, and behavioral norms are necessary to most effectively carry out the strategy. Attributes of the current assumptions, values, and behavioral norms must be compared with the assumptions, values, and behavioral norms required by the strategy. For example, if a market development strategy is being pursued, strategic managers may have to maintain the current culture; for new entrepreneurial ventures or product development, however, the culture may have to change. As discussed in Chapter 6, strategies that involve acquisitions, mergers, and alliances usually have organizational culture implications. Incompatible cultures may contribute to failure of the strategy.

During the situational analysis of the strategic management process, the mission, vision, values, and strategic goals (the directional strategies) were evaluated. The leader must assess whether these directional strategies are still appropriate and are actually reflected in the culture of the organization. Results of this assessment will determine whether the leader needs to create implementation strategies to maintain or change organizational culture. In addition, the current management style should be assessed to determine whether it is supportive of the strategy.

In addition to the comparison of the requirements of the overall strategy to current culture, results of the internal analysis itself may suggest action. The

internal analysis specifies whether the organization's culture is a strength or weakness and whether it might create a competitive advantage or disadvantage. Therefore, the results of the internal analysis must also be considered in the decision to maintain or change the culture. The culture of an organization will greatly influence the extent to which individuals are willing to share decision making, how open individuals are to ideas from patients, and the quality of cooperation among diverse organizational units.⁴⁶

Maintain Organizational Culture

Despite a good match between the attributes of the current culture and requirements of the strategy, the work of management is not complete. Maintaining culture often requires a great deal of hard work. In internal analysis, if aspects of culture are evaluated as strengths having high value (H), being rare (Y), easy or difficult to develop (E or D), and sustainable (Y) – resulting in HYEY or HYDY – maintaining culture is particularly important because culture can be a source of short-term or long-term competitive advantage. Culture can be a powerful weapon in recruiting, efficiency, and innovation. Allowing this strength to deteriorate will lead to competitive disadvantage, particularly when it is common (not rare) among competitors.

Therefore, in maintaining culture, managers should:

- Communicate often the mission, vision, values, and goals – verbally and in writing.
- Behave in ways that are consistent with the values and vision – first through their personal behavior, and then through new hires, promotions, and rewards.
- Review and discuss the values and behavioral norms periodically.
- Ensure that organizational roles, responsibilities, and relationships are supportive of the culture.
- Explicitly communicate which emotions will help the organization be successful.
- Continue to cultivate desirable emotions.⁴⁷

Change Organizational Culture

Changing organizational culture can be difficult and requires a great deal of planning, time, and energy. Strategists Michael Beer and Russell Eisenstat noted that “[w]e’ve become convinced that the most powerful way for leaders to realign their organization is to publicly confront the unvarnished truth about the barriers blocking strategy implementation. Typically, this realignment involves looking closely at the roles and decision rights of various parts of the business, as well as changing the behavior of people at all levels.”⁴⁸ Further, a reworking of the fundamental practices required by matching the current culture with the requirements of the strategy will lead to new values, behaviors, and standards to reinforce the new direction.

When culture is viewed as a weakness (from internal analysis) or the requirements of the strategy call for a different culture, culture-change strategies should be initiated. In cases where ineffective culture is assessed as a common weakness, competitors may be moving to build their own organizational culture to create competitive advantage; therefore, culture-change actions should be initiated. When effective culture is a weakness, the weakness is not common among competitors, and is difficult to develop (HNDY and HNDN), change strategies should be initiated, particularly where competitors may act and achieve a significant competitive advantage. The most serious situation, of course, is where an organization has a weak culture and other organizations have effective cultures (weak culture is not common), and it is difficult to develop a new culture (HNDY and HNDN) resulting in a significant competitive disadvantage. Strategic managers who want to create culture change should focus their energies on a few critical activities:

- Clearly define the desired values and an inspiring direction.
- Redesign the organization's roles, responsibilities, and relationships to support the strategy.
- Discuss and codify behavioral norms.
- Live by the values from the very beginning.
- Clarify the vision and indicate what changes are necessary to achieve the vision. People need a clear sense of where the organization is going and where they should be headed.
- Use simple, powerful, and consistent language.
- Model the kinds of behaviors and practices that management wants infused into the organization through actions. "Walking the talk" gives credibility to the words and provides examples to others in the organization of what behavior is expected.
- Empower other people to start acting in ways that are consistent with the desired values, and to implement new behaviors and practices. Part of empowering others is removing barriers within the organization that are in the way of the desired behavior.
- Look for some quick but sustainable successes. Short-term successes are critical to provide the change effort with some credibility, keep people motivated, and demonstrate positive results to the organization.
- Demonstrate patience and persistence. Major culture change takes a long time – years not months – and the willingness to persist in the face of obstacles and setbacks is critical.⁴⁹
- Explicitly communicate which emotions will help the organization be successful.
- Cultivate desirable emotions.⁵⁰

Step 4: Decide to Maintain or Change the Organization Structure

Strategic managers should strive to keep their structures (and processes) as simple as possible and trim every vestige of unnecessary bureaucracy – for example, extra layers of management.⁵¹ Fundamentally, the structural decision is one of prioritizing standardization versus flexibility and selecting the basic structure that best achieves the required priority. Therefore, strategic managers must evaluate the advantages and disadvantages of each of the structural building blocks and match them with the requirements of the strategy. For example, a different structure may be required to carry out a defender/cost leadership competitive strategy than that for a prospector/differentiation strategy. Defender strategies require a high degree of structural standardization to create cost efficiencies while prospector strategies require a great deal of structural flexibility to develop new technologies and innovative products and services. The strategic thinking map shown in [Exhibit 9-8](#) provides guidance concerning the most appropriate organizational structure based on the strategy requirements of standardization or flexibility.

Strategy Requirements	Functional High Standardization	Divisional	Matrix High Flexibility
High level of coordination	X		
High level of standardization	X		
Area/functional expertise	X		
Main goal of efficiency	X		
High level of control	X		
Develop general managers		X	X
High degree of operating autonomy		X	
Decentralized decision making geared to the market		X	
High need to customize product or services to market	X		
Consistent image		X	
Need local coordination		X	
Many projects using similar technologies			X
Need high level of creativity and innovation		X	X
Need high level of stability	X		
Need to develop new technologies			X
Need to be a cost leader	X		

Need to have service diversity		X	
Large organization		X	

Exhibit 9.8 Strategy Requirements and Organizational Structure

Maintain the Structure

If there is a good match between the characteristics of the current organizational structure and the requirements of the strategy, then the present basic structure should be maintained, although additional coordinating mechanisms may be required. It is not often that organizational structure alone will create long-term competitive advantage; however, structure is a key implementation area (especially when coupled with an effective culture). When it is viewed as a competitively relevant strength, efforts should be made to keep it effective – whether or not it is rare among competitors. In maintaining the present structure, management should:

- Evaluate the present level of communication and coordination and discuss needed additional communication channels and coordinating mechanisms.
- Evaluate the present structure to ensure that there are opportunities for innovation where appropriate.
- Evaluate the management team to ensure that the leadership skills match their positions.
- Inventory the present skills to ensure that they are matched to the structure and strategy.

Change the Structure

If the comparison of the present structure and requirements of the strategy suggest a need to change the basic organizational structure, then management must develop a plan and move very carefully. Ineffective or inappropriate organizational structure can debilitate the organization's strategy – such as might be the case with too many organizational layers, thus delaying decision making – but by itself structure is not generally seen as a significant long-term competitive disadvantage. However, where the organizational structure is viewed as a competitive disadvantage, action must be taken. Reorganization represents a significant change for employees and is often viewed as threatening. Research suggests that reorganizations can cause greater stress and anxiety over possible layoffs that may decrease productivity. To help managers think through reorganization, a re-engineering approach may be taken. Re-engineering reconsiders and changes how tasks connect to each other to produce more efficient overall systems of work.⁵² Therefore, when changing the structure, management should:

- Follow a rigorous disciplined process with clear objectives for added value.
- Develop a flow chart of the total process, including its interfaces with other value chain activities.

- Simplify first, eliminating tasks and steps where possible and analyzing how to streamline the performance of what remains.
- Determine which parts can be automated (usually those that are repetitive, time consuming, and require little thought or decision).
- Introduce advanced technologies that can be upgraded to achieve next-generation capability and provide a basis for further productivity gains in the future.
- Evaluate each activity to determine whether it is strategy critical (strategy-critical activities are candidates for benchmarking to achieve best-in-industry performance status).
- Weigh the pros and cons of outsourcing activities that are non-critical or that contribute little to the organizational capabilities and core competencies.
- Compare the advantages and disadvantages of the organizational building blocks regarding standardization and flexibility.
- Design a structure for performing the activities that remain, then reorganize the personnel and groups who perform these activities into the new structure.⁵³

Changing the organizational structure can be a difficult task and may require some new thinking and new approaches to old problems. Re-engineering efforts that have been undertaken by health care organizations indicate that the use of integrating mechanisms, such as codifying the process, and the use of internal teams and committees during implementation appear to be most effective.⁵⁴ In addition, as they undertake restructuring, strategic managers need to evaluate what competitive benefits are actually accruing to ensure that managers are not just reorganizing to be like everyone else, but for improved outcomes – they must understand how re-engineering affects the organization's competitive position.⁵⁵

Step 5: Decide to Maintain or Change Strategic Resources

Strategic resources are particularly important in implementing strategy. Essentially an organization must have the financial resources, human resources, information systems, and technology to carry out the strategy. Although these factors were, no doubt, considered in the adoption of the broader strategies, external and competitive changes constantly challenge strategic resources. For example, changes in health care policy may place new demands on the organization's technology in terms of tracking quality, or the competition may build new state-of-the-art facilities. Initiating a response requires new financial resources and substantial changes in equipment and facilities. Strategic resources are a key building block in implementing strategy.

Maintain Strategic Resources

If there is a match between the present level of strategic resources and the requirements of the strategy, then efforts should be made to maintain the

financial, human, information, and technology resources. These areas may represent key competitive advantages or disadvantages for an organization. Care should be taken to maintain those areas that are valued by customers and are a strength of the organization. In maintaining strategic resources the leader should do the following:

Financial

- Evaluate whether current financial resources are being used efficiently.
- Determine whether the liquidity is appropriate for meeting ongoing expenses.
- Seek ways to increase profitability without sacrificing other mission-critical factors.
- Assess the current level of leverage to determine if there is an appropriate level of risk.
- Determine whether asset activity can be improved.
- Assess cash-flow management.
- Consider investment opportunities for idle cash.

Human Resources

- Develop training programs to maintain the current human expertise and capabilities.
- Create a talent identification/development program.
- Develop a management succession plan.
- Develop a job market network.

Information Systems

- Assess information systems growth needs.
- Develop information systems plans for operations and upgrades.
- Hire staff or an outside agency with capabilities to manage Big Data if being generated currently or necessary to be competitive.

Technologies

- Make sure there is a plan for facilities and equipment maintenance.
- Develop a facilities and equipment replacement schedule.
- Periodically review the operating procedures, policies, and rules to keep them “LEAN.”
- Review environmental services activities and procedures.
- Evaluate current security procedures.

- Evaluate food service activities.
- Evaluate operation and maintenance procedures.

Change Strategic Resources

If there is a poor match between the present level of strategic resources and the requirements of the strategy, the goal should be to change the financial and human resources, information systems, and strategic technologies to meet the needs of the strategy. As with the service delivery strategies and other support strategies, the organization must be particularly sensitive to situations where it is easy to build a strength (its own or the competition's) because the competition may create a short-term competitive advantage. For example, evidence suggests that the early adoption of technology is often driven by technological competition where competitive rivalry is high (thus the need to eliminate competitive disadvantage). On the other hand, late adoption of technology may be more a result of revenue considerations (the threat of losing revenue).⁵⁶

Changing the type or nature of the financial and human resources, information systems, or facilities and equipment can be a difficult and long-term project. To change these strategic resources, the leader should do the following:

Financial

- Assess whether the current revenue can finance the change.
- Investigate the opportunities to finance the change through the issuance of stock and the infusion of additional equity.
- Investigate the opportunities to finance the change through bonds, mortgages, bank loans, fund raising, or philanthropy.

Human Resources

- Assess job markets to determine the availability of individuals possessing the new required skills.
- Begin recruiting for new skills.
- Develop training programs to retrain individuals with skills no longer needed.

Information Systems

- Consider outsourcing needed changes in information systems.
- Assess the impact of needed changes on the current information systems.
- Assess needs of information systems in pre-service, point-of-service, and after-service activities.

Technologies

- Determine the probable rate of new technology adoption.

- Identify the exact specifications of the need for facilities, equipment, or processes, including space needs.
- Perform cost analysis on the required changes.
- Develop timelines for changing the technologies.
- Investigate the financing alternatives for the required changes.
- Investigate any new required skills or experience to operate or maintain the new facilities or equipment.
- Specify any new required processes or ways of doing things.
- Initiate the facilities, equipment, and technology management renewal.

Step 6: Provide Guidance to Organizational Units

There are many ways to add value in organizations. The value-adding support strategies provide a powerful means to change the organization and create competitive advantage, especially because some of the value-adding support activities are less visible to those outside the organization, making the competitive advantage much more difficult to imitate or duplicate. Decisions concerning the organization's culture, structure, and resources are strategic in nature and should be made by strategic thinkers.⁵⁷ The effectiveness of the organization's overall strategy may be influenced or even determined by the effectiveness of these implementation strategies. [Exhibit 9-9](#) shows a completed strategic thinking map that compares the results of an internal analysis, the selected strategy requirements, and proposed value-adding support strategies for a skilled nursing facility. This map extends and further articulates the strategic thinking maps developed in strategy formulation and the development of the value-adding service delivery strategy. In addition, as with the service delivery strategies, guidance for managing the strategic momentum is provided so that unit managers may develop effective action plans that are tied directly to the organization's strategy.

Adaptive strategy: Vertical integration – enter into a system of care.

Market entry strategy: Identify and enter into an alliance with hospital to assure

Strategic posture: Move from defender posture to analyzer posture.

Positioning strategy: Differentiation based on quality, upscale image.

	Characteristics/Attributes			
Value-Adding Support Strategies	Results of Internal Analysis	Support Requirements of Selected Strategies	Comparison of Strategy Requirements and Results of Internal Analysis	Evaluation Maintain
Organizational	Strong, positive	Culture reflects	Good match.	X

culture Assumptions Values Behavioral Norms	culture based on religious affiliation, caring environment with appropriate behavioral norms (seen as competitive advantage: valuable, rare, difficult to imitate, and sustainable).	upscale differentiation positioning strategy.	However, culture (values and behavior norms) will need to be transferred to alliance partner (requires major organization effort to maintain competitive advantage).	
Organizational structure Function Division Matrix	Strong functional structure (some communication problems across functions, seen as short-term competitive disadvantage; valuable but fairly easy to fix).	Strategy requires specialization; vertical integration through alliance moves organization toward more decentralization.	Fairly good match. However, need to increase coordination and communication, improve communications and coordination through executive and standing committees. Cross-functional task force needed to plan and facilitate alliance.	X
Strategic resources Human resources Information systems Strategic technologies Financial resources	Shortages of clinical personnel, reward system not tied to performance (not seen as competitive disadvantage because the problems are common in the	Strong staff to provide long-term continuity of care and maintain image. Superior IS to support differentiation strategy. Positioning strategies	Poor match in the areas of HR and IS. Need to be improved to implement strategy. Most problems in HR concern personnel shortages, lack of management depth, and the	X

	industry). Little management depth, information system weak, many billing problems (competitive disadvantages). Excellent facilities, recently remodeled, equipment is state of-the-art, effective management facilities and technology (competitive advantage: valuable, rare, difficult to imitate, and sustainable). Strong financially.	(upscale differentiation) requires quality facilities and technology.	reward system. Need major emphasis on recruitment of management and technical staff. Information system outdated. Need development of patient record and billing system. IS critical to the selected positioning strategy. Facilities and technology – continual upgrade and maintenance needed. Finances available to support the strategy.	

Exhibit 9.9 Strategic Thinking Map for Value-Adding Support Strategies for a Skilled Nursing Facility

Strategic Momentum: Support Strategies

The actual management of the support strategies includes the managerial processes, procedures, style, and technologies of the organization and is an inherent part of the organization and the way it operates. Strategic thinking and strategy evaluation should be regarded as normal and necessary parts of what the organization and its managers do. Through the setting of objectives, the performance appraisal process, the compensation program, and so on, managers' actions are coordinated toward agreed-on organizational objectives. Strategic thinking and strategic evaluation become part of the operating procedures and culture (shared values) of the organization. Additional questions to aid strategic managers in managing the support strategies and evaluating their progress and appropriateness are presented in [Exhibit 9-10](#).

1. Is the organization's culture appropriate for the overall strategy?
2. Are the organization's values reflected in the service delivery?
3. Are the behavioral norms appropriate for the strategy?
4. Are the management processes (the way we do things) appropriate for the strategy?
5. Does the organizational structure help to facilitate the overall strategy?
6. Is there a balance between standardization and flexibility?
7. Are additional coordinating or collateral structures required?
8. Does the organization have the financial resources to carry out the strategy?
9. Does the organization have the appropriate human resources, skills, policies, and procedures for the strategy?
10. Is the management talent appropriate?
11. Do the information systems help to facilitate the strategy?
12. Are the facilities and equipment up to date and appropriate to carry out the overall strategy?

[Exhibit 9.10](#) Strategic Thinking Map for Evaluating Support Strategies

Chapter Summary

The value chain activities provide the basis for strategy implementation. After the value-adding service delivery strategies have been developed, the value-adding support strategies should be formulated. The value-adding support strategies are important in implementing the overall strategy and include organizational culture, organizational structure, and strategic resources. These strategies work together with the service delivery strategies to effectively implement the organization's strategy.

The organizational culture permeates the organization and is defined in terms of the shared assumptions, shared values, and accepted behavioral norms. Strategic managers must decide whether the organization's culture will contribute to the accomplishment of the strategy or must change over time. Therefore, the current assumptions, values, and norms must be compared with the requirement of the selected strategy.

The organizational structure should help to implement the strategy. The fundamental building blocks of organizational structure are the functional, divisional, and matrix designs. Each structure has its advantages and disadvantages, and the decision concerning which structure is best to carry out the strategy is based on the need for standardization versus flexibility. Where a high degree of standardization is required, functional structures are desirable. Where a high level of flexibility is required because of diversity of product or markets, or where markets are rapidly changing, divisional or matrix structures may work best. Most organizations use a combination of designs supplemented with coordinating structures such as project teams and cross-functional task forces.

An organization's strategic resources are critical for most strategies. Adequate resources allow for a number of strategic alternatives, whereas having few strategic resources inhibits strategy implementation. Strategic resources include financial, human, information, and technological resources. People are always key and different strategies require different human talents. Responsibility for recruiting and developing the best human resources for the strategy falls to leadership. Strategic information systems and decision support systems can create competitive advantage for organizations through improved customer service and more efficient and effective service delivery. The selection of the strategic technologies is a decision of the strategic leader and is central to strategy implementation. Strategic technologies include the type of facilities and the type and sophistication of equipment. The strategic technologies decisions set the physical context and level of sophistication for service delivery and affect everything from the organization's image to patient satisfaction.

As with the service delivery strategies, the results of the internal analysis for each of the support activities in the value chain must be compared with the requirements of the strategy selected in the strategic management process. Results of that comparison indicate whether there needs to be a strategy that maintains the current status of the support activity or a strategy that changes

the support area. Value-adding support strategies typically maintain current strengths or build new ones, or correct weaknesses in the support activities. For each of the value-adding support areas, actions for maintaining or changing the area are recommended as a way to initiate strategic thinking.

An example of value-adding support strategies developed through a comparison of the results of an internal analysis and the requirements of the selected strategies for each are presented to extend strategic thinking. Chapter 10 demonstrates how individual organizational units must set objectives and develop action plans based on the value-adding service delivery strategies and support strategies selected to achieve directional and adaptive strategies.

Practical Lessons for Health Care Strategic Thinkers

1. Culture, structure, and strategic resources should probably follow strategy; however, the reality is that often strategy follows culture, structure, and the resources of the organization. Often what we do is dependent on what we are able to do with the organization's current culture, structure, and strategic resources.
2. Often it is necessary to change the culture, structure, and strategic resources to successfully compete. These types of changes may take years – time an organization may not have. When the gap between the requirements of the strategy and the results of the internal analysis is too great, strategic managers may have to rethink the strategy itself.
3. Do not underestimate the critical importance of the support services in implementing strategy.

THE LANGUAGE OF STRATEGIC MANAGEMENT: KEY TERMS AND CONCEPTS

Behavioral Norms
Cognitive Assumptions
Cognitive Culture
Cognitive Values
Collateral Organization
Combination Structure
Decision Support System
Direction
Divisional Structure
Emotional Culture
Facilities
Functional Structure
Matrix Structure
Organizational Culture
Shared Assumptions
Shared Values
Strategic Information System (SIS)
Strategic Resources
Strategic Technologies
Structure
Value-Adding Support Strategies

Questions for Class Discussion

1. What part does internal analysis play in the development of value-adding support strategies? What part does strategy formulation play?
2. How do the value-adding support strategies create the “context” for strategy implementation?
3. What is organizational culture? How does it implement strategy?
4. What are the basic building blocks of structure? What are the advantages and disadvantages of each?
5. In what circumstances might a high level of standardization be required? A high level of flexibility?
6. Which do you think changes first, strategy or structure? After formulating your answer and making your case, argue the opposite position.
7. What are the primary differences in the financial strategies needed for expansion, reduction, and maintenance of scope?
8. What are the primary differences in the human resources strategies needed for expansion, reduction, and maintenance of scope? Which type of adaptive strategy is most difficult to implement from a human resources perspective? Why?
9. How can information systems be used to develop competitive advantage?
10. What changes are information systems bringing to health care?
11. Why is facilities management an increasing concern for strategic management?
12. How do facilities affect a health care organization’s strategy?
13. How can the technology/equipment decisions create competitive advantage?
14. How might future internal analyses be affected by the value-adding support strategies?

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Chapter 10

Communicating Strategy and Developing Action Plans

“If well-communicated action plans do not translate into reality, all the efforts devoted to the strategic planning process will have been wasted.”

—PETER GINTER, JACK DUNCAN, LINDA SWAYNE, AUTHORS AND PROFESSORS

Why Communicating the Strategy and Developing Action Plans Are Important

As suggested in the quote above, strategic plans must be translated into specific actions that will move the organization toward achieving its strategic goals, fulfilling its mission, and achieving its vision. Thus, action plans are a clearer and more specific articulation of the broader strategies tailored to the functions of the individual organizational units or departments. Unit managers will need a thorough understanding of the broader organizational strategies. Once these broader strategies (directional, adaptive, market entry/exit, competitive, service delivery, and support strategies) have been clearly communicated to unit managers, they will have detailed maps of the unit tasks that need to be accomplished. In the implementation, organizational momentum will have been created.

Of course, action plans are still just plans. Plans have to be carried out and managed. It is a day-to-day process – it is the work of the organization. Yet, these plans have to be managed with an eye on the mission and strategic goals, guided by the organization's values, and inspired by the vision. Unit managers must be strategic thinkers too! Therefore, action plan managers must be careful not to let the action plans become ends in themselves, mindlessly performed without an understanding of the organization's broader objectives and goals and how the action plans fit with the organization's competitive and value-chain strategies.

Often there is an operational, logistical, or other types of issue unaccounted for in the action plan or perhaps implementation does not work out as intended. In these situations, learning takes place, for we often only learn what works by doing. As managers learn what works, the planners must listen to the doers and be ready to develop new plans. Still, managers must have a plan to start their journey and they must be ready to modify the plan as it is implemented.

Use the concepts in this chapter to develop action plans and be ready to learn by doing!

Learning Objectives

After completing the chapter you will be able to:

1. Describe the interrelationships among situational analysis, strategy formulation, value-adding service delivery and support strategies, and action plans.
2. Discuss how strategies are translated into action plans.
3. List the components of an action plan and explain the function of each component.

4. Cite some reasons that cause strategies to be difficult to implement in health care organizations.
5. Suggest some effective ways to overcome barriers to the implementation of strategies.
6. Explain the need for contingency planning in health care organizations.
7. Relate the map and compass metaphor to strategic thinking, strategic planning, and managing the strategic momentum.

Strategic Management Competency

After completing this chapter you will be able to translate service delivery and support plans into specific action plans for a health care organization.

Implementation Through Action Plans

The situational analysis discussed in Chapters 2 through 5 culminates with a series of strategic goals that, along with the mission, vision, and values, are directional strategies that provide focus for the organization. Adaptive, market entry/exit, and competitive strategies are designed to accomplish the strategic goals and move the organization in the desired direction. Value-adding service delivery and support strategies further shape the strategy, providing guidance and direction to managers who are responsible for implementing action plans.

The desired direction and organizational momentum have been discussed and consensus reached during the strategic planning process, yet no movement has occurred. For real progress to begin, action plans will have to be developed throughout the organization. As Peter Drucker stated, “[strategic] insights are ‘bled off’ and converted into tasks and work assignments.”¹

Implementation strategies have been referred to by various terms. Some organizations refer to implementation strategies as “tactical plans,” although others may use “business plans,” and still others, many in health care, have adopted the term “action plans.” Action plan is the most descriptive term as it connotes the steps required to carry out strategies and meet objectives. In addition, the term “action plan” may be applied to the several different levels within organizations that must develop implementation strategies, and thus lessens confusion. More specifically, *action plan* may be defined as unit-based implementation activities that identify specific steps to accomplish the service delivery and support strategies.

The Level and Orientation of the Strategy

This chapter concerns communicating the overall strategy to those who must develop specific action plans to accomplish the strategy and providing managers with a consistent format for implementation. Note, however, that the strategy is crafted, step-by-step, as managers at all levels commit resources to policies, programs, people, and facilities.² A large integrated health care system may develop strategy at a number of levels – a corporate level, divisional level, organizational level, and unit level. If the strategy has been developed at the corporate level, action plans will be for entire divisions. If the strategy has been developed at the divisional level, action plans will be for individual institutions or organizations comprising the division, such as a hospital (within the hospital division) or a long-term care facility (within the long-term care division). If the strategy has been developed for an individual organization, such as a hospital, the action plans will be developed by functional units within the hospital (such as surgery or pharmacy). Because strategies may be developed for large, complex organizations or small, well-focused units, action plans to implement the strategies will be developed at different levels as well. Trinity Health, introduced in Chapter 1 and illustrated in Exhibit 1–5, portrays the organizational levels and the different orientations.

An effective action plan, regardless of level, consists of objectives that specify how the unit (division, hospital, pharmacy) is going to contribute to the strategy, what actions will be required to achieve the objectives and within what time period, who is responsible for the actions, the resources required to achieve the objectives, and how results will be measured. These elements are required whether the action plan is for entire divisions as part of a complex corporate-level strategic plan or for functional units contributing to the strategic plan of a small organization. Identifying objectives, specifying the timelines and actions, determining who is responsible for accomplishing them, specifying the resources required, and defining how results will be measured is an approach that keeps the strategic plan straightforward and comprehensible. A simple understandable action plan is always preferable to a complex incomprehensible plan.

Decision Logic for Developing Action Plans

As with all the previous strategies, there is a decision logic for the development of unit action plans as shown in [Exhibit 10–1](#). Specifically, unit action plans must accomplish the service delivery and support strategies as well as the competitive strategies. The strategic posture and position strategies may indirectly place demands on various units within the organization. Certainly, a defender strategy requires that all units strive to keep entry barriers high through quality, efficiency, or differentiation. More directly, the value-chain implementation strategies require units within the organization to take specific supportive actions.

Action Plan Development Responsibilities

Every member of the organization cannot realistically be involved in the strategic planning process. A few key players – senior staff, top management, or a leadership team – are needed to provide balanced and informed points of view. Therefore, the development of the initial plan is usually the product of a relatively small number of strategic thinkers. Margaret Meade challenged us to “never doubt that a small group of thoughtful, committed people can change the world; indeed, it’s the only thing that ever has!”³ A small group of thoughtful, committed people can reshape even the most rigid organization.

Because of its involvement in developing strategy, the strategic planning team determines the “broad strokes” of strategy. The team should shape the organization through: a review or revision of the organization’s mission, vision, values, and goals; development of strategy through service delivery and support strategies; and guidance for what needs to be accomplished. However, action plans should be left to the organizational units. Senior managers shape strategic direction less by deciding the specific strategic content than by framing the context – creating “a sense of purpose that not only provides an integrating framework for bottom-up strategic initiatives but also injects meaning into individual effort.”⁴ Others in the organization should use their resourcefulness to develop action plans and carry out the strategy. As George Patton once said, “Never tell people how to do things. Tell them what to do and they will surprise you with their ingenuity.”

Communicating Strategy to Initiate Action Planning

Because everyone cannot be directly involved, many employees within the organization do not know the underlying issues and assumptions that were used to develop the strategy, nor do they know the goals for which they will develop objectives. Therefore, successive layers of management must communicate the overall strategy and provide “maintain or change” guidance for the various units that will need to be engaged if the strategy is to be achieved. For example, if management has determined that an expansion strategy is required, guidance is needed as to which parts of the organization have been identified for the expansion. Managers in the identified part or parts then determine the objectives to accomplish the expansion in that area. When different units have overlapping or integrated activities, multiple groups have to coordinate planning. Communication from the top down and the bottom up – as well as across – is required to engage everyone to do his or her part. Communication of the strategy and getting people who actually do the work to think critically about the strategy itself and its implementation and to express their concerns can help avoid classic communication problems (see Essentials for a Strategic Thinker 10–1, “What Are the Abilene Paradox and Groupthink?”).

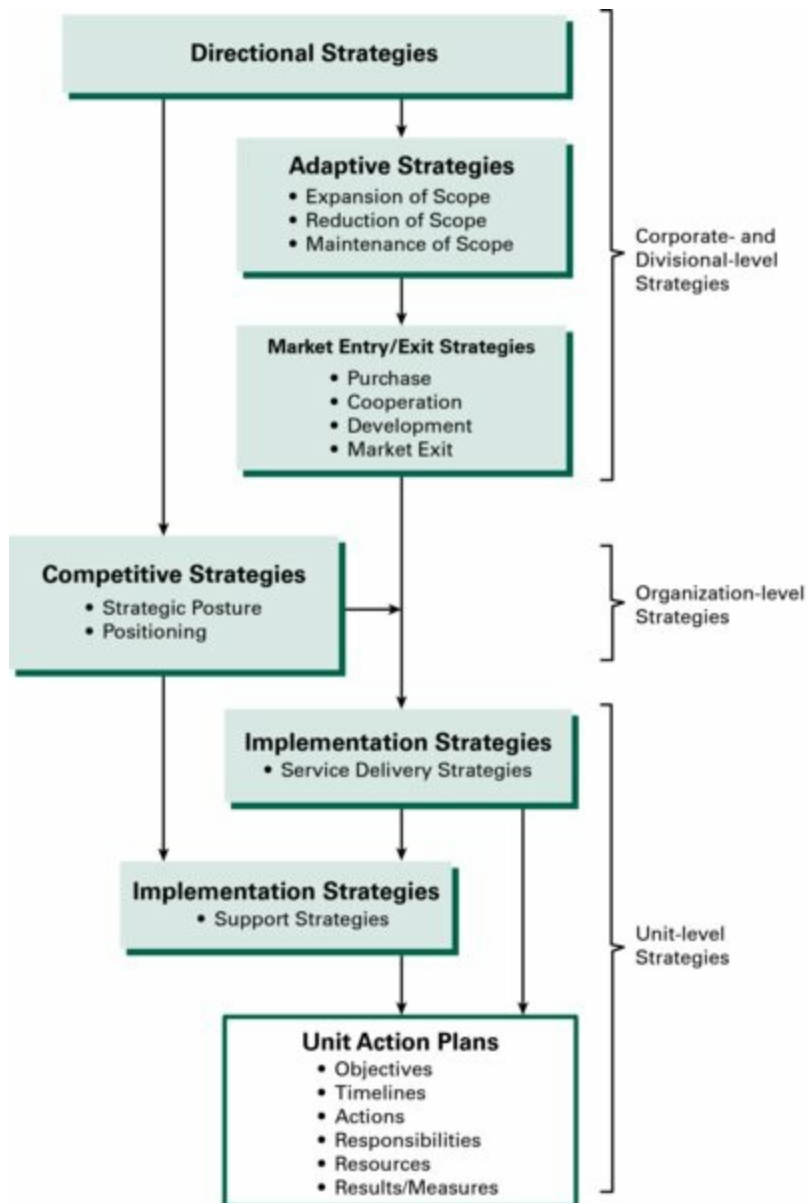


Exhibit 10.1 Decision Logic for Developing Action Plans

ESSENTIALS FOR A STRATEGIC THINKER 10-1

What Are the Abilene Paradox and Groupthink?



The Abilene Paradox is the inability to communicate honestly and manage agreement successfully. The paradox can be recognized in a group decision-making context by its six symptoms: (1) organizational members agree on the nature of a problem or issue they are facing; (2) members agree on the steps that should be taken to address the problem; (3) members fail to reveal their true feelings regarding the problem or the steps involved in addressing it; (4) as a result decisions are made based on inaccurate

information resulting from the lack of communication; (5) counterproductive outcomes result and members become angry and frustrated; and (6) the group fails to resolve the lack of truthful communication and the cycle is repeated.¹

The Abilene Paradox was popularized by Jerry B. Harvey, Professor *Emeritus* at George Washington University.² Although Harvey introduced the idea with a somewhat homey experience of how his family took a trip to Abilene, Texas when no one wanted to go, the phenomenon is seen often in organizations and creates serious problems in the decision-making process.

Groupthink occurs when a collection of people makes faulty decisions because group pressures lead to a deterioration of “mental efficiency, reality testing, and moral judgment.”³ The phenomenon of Groupthink was introduced by Irving Janis, a Yale psychologist, in his book *Groupthink: Psychological Study of Foreign-Policy Decisions and Fiascoes*.⁴ Similar to the Abilene Paradox, Groupthink can be recognized by its symptoms. These are: (1) illusion of invulnerability – extreme optimism in the group encourages taking extreme risks; (2) collective rationalization – members discount warnings and ignore reconsideration of assumptions; (3) belief in inherent morality – members believe in the rightness of their cause and ignore ethical consequences; (4) stereotyped views of others – outsiders as enemies; (5) direct pressure on dissenters – members are pressured not to present views that are counter to the prevailing group; (6) self-censorship – doubts and reservations are not expressed; (7) illusion of unanimity – majority views are assumed to be unanimous; and (8) self-appointed mindguards – members protect the group from information that is contradictory. Members of the group seek conformity and desire harmony even if it results in dysfunctional decisions.

The Abilene Paradox and Groupthink share some things in common but also share some important differences. The most important similarity is that both result in dysfunctional and sometimes irrational decisions. They differ in the sense that in Groupthink individuals are not acting against their conscious wishes and generally feel good about the decisions the group makes. By contrast, in the Abilene Paradox the individuals are acting counter to their own better judgment and are likely to have negative feelings about the decision reached.⁵ It has also been argued that the decision-making group in the Abilene Paradox is in a state of “low energy” and experiences hesitation, carelessness, and passive attitudes. In Groupthink, the group is in a state of “high energy experiencing high cohesiveness, *esprit de corps*, and euphoria.”⁶

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Specific milestones in the strategic planning process should include updates for all employees, periodic discussions regarding how the process is going, and explaining expected timelines for the strategy to be handed over to those who will be responsible for carrying it out. In addition, successes should be shared and celebrated, and challenges should be identified and monitored. For example, some organizations hold weekly, monthly, or quarterly staff meetings to provide open communications with all employees present and encourage their ongoing commitment to carrying out the organization’s strategy. Other organizations have team meetings. It is challenging in health care to have a meeting of all employees because of patient care requirements; however, it is also challenging to implement a strategy if the employees are not engaged. If top management determines that it is impossible to hold a meeting for all employees, the question should be asked: “Why isn’t it possible?” Then, much thought should be given to the question of how management expects to accomplish any strategy if the first decision is: “We can’t do that.”

The Process of Developing Action Plans

Although implementation strategies may be carried out at various organizational levels, implementation plans should have common characteristics. These plans concern translating directional, adaptive, market entry/exit, and competitive strategies into tasks and work assignments (specific actions that accomplish the mission, vision, values, goals, strategies, and value-adding service delivery and support strategies). In addition, these actions must be the responsibility of individuals within the organization and made an integral part of their jobs. Each job should be structured to show how it contributes to the strategic plan. In general, there are seven steps involved in developing action plans (see [Exhibit 10-2](#)).

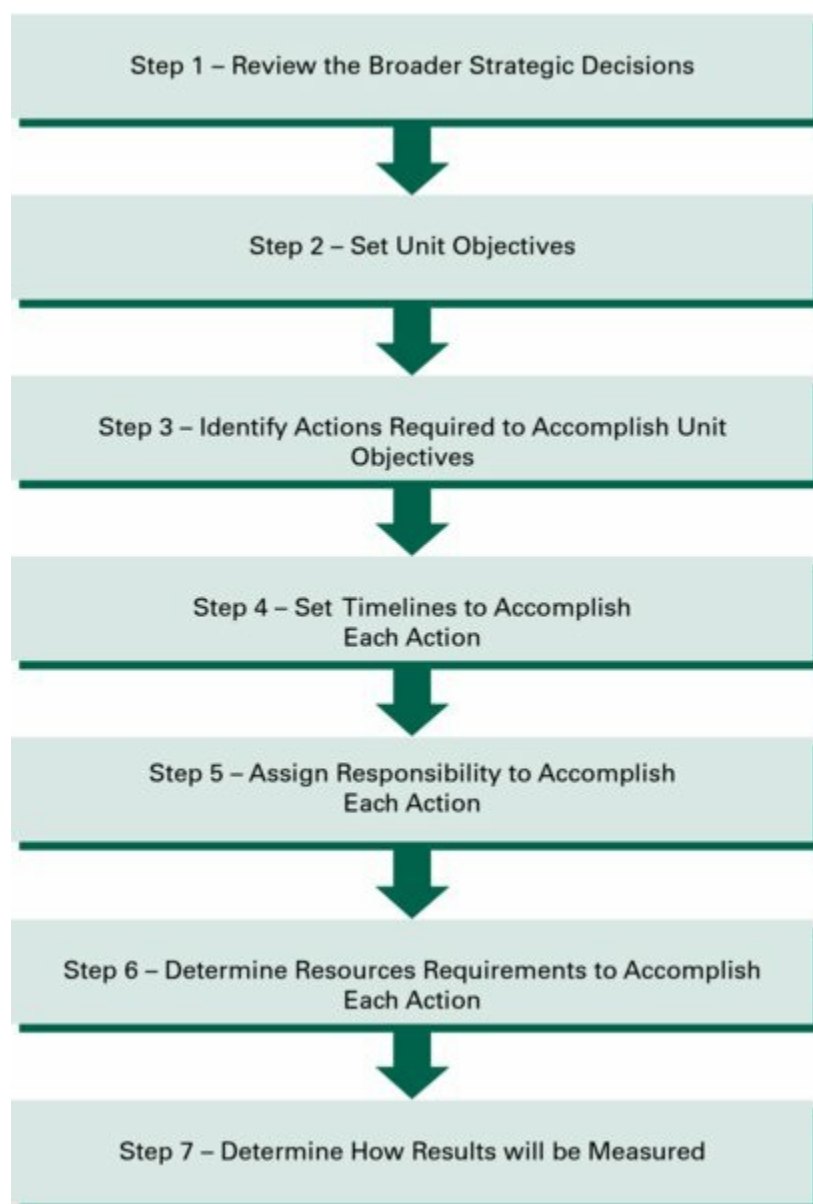


Exhibit 10.2 Process for Developing Action Plans

Action plans initiate the strategy – start the work – and serve as a blueprint for managing the strategy.⁵ As indicated in previous chapters, managers must be ready to think strategically and learn as they carry out their implementation plans. Learning by doing may modify the implementation plan, the strategy itself, or assumptions underlying the strategy.

The Process of Developing Action Plans – Cardiac Rehab Example

The middle section of the strategic management model (see Chapter 1, Exhibit 1–1) provides a step-by-step strategic thinking map to illustrate that strategic planning links situational analysis through strategy formulation and planning the implementation. Action plans provide unit managers with a more detailed blueprint that links unit planning activities to the strategy.

To illustrate, think about the responsibility of the head of Rehabilitation Medicine (RM) in the University Medical Center (UMC), a state supported academic health center. One of UMC's flagship programs is cardiovascular services that provides a wide range of services including bypass surgery, angioplasty, radiofrequency ablation, stents, and other related procedures. A decision was made several years ago to focus on actual procedures and outsource rehabilitation services. Recently a new hospital administrator was hired who initiated strategic planning; one result of the strategic plan focused on developing centers of excellence as a way to differentiate UMC. The new administrator believed that if Cardiovascular Services was to continue as a center of excellence, it had to offer a full line of services including cardiac rehab.

At the present time UMC has a division of RM but it does not include cardiac rehabilitation. The head of RM was asked to develop a plan for building, staffing, and equipping a cardiac rehab unit, and was allocated \$500,000 to fund the start-up with the additional assignment of having the unit up and running in 12 months. The UMC administrator thought the unit could become self-supporting in a couple of years but understood it would take some time and resources to become operational. The first task was to develop an action plan to get the new unit in working order.

Step 1: Review the Broader Strategic Decisions

As Peter Drucker asserted, “The statement, ‘This is what we are here for,’ must eventually become the statement, ‘This is how we do it. This is the time span in which we do it. This is who is accountable.’ This is, in other words, the work for which we are responsible.”⁶ A critically important responsibility of the health care organization's leadership is to carefully articulate its strategy to the unit managers by providing guidance or strategy statements regarding their responsibility to change or maintain the scope of their respective areas. These managers, in turn, are obligated to continue the communication by articulating the manner in which each unit is expected to contribute to service delivery or support services as well as adaptive, market entry/exit, and competitive strategies. Unit manager action plans, in aggregate, represent the implementation plan for the organization.

Step 1: Review the Broader Strategic Decisions – Cardiac Rehab Lab

The vision for UMC's cardiovascular services is to create and maintain a nationally recognized Center of Excellence. Its mission is to provide a wide range of high-quality services including bypass surgery, angioplasty, radio frequency ablation, stents, and other related procedures. The strategic goal is to offer a full line of cardiac services. The strategy for RM is expansion of scope through product development (add cardiac rehabilitation services) and then engage in an enhancement strategy to improve overall quality of services (develop synergies between cardiac rehab and the existing related services). The strategy is to be accomplished through internal development – implement a full-line service delivery strategy with the rehab unit providing after-service delivery.

Step 2: Set Unit Objectives

More specific than strategic goals, unit *objectives* are measurable ends that achieve broader goals. Objectives should possess the following characteristics:

- Objectives should reinforce organizational strategic goals. Strategic goals relate to mission-critical activities. Reinforcing objectives ensures that the various units contribute to the accomplishment of the organization's mission.
- Objectives should be measurable. The objectives of the individual units are tools for the determination of unit effectiveness, and ultimately resource allocation, so the ability to measure and evaluate unit performance is essential.
- Objectives should identify the timeframe for accomplishment.
- Objectives should be challenging but attainable. Objectives that are easy to accomplish do not require stretch. Stretch challenges the organization to move significantly toward its strategic goals and is accomplished through resource leveraging or systematically achieving more than is normally expected to be possible with available resources. Objectives that are impossible to attain are not motivational.
- Objectives should be easy to understand. Individual group members must accomplish the tasks that result in objective attainment. People work harder to achieve objectives they understand and believe are important.
- Objectives should be formulated with the assistance of the individuals who will be responsible for accomplishing the work. Just as strategic leaders should allow managers discretion in determining how strategies will be achieved, unit managers should allow employee input into the development of unit objectives.

Step 2: Set Unit Objectives – Cardiac Rehab Lab

After a review of its broader strategies (mission, vision, product development/enhancement strategy, and so on), the next task of the head of RM was to

establish and communicate precisely the objective that would accomplish the new product development strategy by adding the new cardiac rehab unit for after-service care.

In the action planning process, the head of RM scheduled a meeting of employees and encouraged them to suggest the activities that were required to plan, staff, and equip a new cardiac rehabilitation unit. Next, the objectives of the assignment were discussed. Although several objectives were actually developed by the group, only one objective and its associated activities is illustrated here. An example RM objective that fulfills the criteria for a good objective and contributes to the organization's goal is:

Rehabilitation Medicine Objective – To establish an operational cardiac rehabilitation unit at a cost of no more than \$500,000 by the end of the calendar year.

This increase in service would contribute significantly to the value-adding after-service strategy of Cardiovascular Services. Accomplishing the objective with the allocated budget and within the defined time schedule will be a stretch for RM. The objective's outcome is measurable and easy to understand by those who will be responsible for making things happen in the unit.

Step 3: Identify Actions Required to Accomplish Unit Objectives

When unit objectives have been formulated and agreed on, the next step is to identify the activities necessary to accomplish each objective. The determination of the necessary activities requires careful analysis of the individual actions/activities that must logically be accomplished. This step requires logically thinking through each objective to determine what activities are required and the sequence in which these activities must occur.

Step 3: Identify Actions Required to Accomplish Unit Objectives – Cardiac Rehab Lab

The group developed a list of activities or outline of steps to accomplish the objectives. The list included:

- Acquire space.
- Retrofit space, if necessary.
- Assure parking (some handicapped spaces).
- Advertise, interview, hire a director and two staff members.
- Hire staff (sequentially: director, full-time staff rehab worker, part-time rehab worker).
- Purchase rehab equipment.
- Opening "Celebration."

Step 4: Set Timelines to Accomplish Each Action

A timeline should be established for achieving each activity to ensure that the schedule is maintained. Beginning and ending dates should be established for each activity. This process forces participants to think sequentially regarding the ordering of activities and reinforces a commitment for completion of the individual activities as well as the overall objective. Thinking sequentially about the required activities essentially develops a process for achieving the objective, as some activities must be completed before others can begin. A *process* is a collection of activities that takes one or more kinds of inputs and creates an output that is of value.⁷ Therefore, participants should develop a flow chart or a diagram to pinpoint the required activities. A process orientation helps participants to sequence activities and establish reasonable timing. Further, establishing beginning and completion dates provides personal, unit, and organizational commitment.

Step 4: Set Timelines – Cardiac Rehab Lab

The timeline was developed for the action plan to accomplish the start-up of the unit by the end of the calendar year. The plan's layout is based on the timeline. As shown in [Exhibit 10–3](#), the timelines for the tasks in the unit action plan extend from January through December.

Vision: Create and maintain a nationally recognized Center of Excellence.
Mission: Provide a wide range of high quality services including bypass surgery, angioplasty, radio frequency ablation, stents, and other related procedures.
Strategic Goal: Offer a full-line of cardiac services.
Adaptive Strategy: Expansion of scope through product development (add cardiac rehabilitation services) and then engage in an enhancement strategy to improve overall quality of services (develop synergies between the cardiac rehab and the existing related services).
Market Entry Strategy: The strategy is to be accomplished through internal development.
Value Adding After Service Delivery Strategy: Cardiovascular Services. Change. Start-up a cardiac rehabilitation services unit.
Objective: To establish an operational cardiac rehabilitation services unit at a cost of no more than \$500,000 by December 31 of current calendar year.

Activity	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Revenues	Costs	Responsible Person	Comments
Budget and New Revenue													\$500,000			
Costs																
Inventory existing space in or near rehab unit.														\$1,000	Facilities Management	Identify all space in or adjacent to existing (the current) rehab unit
Acquire 7,500 sq.ft.														\$80,000	Director of Rehab Services	\$8,000 per month for 10 months
Remodel acquired space														\$21,000	Construction Services	Provide for special facilities
Expand curb side parking														\$15,000	Construction Services	Expand existing space
Advertise jobs for rehab unit 2.0 RN 2.0 PT 1.0 Receptionist														\$4,500	HR Division	Advertise in professional media
Order basic rehab equipment														\$250,000	UMC Purchasing	Treadmills Stationary Bikes Wireless Monitors
Hire initial staff 1.0 RN 1.0 PT														\$45,000	HR Division	Four months for 1.0 RM and 1.0 PT
Hire additional staff													\$15,000*	\$20,000	Cardio-vascular Services	Grand opening expenses
Open rehab unit for patients														\$10,000	HR Division	1.0 RN 1.0 PT 1.0 Receptionist
Total													\$515,000	\$446,500		

* One month projected revenue collected from patients/insurers.

Exhibit 10.3 Example of Cardiac Rehabilitation Action Plan

Step 5: Assign Responsibility to Accomplish Each Action

A specific individual or group of individuals should be assigned the responsibility for ensuring that each activity is accomplished. Assigning responsibility for the accomplishment of each activity in the proper sequence helps to build ownership. The assignment of responsibility also provides another important function – in the periodic updates of progress on the action plans, there is an identified spokesperson who can provide precise updates on each activity. In addition, if individuals know they will be called on to report at the update meetings, they are incentivized to stay on schedule.

Step 5: Assign Responsibility – Cardiac Rehab Lab

The timeline identifies the person or department responsible for each activity and because it is a column within the timeline, it serves to remind the responsible person when the task needs to be completed for the successful accomplishment of establishing the cardiac rehab service. As mapped in [Exhibit 10–3](#), there are a variety of personnel who must collaborate to ensure the project is completed on time and contributes to the success of the Cardiovascular Services Center of Excellence.

Step 6: Determine Resources Requirements to Accomplish Each Action

The expected revenues as well as costs and other resources associated with achieving each activity must be determined to estimate any additional resources needed so they can be incorporated into the unit's budget request. It is unrealistic to ensure accountability unless there is a commitment of resources to the accomplishment of each activity. Therefore, resources should be committed to enable those who have accepted accountability to complete the task.

Step 6: Determine Resources Requirements – Cardiac Rehab Lab

The cost associated with accomplishing each activity is identified. This action plan projects net operating revenues consisting of the allocated budget and one month operating revenue of \$515,000 and start-up costs of \$446,500. The head of Rehabilitation Services believes she can implement the start-up at \$49,500 under budget; however, after the first year, additional staff will have to be hired, but no further hiring is planned after that. The facilities remodeling will be complete and the introductory promotion expenditures will be reduced significantly to a maintenance level. Therefore, in year two and beyond, expectations are that space rental, equipment depreciation, and personnel costs will be approximately \$600,000 per year. The operations of the Rehab unit will require at least \$50,000 of operating revenue per month (substantially more than the \$15,000 during the one month of operations in the first year). As the information regarding the availability of cardiac rehabilitation is disseminated, expectations are that the revenues will be sufficient to cover the costs plus setting some resources aside to cover equipment replacement, unexpected personnel turnover, and so on.

Step 7: Determine How Results will be Measured

Generally, managing action plans involves agreeing to objectives, measuring performance, evaluating performance against the objectives, and taking corrective action when necessary. Together these processes are a matter of controlling the strategy. More specifically, *strategic control* is the process of determining whether the strategies are successful and taking corrective action if necessary. In addition, part of strategic control is ensuring that all organizational units act in concert so that the level of actual performance comes as close as possible to a set of desired performance specifications. One method of performance evaluation used in health care organizations is LEAN Six Sigma (see Essentials for a Strategic Thinker 10–2, “What Is LEAN Six Sigma?”).

ESSENTIALS FOR A STRATEGIC THINKER 10–2

What Is LEAN Six Sigma?



LEAN Six Sigma is a five step process (Define–Measure–Analyze–Improve–Control or DMAIC) that aims to improve processes.¹ LEAN Six Sigma is a variation of the original tenets of Six Sigma – a method of statistical analysis designed to manage manufacturing quality control processes. *LEAN Six Sigma* combines the concepts of “LEAN Thinking” or simply “LEAN” – re-thinking processes to identify value-adding and non-value-adding activities and to eliminate the non-value-adding activities using Six Sigma tools for measuring and controlling variances in process outcomes.^{2,3,4,5}

LEAN Six Sigma is implemented through projects sponsored at the highest levels in an organization. A project is “a chronic problem scheduled for solution.”⁶ Projects are classified as either “quick wins” or “advanced.” The re-thinking processes of LEAN are best suited for quick wins with an emphasis on *best practices* and standardized solutions. LEAN Six Sigma outcomes include improvements in process speed, lead times, and reductions in inventories. The data-based analytics of Six Sigma are best suited for advanced projects – those with complex processes and many opportunities for data collection and analysis.⁷

LEAN Six Sigma applications in health care have been more successful in mid-sized hospitals from 250–300 beds than in large academic medical centers primarily because it is “difficult to turn” larger organizations. However, the more successful implementations of LEAN Six Sigma can lead to a 20–50 percent return on investment. Streamlining processes that lead to reductions in central line infections, for example, can “have a huge effect on the bottom line.”⁸

The Johns Hopkins University’s Armstrong Institute for Patient Safety and Quality was one of the first organizations to apply LEAN Six Sigma in the health care system. Over the past decade it has experienced a number of successes. Some of the more important include: (1) reduction of the 30-day

readmission rate of heart failure patients from 24 percent to 15.5 percent; (2) 50 percent reduction in the rate at which red blood cells had to be discarded resulting in an \$800,000 saving in the first four years; (3) reduced total time for Botox administration from 42 minutes to 24 minutes in the outpatient neurology clinic; and (4) realized an additional \$50,000 a month for charges related to supplies in an interventional radiology service.⁹

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Step 7: Determine How Results will be Measured – Cardiac Rehab Lab

Results will be measured by the opening date for cardiac rehab being prior to December 31st and the cardiac rehab unit cost to open being \$500,000 or less, as illustrated in [Exhibit 10–3](#). A final column is provided in the unit action plan for comments, should clarification be needed regarding an activity, timeline, budget, or responsibility assignment.

Managing the Strategic Momentum

Managing the strategy provides managers with a means of determining whether the organization is performing satisfactorily; it is an explicit process for controlling – refining or completely altering – the strategy. Therefore, strategic managers must monitor, evaluate, and adjust the action plans. [Exhibit 10–4](#) provides some questions to initiate strategic thinking for assessing the appropriateness and effectiveness of the action plans. These questions may generate information for revising the strategies or action plans.

1. Has the organization's overall strategy been well communicated to all members of the organizational units?
2. Do the organizational units have the financial resources required for successful implementation of the strategy?
3. Is there a high level of commitment to the strategy within the organizational units?
4. Has the organizational unit developed action plans, including realistic objectives, timelines, responsibilities, and budgets?
5. Are the unit objectives consistent and compatible with the strategy?
6. Do the organizational units have the managerial and employee capabilities required for successfully implementing the organization's strategy?
7. Do the combined action plans accomplish the overall goals of the organization?

[Exhibit 10.4](#) Strategic Thinking Map for Evaluating the Action Plans

Focusing on Strategy through Implementation: A Balanced Scorecard Approach

The action plan is one of several widely used approaches to assist in the implementation of strategies. Another tool for focusing on implementation as strategy is the *Balanced Scorecard* that links the organization's overall strategy to short-term actions including a financial perspective, customer perspective, internal perspective, and a learning/growth perspective.⁸ The Balanced Scorecard is especially useful in encouraging decision makers to focus on more than financial measures based on past performance. As suggested in Essentials for a Strategic Thinker 10–3, “What Is the Balanced Scorecard?” and illustrated in [Exhibit 10–5](#), the Balanced Scorecard is compatible with, and complementary to, the value chain approach discussed in this text.

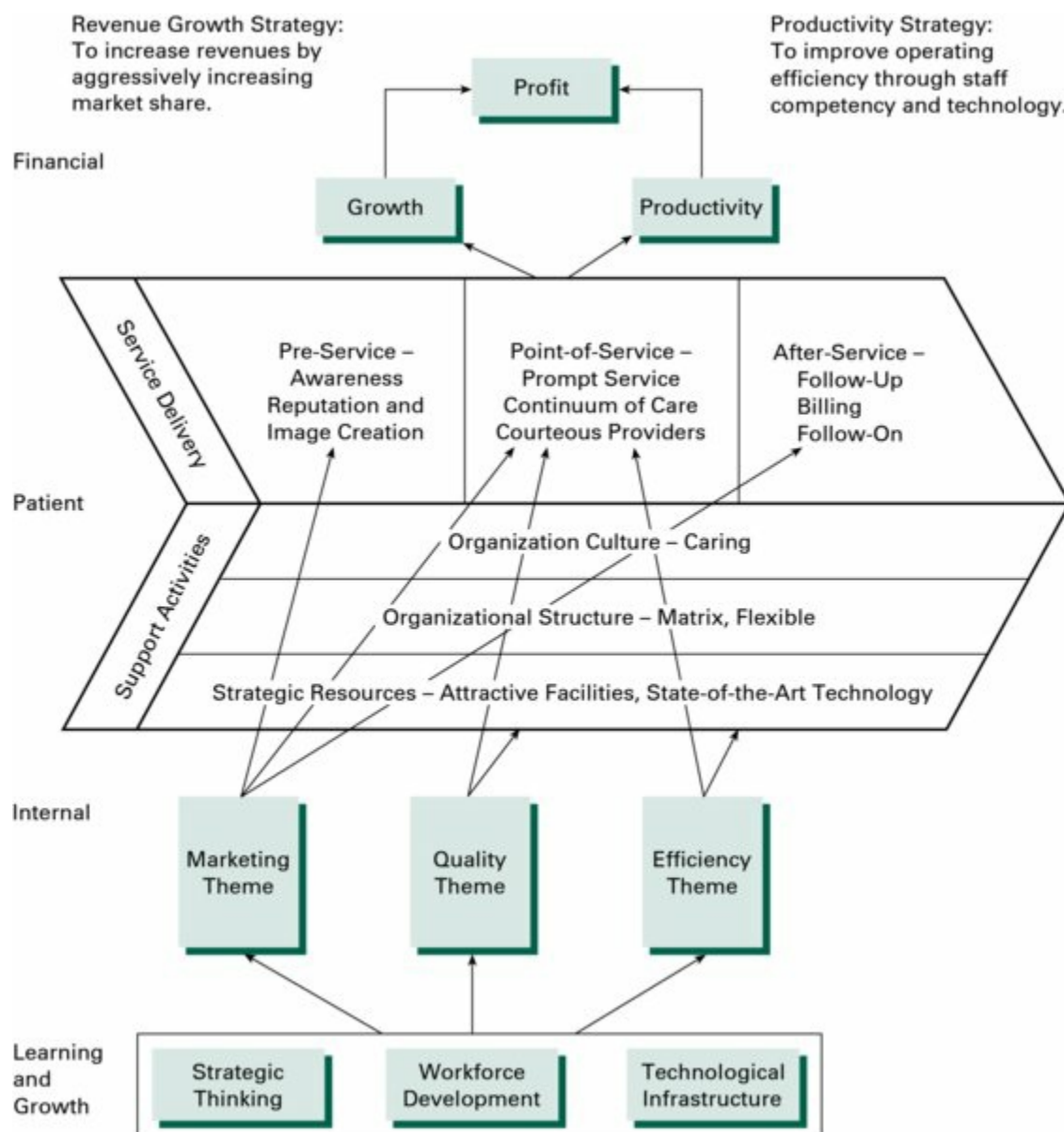


Exhibit 10.5 Health Care Provider Balanced Scorecard Strategy Map

Source: Adapted from Robert S. Kaplan and David P. Norton, “Having Trouble with Your Strategy? Then Map It,” *Harvard Business Review* 78, no. 5 (2000), pp. 168–169.

The primary benefit of the Balanced Scorecard approach is to focus the health care organization on those aspects of its operations that most directly impact the accomplishment of its strategies. By identifying those factors that most directly influence successful outcomes and concentrating on accomplishing and improving them, resources of the organization can be used most effectively and efficiently.

ESSENTIALS FOR A STRATEGIC THINKER 10-3

What Is the Balanced Scorecard?



Robert S. Kaplan and David P. Norton observed that the traditional view of corporate performance was developed by, and for, industrial-age companies – a view that is no longer appropriate in an age of information and services. Manufacturers create value by managing tangible assets, whereas modern knowledge-based organizations create value by deploying intangible assets such as customer relations, innovative services, high-quality and responsive operations, information technology, databases, and employee competencies. Originally the Balanced Scorecard was concerned with measurement and control. Kaplan and Norton now believe it is a tool for implementing strategy – for dealing with the numerous cases where strategies fail because they are not implemented appropriately.

The Balanced Scorecard approach links the organization’s strategy to short-term actions. As the concept evolved, four perspectives were identified for transforming the Balanced Scorecard into a strategic management implementation system: the financial perspective, the customer perspective, the internal perspective, and the learning/growth perspective. The usefulness of the Balanced Scorecard in health care has been evaluated in a number of provider sectors and numerous international settings.

First, if the Balanced Scorecard is to be an effective strategic management system it should be useful in translating the vision into an integrated set of objectives that, when accomplished, contribute to long-term success. Second, successful implementation relies on effective communication with, and linking to, the units that comprise the larger organization. Third, action plans allow the integration of strategic and financial plans. And finally, feedback and learning are developed and nurtured such that consistent decisions are made throughout the organization and resources are allocated in a logical manner.

Additionally, understanding of the cause-and-effect relationships among all the performance indicators is important. Performance indicators are

generally divided into two major categories. These are “performance drivers/leading indicators” and “outcome measures/lagging indicators.” The former are drivers of future financial performance whereas the latter are the result of earlier actions.

Depending on the type of organization, performance excellence may be defined in different ways. In the for-profit sector, for example, earnings and financial achievements are central to success. In a public mental health setting, excellence is more likely to be defined in non-financial terms. In this sector excellence might be “fully meeting the needs of those who require the services most, at the lowest cost to the organization, within the limits and directives set by higher authorities.”

Regardless of the sector, health care or business, for-profit or not-for-profit, the vision and goals of an organization must be translated into tangible strategic objectives that relate to critical success factors. Action plans describe the specifications and steps to be taken to achieve the targets or goals. These plans drive actions strategically to attain the vision and deliver excellence at all levels of the organization. Actions have to be linked to each Balanced Scorecard indicator.

Balanced Scorecards are one way to define what is important in an organization, develop ways to measure important goals, and thereby assist in focusing the organization on its strategic direction. Other tools are available; however, the Balanced Scorecard has become an increasingly important element in the strategic manager’s toolbox.

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The Humber River Hospital (HRH) is a large Canadian acute care hospital with 656 beds that employs over 700 physicians and 3,000 staff. Affiliated with the University of Toronto and Queen’s University, HRH was the first digital hospital in Ontario and is known as an innovative and technologically advanced health

care organization.⁹

HRH developed a Balanced Scorecard to measure its activities relative to its mission, vision, and values. Following established custom, it divided its scorecard into four quadrants to ensure it had a balanced approach to its operations. The four quadrants were stakeholders (patients and their families, physicians, staff, and volunteers), learning and growth, financial performance and accountability, and internal processes (delivering safe care).

Key performance indicators (KPIs) were developed for each quadrant to ensure progress was made in all four areas. Leadership used the acronym SMART (objectives should be specific, measurable, achievable, realistic, and timely) as the guideline for developing KPIs and to ensure that KPIs provided meaningful measures of progress.

To illustrate, with regard to stakeholders, HRH measured the overall rating of medical, surgical, and emergency operations; employee and physician engagement; and community consultation. In the area of learning/growth, items such as leader retention rate, grievances received and resolved prior to arbitration, vacancy rates, and so on were measured. Financial and accountability measures included total overtime as a percent of productive hours, absenteeism rate, and emergency room wait time. Finally, examples of internal process measures included publicly reported infection prevention and control measures, percent compliance with hand hygiene, hospital standardized mortality rates, and rate of patient falls.

The goal of HRH, as with most organizations using the Balanced Scorecard, is to achieve a “balanced approach” to its operations that emphasize both financial and non-financial factors, enabling the organization to operate efficiently while simultaneously acknowledging the unique aspects of health care that require attention to other factors such as high-quality services that are safely delivered.

The Balanced Scorecard, as a performance measurement tool, provides an important linkage between strategy implementation and control. The Balanced Scorecard has been adapted to more and more sectors, such as not-for-profit, governmental, and educational sectors, and has experienced potential improvements in the metrics employed in evaluating performance.¹⁰

Implementation Challenges

Although many organizational resources are devoted to strategy formulation, strategies are often not implemented for a variety of reasons including a lack of understanding of the strategy, a diversion to more urgent demands for action, or a lack of appreciation for the difficulty of actually making strategy happen. Understanding the many likely conflicting attributes, ironies, or contradictions that occur in attempting to manage the future is a good start toward better comprehending strategy and implementation difficulties.

Typically, more attention has been given to strategy formulation and its link to organizational performance than to the intervening process of strategy implementation. In addition, the organization's culture and hierarchical structure may have been ignored and those responsible for implementation may know little about the thinking that provided the basis for the strategy. Research in hospitals has confirmed that consensus around strategic decisions builds commitment to the strategy and commitment leads to successful implementation, although it sometimes progresses at a slow pace.¹¹

Seven deadly sins have been identified that doom effective strategy implementation:

1. **Apathy:** The strategy is lacking in terms of rigor, insight, vision, ambition, or practicality. If the strategy is simply more of the same, comfortable, and incremental, it will not create the excitement needed for successful implementation.
2. **Uncertainty:** People are not sure how the strategy is to be implemented. Leaders are too impatient and are focused on results to make the strategy happen; therefore, communicating details about how implementation is to proceed is thought of as time-consuming indecisiveness.
3. **Mystery:** The strategy is communicated on a "need-to-know" basis rather than freely throughout the organization.
4. **Neglect:** No one is responsible for every aspect of strategy implementation. Failure to carefully see to all aspects of implementation results in oversights and confusion.
5. **Fragmentation:** Leaders send mixed signals by dropping out of sight when implementation begins. The absence of leadership implies that implementation is not worthy of their attention and, therefore, unimportant.
6. **Hindrance:** Unforeseen obstacles to implementation will inevitably occur. The responsible people should therefore be prepared for these barriers and be encouraged to overcome them in creative and innovative ways.
7. **Evasion:** Strategy becomes all-consuming and details of day-to-day operations are lost or neglected. Strategy is important, but so are operations.¹²

Effective strategy implementation requires the same determination and effort

that is devoted to situational analysis and strategy formulation. If the barriers to effective implementation are to be eliminated or overcome, a number of actions will be required. Everyone in the organization has to be a partner in implementation. Strategies are organization-wide and require inter-unit and cross-functional cooperation. Successful strategies require a willingness to seek the good of the entire organization over any single part. Unit managers have to broaden their view and the organization's leadership has to evaluate success based on contribution to the whole rather than to a single unit.¹³

Strategic managers are responsible for turning their vision into a compelling strategy for the future. A compelling vision elevates unclear strategies and conflicting priorities into a consistent pathway to success. The message from visible and engaged leadership is clear – strategy implementation is important.

When strategy is important, it will be a part of the budgeting, performance evaluation, and reward system of the health care organization. A primary reason strategies are not implemented is because, in many health care organizations, effective or ineffective implementation makes little or no difference in resource allocation or reward distribution. People, therefore, concentrate on what they perceive as the important things – those things that actually affect their budgets and their paychecks.¹⁴

Contingency Planning

Contingency planning is the development of alternative plans that may be put into effect if strategic assumptions change quickly or dramatically, or if organizational performance is lagging. This type of planning may be incorporated into the normal strategic management process at any level and is a part of managing the strategic momentum. Contingency planning is really about resourcefulness. Strategic thinkers ready themselves for alternative routes.¹⁵ Therefore, alternative plans are the result of strategic thinking and provide leadership with a different course of action until further analysis can be undertaken and a different strategy – more appropriate for the changed strategic assumptions – adopted.

The more turbulent, discontinuous, and unpredictable the external conditions, the more likely it is that unexpected or dramatic shifts will occur and the greater the need for contingency planning. In these situations the better developed the contingency plans are, the more likely the organization will achieve its strategic goals.¹⁶ Incorporating contingency planning requires top management to have some very specific contingency plan triggers that are understood by everyone and significant enough to require a change.

Strategic plans are based on the events and trends that management views to be the most likely (the strategic assumptions). However, these events may not occur, or trends may weaken, or accelerate far faster than strategic managers anticipated. Therefore, contingency plans are normally tied to key issues or events occurring or not occurring. For instance, if strategic thinkers have based the strategy on an expanding economy but are presented with clear evidence that the economy is slipping into a recession, contingency plans may be activated. Similarly, the announcement that a major competitor is leaving the market may present an opportunity that initiates contingency plans for market development. Such contingency planning forces strategic managers to think in terms of possible outcomes of the strategy.

As illustrated in Essentials for a Strategic Thinker 10–4, “What Is Continuity of Operations Planning?” one type of contingency planning that has gained importance in recent years is continuity of operations planning (COOP). *Continuity of operations plans* are internal preparations that ensure primary essential functions are ongoing despite a wide range of emergencies.¹⁷ These plans are designed to ensure the essential functions of organizations are continued in the event of the most unpredictable disasters – hurricanes, tornados, floods, pandemics, and so on.¹⁸

ESSENTIALS FOR A STRATEGIC THINKER 10–4

What Is Continuity of Operations Planning?



Survival is the most basic instinct of all living things and the fundamental goal of organizations. Today's world is a dangerous place as man-made and natural disasters have become increasingly prevalent, making organizational survival more challenging and disrupting the lives and functioning of employees, suppliers, customers, and organizational infrastructure. In the 21st century, the Federal Emergency Management Agency (FEMA) has issued 2,021 major disaster declarations, an increase of more than 90 percent for a comparable period at the end of the 20th century.¹ Increasingly, one of the most important contingency plans is the continuity of operations plan or COOP.

FEMA states: “*Continuity planning* is simply the good business practice of ensuring the execution of essential functions and a fundamental duty of public and private entities responsible to their stakeholders.”²

There are a number of reasons why health care organizations do not have continuity of operations plans. Some of the more important include the temptation to deny the possibility of low-probability events, the upfront cost of planning, the possibility of little or no payback, and the pressing nature of current problems. Moreover, guidance for what should be a relatively simple process is typically so complex that many organizations choose to take their chances rather than devote the time and resources necessary to prepare a comprehensive and complicated plan for a low-probability event.

Continuity of operations planning does not have to be complicated and bureaucratic. In fact, the major benefits of this type of planning may be obtained by going through a relatively simple process that requires carefully answering four important questions and establishing a method for ensuring the plan is practiced and perfected. The four critical questions are:³

1. What are the Essential Functions of the Business? Essential functions are defined as those organizational functions and activities that must be continued under any and all circumstances (FEMA, 2004). It should be noted that COOP is greatly facilitated by the existence of a carefully formulated strategic plan. If the organization has a well-understood mission statement, the essential functions should flow logically from this statement. Critical success factors in a particular industry are those activities that a firm must accomplish to compete successfully. Essential functions is a similar concept although critical success factors apply to all firms in a particular industry or industry segment, whereas essential functions only apply to a single organization.

Essential functions are those things that cannot be interrupted for an extended period of time under any circumstance if the organization is to continue to accomplish its purpose. Thus, a list of these functions must result from serious examination by the individuals who best understand the business. Moreover, the individuals involved in identifying essential functions must be able to “step outside their silos” and think about the

organization as a whole.

2. What is the Order of Leadership Succession? Survival of disasters requires leadership. Once the list of essential functions is generated and agreed on, individuals must be identified who will be held accountable for ensuring each essential function is accomplished.
3. Who Will Be in Charge? An incident command structure (ICS) must be established and communicated in advance of any disastrous event. An effective ICS begins with a continuity coordinator. Every organization that is seriously considering the development of a COOP should designate a continuity coordinator. This individual should have a thorough knowledge of the business, the industry, and the human and non-human resources of the organization. This individual will activate the event response on orders from the CEO and will assume operational responsibility for the implementation of the plan. The ICS should be closely aligned with the order of succession and clear decision-making authority should be defined.
4. What Resources Will Be Required by Designated Leaders? Leaders accountable for accomplishing essential functions cannot succeed without resources. Five types of resource are essential for ensuring continuity of operations – facilities, communication, records and databases, supplies, and human resources. Finally, COOP requires testing. Developing a plan is not enough.

For a plan to be effective it has to be exercised and tested. Exercising the plan forces everyone to continually think about survival, risks, and making the plan a living document that is regularly updated. Verification means trying out the plan under simulated conditions. Testing and re-testing is the only way to be sure that when the emergency occurs your plan will swing into action. Activation will occur only if everyone is familiar with the plan, committed to his/her role in making the plan a reality, and aware of their responsibilities and how their responsibilities relate to plan effectiveness.

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Source: Andrew C. Rucks, PhD, Professor, School of Public Health, University of Alabama at Birmingham.

To provide strategic control for organizations, effective contingency planning involves a seven-step process:

1. Identify both favorable and unfavorable events that could possibly derail the strategy or strategies.
2. Specify trigger points. Calculate a likely timetable for contingent events to occur.
3. Assess the impact of each contingent event by estimating the potential benefit or harm.
4. Develop contingency plans. Be sure that contingency plans are compatible with current strategies and are economically feasible.
5. Assess the counter-impact of each contingency plan. Estimate how much each contingency plan will capitalize on or cancel out its associated contingent event. Doing so will quantify the potential value of each contingency plan.
6. Determine early warning signals for key contingent events. Monitor the early warning signals.
7. For contingent events with reliable early warning signals, develop advance-action plans to take advantage of the available lead time.¹⁹

Strategic Momentum: A New Beginning

The model of strategic management introduced in Chapter 1 presented managing strategic momentum as the last stage of the model. However, managing the strategic momentum is an inherent part of all the strategic management processes. Once plans are developed, they must be actively managed, implemented, and controlled to maintain the momentum of the strategy. Strategic managers are controlling the strategic momentum as – simultaneously – they consider the reasons for strategic change. Strategic managers must continually balance control and change. Perhaps the best explanation is that strategic management is circular and all of its processes are continuous. For instance, strategic thinking and situational analysis are not halted so that strategy formulation may begin. All are continuous and affect one another (review in Chapter 1: Essentials for a Strategic Thinker 1–4, “What is Management Control?”).

Nevertheless, the act of managing provides the momentum for change, and change is a fundamental part of survival. As health care leaders manage momentum and change their organizations, they chart new courses into the future. In effect, they create new beginnings, new chances for success, new challenges for employees, and new hopes for patients. Therefore, it is imperative that health care managers understand the changes taking place; they should not simply be responsive to them, but strive to create the future. Health care leaders must see into the future and create new visions for success. Organizations that fail to change, ultimately will fail (see Essentials for a Strategic Thinker 10–5, “What Is the Icarus Paradox?”).

ESSENTIALS FOR A STRATEGIC THINKER 10–5

What Is the Icarus Paradox?



The Icarus Paradox is a description of what happens when the factors that create exceptional success are the same factors that lead to subsequent failure. The concept resulted from a study of 200 companies by Danny Miller and reported in his book, *The Icarus Paradox: How Exceptional Companies Bring about Their Own Downfall*.¹

Icarus was a character in Greek mythology whose wax wings allowed him to fly so well that, despite warnings that the wings would melt, he flew too close to the sun where, indeed, the wax melted and Icarus fell to his death in the sea. The same thing can happen to organizations that blindly follow successful patterns or trajectories despite clearly changing conditions.

Unfortunately, sometimes organizations become comfortable with success

and over-confident in their operations. When conditions change, managers avoid modifying their previous strategies because of their past extraordinary successes. They fail to see the new demands of change and fail to adapt their strategies, policies, and processes accordingly. These failures often open the door to their less successful competitors that are willing to adapt to a new formula for success.

Organizations intuitively focus on the things that make them successful – quality of services or products, customer service, technological sophistication – and, for a time, this focus serves them well. The focus, however, is often at the expense of other products, services, and processes. When things change, the highly successful organizations are frequently the last ones to recognize the changes taking place and competitors respond better and faster to changing conditions. The highly successful organization is left behind in the competitive race precisely because it is so good at the products or processes being displaced.

Thinking about the Icarus Paradox helps us understand why health care organizations must be cautious when enjoying their competitive advantage in a particular marketplace. If the advantage leads to complacency, the organization and its leaders may be in danger of being overcome by competitors that are more perceptive to external changes and more likely to seek the advantages created by emerging opportunities.

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The Map and Compass

Chapter 1 introduced the concept of the map and the compass. Recall that maps provide explicit directions and start the organization on its journey. Sometimes, as organizations progress, however, the landscape or landmarks have changed, or in other cases the organization is not really sure exactly where it should be headed. In these instances, the compass is more valuable to chart the course. Through strategic planning, organizations create plans (maps) for the future but must be willing to abandon the plan as the situation changes, new opportunities emerge, or managers find out what really works. This requires strategic thinking and leadership – leaders who recognize discontinuities and the need for change before others and commit to managing for the new realities.

Each chapter in this text has presented a strategic thinking map (rational model) for accomplishing strategic management. These maps provide guidelines for strategic management, including the general environment, health care system, service area competitor analysis, internal analysis, and so on. The maps keep leaders from being overwhelmed and provide some perspective to chart where they are going and what they want to accomplish. In addition, the maps initiate action toward renewing the organization. Without a map it is difficult to start the journey; however, similar to an organization's plans, these rational models cannot anticipate everything – nor can they be universally applied. They will not be a perfect fit for every organization, yet they can provide the initial logical direction for exploring and learning. They may be used to spark creative thinking. Therefore, the organization must reinvent the processes and learn as it goes. True creativity – the kind that is responsible for breakthrough innovations in our society – always changes the rules.

Do not work for the map; allow the map to work for you. When the strategic thinking map no longer provides direction and insight, management must dare to innovate and recreate the process – use a compass. The vision for the organization and its future should be used to determine what to do today to make it happen.

Finally, strategic management requires concentrated effort and takes practice. Lasting change will be made only through a lifelong commitment to a continuing discipline. Lasting organizational change (renewal) comes from thinking strategically and adopting sound management principles that are practiced on a continuing basis. There are no quick fixes. Using strategic thinking, strategic planning, and managing the strategic momentum to go forward enables the organization to change itself, and potentially the world.

Chapter Summary

Successful implementation relies on communicating the strategic plan and developing action plans – the translation of organizational strategies into actions. Otherwise, strategy remains little more than wishful thinking. Action plans make strategy happen, yet strategy cannot happen if people do not understand their roles in accomplishing the strategies of the organization.

The interrelationships among situational analysis, strategy formulation, and action plans are critical for managers and employees to comprehend because, unless understanding is achieved, action plans are unlikely to reflect organizational priorities.

Action plans should contain clear objectives that, when accomplished, will achieve the strategies of the organization. These objectives should be measurable, easy to understand, contain timeframes, and involve the individuals responsible for accomplishing them in their formulation. If they are to be effective guides to behavior, unit objectives – whether the unit is a division, a single entity, or a department – must be understood and agreed on by the members of that unit who are responsible for accomplishing the tasks necessary to achieve the objectives.

Action plans are important tools to accomplish the strategies of health care organizations. They outline the activities required for the accomplishment of each unit objective, along with an estimate of resources generated and expended in the accomplishment of each unit objective. In addition, action plans specify the time requirements for the accomplishment of each action and the individual or group responsible for ensuring the action is completed on time. Action planning is an effective aid in the formulation of unit budget requests and when rewards are based on action plan accomplishments everyone recognizes their importance. Finally, the Balanced Scorecard is discussed as a mechanism for effectively managing strategy implementation as it has evolved from a comprehensive performance measurement tool to a strategy implementation tool.

The strategic management planning process often “falls apart” at implementation. Less attention is given to implementation in most strategic management texts because it is so difficult to provide the specifics (there is no generic implementation strategy but, rather, a series of requirements: objectives, timelines, responsibilities, resources, and results measures). Implementation is specific to an organization, a strategy, a service area, and a culture.

Because strategic assumptions may change, contingency planning is essential to enable an organization to quickly change direction in a fast-paced environment. The map is a useful guide for known destinations whereas the compass aids in times of greater uncertainty.

Practical Lessons for Health Care Strategic Thinkers

1. Too many strategic plans are not implemented and when implementation is neglected, valuable time and resources are wasted.
2. Action plans are integral parts of the strategic planning process. These plans are the guideposts for making the strategy come alive.
3. Action planning is a valuable tool in communicating the organizational strategy to the individuals responsible for implementing the plan.
4. Continuity planning is important because having a backup for the primary plan is a good practice in light of changing external and internal factors.
5. Critical in maintaining strategic momentum is strategy evaluation and control. Through strategy evaluation and control, managers regulate, guide, and direct the strategy and within that process, emergent learning takes place and strategic thinking is re-initiated.

THE LANGUAGE OF STRATEGIC MANAGEMENT: KEY TERMS AND CONCEPTS

Action Plan

Balanced Scorecard

Best Practices

Contingency Planning

Continuity of Operations Plans

LEAN Six Sigma

Objectives

Process

Strategic Control

Questions for Class Discussion

1. Explain the relationship between situational analysis and action plans.
2. List the important components of action plans. Which component do you think is the most important? The least important? Explain your response.
3. How are the action plans for a division (for example, hospital division) similar to action plans for a department (such as housekeeping)? How are they different?
4. How do action plans assist in the allocation of organizational resources in line with strategies?
5. Are the costs associated with accomplishing the unit objectives the only ones that should be included in budget requests? Why or why not?
6. What are the primary characteristics of unit objectives? Are these characteristics descriptive of good organizational strategic goals? Why or why not?
7. What is a Balanced Scorecard? In what ways is it a means of focusing attention on strategy implementation?
8. What are some of the primary barriers to the effective implementation of strategies in health care organizations? How can each be overcome or removed?
9. Should every organization formulate contingency plans? Why or why not?
10. Explain how strategic momentum and strategic control may lead to a

new beginning.

11. Explain how vision, mission, values, goals as well as the adaptive, market entry/exit, competitive, and implementation strategies are a part of strategic control.
12. Explain whether a map or a compass is better for your career path in health care.

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Resource 1

Analyzing Strategic Health Care Cases

“Case studies provide low-risk experience.”

How do students of management gain experience in strategic thinking and making strategic decisions in health care organizations? One way is to work their way up the organization – holding a variety of positions, observing others, experimenting as they develop their decision-making skills – as they deal with issues and develop strategies. Then, when the opportunity presents itself, they combine what they have learned from others and their own management philosophy, and do the best they can. Unfortunately, learning chiefly through experience may be risky in rapidly changing environments and in the often unique situations that health care managers and leaders face.

Hospitals, HMOs, long-term care facilities, public health and other health services organizations prefer to trust important decision making to accomplished managers and leaders. Case studies have been used successfully as a surrogate method to provide aspiring managers and leaders with experience in strategic thinking, strategic planning, and making decisions without undertaking substantive risk. The best case studies contain real situations actually faced by managers and leaders in health care organizations and are documented in a way that makes them useful in providing experience for future strategic decision makers. Because many instructors in strategic management classes use case studies to provide future health care decision makers experience in making strategic decisions, this resource has been included, not to prescribe how cases should always be solved, but to offer some initial direction on how to surface and address the real issues.

An Overview of Case Analysis

Case analysis provides health care students with an exciting opportunity to act in the role of a key decision maker. From hospitals to community blood centers to physicians' offices, students have the chance to learn about a variety of health and medical organizations and to practice decision-making skills through analyzing cases.

The decisions required to “solve” cases represent a wide range of complexity, so that no two cases are addressed in exactly the same manner. However, the strategic thinking maps presented in this text provide frameworks to aid in strategically thinking about case issues. The fundamental task of the case analyst is to make decisions that will serve as a map to guide the organization into the future. Therefore, most case instructors will expect a comprehensive plan for the organization that addresses relevant current issues and provides a viable and reasonably complete strategy for the future. To achieve this goal, the case analyst typically should:

- Summarize the key issues.
- Analyze the situation.
- Develop an organizational strategy.
- Develop an implementation plan.
- Set benchmarks to measure success.

These categories represent the major elements of strategy development and make appropriate section headings for a case analysis written report or presentation. First, using the strategic thinking map presented in Chapter 1 (Exhibit 1–1), it is important to do some serious strategic thinking about the external environment of the organization – the political/legal, economic, social/cultural, technological, and competitive situations faced by the case characters. After gathering information about the issues in the general environment, health care system, and the service area, the service area competitors should be assessed. Next, it is important to relate the internal resources, competencies, and capabilities of the organization to external conditions, which will require a thorough and objective analysis of the competitively relevant strengths and weaknesses. The value chain provides a useful tool for uncovering these strengths and weaknesses. These strengths and weaknesses must be evaluated according to their potential to create competitive advantages or disadvantages for the organization. External issues and the organization's competitive advantages and disadvantages provide the basis for strategy formulation. In addition, to create the strategy for a health care organization, understanding its unique mission, vision, values, and strategic goals (directional strategies) is necessary.

Once the situational analysis is complete, strategic alternatives can be generated as possible solutions to the issues identified in the case. Consideration must be given to the feasible adaptive strategies, market entry/exit strategies, and

competitive strategies that provide the means for achieving the organization's mission and goals and lead to the accomplishment of its vision. The effectiveness of the chosen alternative for each type of strategy must be evaluated. In addition, attention must be given to the likely outcomes resulting from the different choices. After the evaluation, a recommendation needs to be made from among the alternatives.

Nothing will happen, of course, unless the strategy can be implemented. Therefore, the case analyst must address how the strategy will be carried out. The development of a practical implementation plan should include specific service delivery and support strategies and, where possible, action plans. These areas are important because they create value for the organization and translate strategy into organizational and individual actions – the work to be done.

Finally, the case analyst should consider how the success of the proposed strategy should be measured. Returning to the mission, vision, values, and goals will provide an initial measure of success. Other measures will include fit with the changing external environment, internal changes (development of competitive advantages and lessening of competitive disadvantages), and other more specific measures such as financial measures, market share, revenue growth, and so on.

Although the approach outlined here is logical, it is important to remember that a case should be approached and appreciated as a unique opportunity for problem solving. If everyone agrees that a case has only one solution – there's only one right answer – then it is not a good decision-making aid, and rather than applying decision logic and learning from others, participants will simply rehash case facts. Moreover, managers in health care organizations rarely face problems where the solution is obvious to everyone. This does not mean that there are no good and bad answers or solutions in case analysis; some are better than others on the basis of the logic presented. Sometimes the issues presented in a case are not even problems (defined as a negative occurrence that needs to be addressed). Often the greatest challenge facing an organization is recognizing and acting on an opportunity rather than solving a problem. The evaluation of a case analysis is often based more on the approach and logic employed than the precise recommendation offered.

Cases, Strategic Management, and Health Care Organizations

Cases add realism that is impossible to achieve in traditional lecture classes. Realism results from the essential nature of cases, although students may complain that cases fail to provide all the information necessary for decision making. The complaint is valid because cases rarely provide everything that is needed; however, decision makers in health care organizations rarely have all the information they want or need when they face decisions. Risks must be taken in case analysis just as in actual decision making.

Risk Taking in Case Analysis

Any decision about the future involves uncertainty. Decision making under conditions of uncertainty requires that means be devised for dealing with the risks faced by leaders. Cases are valuable aids in this area because they allow the analysts to practice making decisions in low-risk environments. Decisions in a poor case analysis may be embarrassing, but at least they will not result in the closure of a hospital or medical practice. At the same time, the lessons learned by solving cases and participating in discussions will begin to build problem-solving skills.

Solving Case Problems

Solving a case is much like solving any problem. First, information is gathered and issues are defined; the competitive situation is analyzed; alternatives are generated, evaluated, selected, and implemented. Although the person solving the case seldom has the chance to implement a decision, he or she should always keep in mind that recommendations must be tempered by the limitations imposed on the organization in terms of its resources, competencies, and capabilities (although strategies to improve these areas may be required). As the success or failure of the recommendation is analyzed, lessons are learned that can be applied to future decision making.

Alternative Perspectives: Passion or Objectivity

Different hypothetical roles can be assumed when analyzing cases. Some prefer to think of themselves as a passionate advocate for a particular course of action while others prefer to observe the case from the detached objectivity of a consultant who has been employed by the organization to solve a problem.

Either the advocate or the consultant perspective may be assumed, but the first offers some unique advantages. To answer the questions from the advocate's perspective, understanding what is inside the decision maker's head – to feel the excitement and fear of doing new and innovative things in the dynamic and complex health care system – is important. The passion and frustration of the advocate suggest why some case analysts prefer to assume the objective posture of a consultant. Not being in the front line can sometimes suggest alternatives that cannot be seen by those directly involved in making payroll and paying the bills. The consultant can more easily play the devil's advocate and point out how actions are at odds with current theory. Although the fun and excitement of case analysis is enhanced by assuming the decision maker's role of an influential advocate with a specific strategy in mind, the options might be expanded through the more objective and detached outlook of an outsider. There are no absolutely correct or incorrect answers to complex cases. The most important lesson is to learn problem-solving and strategic management skills.

Reading the Case

Effective case analysis begins with data collection. This means carefully reading the case, re-reading it, and sometimes reading it yet again. Rarely can anyone absorb enough information from the initial reading of a comprehensive case to adequately solve it. From the very first reading of the case, the analyst should start to list the external issues and the organization's internal strengths and weaknesses. For example, when a significant issue is discovered it should be marked for more detailed examination. "Is the issue financial? Do the primary issues appear to be those of human resources, capital investment, or marketing?" Perhaps there are few, if any, apparent issues with negative consequences. The strategic issue facing the organization may be one to be exploited or it may have both positive and negative aspects. For example, health insurance reform has created some interesting positive and negative consequences for many health care organizations.

Listing the possible strengths and weaknesses in the initial reading provides some perspective concerning the organization's resources, competencies, and capabilities. This list will provide a basis for further investigation and provide a guide for additional information gathering. Once the situation has been reviewed, a better evaluation of the issues facing the organization can be made. An effective way of summarizing the results is through the use of a SWOT analysis (refer to Chapter 7, Exhibit 7-3) or an external/internal strategy matrix (refer to Chapter 7, Exhibit 7-4), which shows the long- and short-term competitive advantages and disadvantages as well as external issues.

Gathering Information

The information required to successfully analyze a case comes in two forms. The first type of information is given as part of the case and customarily includes history of the organization, its organizational structure, its management, and its financial condition. Gathering this information is relatively easy because the author of the case has typically done the work.

A second type of information is "obtainable." This information is not provided in the case or by the instructor but is available from secondary sources in the library, familiar magazines and other publications, as well as online. Obtainable secondary information helps with understanding the nature of the service category, the competition, and even some managers, past and present, who may have made an impact on the service category.

If the case does not include service category information or competitor information, the instructor may expect the class to do some detective work before proceeding. Students should investigate to find out what is happening in the service category and learn enough about trends to position the problems discussed in the case in a broader health care context. The culture of the organization or the style of the chief executive officer may constitute relevant information (though some instructors do not want students to investigate

beyond the date of the case or to gather additional service category data; therefore, students must ask the instructor's preference). Be sure to consult the professor prior to analyzing your first case. Furthermore, if the first thing that students do after receiving a case assignment is to go to the web to search what the company did in the situation presented, they are much less likely to be able to develop innovative solutions. The assumption is that the company did the right thing, when in fact if the company had a chance to do it all over again, a completely different strategy might have been pursued. Good cases, as in life, have a number of options that have to be weighed, and a number of reasonable alternatives evaluated before drawing a defensible solution.

Case Analysis Using the Strategic Thinking Maps

The strategic thinking maps presented in this text provide a means of thinking through strategic management issues and serve as road maps to case analysis. They are useful for analyzing cases and succinctly presenting strategic management decisions in written reports and presentations. The following discussion provides some tips for using the strategic thinking maps in each of the major elements of case analysis – surfacing the issues, situational analysis, development of the strategy, and development of the implementation plan.

Tips on Surfacing the Issues

The discussion and questions presented in the “Managing Strategic Momentum” section of each chapter are designed to bring attention to present and potential issues. In case analysis, issues include not only problems that need to be rectified, but also situations where things may be working well but improvements are possible. The problem may actually be an opportunity that can be capitalized on if the organization acts consciously and decisively. With careful analysis, patterns can be detected and discrepancies between what actually is and what ought to be become more apparent. In other words, fundamental issues, not mere symptoms, begin to emerge.

Problems vs. Symptoms

It is important to realize that the things observed in an organization and reported in a case may not be the real or essential issues. Often what analysts observe are the symptoms of more serious core problems. For example, increasing interest rates and cash-flow discrepancies appear to be problems in many case analyses. In reality, the issue is the fundamental absence of adequate financial planning. The lack of planning simply manifests as a cash-flow problem and rising interest rates certainly complicate cash flow.

Frequently, hospitals conclude that they have a marketing problem when bed occupancy rates decline. Someone may suggest that the marketing department is not doing a good job of convincing physicians to use the hospital or that the hospital is not spending enough on advertising. The real issue, however, might be fundamental changes in the demographics of the market area or an outdated services mix that no amount of advertising will overcome. In organizations as complex as health care, problems may have more than a single cause, so the analyst must not be overly confident when a single, simple reason is isolated. In fact, the suggestion of a simple solution should increase rather than decrease skepticism.

Using Tools

Identifying key issues requires that information be carefully examined and analyzed. Often, quantitative tools are helpful. Financial ratio analysis of the

exhibits included in the case will sometimes be helpful in the identification of the real problems. In arriving at the final determination of core problems, the analyst should try not to slip into “paralysis by analysis” and waste more time than is necessary on identifying problems. At the same time, premature judgments must be avoided because then real issues may be missed. One general guideline is that when research and analysis cease to generate surprises, the analyst can feel relatively, though not absolutely, sure that adequate research has been conducted and the key issues have been identified.

Check Facts

The issue discovery process should not become myopic. For example, there may be a tendency on the part of individuals interested and experienced in accounting and finance to see all problems in terms of accounting and finance, whereas a physician approaching the same case will likely focus on the medical implications. This approach is too limited a view for effective strategic decision makers. Strategic analysis effectively transcends a single function. Insistence on approaching case analysis exclusively from the viewpoint of the analyst’s expertise and training is not likely to produce an accurate overall picture of the situation facing the organization; nor is this approach likely to improve the organization’s performance.

Information, either given or obtained, must never be accepted at face value. If a CEO states that the hospital delivers outstanding quality care, it should not be accepted as a statement of fact without some thought. For example, a character in the case may voice an opinion that is not grounded in fact. The ratios on a long-term care facility’s financial statements may look strange, but are they? Before jumping to such a conclusion, analysts should look at the financial ratios in a historical perspective. Even better, they should look at the history (as well as similar ratios) of other long-term care facilities of the same size during the same time period.

Relevant Issues

Once the issues are identified, they must be precisely stated and their selection defended. The best defense for the selection of the key issues is the dataset used to guide the issue discovery process. The reasons for selection of the issues should be briefly and specifically summarized along with the supportive information on which judgments have been based. The issue statement stage is not the time for solutions. Focusing on solutions at this point will reduce the impact of the issue statement. If the role of consultant has been assumed, the issue statement must be convincing, precise, and logical to the client organization, or credibility will be reduced. If the role of the strategic advocator has been selected, the student must be equally convincing and precise. The strategic decision maker should be as certain as possible that the correct issues have been identified to pursue the appropriate alternatives.

The statement of the issues should relate only to those areas of strategy and operations where actions have a chance of producing results. The results may be either increasing gains or cutting potential losses. Long- and short-range

aspects of issues should be delineated. In strategic analysis the emphasis is on long-range issues rather than merely handling emergencies and holding things together. However, in some situations, immediate problems have to be solved and then a strategy developed to avoid similar situations in the future (combination strategy).

It is important for students to keep in mind that most strategic decision makers can deal with only a limited number of issues at a single time. Therefore, identify key result areas that will have the greatest positive impact on organizational performance.

Tips on Analyzing the Situation

Situational analysis is one of the most important steps in analyzing a case. In most instances instructors will expect comprehensive external and internal analyses. For external analysis, the case analyst may want to use and present a variety of tools including a trend analysis, stakeholder analysis, the development of a scenario, and service area competitive analysis. Whatever method is used, a clear picture and assessment of the external environment should be presented. Chapters 2 and 3 provide strategic thinking maps for assessing the external environment.

For the internal analysis, it is important that the case analyst understands the strengths and weaknesses of the organization in terms of its resources, competencies, and capabilities. Therefore, the case analyst may want to use the value chain, as discussed in Chapter 4, to map resources, competencies, and capabilities and assess their strategic relevance using the criteria of value, rareness, imitability, and sustainability.

Understanding the mission is a good starting point to assess the directional strategies. If a mission statement is included in the case, the analyst should ask “Does it serve the purpose of communicating to the public why the organization exists? Does it provide employees with a genuine statement of what the organization is all about?” In addition, the other directional strategies (vision, values, and strategic goals) should be evaluated as to their appropriateness to the organization and its environment. The vision and goals provide a profile of the future and targets to focus organizational actions. The case may (or may not) indicate what the health care organization plans to achieve in the next year and where it hopes to be in three years, or even in five years. As with mission statements, if the vision and goals are not explicitly stated, there is a need to speculate about them because they will be the standards against which the success or failure of a particular strategy will be evaluated. Moreover, because strategic planning is futuristic and no one can predict the future with complete accuracy, vision and goals should always be adaptable to the changing conditions taking place in the organization and in the service category. An organization may be forced to face a major strategic problem simply because it was unwilling to alter its vision and goals in light of changing conditions.

Tips on Formulating the Strategy

After the situational analysis, a recommended course of action – the strategy – must be developed. Thus, adaptive, market entry/exit, and competitive strategies for the organization must be recommended and defended. Exhibit 6–4 provides a strategic thinking map depicting the various alternatives for each of the types of strategy in the strategy formulation process.

Effective Alternatives

If obtaining and organizing information have been done well, the generation of strategic alternatives will be a challenging yet attainable task. Good alternatives possess specific characteristics:

- They should be practical or no one will seriously consider them. Alternative courses of action that are too theoretical or abstract to be understood by those who have to accomplish them are not useful.
- Alternatives should be specific.
- Alternatives should be related to the key issue they are intended to address. If the strategic alternatives generated do not directly address key issues, the analyst should ask how important the issues are to the case analysis; rethinking the issues may be required.
- Alternatives should be implementable. An implementable alternative is one that can be reasonably accomplished within the constraints of the financial and human resources available to the organization.
- Alternatives should be able to be placed into action in a relatively short period of time. If it takes too long to implement a proposed solution, it is likely that the momentum of the recommended action will be lost.

Alternative Evaluation

Alternatives should be evaluated according to both quantitative and qualitative criteria. Financial analysis provides one basis for examining the impact of different courses of action. However, a good alternative course of action is more than merely the one with the highest payoff. It may be that the culture of the organization cannot accommodate some of the more financially promising alternative courses of action. For the adaptive strategies, one or more of the decision-making tools discussed in Chapter 7 should be used – external/internal strategy matrix, PLC analysis, BCG portfolio analysis, extended portfolio matrix analysis, SPACE analysis, or program evaluation. For the market entry/exit and competitive strategies, matching the external conditions appropriate for the strategies with the internal requirements of the strategies as discussed in the text, alongside the internal strengths and weaknesses and external conditions described in the case, provides a basis for selecting and defending these strategies (Chapter 7).

The case analyst should be able to map the strategies selected in the strategy formulation process. Strategy maps similar to the one presented in Exhibit 7–25, an example for a long-term care organization, show the decision logic for each strategic initiative and provide an excellent overview of the strategy of the

organization.

Tips on Developing Implementation Strategies

Once a strategic alternative has been selected, an action plan is required. Action planning moves the decision maker from the realm of strategy to operations. Now the question becomes, “How does the group accomplish the work in the most effective and efficient way possible?”

The task of case analysis does not require actual implementation; however, because the strategies must be implementable, it is necessary that thought be given to how each strategy would be put into action. Therefore, value-adding service delivery and support strategies must be developed as well as action plans. This process is a continuation of the linkage started in strategy formulation – the implementation strategies are the means to achieve the overall organizational strategies.

Each element of the value chain should be addressed, comparing the results of the internal analysis with the requirements of the selected strategy. Matching the present situation with the requirements of the strategy provides a basis to maintain the value chain element or change it to meet the needs of the strategy. Exhibits 8–9 and 9–7 provide templates for information instructors might expect for presenting the value-adding strategies. Exhibits 8–10 and 9–9 provide examples of completed templates for a skilled nursing facility.

Next, action plans for the major organizational units affected by the strategy should be developed. Objectives, action plans, and budgets should be addressed if enough detail is provided in the case. Finally, the responsibility for accomplishing the different groups of tasks must be clearly assigned to the appropriate individuals. Although this is not always possible in case analysis, it is important that consideration is given to how, in a real organization, the recommendations would be accomplished. If, in the process of thinking about how different activities will be completed, it becomes apparent that the organization lacks the resources or the structure to accomplish a recommendation, another approach should be proposed.

The process of developing action plans for important organizational units – whether a highly focused unit, such as a pharmacy, or a broadly focused unit, such as a hospital division for a health system – should not be neglected. Organizations sometimes spend large amounts of money and resources developing strategic plans only to discover that they are not prepared to implement them in an effective manner.

Making Recommendations

Making good recommendations is a critical aspect of successful case analysis. If recommendations are theoretically sound and justifiable, people will pay attention to them. If they are not, little is likely to result from all the work done to this point.

One effective method for presenting recommendations is to relate each one to organizational strengths. Or, if necessary, a recommendation may be related to addressing a weakness. If the organization has sufficient financial strength, the recommendations should highlight how each alternative will capitalize on the strong financial condition. If, on the other hand, the resources are limited, it will be important to avoid recommendations that rely on resources that are not available; a combination strategy to gain new resources might be recommended.

It will be particularly useful to ask the following questions when making recommendations:

- Does the organization have the financial resources needed to make the recommendation work?
- Does the organization have the personnel with the right skills to accomplish what will be required by each recommendation?
- Does the organization have methods to monitor whether or not the recommendations are being accomplished?
- Is the timing right to implement each recommendation? If not, when will the timing be right? Can the organization afford to wait?

Finalizing the Report

Preparation and presentation is the final activity in most case analyses. Although the form of the report may vary, the goal is the same – to summarize and communicate in an effective manner what the analysis has uncovered and what the organization should do.

Decision making is the intended result of the report. The analysis must be complete; but the emphasis should be on making the entire report brief enough to encourage people to read it and comprehensive enough to ensure that no major factors are overlooked – especially those that might adversely affect the decision. Therefore, charts and flow diagrams can be effective. In a brief outline, the important sections of a case analysis report include:

- Executive summary – Usually one page, and rarely more than two pages, it functions as an abstract. Its purpose is to force the writer to carefully evaluate what is really important in all the accumulated facts and data. It is not an introduction (no company history, no re-statement of case facts, etc.). Include what the CEO would want to know: what is the issue, what are the recommended strategies (the hierarchy of strategies), how much will it cost. If he or she wants more information on any of the points in the Executive Summary, they should be discoverable in the Table of Contents to find the correct pages for more information.

- Body of the case report

Key Issues: with the rationale for focusing on them.

Situational Analysis: results of the external analysis, service area competitor analysis, and internal analysis, as well as analysis of the directional strategies.

Strategy Formulation: feasible alternatives for directional, adaptive, market entry/exit, and competitive strategies.

Recommendation: analysis of the feasible alternatives, and which one or ones is/are recommended.

Implementation Strategies: service delivery and support strategies with linkage to the directional, adaptive, market entry/exit, and competitive strategies.

Benchmarks for Success and Contingency Plans: measures of success for the strategy and alternative plans if a major opportunity or threat is subject to change in the short run (contingency plan).

Conclusions

Case analysis is an art. There is no one precise way to accomplish the task, and the analysis has to be adapted to the case problem under review. The analyst must keep in mind that case analysis is a logical process that involves: (1) clearly defining strategic issues; (2) understanding the situation – the organization, service area/service category, and environment; (3) developing a strategy to enable the organization to accomplish its mission and vision; and (4) formulating an implementation plan.

The work of case analysis is not over until all these stages are completed. Often a formal written report or oral presentation of the recommendations is required. Case problems provide a unique opportunity to integrate all that students have learned about decision making and direct it toward issues faced by real organizations. It is an exciting way to gain experience with decision making. Students should take it seriously and develop their own systematic and defensible ways of solving management problems.

Resource 2

Health Care Organization Accounting, Finance, and Performance Analysis

“In the end, it is all about the balance sheet.”

—BY ANDREW C. RUCKS

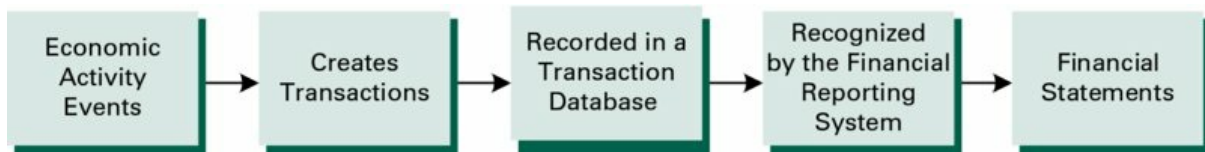
The purpose of this resource is to provide an overview and explanation of financial and accounting concepts as they relate to health care organizations. From Chapters 1 through 10 of this text, students have learned that many strategic decisions are influenced by the financial resources of the organization. Similarly, the financial resources of an organization are shaped through the implementation of its strategic plan. The ability to trace cause and effect relationships between managerial decisions and the financial resources of the organization is a fundamental management skill; therefore, this source is intended to provide a framework for understanding and managing the key elements of a health care organization’s financial resources.

The financial resources of an organization are summarized through its accounting. Accounting is the process of recording, summarizing, reporting, and analyzing the economic activity of an organization. To maintain comparability of reports of economic activity of different organizations, the accounting process is governed by generally accepted accounting principles (GAAP). In the United States GAAP (pronounced gap) is developed by two organizations: the Financial Accounting Standards Board (FASB, pronounced faz•bee), the authority for establishing the “financial accounting and reporting standards for public and private companies and not-for-profit organizations that follow Generally Accepted Accounting Principles (GAAP)”¹ and the Governmental Accounting Standards Board (GASB, pronounced gaz•bee), which is “the independent organization that establishes and improves standards of accounting and financial reporting for U.S., state, and local governments.”² Internationally, GAAP is developed by the International Financial Reporting Standards Foundation (IFRSF) and its standard-setting body, the International Accounting Standards Board (IASB), “an independent, private-sector body that develops and approves International Financial Reporting Standards (IFRSs).”³

The purpose of accounting is to provide information to decision makers. Financial accounting focuses on the specific needs of external decision makers such as investors and regulators, whereas managerial accounting focuses on the specific needs of internal decision makers – the leaders and managers of the organization. Therefore, managerial accounting is the primary focus of this resource that addresses for-profit and not-for-profit health care organizations and incorporates GAAP guidelines.

Basis of Accounting

[Exhibit R2-1](#) demonstrates the relationship among an organization's economic activity, the creation and recording of transactions, and financial reporting through financial statements. The first step, economic activity, occurs when a health care organization has an economic exchange with an individual or another organization. For example, when a physician enters an order for a medical test, an economic exchange is initiated as the service (medical test) is exchanged for a charge to the patient's account for that service. Similarly, the purchasing department of an assisted-living facility placing an order for janitorial supplies engages in an economic exchange. The supply order transaction involves the assisted-living facility creating and transmitting a purchase order to a janitorial supplier authorizing it to deliver the supplies and transmit a sales invoice for the supplies that will subsequently be paid by the assisted-living facility. Transactions are recorded through the accounting system and, based on GAAP, the cumulative results of these transactions are summarized in the assisted-living facility's financial statements and the janitorial supplier's financial statements.



[Exhibit R2-1](#) Economic Activity, Transactions, Recording, and Financial Reporting

The processing of transactions for reporting in financial statements requires an organization to choose a basis of accounting. The choice of the basis of accounting affects the timing of data available for financial reports. Organizations have a choice between a cash or accrual basis of accounting. The difference between a cash basis and an accrual basis is simply the occurrence of events that determine when the data recorded about a transaction becomes available for financial reporting. In other words, the basis of accounting specifies when a transaction is recognized. In cash-basis accounting, a transaction is recognized when it is converted to cash – when there is an inflow or outflow of cash. Accrual-basis accounting transactions are recognized when they occur – when the transaction decision is made (when the order is placed). Using the order of janitorial supplies as an example, if the assisted-living facility chooses cash-basis accounting, the value of the order will not be recognized, that is, made available to the financial reporting system, until a cash payment (usually a bank draft or electronic transfer) is made to the supplier for the janitorial supplies. On the other hand, if the assisted-living facility chooses accrual-basis accounting, the order transaction will be recognized at the time the order is entered into the purchasing system. Likewise, if the janitorial supplier chooses the cash basis of accounting, the sale of supplies will not be recognized until it receives a cash payment from the assisted-living facility; and if the supplier chooses the accrual basis of accounting, the sale will be

recognized when the order is shipped or delivered to the assisted-living facility. As one may imagine, the simultaneous use of cash-basis and accrual-basis accounting would create considerable confusion; therefore, GAAP does not permit the mixing of cash basis of accounting and accrual basis of accounting.

Financial Reporting

Accounting systems are designed to capture the economic activities of an organization. The summarization of an organization's economic activity through financial reporting discloses the "financial condition" or "financial position" – the status of assets, liabilities, and equity – the elements of the accounting equation. The accounting equation is shown in [Exhibit R2-2](#).

For-profit organization:	assets	=	liabilities + equity
Not-for-profit organization:	assets	=	liabilities + net assets

[Exhibit R2-2](#) The Accounting Equation

The accounting equation states an equivalency – what an organization owns (assets) must equal what it owes (liabilities plus equity). Liabilities and equity disclose how assets are financed. Another way of viewing the accounting equation is that things of value owned by the organization (its assets) are equal to the source of funds used to purchase the assets – by debt (termed liabilities) or through its own resources (termed equity) representing investments of owners (shareholders or partners) or earnings retained by the firm (not distributed to owners).

As [Exhibit R2-2](#) illustrates, the nomenclature for what an organization owns varies between for-profit and not-for-profit organizations; however, the meaning of the equations are the same – uses of funds must equal the sources of funds. The term for owned resources in for-profit organizations is equity and the term used by not-for-profit organizations is net assets. The accounting equation is the origin of the three primary financial statements: (1) the balance sheet (for-profit organizations) and statement of financial position or statement of financial condition (not-for-profit organizations);⁴ (2) the income statement (for-profit organizations) and statement of activity (not-for-profit organizations), and (3) the statement of cash flows (for-profit and not-for-profit organizations) as shown in [Exhibit R2-3](#).

What the Financial Statement Shows	Titles Used with For-Profit Organizations	Titles Used with Not-For-Profit Organizations
Reports as of a specific date: the assets owned, liabilities owed, and equity (for-profit organizations) or net assets (not-for-profit organizations).	Balance sheet	Statement of financial position Statement of financial condition Balance sheet

Reports for a period of time, usually 12 consecutive months (a fiscal year): the revenues received, and the expenses incurred by an organization. The difference between revenue and expenses is profit or loss (for-profit organizations) or a surplus or deficit (not-for-profit).	Income statement	Statement of activity Statement of operations
Reports for a period of time, usually a fiscal year: the exchange of money between the organization and outside parties, thus reporting the sources of cash received (e.g. the sale of services) and the uses of cash for operations plus any financial arrangements such as investing.	Statement of cash flows	Statement of cash flows

Exhibit R2-3 The Three Primary Financial Statements

Another difference between for-profit and not-for-profit organizations is the concept of ownership. For-profit organizations have stockholders that invest in the organization through the purchase of shares of stock, resulting in the stockholders having an equity interest in the organization. The sum of equity investments in a for-profit organization is part of what is referred to as stockholders' equity. Stockholders' equity may also be called capital or net worth. If the value of an organization's assets exceeds its debt, stockholders' equity represents the funds that would be left in the event the organization liquidated all of its assets (sold the assets) and paid off all its debts (liabilities). Stockholders' equity may also include earnings or profits that the management of an organization has decided to retain or reinvest in itself, termed retained earnings. For-profit organizations may reduce the value of retained earnings by paying amounts to stockholders as dividends.

Not-for-profit organizations do not have owners per se, and therefore do not have stockholders; however, they have parties that are interested in the vision and mission of the organization. Interested parties may make monetary contributions to a not-for-profit organization, in which case they are termed stakeholders. Not-for-profit organizations do not pay dividends or distributions to stakeholders. However, not-for-profit organizations may have funds left over after paying all expenses, termed surplus, which may, at the discretion of management, be paid as wages to employees or retained or reinvested in the organization.

It should be noted that managerial decisions to reinvest earnings or surpluses serve the same purposes in both for-profit and not-for-profit organizations. Reinvested earnings may be used to purchase new assets such as technologies, remodel/expand facilities, acquire other organizations, invest in financial instruments (stocks, bonds, mutual funds), and so on.

The Balance Sheet/Statement of Financial Position

The structure of the balance sheet and the statement of financial position reflects the accounting equation: assets = liabilities + equity. The general form of the balance sheet and statement of financial position is shown in [Exhibit R2-4](#). As illustrated in [Exhibit R2-4](#), assets, liabilities, and equities are presented in separate accounts. Assets generally are listed in order of their degree of liquidity (the ease with which assets are convertible into cash) from current assets to long-term assets. Current applied to assets means convertible into cash within one year; when applied to liabilities, current means a debt due that must be paid within one year. Liabilities are listed in order of the degree of their maturity – current liabilities followed by longer-term liabilities. Equities consist of contributed capital and retained earnings or retained surplus.

For-Profit Organizations	Not-For-Profit Organizations
Balance Sheet	Statement of Financial Position
Assets	Assets
Current Assets	Current Assets
Long-term Assets	Long-term Assets
Total Assets	Total Assets
Liabilities and Equity	Liabilities and Net Assets
Current Liabilities	Current Liabilities
Long-term Liabilities	Long-term Liabilities
Equity	Net Assets
Total Liabilities and Equity	Total Liabilities and Net Assets

[Exhibit R2-4](#) The Structure of the Balance Sheet and Statement of Financial Position

The financial statements of Frederick Regional Health System, Inc. (FRHS) are presented throughout this resource as an example of the financial statements produced by a health care organization. FRHS is a private, not-for-profit, managed services organization headquartered in Frederick, Maryland. FRHS includes a 233-bed acute care hospital and provides many health care services throughout Frederick County (Maryland) and the surrounding four-state region. Annually, the health system records more than two million outpatient encounters as well as 75,000 visits to its Emergency Department and more than 22,000 hospital admissions.⁵

[Exhibit R2-5](#) presents FRMH's balance sheet. Several line items in the FRMH balance sheet demonstrate common practices in the reporting of financial position or condition.⁶

Consolidated Balance Sheets (in thousands)

	June 30	
	2015	2014
Assets		
Current assets:		
Cash and cash equivalents	\$31,432	\$33,668
Patient receivables, net	48,100	47,109
Other receivables	1,860	1,843
Inventory	6,006	4,405
Prepaid expenses	2,430	3,692
Loss on sale of property and equipment	3,093	4,033
Promises to give, net	787	711
Total current assets	93,708	95,461
Net property and equipment	202,055	199,089
Other assets:		
Assets limited as to use	8,840	19,546
Investments – donor restricted	5,855	3,705
Promises to give, net	3,786	3,447
Long-term investments	134,931	132,552
Other investments	5,752	3,489
Debt issuance costs, net	1,379	1,510
Other assets	5,331	5,739
Total other assets	165,874	169,988
Total assets	\$461,637	\$464,538
Liabilities and net assets		
Current liabilities:		
Current maturities of long-term debt and capital lease obligations	\$5,103	\$5,697
Accounts payable	22,052	20,767
Accrued expenses	18,402	20,561
Advances from third-party payors	9,813	8,546
Other current liabilities	2,475	4,693
Total current liabilities	57,845	60,264
Long-term liabilities, net of current portion:		
Long-term debt and capital lease obligations	161,012	166,275
Interest rate swap contract	11,277	11,238
Accrued pension expense	18,868	16,602
Other loss on sale of property and equipment	19,487	19,972
Total long-term liabilities, net of current portion	210,644	214,087
Total liabilities	268,489	274,351
Net assets:		
Unrestricted	182,721	182,314
Temporarily restricted	9,451	6,897
Permanently restricted	976	976
Total net assets	193,148	190,187
Total liabilities and net assets	\$461,637	\$464,538

Exhibit R2-5 Frederick Regional Health System, Inc. and Subsidiaries**Assets**

Cash and cash equivalents – Funds deposited in commercial banks or in highly liquid and secure investments such as short-term U.S. Treasury Bills.⁷

Assets limited as to use – The value of current assets on which donors have imposed restrictions that limit the use of the assets.

Patient receivables, net – Funds due either from patients directly or from third-party payors such as a health insurance company, Medicare, or Medicaid. The term net simply means that the hospital expects that some of the amount due will not be paid and, therefore, it has deducted the expected amount that will not be paid from the total amount due.

Inventory – The fair value of supplies and materials that will be consumed in the process of providing patient services. An organization selects a method of

determining the fair value of assets. For inventory, a typical valuation policy will use the method of “the lower of cost or market.” This valuation methodology means that at the time an inventory is taken (items in inventory counted), the value of each item will be based on either what was paid for it at its time of purchase (also known as historical cost) or its value in the marketplace at the time of the inventory, whichever is lower. In addition, the organization will adopt an inventory consumption policy – either FIFO (first-in, first-out) consuming the oldest items first or LIFO (last-in, first-out) consuming the newest items first. Determining the fair value of assets as well as liabilities is sometimes a complex task.⁸

Prepaid expenses – The value of current assets for which payment has been made, but the use for which the asset is intended has not yet occurred. The concept of prepayment is generally associated with expenses that are incurred as lump-sum payments and will be used or consumed over a period of time. Insurance premiums paid for coverage in the areas of property and casualty, product liability, officer errors and omissions, and vehicle coverage are examples of expenditures that are paid as a lump sum, either annually or semi-annually. Other examples include subscriptions to publications, accrued employee vacation days, and accrued employee sick leave. Any expense item for which the provider of goods/services is willing to accept payment for the delivery of goods/services in the future would be classified as a prepaid expense.

Assets limited as to use – (A classification used in both the current assets and other assets sections of the balance sheet.) The fair value of assets for which donors have imposed restrictions or conditions as to use. For example, if a donor made a gift to the hospital, but restricted the use of the gift or its earnings to the Neonatology Department, then the fair value of the investment will be included in this balance sheet account.

Promises to give, net – (A classification used in both the current assets and other assets sections of the balance sheet.) The value of gifts promised to be delivered within one year (current assets) or to be delivered at a time that is beyond one year (other assets). The term net conveys the same connotation described earlier – the hospital does not expect to receive all gifts that have been promised and thus has reduced the total value of promises by an amount consistent with this expectation.

Net property and equipment – (This account may also be labeled Property, plant, and equipment.) The sum of the book value of land and the net book value of long-lived physical or fixed assets. Book value is the historical cost of an item; net book value is historical cost less accumulated depreciation. The accounting for fixed assets is intended to allocate the cost of the asset over its useful life. Therefore, a fixed asset is reduced in value (expensed) each year by an amount that is a function of its overall life expectancy. This reduction is reported on the income statement as depreciation expense – a non-cash expense that is the annual allocation of the historical cost of the fixed asset. Property and equipment (long-term assets) are valued at their historical value rather than fair market value or replacement value because, in general, they are not intended for sale. This account includes the value of capital leases (also known as financial leases). A capital lease refers to a situation where a health care organization

leases an asset for its entire useful life. The value of the asset is reduced annually by the year's lease payments and the lease payments are recorded as a cash expense on the statement of activities or income statement.⁹

Long-term investment – The value of unrestricted investments in stocks, bonds, and mutual funds. The valuation placed on these investments is the fair market value on the date of the publication of the financial statement. For tax accounting purposes, the value of long-term investments may be either fair market value, historical cost, or the lower of either fair market value or historical cost. Long-term investments are usually the last item in the assets section of the balance sheet.

Liabilities and Equity/Net Assets

Liabilities are listed in the order of maturity from current liabilities (maturing in less than one year) to long-term liabilities (maturing in more than one year).

Accounts payable – The amounts owed to vendors and creditors for goods and services rendered, or in other words, unpaid bills.

Long-term liabilities – The fair market value of liabilities with maturities exceeding one year. Common long-term liabilities include mortgages, notes payable, and bonds. The term note is a generic term used for formal written obligations (contracts) to banks or other creditors. Notes may or may not involve collateral. Collateral is an asset that is pledged by the borrower in the event of default (inability of the borrower to pay a note at a time when a payment is due). Should there be a default, the lender may take possession of the collateral or cause it to be sold to satisfy the obligation of the borrower to the lender.

Accrued expenses – The value of certain expenses such as utilities that have been expensed (recorded on the statement of activities or income statement), but have not yet been remitted to a vendor.

Net assets – unrestricted – The value of net assets that is not restricted by stipulations imposed by donors.

Net assets – temporarily restricted – The value of net assets with uses limited by donor stipulations for which the restrictions will either expire with time or through the actions of the hospital.

Net assets – permanently restricted – The value of net assets with donor-specified restrictions of use for which the donor stipulations will not expire either with time or action of the hospital.

Total liabilities and equity/net assets – The sum of total liabilities and total net assets must be equal to the value of total assets. The balance sheet must balance – total assets must equal total liabilities plus net assets.

The Income Statement/Statement of Activities

Similar to the balance sheet, the structure of the income statement and the statement of activities (or statement of operations – they are used interchangeably) is based on a simple equation. For the income statement and statement of activities: earnings = revenues – expenses. The general form of the income statement and statement of operations is shown in [Exhibit R2-6](#). The timeframe covered by the information in an income statement or statement of activities is usually one year, specifically, the fiscal year of the organization preparing the report. Nevertheless, these financial reports may be prepared for any period such as a month or year-to-date; however, when used as reports to stockholders, stakeholders, and regulators, the timeframe of the report is the fiscal year.

For-Profit Organizations	Not-For-Profit Organizations
Income Statement	Statement of Operations
Revenue	Unrestricted revenue
Sales	Patient service revenue, net
Less discounts	Other operating revenue
Net sales	Gifts
Total sales	Total unrestricted revenue
Operating expenses	Operating expenses
Cost of goods sold	Cost of goods sold
Employee expenses	Employee expenses
Utilities	Utilities
Insurance	Insurance
Depreciation	Depreciation
Total operating expenses	Total operating expenses
Operating income	Operating income
Other income and expenses	Other income and expenses
Gain (loss) on sale of assets	Gain (loss) on sale of assets
Investment gain (loss)	Investment gain (loss)
Non-operating expenses	Non-operating expenses
Total other income, net	Total other income, net
Profit (loss)	Surplus (deficit)

Exhibit R2-6 The Structure of the Income Statement and Statement of Activities

Generally, revenue and expenses associated with operations of the organization

are separated from non-operating income and expenses. The difference between the two is that operations revenues and expenses are the result of directly fulfilling the organization's mission while non-operating revenues and expenses are ancillary to, although supportive of, the mission of the organization.

[Exhibit R2-7](#) presents the statement of operations of Frederick Regional Health System. A number of important line items in the Frederick Regional Health System statement of operations demonstrate common practices in the reporting of financial position or condition for a not-for-profit.

Consolidated Statement of Operations (in thousands)

	Year Ended June 30	
	2015	2014
Unrestricted revenue and other support:		
Net patient service revenue	\$358,596	\$345,364
Provision for bad debt	(3,099)	(11,402)
Net patient revenue less provision for bad debt	355,497	333,962
Other operating revenues	9,068	10,757
Gifts, bequests, and contributions	2,968	2,241
Loss on sale of property and equipment	162	132
Total unrestricted revenue and other support	367,695	347,092
Operating expenses:		
Salaries and wages	130,059	147,591
Employee benefits	37,602	38,027
Professional fees	13,605	12,978
Cost of goods sold	58,211	56,343
Supplies	9,753	9,357
Contract services	71,287	36,927
Other	11,618	11,985
Utilities	4,265	4,272
Insurance	1,017	3,821
Depreciation and amortization	24,311	25,852
Interest	4,529	4,874
Total operating expenses	366,257	352,027
Operating income (loss)	1,438	(4,935)
Other income (loss), net:		
Gain (loss) on sale of assets	(97)	(116)
Investment gain (loss), net	7,016	6,161
Change in unrealized gains on trading securities, net	(4,308)	10,744
Realized and unrealized losses on interest rate swap contract, net	(2,482)	(2,156)
Other non-operating income, net	387	944
Total other income (loss), net	516	15,577
Excess of unrestricted revenue and other support over expenses	1,954	10,642
Other changes in unrestricted net assets:		
Pension adjustment	(1,679)	(3,738)
Released from restriction used to purchase capital	132	144
Increase (decrease) in unrestricted net assets	407	7,048

[Exhibit R2-7](#) Frederick Regional Health System, Inc. and Subsidiaries

Unrestricted revenue and other support – Funds from four sources: (1) patient services; (2) other operating revenue such as food services, pharmacy, and gift shop; (3) contributions from donors that are given without donor restrictions; and (4) funds made available by the expiration of donor restrictions.

Operating expenses – Funds expended on activities that are integral to the

mission of the hospital. Within the set of accounts reported is one labeled “Cost of goods sold.” It should be noted that the value of the cost of goods sold (COGS) is derived through the consumption of items from the inventory account that is found on the hospital’s balance sheet.

Realized and unrealized losses on interest rate swap contract, net – Interest rate swap contracts are financial instruments used by organizations to mitigate the financial risk (uncertainty of the amount of interest due in any period) associated with variable-rate bond debt. A variable-rate bond is one for which the interest due is associated with or “tied to” some widely accepted rate such as the London Interbank Offer Rate (LIBOR) and as such may change periodically as the associated benchmark rate changes. A fixed-rate bond is one for which the rate of interest will not change from the time of issuance until its maturity. In this case, Frederick Memorial Hospital entered into an interest rate swap agreement associated with the issuance of variable-rate bonds to fund some of its capital needs. A realized loss represents an amount of money that the hospital actually lost through the execution of part of the rate swap contract and any part of the total loss that is unrealized is an amount that has not been converted to funds that exchanged hands, but represents a potential loss when it is converted to funds or realized. The accounting is reflective of the application of GAAP to the interest rate swap contract.¹⁰

Increase in unrestricted net assets – The value of the surplus reported by Frederick Regional Health System. The value of the increase in unrestricted net assets is included in the line item total net assets in the balance sheet shown in [Exhibit R2-5](#). The reporting of the surplus is identical to the manner in which profit is reported by for-profit organizations. In for-profit organizations, the value of profit would be included in the line item retained earnings in the balance sheet.

The Statement of Cash Flows

As with the balance sheet and income statement, the structure of the statement of cash flows is based on a simple equation: change in cash = cash from operations + cash from investing activities + cash from financing activities. Operations are activities in pursuit of the mission of the organization, investing activities add or remove fixed assets, and financing activities are associated with issuing and repaying debt and issuing and purchasing stock (applicable to for-profit organizations). The general form of the statement of cash flows is shown in [Exhibit R2-8](#). The timeframe covered by the information in a statement of cash flows is usually one year; specifically, the fiscal year of the organization. However, as previously described, these financial reports may be prepared for any period such as a month or year-to-date; however, when used as reports to stockholders, stakeholders, and regulators, the timeframe of the report is the fiscal year.

For-Profit Organization	Not-For-Profit Organization
Statement of Cash Flows	Statement of Cash Flows
Cash flows from operations	Cash flows provided by operating activities
Profit (loss)	Surplus (deficit)
Depreciation	Depreciation
Changes in assets and liabilities	Changes in assets and liabilities
Net cash provided by operations	Net cash provided by operating activities
Cash flows from investing activities	Cash flows from investing activities
Additions of fixed assets	Additions of fixed assets
Acquisitions	Acquisitions
Other	Other
Net cash used by investing activities	Net cash used by investing activities
Cash flows from financing activities	Cash flows from fundraising and financing
Net change in borrowings	Proceeds from contributions
Cash dividends paid	Net cash provided by fundraising and financing activities
Other	Net increase (decrease) in cash
Net cash provided by financing activities	Cash at beginning of year
Net increase (decrease) in cash	Cash at end of year
Cash at beginning of year	

Cash at beginning of year	
Cash at end of year	

Exhibit R2-8 The Structure of the Statement of Cash Flows

The statement of cash flows at first glance appears to be almost identical for both for-profit and not-for-profit organizations. However, a significant difference is found in the financing activities portion of the statement of cash flows. Both for-profit and not-for-profit organizations may borrow funds; however, only for-profit organizations may pay dividends or issue stock, and only not-for-profit organizations may engage in fundraising activities and solicit contributions and gifts that are tax-deductible for the donors.

[Exhibit R2-9](#) presents the statement of cash flows for Frederick Regional Health System. Major sections of the statement include:

Consolidated Statements of Cash Flows (in thousands)		
	Year Ended June 30	
	2015	2014
Operating activities		
Change in net assets	\$2,961	\$8,578
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation of property and equipment	24,311	25,852
Amortization of original issue discount, premium, and bond issue costs	(29)	(68)
Equity in earnings of joint ventures and Premier non-cash component	(1,277)	(232)
Loss on sale of property and equipment	333	116
Change in unrealized gains on trading securities, net	4,311	(10,744)
Proceeds from realized gains on investments – trading	(6,554)	(3,436)
Increase in investments – trading	(1,828)	(4,720)
Proceeds from restricted contributions	(294)	(276)
Change in pledges receivable	(415)	(1,062)
Realized and unrealized losses on interest rate swap, net	2,482	2,156
Change in operating assets and liabilities:		
Receivables, patient and other	(1,008)	(470)
Other assets	408	(1,507)
Inventories and other assets	(339)	(1,037)
Accounts payable	1,285	1,953
Accrued expenses	(2,159)	1,207
Accrued pension expense	2,266	4,441
Advances from third-party payors	1,267	(216)
Other short-term liabilities	(2,218)	1,420
Other long-term liabilities	(485)	3,134
Net cash provided by operating activities	23,018	25,089
Investing activities		
Decrease in assets limited as to use-non-trading, net	11,646	3,162
Realized losses on interest rate swap contract	(2,442)	(2,545)
Increase in other investments	(1,444)	0
Purchases of property and equipment	(27,610)	(21,132)
Net cash used in investing activities	(19,850)	(20,515)
Fundraising and financing activities		
Proceeds from restricted contributions	294	276
Repayments of long-term debt	(5,698)	(9,305)
Deferred financing costs paid	0	(70)
Proceeds from borrowing	0	5,000
Net cash used in fundraising and financing activities	(5,404)	(4,099)
Net (decrease) increase in cash and cash equivalents	(2,236)	475
Cash and cash equivalents at the beginning of the year	33,668	33,193
Cash and cash equivalents at the end of the year	\$31,432	\$33,668

Exhibit R2-9 Frederick Regional Health System, Inc. and Subsidiaries

Cash flows provided by operating activities – Cash inflows and outflows from activities associated with fulfilling the organization’s mission.

Change in net assets – The value of earnings from the statement of operations. This entry also links the statement of operations to the statement of cash flows. From this point forward in the statement of cash flows, all adjustments reflect changes in accounts reported on the statement of financial position or balance sheet.

Depreciation and amortization – Depreciation is a non-cash expense reported on income statements (statement of operations). As an expense, it reduces earnings; however, a non-cash expenditure does not cause any change in any of the cash asset categories; therefore, a change in net assets or operating income or loss must be adjusted by the value of depreciation in order to reconcile the apparent removal of cash by including depreciation in the expense section of the income statement. In other words, depreciation must be added to earnings or loss in order to obtain the true cash value of earnings or loss.

Changes in operating assets and liabilities – The amount of cash is reduced by increases in the value of assets and decreases in liabilities. Further, the amount of cash is increased by decreases in the value of assets or increases in the value of liabilities. Depreciation is an example that ties the Statement of Operations and the Consolidated Balance Sheet to the Statement of Cash Flows and demonstrates the effect of a decrease in the value of assets. Depreciation and amortization records the systematic reduction in the value of tangible assets, e.g. computers and vehicles, over the useful life of the assets. Depreciation and amortization are also an operating expense and are reported on the Statement of Operations. In 2015, FRHS reported \$24,311 in depreciation and although it is not possible to find this specific dollar amount on the Consolidated Balance Sheet, it is present in summary form. The depreciation and amortization expense recorded on the Statement of Operations was a non-cash expense, meaning no check was written in this amount – it served to reduce earnings, but since it was non-cash, its value must be shown on the Statement of Cash Flows as a cash inflow. The other reason to show it as a cash inflow is that depreciation and amortization reduces the value of assets.

Cash flows used in investing activities – The inflow and outflow of funds associated with the sale and purchase of long-lived assets and investment instruments. The primary driver for the cash outflow in this category for FRHS was the purchase of property and equipment in 2015 to the value of \$27,610.

Cash flows from fundraising and financing activities – The inflow and outflow of cash through transactions with donors and creditors. In 2015, FRHS made a major reduction in long-term debt financing by repaying \$5,698 of long-term debt. This repayment was a cash outflow in the form of payments to bond holders.

Cash and cash equivalents at end of year – The value of cash reported in the asset section of the statement of financial position or balance sheet.

Financial Performance Analysis

Financial reports are important in themselves, but require analysis to provide useful investor and managerial decision-making information. Ratio analysis is a common method for assessing the financial performance of an organization. Typical financial performance measures are shown in [Exhibit R2-10](#) for profit and not-for-profit organizations. These analytical measures address the following financial performance concepts:

Measures of liquidity

For-profit organization

$$\text{current ratio} = \text{current assets} \div \text{current liabilities}$$

$$\text{liquid ratio} = (\text{cash} + \text{accounts receivable}) \div \text{current liabilities}$$

Not-for-profit organization

$$\text{current ratio} = \text{unrestricted current assets} \div \text{unrestricted current liabilities}$$

$$\text{available funds ratio} = (\text{cash} + \text{accounts receivable}) \div \text{unrestricted current liabilities}$$

Measures of profitability and return on investment

For-profit organization

$$\text{return on equity} = \text{net income} \div \text{shareholders' equity}$$

$$\text{operating ratio} = \text{operating income} \div \text{total sales}$$

Not-for-profit organization

$$\text{return on net assets} = \text{changes in net assets} \div \text{total net assets}$$

$$\text{operating income ratio} = \text{operating income} \div \text{total unrestricted revenue}$$

Measures of asset turnover

For-profit organization

$$\text{total asset turnover} = \text{total sales} \div \text{total assets}$$

$$\text{current asset turnover} = \text{total sales} \div \text{current assets}$$

$$\text{fixed asset turnover} = \text{total sales} \div \text{long-term assets}$$

Please note that total sales and total unrestricted revenue are equivalent.

Not-for-profit organization

$$\text{total asset turnover} = \text{total unrestricted revenue} \div \text{total assets}$$

$$\text{current asset turnover} = \text{total unrestricted revenue} \div \text{current assets}$$

$$\text{fixed asset turnover} = \text{total net sales} \div \text{net property and equipment}$$

Measures of financial leverage

For-profit organization

$$\text{debt-to-assets ratio} = (\text{current liabilities} + \text{long-term liabilities}) \div \text{total assets}$$

$$\text{debt-to-equity ratio} = (\text{current liabilities} + \text{long-term liabilities}) \div \text{equity}$$

Not-for-profit organization

$$\text{debt-to-assets ratio} = (\text{current liabilities} + \text{long-term liabilities}) \div \text{total assets}$$

$$\text{debt-to-net assets ratio} = (\text{current liabilities} + \text{long-term liabilities}) \div \text{total net assets}$$

Exhibit R2-10 Formulas for Measuring Financial Performance

Liquidity – Measures the ability of an organization to pay its bills and, more importantly, to determine if an organization is financing assets with similar liabilities. In general, current assets should be fully financed by current liabilities (1:1 ratio).¹¹

Profitability and return on investment – Measures the efficiency with which an

organization employs capital contributed or invested in the organization and reinvested through the retention of earnings.

Asset turnover – Measures the relationship between revenue generation (sales) and investment in assets; low values indicate asset-intense businesses whereas high values indicate lower asset intensity, meaning lower investments are required to generate each dollar of revenue; financial leverage measures the extent to which the organization depends on debt to finance its operations, and thereby its exposure to financial risk.¹²

The application of the financial performance analysis measures to FRHS is presented in [Exhibit R2-11](#). The dollar values shown in [Exhibit R2-11](#) are derived from the financial statements found in [Exhibit R2-5](#), [Exhibit R2-7](#), and [Exhibit R2-9](#). The two measures of liquidity, the current ratio and the available funds ratio, indicate that liquidity improved by small amounts from 2014 through 2015 and that FRHS is highly liquid with at least 58 percent more liquid assets than current liabilities. As a general rule of thumb, liquidity ratios exceeding 1.25 are considered to be excellent, and those below 1.0 indicate a deficiency in liquid assets; however, comparing liquidity to other similar-sized hospitals with a similar patient base for the same time period would provide a better indicator of FRHS's liquidity.

		2015	2014
	Current assets	93,708	95,461
	Current liabilities	57,845	60,264
	Current ratio	1.62	1.58
Liquidity	Cash	31,432	33,668
	Accounts receivable	48,100	47,109
	Other receivables	1,860	1,843
		81,392	82,620
	Unrestricted current liabilities	57,845	60,264
	Available funds ratio	1.41	1.37
Profitability and return on investment			
	Change in net assets	2,961	8,578
	Total net assets	193,148	190,187
	Return on net assets	1.53%	4.51%
	Operating income	1,438	-4,935
	Total unrestricted revenue	367,695	347,092
	Operating income ratio	0.004	-0.014
Asset Turnover			
	Total unrestricted revenue	367,695	347,092
	Total assets	461,637	464,538
	Total asset turnover	0.80	0.75

Total unrestricted revenue	367,695	347,092
Current assets	93,708	95,461
Current asset turnover	3.92	3.64
Total sales/Total unrestricted revenue	367,695	347,092
Net property and equipment	202,055	199,089
Fixed asset turnover	1.82	1.74
Financial Leverage		
Current liabilities	57,845	60,264
Long-term liabilities	210,644	214,087
	268,489	274,351
Total assets	461,637	464,538
Debt-to-assets ratio	0.582	0.591
Current liabilities	57,845	60,264
Long-term liabilities	210,644	214,087
	268,489	274,351
Total net assets	193,148	190,187
Debt-to-equity ratio	1.390	1.443

Exhibit R2-11 Financial Performance of Frederick Regional Health System
2014–2015 (dollars in thousands)

The two profitability and return on investment measures – return on net assets and operating income ratio – show conflicting views of profitability. Return on assets for FRHS declined from 4.51 percent in 2014 to 1.53 percent in 2015 while the operating income ratio improved from a negative value in 2014 to a positive value, although quite small, 0.4 percent in 2015. The operating income ratio may also be interpreted as the operating margin, indicating the relationship between revenue and operating costs. The operating margin for FRHS may be characterized as thin, but moved from a negative value in 2014 to a positive one in 2015.

The total asset turnover rate for FRHS, 0.75 times in 2014 and 0.80 times in 2015, indicates that the hospital is an asset-intensive organization – meaning that large amounts of total assets are required for revenue generation. By examining the fixed asset turnover and current asset turnover rates, it is revealed that fixed assets (property, plant, and equipment) contribute more to asset intensity for the hospital than current assets, as one would expect.

In terms of financial leverage, FRHS finances just over one-half of its assets with debt (debt-to-asset ratio of 0.591 in 2014 and 0.582 in 2015). The proportion of equity supporting the health system's assets changed by a very small amount between 2014 and 2015 (debt-to-equity ratio of 1.443 in 2014 and 1.390 in 2015). The leverage ratios are a reflection of managerial decisions concerning the sources of long-term funds for the hospital, indicating that management is comfortable with more debt financing than equity financing.

Financial Forecasting

The development of pro forma financial statements is an integral part of developing budgets for a health care organization. The financial statements provide an excellent template for developing budgets. Each line item should be carefully modeled in terms of developing data and assumptions about the drivers of each. For example, the identification of capital projects (buildings, expensive equipment, clinics, etc.) and their timing plus developing assumptions about interest rates are integral to developing not only a capital budget, but also a pro forma statement of cash flows and balance sheet. Examining data on patient mix, third-party payer payment trends, Medicare and Medicaid reimbursement rates, and the impact of the Affordable Care Act or its replacement are essential in developing a detailed operating budget. A detailed operating budget will produce expected revenue and expense data that should be used to produce a pro forma statement of activities (or income statement), which in turn will inform a pro forma balance sheet and statement of cash flows.

Notes

1. "About the FASB." Available at: www.fasb.org/jsp/FASB/Page/SectionPage&cid=1176154526495.
2. "Facts about GASB." Available at: www.gasb.org/cs/BlobServer?blobcol=urldata&blobtable=MungoBlobs&blobkey=id&blobwhere=11758240
3. "About the IASB." Available at: www.iasplus.com/en/resources/ifrsf/iasb-ifrs-ic/iasb.
4. In the health care system, it has become common for not-for-profit hospitals to establish or acquire for-profit subsidiaries and enter into for-profit joint ventures. See, for example, the joint venture between Ascension Health and Oak Hill Capital Partners as described in Joe Carlson, "Offering Salvation: Ascension, Equity Firm Forge Deal They Say Could Save Catholic Hospitals," *Modern Healthcare* 41, no. 8 (February 21, 2011), p. 6. Not-for-profit hospitals with for-profit subsidiaries prepare financial statements that combine the reports of the not-for-profit components with the for-profit ones and may use the financial statement titles of for-profit organizations; however, the contents of the reports use not-for-profit nomenclature. The combining of financial statements of subsidiaries is termed consolidation, and these financial statements generally include the term "consolidated" in their title.
5. Financial statements for the Frederick Regional Health System are available at: www.fmh.org/documents/PDFs/FMH2011Statements.pdf. The notes that accompany the financial statements are an integral part of the financial statements. The financial statements of Fredrick Regional Health System are used with permission.
6. FRHS's financial statements include the accounts and transactions of the not-for-profit hospital, Frederick Memorial Hospital, Inc., the Monocacy Insurance, LTD, a provider of primary medical professional liability and primary general liability coverage for FRHS, the physician enterprise Monocacy Health Partners, LLC, and the for-profit, Frederick Health Services Corporation (FHSC).
7. U.S. Treasury bills are short-term securities with maturities of one year or less. Typical maturity terms are 4, 13, 26, and 52 weeks. More information is available at: www.treasurydirect.gov/instit/marketable/tbills/tbills.htm.
8. Aswath Damodaran, *Investment Valuation: Tools and Techniques for Determining the Value of Any Asset* (Hoboken, NJ: John Wiley & Sons, 2012).
9. The accounting for leases is explained in detail in FASB statement number 13, found at: www.fasb.org/cs/BlobServer?blobcol=urldata&blobtable=MungoBlobs&blobkey=id&blobwhere=11758209

10. A thorough treatment of the nature and mathematics associated with interest rate swaps is beyond the scope of this resource; however, a brief explanation of interest rate swaps is appropriate. An interest rate swap is an agreement between a borrower (in this case of Frederick Memorial Hospital, the issuer of bonds) and another party to exchange interest payments on debts without exchanging the underlying debt. The purpose of such a transaction is to permit the payer of variable interest rates to hedge against or stabilize the potential volatility of interest rates during a period of perceived economic instability and for a fixed-rate borrower to obtain what it perceives to be a better or lower interest rate. By way of example, organization A issues variable-rate debt in the amount of \$1M that adjusts monthly at a rate of “Treasury 30 + 2%” (meaning the monthly interest rate paid by the U.S. Treasury on 30-year notes plus 2 percent; thus, if the 30-year Treasury rate is 3 percent, organization A will pay a rate of 5 percent, if the 30-year Treasury rate is 6 percent, organization A will pay 8 percent, etc.) and organization B issues \$1M of debt at a fixed rate, say 8 percent. Organization A is concerned that interest rates will vary significantly over the next few years and wants to stabilize its cash outflows and organization B feels uncomfortable with its interest rate. Organization A and organization B decide to “swap” interest rates. They enter into a contract on a “notional” debt between the two (notional means that the money does not change hands) in which organization A agrees to pay organization B a fixed rate on the notional debt, say 7 percent, and organization B agrees to pay a variable rate, say 30-year Treasury + 0.5 percent. In this manner, organization A pays a fixed amount of funds each month for its debt and organization B pays a variable rate, achieving a comparative advantage for both parties. A good overview of interest rate swaps may be found in James Bickler and Andrew H. Chen, “An Economic Analysis of Interest Rate Swaps,” *Journal of Finance* 41, no. 3 (July 1986), pp. 645–655. The mechanics of interest rate swaps may be understood by viewing two lessons from the Kahn Academy – “Interest rate swap 1” available at: www.khanacademy.org/economics-finance-domain/core-finance/derivative-securities/interest-rate-swaps-tut/v/interest-rate-swap-1 and “Interest rate swap 2” is available at: www.khanacademy.org/economics-finance-domain/core-finance/derivative-securities/interest-rate-swaps-tut/v/interest-rate-swap-2.

11. The liquid ratio is also known as the quick ratio and the acid test ratio. For organizations with significant inventory values, there are alternate formulations of the liquid ratio. The quick ratio of for-profit organizations is:

quick ratio	=	(current assets – liability) ÷ current liabilities

The quick ratio for not-for-profit organizations is:

quick ratio	=	(unrestricted current assets – liability) ÷ unrestricted current liabilities

12. The reader is directed to two significant works for a more detailed discussion and presentation on financial performance measures and techniques: Robert C. Higgins, *Analysis for Financial Management*, 11th edn (New York:

McGraw Hill, 2016) and Helisse Levine and Anne G. Zahradnik, "Online Media, Market Orientation, and Financial Performance in Nonprofits," *Journal of Nonprofit & Public Sector Marketing* 24, no. 1 (2012), pp. 26–42.

Resource 3

Health Care Acronyms

“Acronyms are a type of shorthand used by industry insiders.”

Legislative/political, economic, social/demographic, technological, and competitive changes over the past three decades have shaped the health care system and contributed to the creation of a new language to describe it. This appendix examines the growing list of health care acronyms and abbreviations that characterize the nature of industry change.

ACA (Affordable Care Act)

See also PPACA (Patient Protection and Affordable Care Act). Massive attempt to reform health care in the United States by then president Barack Obama.

ACC (ambulatory care center)

Walk-in and outpatient services provided. ACO (accountable care organizations) Groups of doctors, hospitals, and other health care providers who willingly come together to take responsibility for providing coordinated high-quality care to improve health status and care.

AHC (academic health center)

A group of related institutions including a teaching hospital, a medical school and its affiliated faculty practice plan, as well as other health professional schools. See also AMC (academic medical center).

ALOS (average length of stay)

A measure that hospitals use to determine whether treatment is within an appropriate range (often tied to reimbursement rates).

AMC (academic medical center)

A university-based hospital or health system that is organizationally or administratively integrated with a medical school. See also AHC (academic health center).

APC (ambulatory payment codes or ambulatory payment classification)

Used in reimbursements, greater detail incorporated into ICD-10 (International Classification of Diseases 10th revision); method for payment of outpatient care for Medicare patients and some Medicaid patients (depending on the state).

APG (ambulatory payment group)

A prospective payment system in managed care, similar to inpatient DRGs (Diagnosis Related Groups), used for free-standing diagnostic and treatment centers, hospital-based outpatient treatments, ambulatory surgery, and emergency departments. APGs collect together procedures and medical visits that share similar characteristics and resource utilization patterns for payment purposes. This new methodology allows for greater payment

homogeneity for comparable services across all ambulatory care settings (i.e. outpatient department, ambulatory surgery, emergency department, and diagnostic and treatment centers) making Medicaid reimbursement more transparent and reimbursing based on patients' conditions and severity.

ASC . (ambulatory surgery center)

Outpatient surgery procedures performed within these centers that are sometimes totally independent or sometimes closely tied to and near hospitals.

CBO . (community-based organizations)

Under ACA (Affordable Care Act), CBOs are funded to work with discharged Medicare patients to avoid social problems thoughtfully and inexpensively. Examples include not having transportation for follow-up doctor visits; not filling prescriptions or taking medications; dialing 911 when they are anxious, lonely, or have an adverse drug reaction. The goal is to help patients self-manage their post-hospital care through home visits, counseling, financial assistance, meals and nutrition, legal aid, and follow-up phone calls for 30 days to avoid readmissions.

CDC . (Centers for Disease Control and Prevention)

Provides national official vital statistics (for example disease incidence, births, deaths, and so on).

CHIP (Children's Health Insurance Plan)

Provides health care to children through both Medicaid and separate CHIP programs; administered by states, according to federal requirements; funded jointly by states and the federal government. Formerly SCHIP (State Children's Health Insurance Program), originally created by the Balanced Budget Act of 1997 to help states insure low-income children who are not eligible for Medicaid but could not afford private insurance.

CMS (Center for Medicare and Medicaid Services)

Part of the U.S. Department of Health and Human Services, the contracting agency for HMOs (health maintenance organizations) that seek direct contractor/provider status for provision of Medicare and Medicaid benefits.

CON (certificate of need)

Laws in some states require a CON to determine whether the state will permit a hospital or a physician's practice to open or add beds, operating rooms, or expensive pieces of technology (see Essentials for Strategic Thinkers 3–2 for an extensive review of CONs).

C-suite (chief officers of the health care organization)

CEO (chief executive officer); CFO (chief financial officer); CIO (chief information officer); CMO (chief marketing officer or chief medical officer); COO (chief operations officer); and CNO (chief nursing officer).

DRG (diagnosis-related group)

A classification system using 383 major diagnostic categories that assign inpatients into case types. It is used to facilitate utilization review, analyze patient case mix, and determine hospital reimbursement for Medicare. For example, the classification DRG 320 indicates a kidney and urinary tract infection.

DSH (disproportionate share hospital)

Programs that provide for additional payments to hospitals that serve a large number of low-income inpatients.

EHR (electronic health record)

A comprehensive digital file of all health information for a person, meant to focus on preservation of health rather than medical problems. See also EMR (electronic medical record).

EMR (electronic medical record)

A medical document stored in a machine-readable format. Data are entered into the record via many different sources, including computerized entry and voice recognition systems plus various document imaging systems. Also called an electronic patient record.

EPO (exclusive provider organization)

Although structurally similar to a PPO (preferred provider organization) an EPO can simply be a network of health care providers; the plan beneficiaries cannot go out of the network or they must pay the entire cost of services. EPO physicians are reimbursed only for services actually provided to plan beneficiaries (rather than a capitated rate).

FDA (Food and Drug Administration)

The most comprehensive consumer protection agency in the United States; its origins can be traced back to the Patent Office in 1848. FDA's modern regulatory functions began with the 1906 Pure Food and Drugs Act, a law that prohibited interstate commerce in adulterated and misbranded food and drugs. The FDA approval process for patented drugs is noteworthy. See www.fda.gov.

FEHBP (Federal Employee Health Benefit Plan)

Covers civilian government employees and annuitants; still kept separate from other health plans; used as a benchmark for comparables of plans to be developed under ACA (Affordable Care Act).

FFS (fee for service)

Refers to a provider that charges the patient according to a fee schedule set for each service or procedure performed; the patient's total bill will vary by the number of services or procedures actually performed.

FSA (flexible spending account)

A federal program that allows for an account where an employee contributes money from his/her salary (before taxes are withheld) that can be used for reimbursement of out-of-pocket health care and dependent care expenses. In 2017, a maximum of \$500 can be rolled over to the next year. Typically one person cannot have an HSA (health care savings account) and an FSA.

HEDIS (Healthplan Employer Data and Information Set)

A set of standardized measures of health plan performance that allows comparisons of quality, access, satisfaction, membership, utilization, financial information, and management.

HIE (health insurance exchange)

An organized regional network that enables hospitals, physicians, and other care providers to upload and access patient health information – from

affiliates to competitors – to share clinical data that can improve a patient's overall care.

HIPAA (Health Insurance Portability and Accountability Act)

Enacted in 1996, it primarily ensures the right of privacy for an individual's health care information; restricts access to individuals' private medical information. It includes five primary sections or "titles." Title 1: Health Care Access, Portability, and Renewability Title 2: Preventing Health Care Fraud and Abuse; Administrative Simplification Title 3: Tax-Related Health Provisions Title 4: Application and Enforcement of Group Health Plan Requirement Title 5: Revenue Offsets.

HMO (health maintenance organization)

An organization interposed between providers and payers that attempts to "manage the care" on behalf of the health service consumer and payer. HMOs are responsible for both the financing and delivery of comprehensive health services to an enrolled group of patients.

HPID (health plan identifier)

An attempt to simplify the claims process by standardizing the identifier format. For consistency, all insurers will have a unique code, structured in a standard format.

HRA (health reimbursement accounts)

Somewhat similar to HSAs (health savings accounts); however, only the employer contributes to the fund (employees may not apply salary deductions to the account). The employer sets the restrictions and unused dollars are retained by the employer and can be rolled over to the next year, but do not move with the employee if he/she changes employers.

HSA (health care savings account) or MSA (medical savings account)

Health care or medical savings accounts are tax-deferred programs coupled with high deductible health plans. Designed primarily for the self-employed, contributions by the business or the employee to the savings account are limited (2017: \$3,400 for an individual and \$6,750 for family coverage); with a cost of \$1,300 for the HDHP; out-of-pocket expenses are limited to when the insurance kicks in to cover the cost of extended or catastrophic care. MSAs can be used to pay for most forms of health care, including disability, dental care, vision care, and long-term care; however, withdrawals not used for medical expenses are charged 20 percent of the amount of the distribution (2012) and over-the-counter drugs only qualify when they have been prescribed by a physician. Leftover funds can be rolled over to the next year or withdrawn as taxable income.

ICD-9 (International Classification of Diseases, 9th revision diagnosis coding standard)

ICD-9, in place for 30 years using 13,000 different codes, is to be replaced with ICD-10.

ICD-10 (International Classification of Diseases, 10th edition diagnosis and procedure codes)

Offers 68,000 codes to provide more accurate information to chart,

measure, and bill patient encounters; instead of coding “fracture of forearm,” health care providers will be able to provide details: “torus fracture of lower end of right radius, subsequent encounter for closed fracture with routine healing” by using ICD-10s alphanumeric language; additional coding covers ambulatory services and inpatient discharges. Implementation was to begin October 1, 2013; postponed twice and began October 1, 2015 with regular updates beginning October 1, 2016.

IDS (integrated delivery system)

IDSs combine and own, or closely coordinate, multiple stages of health care delivery. The integration usually includes many steps in the full spectrum of health services delivery, including physicians, hospitals, and long-term care facilities.

IPA (independent practice association)

A legal entity composed of physicians who have organized for the purpose of negotiating contracts to provide medical services. Typically, physicians maintain their independent businesses but come together as a group to negotiate with payers. A super-IPA has many IPAs rolled into one to contract with payers.

IPO (independent practice organization)

See IPA.

JC (Joint Commission, formerly Joint Commission on the Accreditation of Healthcare Organizations)

The major accrediting body for many health care organizations. Hospitals must be JC-accredited to receive Medicare and Medicaid funds; thus, the organization has great importance in the health care delivery system.

LOS (length of stay)

Length of stay is sometimes referred to as **ALOS** (the average length of stay) or **AMLOS** (the arithmetic mean length of stay). It is the average number of days patients stay in the hospital for a specific diagnosis-related group.

MACRA (Medicare Access and CHIP Reauthorization Act)

An effort to reimburse physicians for Medicare outpatient care based on service-value rather than service-volume; performance reporting began in 2017 and full implementation is scheduled for 2019. Physicians can choose one of two tracks: MIPS (merit-based incentive payment system) or APMs (alternate payment models). Most physicians are expected to select the MIPS program as it is a blend of reimbursement based on both volume and value. It requires data reporting on four performance categories that drive payment bonuses and penalties. Participating in an APM is potentially more lucrative; however, operating under APM contracts entails significant upside and downside risk.

MCO (managed care organization)

Any organization whose goal is to eliminate excessive and unnecessary service, thereby keeping health care costs manageable.

MLR (medical loss ratio)

The Patient Protection and Affordable Care Act requires that no more than 20 percent of insurers' premium payments from individual and small group

plans may be spent on administrative expenses. The remaining 80 percent of premiums is to be spent on direct patient care and improvements in quality of care. If the 20 percent is exceeded, the insurer must pay financial rebates to the members. In 2015, \$2.4 billion was rebated to members. A state may apply for an exception to waive the penalties (or delay implementation) if it believes that the 80/20 standard would “destabilize a state's individual and small group market.”

MMA (Medicare Prescription Drug, Improvement, and Modernization Act of 2003)

Made prescription drug costs more manageable for Medicare patients.

MSA (medical savings account)

See **HSA** (healthcare savings account).

MSO (management service organization)

A legal corporation formed to provide practice management services to physicians. At one extreme, an MSO could own one practice or several hundred practices. At the other extreme, an MSO may not own any physician practices or provide management services. In that case, the MSO would be strictly an entity that signs managed care contracts for an affiliated provider group. Typically, an MSO will require a commitment of 10 to 40 years from the physician or group practice contracting for its services.

NCQA (National Committee for Quality Assurance)

A private, not-for-profit organization dedicated to improving health care quality. NCQA is governed by a board of directors that includes employers, labor representatives, consumers, health planners, quality experts, policy makers, and representatives from organized medicine. Its mission is to improve the quality of health care; it strives to transform health care quality through measurement, transparency, and accountability.

NIH (National Institutes of Health)

One of the agencies of the Public Health Service, a part of the Department of Health and Human Services of the U.S. federal government. The NIH is responsible for medical and behavioral research for the United States.

NP (nurse practitioner)

A nurse who serves as the initial contact into the health care system and coordinates community-based services necessary for health promotion, health maintenance, rehabilitation, or prevention of disease and disability. Nurse practitioners work interdependently with other health professionals to provide primary health care in many communities.

OON (out of network)

Describes health care services received from providers who do not participate in a managed care program's contracted network of providers. Typically, patients pay all costs out of pocket (no reimbursement) if an OON provider is used. **OSHA (Occupational Safety and Health Act)** A comprehensive plan for regulating workplace safety enacted in 1970.

OTC (over the counter)

Drugs sold without the requirement of a prescription.

PA (physician assistant)

An allied health professional who, by virtue of having completed an educational program in the medical sciences and a structured clinical experience in surgical services, is qualified to assist the physician in patient care activities. Physician assistants may be involved with patients in any medical setting for which the physician is responsible, including the operating room, recovery room, intensive care unit, emergency department, hospital outpatient clinic, and the physician's office.

PCMH (patient-centered medical home)

Established by the ACA; a model that aims to provide comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes through quality, effectiveness, and efficiency of the care.

PCP (primary care physician)

A physician responsible for coordinating and managing the health care needs of members in a network. PCPs may be trained in primary care, pediatrics, obstetrics/gynecology, internal medicine, or family medicine. They determine hospitalization and referral to specialists for their patients.

PHO (physician–hospital organization)

An organization designed to integrate a hospital and its medical staff to contract with payers as a single entity. Physicians retain their independence. A super-PHO has many PHOs rolled into one to contract with payers.

PMPM (per member per month)

Under capitation, the amount paid to care for each member per month, regardless of the number and extent of services used by the member.

POS (point-of-service)

Combines a health maintenance organization insurance plan with traditional insurance. “Point-of-service” refers to members deciding whether to go in or out of the network. The employee belongs to a managed care plan but can opt for the traditional plan anytime. POS members usually pay less when they stay within the **HMO** (health maintenance organization) network but can avoid restrictions. When they choose the traditional insurance plan, typical coverage requires them to meet a deductible and 70 to 80 percent of health care costs are paid. Sometimes POS is called an “HMO with an escape hatch.”

PPACA (Patient Protection Affordable Care Act) Often shortened to “Affordable Care Act”

, sometimes called “Obama-care.” Enacted in 2010, only a few parts of the legislation went into effect immediately (required insurance companies to cover children to age 26), others were to be phased in (adoption of ICD-10 in 2013, extended to 2014 and then 2015). Most sweeping change for health care since Medicare and Medicaid in the 1960s.

PPO (preferred provider organization)

An entity through which various health plans or carriers contract to purchase health care services for patients from a selected group of providers, typically at a better per-patient cost. Patients not using the PPO's physicians and hospitals pay a higher price; however, patients not using an HMO pay a much higher price and in fact may not be reimbursed for using a non-HMO-

approved provider. HMOs typically have lower premiums than PPOs (see also **HMO**).

PPS (prospective payment system)

A system designed to control costs for Medicare and Medicaid patients. Rather than reimbursing on a retrospective cost-plus system, PPS legislation in 1983 reimbursed hospitals on a prospective (predetermined) basis. For example, a hospital would know that it would receive a set amount to treat a broken hip. If the patient could be treated at a cost lower than the reimbursed amount, the hospital could keep the “profit.” On the other hand, if the hospital spent more than the reimbursable amount, for whatever reason, it had to absorb the loss.

PSO (provider-sponsored organization)

Integrated groups of doctors and hospitals that assume managed care (often Medicare) risk contracts.

RBRVS (resource-based relative value scale)

A national fee system for Medicare payments to physicians. The fee schedule is designed to shift payment patterns from a number of more costly specialties (such as those in surgery) to primary care. SCHIP (State Children's Health Insurance Plan) Has been phased out and CHIP (Children's Health Insurance Plan) is its replacement.

SNF (skilled nursing facility)

An institution that provides inpatient skilled nursing care and rehabilitative services and has transfer agreements with one or more hospitals.

TPA (third-party administrator)

A firm that performs administrative functions such as claims processing and membership for a self-funded health care insurance plan or a start-up managed care plan.

UR (utilization review)

The review of services delivered by a health care provider to evaluate the appropriateness, necessity, and quality of the prescribed services.

Resource 4

Glossary of Strategic Management Terms

“To understand a discipline, one must first speak its language.”

Abilene Paradox

The inability to manage agreement in an organization where organizational members fail to reveal their true feelings regarding a problem or the steps involved in addressing it, often resulting in a decision that none of the participants prefers. (Chapter 10)

Acquisition

Market-entry strategy for expansion through the purchase of an existing organization, a unit of an organization, or a product/service. (Chapter 6)

Action Plan

Unit-based implementation activities that identify specific steps to accomplish the service delivery and support strategies. (Chapter 10)

Adaptive Strategy

A corporate-level decision specifying the organization's scope with a focus on expanding, reducing, or maintaining operations. (Chapter 6)

After-Service

A key area in the value chain where value can be added for the customer/patient post direct health care delivery; includes follow-up, billing, and follow-on. (Chapter 4)

After-Service Strategy

The development of an implementation plan to maintain or change post-health care service delivery activities by comparing the results of the internal analysis with the requirements of the selected broader organizational strategies. (Chapter 8)

Alliance

An agreement between two or more organizations that is designed to achieve some long-term strategic purpose not possible by the organizations separately. (Chapter 6)

Alternative Medicine

See Complementary and Alternative Medicine (CAM). (Chapter 3)

Analytical/Rational Approach (to Strategic Management)

Reliance on a logical sequence of planning steps to develop a strategic plan. The assumption underlying an analytical approach is that one can develop a predetermined logical plan and carry it out without change. (See also Emergent Approach) (Chapter 1)

Analytics

Systematic analysis of mass amounts of historical data to discover patterns/trends; used to predict future patterns/trends. (See also Big Data)

(Chapter 2)

Analyzer Strategic Posture

An organization that tries to balance stability and change by maintaining stable operations – typically in core businesses – but also searches for new opportunities to engage in market innovation in other areas. (Chapter 6)

Assessing (External Change)

A process for the evaluation of the significance and impact of forecasted external issues on an organization. (Chapter 2)

Asset Turnover

Measures the relationship between revenue generation (sales) and investment in assets; low values indicate asset-intensive businesses; high values indicate lower asset intensity, meaning lower investments are required to generate each dollar of revenue. (Resource 2)

Backward Vertical Integration

A strategy to grow (add members) along an organization's channel of distribution toward its suppliers or toward earlier stages on the continuum of care (upstream, away from the consumer). (Chapter 6)

Balance Sheet

Statement of financial position where assets equals liabilities plus equity of a for-profit organization or net assets for a not-for-profit organization. (Resource 2)

Balanced Scorecard

A tool for focusing on strategy implementation that links the overall organization's strategy to short-term actions; includes a financial perspective, customer perspective, internal perspective, and learning/growth perspective. (Chapter 10)

Barriers to Entry

Factors that make entering a new market difficult or expensive for an organization; includes existing economies of scale and other cost advantages, product differentiation, customer switching costs, capital requirements, gaining access to distribution channels, and legal constraints; high entry barriers limit competition. (Chapter 3)

Barriers to Exit

Factors that make it difficult or expensive for organizations to leave a market; includes economic, strategic, and emotional obstacles; high exit barriers contribute to increased rivalry among existing competitors. (Chapter 3)

BCG Portfolio Analysis

Evaluation of an organization's products and services in terms of relative market share and market growth rate. The products and services may then be characterized as stars, cash cows, problem children, or dogs and strategic alternatives generated; often depicted graphically in four quadrants. (Chapter 7)

Behavioral Norms

The expectations that are common among members of a group or organization concerning appropriate ways to act and interact. (Chapter 9)

Benchmarking

A management process of comparing an organization against a set of its peers or top performers on critical metrics for success. (Chapter 7)

Best Practices

A process, procedure, or methodology in use that has been shown by evidence to yield superior outcomes (best practices may become standards for widespread adoption). (Chapter 10)

Big Data

Bits of disparate information characterized by volume, velocity, and variability with so much mass that non-distributed techniques are required to analyze it to uncover patterns and correlations. (See also Analytics) (Chapter 2)

Billing Activities

Processes involved in delivering clear, correct, simple to understand statements of services rendered with the associated costs to be paid by the health care consumer. (Chapter 8)

Black Swan Event

An occurrence or phenomenon that lies outside expectations, has a significant impact, and forces observers to develop explanations that make the phenomenon seem predictable. (Chapter 3)

Blue Ocean Strategy

Plans to enter and compete in new untapped market spaces where the opportunity for high growth and profits appears to exist. (See also Red Ocean Strategy) (Chapter 7)

Brainstorming

A group process of free flowing idea generation and discussion; typically used in strategic management to better understand an issue, assess the impact of an issue, or to generate alternatives. (Chapter 2)

Brand

A unique symbol, image, or other identifier that creates an image of an organization, service, or product that differentiates it from competitors; provides identification and a guarantee of quality; implies trust, consistency, and expectations of satisfaction thereby reducing risk; and it (words, symbol, design) can be protected through trademark law. (Chapter 8)

Brand Equity

A perceptual predisposition to support a product/service that has proven to be satisfactory; based on stored knowledge it represents the biased behavior a consumer has for the known identifiable among competing unbranded equivalents; earned through the marketing mix variables (product, price, place, and promotion are the basic building blocks) that are under an organization's control, enabling marketers to grow the product/service's value in the marketplace through satisfied customers. (Chapter 8)

Business Model

The way value is delivered to the customer; the customer value proposition; an enduring approach to deliver value. (Chapter 6)

Capability

Ability to purposefully and effectively muster, coordinate, and deploy resources and competencies. (Chapter 4)

Capital

Stockholders' equity. (Resource 2)

Center for Medicare and Medicaid Services (CMS)

Part of the U.S. Department of Health and Human Services (HHS) that administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace. (Chapter 2)

Centralization

Where a single core group/person, typically top management, makes key decisions for the entire organization. (Chapter 7)

Certificate of Need (CON)

Federal/state authorization to acquire, expand or create facilities; used to regulate supply of services relative to demand by eliminating over spending or protecting access. (Chapter 3)

Channel of Distribution

Formal or informal chain of businesses that move the product/service from where it is made to where it is sold/ delivered to the final consumer. (Chapter 6)

Clinical Pathway

A visualization of a patient's health care plan used for optimizing health care resources and enhancing the quality of care. (Chapter 8)

Clinical Process Innovation

The generation, acceptance, and implementation of new ideas, tools, or support systems aimed at systematically improving health care delivery for better patient care. (Chapter 8)

Cognitive Assumptions

Common understanding of "who we are" (mission) and "what we are trying to accomplish" (vision and strategic goals) and the belief in the values of the organization. (Chapter 9)

Cognitive Culture

Explicit intellectual values, norms, artifacts, and assumptions that serve as a guide for behavior; determined by stated directional strategies and organizational systems, practices, and processes. (Chapter 9)

Cognitive Values

The understanding of "the way we do things;" reflects the organization's stated principles and norms. (Chapter 9)

Collateral Organization

A system of teams, task forces, committees, and ad hoc groups to supplement the basic structure. (Chapter 9)

Combination Strategy

Using a number of different strategies simultaneously to synergistically achieve goal/objectives for different products/services or service areas. (Chapter 6)

Combination Structure

Use of more than one type of organizing approach (centralized, decentralized, matrix). (Chapter 9)

Community

A group of people living together in a defined place – a neighborhood, village, town, city, county, region, or an entire country; collections of individuals who share some feature in common. (Chapter 2)

Community Need

One dimension for determining the strategy for a not-for-profit organization's programs based on clear, agreed on requirements; considers the degree to which other institutions provide similar services to meet the shared purpose of meeting community health objectives. (Chapter 7)

Compass

A metaphor for an intuitive sense of direction and leadership. (Chapter 1)

Competency

Skill-based human intellectual know-how or knowledge. (Chapter 4)

Competitive Advantage

Organizational strengths that are: valued by stakeholders, relatively rare among competitors, relatively difficult to duplicate by competitors, and can be sustained by the organization. (Chapters 3 & 4)

Competitive Strategy

Two types of strategies that determine an organization's strategic posture and position *vis-à-vis* other organizations within the market (generic strategies). These strategies are market-oriented and best articulate competitive advantage. (Chapter 6)

Competitively Relevant Strength

Organizational or product/service attributes or characteristics that are: valued in the marketplace, rare, difficult to imitate, and can be sustained. (Chapter 4)

Competitively Relevant Weakness

Organizational or product/service attributes or characteristics that are: valued in the marketplace, not common among competitors, difficult for the organization to correct, and sustainable by competitors. (Chapter 4)

Competitor Analysis

An analysis of organizations providing similar products/services within a service area to identify strengths and weaknesses, competitive intentions, and the grouping of those organizations that are most alike and vying for the same customers/clients. (See Strategic Group) (Chapter 3)

Complementary and Alternative Medicine (CAM)

A group of diverse medical and health care systems, practices, and products used for medical interventions, health promotion, or disease prevention that are generally not considered to be part of conventional medicine nor generally underwritten by health insurance plans. (Chapter 3)

Complex Adaptive System

Interacting structures (organizations or parts of organizations) evolving in response to change. (Chapter 1)

Concentric Diversification

A strategy to move the organization outside of its core business into an area that is somewhat similar to its present operations with the intent to create a “circle” of related products/services (a form of related diversification). (Chapter 6)

Conglomerate Diversification

A strategy to move the organization outside of its core business into an area that is dissimilar to its present operations (a form of unrelated diversification). (Chapter 6)

Conglomeration

A decision that involves the acquisition of numerous related and unrelated business/service lines. (Chapter 1)

Contingency Planning

The development of alternative plans that may be put into effect if strategic assumptions change quickly or dramatically or if organizational performance is lagging. (Chapter 10)

Continuity of Operations Plan

Internal plans to ensure primary essential functions are ongoing despite a wide range of emergencies. (Chapter 10)

Continuous Quality Improvement (CQM)

A process and ongoing effort to obtain better results through incremental changes that enhance efficiency. (Chapter 8)

Continuum of Care

An integrated system of health care that offers a range of services including pre-acute, acute, and post-acute services with the purpose of increasing the comprehensiveness of health care while simultaneously controlling the demand for and cost of health care services. (Chapter 6)

Control

See Management Control. (Chapter 1)

Cooperation Strategy

Organizations agreeing to work together to achieve a common goal through mergers, alliances, or joint ventures. (Chapter 6)

Corporate Governing Board

A group comprised of experts in the field who advise top management; typically involved in oversight, strategic planning, and policy making. (Chapter 5)

Corporate-Level Strategy

An overall plan for the broadest organizational level that positions the organization in multiple markets served with multiple products. (Chapter 1)

Cost Leadership

A generic positioning strategy designed to gain an advantage over competitors by producing a product/providing a service at a lower cost than competitors. (See Generic Strategy) (Chapter 6)

Creative Tension

When leaders develop a view of where they want to be in the future (vision)

that is significantly different from where the organization is now. (Chapter 5)

Critical Success Factor

An attribute or characteristic that is essential for surpassing all or most competitors. (Chapter 5)

Critical Success Factor Analysis

Process to identify a limited number of activities for a service category within a service area for which the organization must achieve a high level of performance if it is going to be successful. (Chapter 3)

Culture

See Organizational Culture. (Chapter 9)

Current Assets

Assets (including cash, accounts receivable, and so on) that are convertible into cash within one year. (Resource 2)

Customer Capital

The value of customer relationships and the contribution this value makes to future growth prospects. (Chapter 8)

Customer Focus

Corporate policies formulated with the customer/end user/patient in mind. Involves satisfaction, convenience, and quality. (Chapter 1)

Decentralization

Where key organizational decisions are distributed throughout the organization closer to the customer. (Chapter 7)

Decision Support System

A strategic information system that collects unorganized data and converts them into useful information to enable managers to make better choices/plans of action. (Chapter 9)

Defender Strategic Posture

An organization that focuses on a narrow market with a limited number of products/services and aggressively attempts to protect its market segment against other competitors through pricing or differentiation strategies. (Chapter 6)

Delphi Method

A process for the development, evaluation, and synthesis of individual points of view through the systematic solicitation and collation of individual judgments on a particular topic; in effect a funnel approach to narrow various viewpoints to a workable solution. (Chapter 2)

Development Strategy

A specific plan to enter a new market using internal resources through internal development, internal ventures, or reconfiguring the value chain. (Chapter 6)

Dialectic Inquiry

A point and counterpoint process of argumentation where a thesis is argued against an antithesis to develop a synthesis of ideas or issues. (Chapter 2)

Differentiation

A generic positioning strategy to make the product/service unlike others, or

appear to be unlike others; readily distinguishable or unique among competitors' products/services. (See Generic Strategy) (Chapter 6)

Direction

Stepping down the strategic plan to the specifics of what actual work has to be done. (Chapter 9)

Directional Strategies

The broadest strategies that set the fundamental direction of the organization by establishing mission, vision, values, and overall strategic goals. (Chapter 1)

Disruptive Capability

The ability to develop novel strategic insights, recognizing and arranging resources and competencies to develop new strategies – before or better – than competitors. (Chapter 4)

Disruptive Innovation

Term that describes a novel product/service/process that upsets the status quo in a market that becomes so fundamentally different it displaces market leaders through creation of new markets and value networks. (Chapter 8)

Diversification

Adding new related or unrelated products/services/businesses outside the organization's core business(es). (Chapter 6)

Diversity

The breadth of lived experiences by people from different backgrounds and may relate to identities such as race, ethnicity, age, sex, sexual orientation, gender identity, disability, social class, religion, political identity, and national origin. (See also Inclusion) (Chapter 9)

Divestiture

A reduction of scope strategy in which an operating unit is sold off as a result of a decision to exit the market. (Chapter 6)

Divisional Structure

An organization developed on the basis of products/services, geographic markets, or customers; results in semi-autonomous strategic business units (SBUs) or strategic service units (SSUs). (Chapter 9)

Divisional-Level Strategy

An overall plan for a corporate division or single product – single market organization. (Chapter 1)

Downsizing

Reduction in employees, manufacturing, products/services; frequently in an effort to reduce expenses and improve organizational efficiency. (Chapter 1)

Dynamic Capability

The ability to make ongoing improvements to the organization's activities through learning, renewal, and change over time; skill at adapting resources, or competencies, or both to external changes. (Chapter 4)

Economies of Scale

Cost advantages that arise with increased volume. (Chapter 3)

Electronic Health Record (EHR)

Digital version of a patient's medical chart and other important personal information (such as X-rays, family health history, etc.) designed to improve care, communication, and coordination. (Chapter 6)

Emergent Approach (to Strategic Management)

Reliance on intuitive thinking, leadership, and learning with the understanding that because of external change, strategic plans evolve as strategy unfolds and the organization learns what works and what does not. (See also Analytical Approach) (Chapter 1)

Emergent Strategy

A relatively unexpected strategy that develops as uncontrollable and unanticipated external events unfold. (Chapter 1)

Emotional Culture

Affective values, norms, artifacts, and assumptions that serve as a guide for behavior; how people feel in the organization such as joy, fear, sadness, and so on. (Chapter 9)

Enhancement

Seeking to improve operations within present product or service categories through quality programs, increasing flexibility, increasing efficiency, speed of delivery, and so on. (Chapter 6)

Enterprise Value (EV)

The sum of the market value of total debt plus equity minus cash; the value invested in an organization by debt and equity holders. (Resource 2)

Equity

The value of investments owned by stockholders of a for-profit organization. (Resource 2)

Evidence-Based Management (EBMgt or EBM)

An emerging philosophy that employs current best practices that have been tested in real-world organizational settings and for which there are facts and supporting data documenting their efficacy. (Chapter 8)

Expansion of Scope Strategy

Growing an organization through diversification, vertical integration, market development, product development, or penetration. (Chapter 6)

Expert Opinion

Well-informed individuals' insight into an issue/trend/situation; typically used in external analysis to identify, monitor, forecast, and assess external trends, issues, and events. (Chapter 2)

Extended Portfolio Matrix Analysis

An extension of the Boston Consulting Group (BCG) Portfolio Matrix to account for profitability in situations where high market share does not necessarily mean high profitability – an assumption underlying the BCG Portfolio Matrix. (Chapter 7)

External Analysis

A strategic thinking activity directed toward identifying, aggregating, and interpreting the issues that are outside the organization to determine the implications of those issues on the organization as well as to provide

information for internal analysis and the development of the directional strategies. (Chapter 2)

External/Internal Strategy Matrix

An alternative development tool that juxtaposes issues occurring outside the organization with competitive advantages and disadvantages “owned” by the organization. (Chapter 7)

Facilities

The physical environment of an organization. (Chapter 9)

Financial Accounting

Information provided about the organization’s funds that focuses on the specific needs of external stakeholders. (Resource 2)

Financial Leverage

Calculates the extent to which the organization depends on the use of debt to carry out its operations; a measure of exposure to risk. (Resource 2)

First-Mover Advantage

Benefits that belong to the organization creating a new market. (Chapter 5)

Focus Groups

A facilitated process typically using 10–15 people to surface, develop, evaluate, and reach conclusions about an issue. (Chapter 2)

Focus Strategy

An organization that directs its efforts toward the particular needs of a smaller, well-defined market segment – a niche within the total market – using the generic strategies of cost leadership or differentiation. (See also Generic Strategy) (Chapter 6)

Focused Factory

An organization that provides comprehensive services across multiple markets (horizontal integration) for a specific category; in health care a specific disease such as cancer, diabetes, renal disease, asthma, or cardiac disease. (Chapter 6)

Follow-On

Additional services provided after the initial point-of-service delivery. (Chapter 8)

Follow-Up

An effort to improve satisfaction for the patient by checking with the consumer/patient concerning the quality, effectiveness, and satisfaction with the point-of-service encounter; understanding of the billing; and providing service to determine next steps in the healing process (may include long-term or step-down care). (Chapter 8)

For-profit Organization

An organization with owners or shareholders seeking to earn a profit (revenues exceeding costs) as a return on an investment in that organization. (See also Not-for-profit Organization) (Chapter 1 & Resource 2)

Forecasting (External Change)

Based on current data and trends, a process of extending trends and issues that the organization is monitoring to predict the future state of a

phenomenon. (Chapter 2)

Forward Vertical Integration

A strategy to grow (add members) along the channel of distribution toward the consumer or toward later stages for the continuum of care (downstream). (Chapter 6)

Franchise

The granting of the right for a prescribed period of time to use a business model and brand in an exclusive geographic area (territory) for a fee. (Chapter 6)

Functional Structure

An organizational arrangement based on the primary activities or processes required for producing the product/service of the organization. (Chapter 9)

General Environment

The broadest set of individuals and organizations generating external change including government institutions, business organizations, educational institutions, research organizations, individuals, and consumers; events that typically affect all industries. (Chapter 2)

Generally Accepted Accounting Practices (GAAP)

Developed by the Financial Accounting Standards Board and Governmental Accounting Standards Board to maintain comparability of reports of economic activity of different organizations. (Resource 2)

Generic Strategy

Positioning strategies – cost leadership or differentiation; may be marketwide or focused on a particular market segment. (Chapter 6)

Geographical Information System (GIS)

Software that captures, manages, analyzes, interprets, and creates visualizations of physical surroundings (dynamic maps, retail locations, terrain, and so on); related to three dimensional data (geospatial data). (Chapter 9)

Government Health Care Insurance

Programs that enhance access to health care for specific groups of eligible beneficiaries through funded payment such as Medicare, Medicaid, and Children's Health Insurance Program (CHIP); others deliver services directly to beneficiaries such as TRICARE, the Veterans Administration (VA), and the Indian Health Service (IHS). (Chapter 2)

Gray Rhinos

High-probability, high-impact issues that everyone acknowledges as threats because there has been a series of warnings and visible evidence; but leaders fail to address them (obvious but neglected risks). (Chapter 2)

Grouphink

A decision-making phenomenon that occurs when a number of people make faulty decisions because of collective pressure that leads to a deterioration of mental efficiency, reality testing, and moral judgment; members seek conformity and desire harmony even if it results in dysfunctional decisions. (Chapter 10)

Harvesting

A reduction of scope strategy to continue operating in a declining business, reaping any remaining available profits without investing additional resources. (Chapter 6)

Health Information Technology (IT)

A broad term that refers to a wide range of equipment, software, and applications designed to store, share, and analyze health data; includes electronic health records (EHRs), health information exchanges (HIEs), and others. (Chapter 6)

Health Insurance

In return for payment of a premium to a commercial, not-for-profit, or government agency, a guarantee is offered to cover the cost for medical care, hospitalization, surgery, and other expenses to receive care for an illness, disease, or condition. Specialized coverage may be purchased for certain diseases (cancer, for example) and some coverage exempts certain conditions. (Chapter 1)

Health Policy

Rules, regulations, legislation, and executive actions that apply to all consumers and providers of health care. (Chapter 1)

Holacracy

Self-managed teams; also called podularity, circles, and organic organizations; members share responsibility for the success of the team. (Chapter 9)

Horizontal Integration

A type of market development – a method of obtaining growth across markets by acquiring or affiliating with direct competitors rather than using internal operational or functional strategies to gain/grow market share. (Chapter 6)

Icarus Paradox

A situation where the very factors that created exceptional organizational success also sow the seeds for its failure; the organization knows only one way to be successful and when the world changes, it cannot adjust. (Chapter 10)

Implementation Plan

A series of specific steps/activities that are formulated to accomplish strategic goals and are directed toward service delivery and organizational support activities. (Chapter 1)

Implementation Strategy

Selected action plans directed toward adding value in service delivery and organizational support areas; all important concluding activities in the hierarchy to accomplish previously determined goals and objectives; sometimes overlooked. (Chapter 6)

Inclusion

Goes beyond recognition of race, ethnicity, age, sex, sexual orientation, gender identity, disability, social class, religion, political identity, and national origin differences and focuses on valuing (embracing) these

differences. (Chapter 9)

Income Statement

Statement of earnings – revenues minus expenses – of a for-profit organization. (Resource 2)

Inevitable Surprises

Events that will occur in the future for which there are discernable signs, patterns, or signals of their likely occurrence today. (See also Predictable Surprises) (Chapter 2)

Integrated Health System

A method that offers a range of patient care and support services coordinated in a functionally unified manner. (Chapter 6)

Integrative Medicine

Medical approaches that incorporate elements of complementary and alternative medicine (CAM) with traditional western medicine; over time some CAM therapies have become mainstream. (Chapter 3)

Interlocking Directorates

Two or more boards of directors have members that serve on the boards of the same organizations; the two or more organizations involved are thus overlapping and proprietary information is shared. (Chapter 5)

Internal Development

Method to expand the scope of an organization by using existing organizational resources to create new products/services or to enter new markets. (Chapter 6)

Internal Venture

Method to expand the scope of an organization by creating a separate, relatively independent entity within the organization to develop new products/services or to enter new markets. (Chapter 6)

Intrapreneuring

Risk taking and innovative behavior within an existing, mature organization. (Chapter 1)

Inversion

Also termed expatriation, strategy to relocate the parent company to a low-tax country; primarily focuses on reducing the corporate income tax burden. (Chapter 6)

Issue Impact and Probability Prioritization

The classification of events/occurrences/concerns in the external environment based on an assessment of the importance of the event/occurrence/concern and the likelihood that it will continue to remain important in the future. (Chapter 2)

Issue Map

A matrix of events/occurrences/concerns that combines the general environment, health care system, and service area on one axis with categories of events/occurrences/concerns (economic, social/demographic, legislative/political, technological, and competitive) on the other axis; the matrix cells may be filled in with identified events/occurrences/concerns

and their implications through the steps of the external analysis process – scanning, monitoring, forecasting, and assessing. (Chapter 2)

Joint Venture

A contractual agreement between two or more organizations to work together and combine resources to accomplish a designated task or project. (Chapter 6)

Kaizen

Japanese term for continuous improvement; a process and ongoing effort to achieve slightly better results that enhance efficiency through small improvements every day. (Chapter 8)

Keeper of the Vision

Individuals who champion, communicate, and model the hope for the future of the organization; often the chief executive officer or another high-ranking executive. (Chapter 5)

Leadership

Creating a vision and sharing it; aligning individuals and building coalitions; motivating and inspiring. (Chapter 1)

LEAN Six Sigma

A five-step process (Define–Measure–Analyze–Improve–Control (DMAIC)) that aims at eliminating defects. (Chapter 10)

Leveraging

Usually thought of in financial terms, using debt to finance assets (utilizing borrowed money); however, other resources may gain additional clout as well by accumulating, concentrating, complementing, and linking resources to create synergy or higher-order value. (Chapter 4)

Liability of Newness

The disadvantages of early entry into a new market typically in the form of uncertainty, the learning curve, risks of variable demand, and costs of new technological investments. (Chapter 5)

Licensing

An agreement for rights to a technology, product, trademark, franchise, or exclusive geographic area (territory) developed by one organization and contracted for use by another for a fee. (Chapter 6)

Liquidation

A reduction of scope strategy involving the termination of a unit through the sale of all its assets. (Chapter 6)

Liquidity

Measures the ability of an organization to pay its bills; determines whether an organization is financing assets with similar liabilities. In general, current assets should be fully financed by current liabilities (1:1 ratio). (Resource 2)

Long-Range Planning

Planning method developed in the 1950s to forecast demand for current products/services to enable managers to better develop marketing and distribution, production, human resources, and financial plans. (Chapter 1)

Macro-environment

The broadest of an organization's external surroundings (the general or societal environment). (Chapter 2)

Maintenance of Scope Strategy

A plan for an organization where few changes are required in the target markets or the organization's products/services; includes enhancement and status quo strategies. (Chapter 6)

Managed Care

Refers to health insurance plans or organizations (HMOs, PPOs, and POSs) that contract with doctors, hospitals, clinics, pharmacies, and others to provide, control, and efficiently oversee the costs and quality of health care for plan enrollees. (Chapter 7)

Management by Objectives

A supervisory approach based on setting clear and concise goals, participative goal setting, and evaluation based on results. (Chapter 1)

Management Control

To regulate, guide, direct; managing the behavior or outcome of some process, program, or plan; a measurement of the actual against the plan. (Chapter 1)

Managerial Accounting

Financial information that focuses on the specific needs of internal organizational decision makers. (Resource 2)

Map

A metaphor for a plan, guideline, or method. (Chapter 1)

Mapping Competitors

The grouping of challengers within a service area that most directly compete with each other; strategic groups portrayed graphically. (Chapter 3)

Market Development

A strategy to enter new target or service segments or service areas with an organization's present products/services. (Chapter 6)

Market Entry Strategy

A plan to carry out the adaptive strategy through purchase, cooperation, or internal development strategies. (Chapter 6)

Market Exit Strategy

A decision to leave all or part of the service area relatively quickly (using divestiture, liquidation, or retrenchment) or to leave slowly (using harvesting). A harvesting decision entails leaving all or part of the service area relatively slowly (serving fewer customers, reducing geographic areas served, or reducing the product line), or completely leaving the market. (Chapter 6)

Market Share

One organization's sales compared to total sales expressed as a percentage; percentage of value of services garnered by one organization of a product/service category in a service area at a specific point in time. (Chapter 1)

Market/Marketing Research

Any data gathering about the customers in a service area, or potential customers, or new service areas; or activities such as the desired attributes of the product/service, appropriate price, most convenient place to obtain the product/service, and the type of promotion to best inform customers (potential as well as current). (Chapter 8)

Marketwide Strategy

Product/service positioning in the service area to appeal to a broad audience (in a broad service area) using the generic strategies of cost leadership or differentiation. (See also Generic Strategy) (Chapter 6)

Mass Customization

Modifying the attributes or characteristics of a widely available product or service to better meet the particular needs of individual customers. (Chapter 8)

Matrix Structure

An organization design based on the need for more expertise in a variety of areas in an organization; a hybrid organization between centralized and functional management designs; centralized functional specialists interact with and provide services to project or program teams. (Chapter 9)

MBWA (Management by Wandering Around)

Technique popularized by Tom Peters whereby managers are encouraged to get out of their offices, move around sites where the actual work is done, and talk/interact with the people doing the work. (Chapter 1)

Medicaid

A national social insurance program administered by the U.S. Federal government for individuals whose income and resources are insufficient to pay for health care. (Chapter 2)

Medical Tourism

The practice of travelling to a country, other than one's own, for the purpose of obtaining medical treatment to improve health or undergo elective procedures at a lower cost and in a destination (vacation) environment. (Chapter 3)

Medicare

A national social insurance program administered by the U.S. Federal government funded through a payroll tax providing catastrophic health insurance for elderly Americans (65 and older) and some people with disabilities who are unable to care for themselves; regular medical care and prescriptions are not covered by Medicare (Parts B and D need to be purchased) which came as a surprise to many Americans who believed their contributions "took care of their health care" after they retired. (Chapter 2)

Merger

A cooperation strategy where two organizations combine through mutual agreement to form a single new organization – often with a new name. (Chapter 6)

Mission

The organization's distinctive purpose or reason for being – a broadly defined and enduring purpose that distinguishes the organization from other

organizations of its type and identifies the scope of its operations in terms of product/service/markets. (Chapter 5)

Mission Creep

The tendency to add services/products based on the needs of the community (not originally part of the organization's stated purpose), in the hope that additional revenues would follow. (Chapter 5)

Mission Drift

The tendency to move into new businesses and programs that are not in line with the organization's stated purpose. (Chapter 5)

Monitoring (External Change)

The tracking of various issues identified in the scanning process to add data concerning the item under consideration to confirm or disconfirm the issue or its impact. (See also External Analysis) (Chapter 2)

Needs Assessment

A systematic process for identifying gaps between the current state of "What is" (real) and the desired state of "What should be" (ideal); allows an organization to identify and prioritize needs; determine criteria for solutions; make data-informed decisions regarding human, financial, and other resources; and implement actions to improve programs, services, organizational structure, and operations. (Chapter 7)

Needs/Capacity Assessment

An evaluation method for developing strategy alternatives for not-for-profit and public organizations based on the community's problems and the organization's ability to deliver programs that resolve the problem. (Chapter 7)

Nested Systems

A hierarchy of structures, where one structure is contained within a broader structure and that structure is, in turn, contained within a still broader structure. For example, health care organizations are a part of and impact their service areas; the services areas are a part of and impact the health care system; and the health care system is a part of and impacts the broader general or macro-environment. (Chapter 2)

Net Assets

Owned resources of an organization; used in not-for-profit balance sheets. (Resource 2)

Net Income

Total earnings derived from total revenues minus all costs. (Resource 2)

Net Worth

The value determined by subtracting long-term liabilities from net assets of a not-for-profit organization; subtracting long-term liabilities from equity of a for-profit organization. (Resource 2)

Nominal Group Technique (NGT)

A facilitated discussion process for developing consensus on an issue or problem where individuals present ideas, discussion occurs, and consensus is reached through a voting process. (Chapter 2)

Not-for-profit Organization

An organization that has no private owners or shareholders (may be government funded) usually set up to help people or further the common goals of a group. (See also For-profit Organization) (Chapter 1)

Objectives

Measurable ends that achieve broader goals; should be SMART = specific, measurable, actionable, realistic, and time-bound. (Chapter 10)

Objective Strength or Weakness

Resources, competencies, or capabilities that everyone generally recognizes and acknowledges that an organization has or does not have. (Chapter 4)

One-Minute Manager

Management approach based on a book by Kenneth Blanchard and Spencer Johnson founded on three techniques of effective management – one minute goals, one minute praise, and one minute reprimand. (Chapter 1)

Operating Margin

The value created by subtracting the costs of the processes of an ongoing business or not-for-profit organization from its revenue; also expressed as a percentage by dividing operating margin by revenue. (Resource 2)

Organizational Capacity

One dimension for determining the strategy for a not-for-profit organization's programs based on its ability to initiate, maintain, and enhance its programs; includes an assessment of the program's funding, other available organizational resources and skills, and the program's fit with mission and vision. (Chapter 7)

Organizational Culture

Shared values, norms, artifacts, and assumptions that serve as a guide for behavior; made up of the cognitive and emotional cultures. (Chapter 9)

Organizational-Level Strategy

An overall plan for single entity competing within a specified well-defined service area. (Chapter 1)

Participative Management

A management philosophy that involves individuals in the determination of goals and performance standards for their own jobs. (Chapter 1)

Patient Portal

Online applications (apps) that enable consumers to access their personal health information and to communicate with their health care providers from anywhere with internet access at any time using an account with a protected username and password. (Chapter 8)

Penetration Strategy

A plan to increase volume and market share by better serving current markets with current products/services through enhanced pricing, advertising, sales promotions, sales force, and publicity. (Chapter 6)

Philanthropic Governing Board

An advisory group to top management in service-oriented organizations that are selected based on broad representation of diverse stakeholders with

fundraising capabilities. (Chapter 5)

Pioneering (Organization)

Organization seeking first-mover advantages; an organization attempting to go where no others have gone. (Chapter 5)

Platform Technology

Bringing together producers and consumers in high-value exchanges; exchanges occur online and are mainly information, contacts, and interaction (its source of value). (Chapter 6)

Point-of-Service

A key area in the value chain where the health/medical care is actually delivered and value can be created for the customer/patient through clinical operations and marketing. (Chapter 4)

Point-of-Service Strategy

The development of an implementation plan to maintain or change activities that engage with the patient/customer by comparing the results of the internal analysis with the requirements of the selected broader organizational strategies. (Chapter 8)

Portfolio Management

A business approach that allows for the assessment of an organization's market position as a whole or as a collection of individual product/service lines. (Chapter 1)

Positioning Strategy

Marketwide or focus approaches using the generic strategies of cost leadership or differentiation. (See Generic Strategy) (Chapter 6)

Pre-Service

A key area in the value chain where value can be created for the customer/patient before the direct health care is actually delivered; includes marketing research, marketing, target market(s) selection, branding, pricing, distribution/logistics, promotion, and so on. (Chapter 4)

Pre-Service Strategy

The development of an implementation plan to maintain or change activities prior to direct delivery of health/medical care by comparing the results of the internal analysis with the requirements of the selected broader organizational strategies. (Chapter 8)

Predictable Surprises

Events that occur and surprise decision makers because of their cognitive, organizational, and political shortcomings – including biases, faulty external scans, and specialized interests that invoke individuals or groups to act in their own self-interest (contrary to those who use good skills and avoid specialized self-interests enabling their organizations to prepare for the predictable, thus no surprise). (Chapter 2)

Primary Providers

Individuals and organizations that provide health services directly to patients including physicians, nurses, hospitals, skilled nursing facilities, and so on; often associated with the primary care physician. (Chapter 2)

Private Health Insurance

Health care coverage offered by commercial and not-for-profit organizations that require enrollment (membership) and premiums or fees usually paid monthly to cover the cost of care. (Chapter 1)

Process

A collection of activities that takes one or more kinds of input and creates an output that is of value. (Chapter 10)

Product Development

A strategy to introduce new goods/services/ideas to an organization's present markets. (Chapter 6)

Product Life Cycle (PLC) Analysis

A method used to develop strategy alternatives based on the principle that all goods and services progress through the distinct stages of introduction, growth, maturity, and decline with similar activities occurring during each stage; typically graphically portrayed. (Chapter 7)

Profitability

Measures the efficiency with which an organization employs capital contributed to, or invested in, the organization and reinvested through the retention of earnings; revenues minus costs. (Resource 2)

Program Evaluation

An analysis method used particularly by not-for-profit and public organizations for assessing their portfolio of offerings and developing strategic alternatives in situations where market share, service category strength, and competitive advantage are not relevant. (Chapter 7)

Program Priority Setting

An analysis method used particularly by not-for-profit and public organizations that involves rank ordering programs when all programs are considered important but resources are limited. (Chapter 7)

Program Q-Sort Evaluation

A forced-choice ranking procedure for differentiating and reaching consensus on the importance of programs/issues and setting priorities, especially when all programs are important. (Chapter 7)

Prospector Strategic Posture

An organization that frequently searches for new market opportunities and regularly engages in experimentation and innovation. (Chapter 6)

Purchase Strategy

An expansion of scope strategy that uses financial resources to enter a market quickly through acquisition, licensing, or venture capital investments. (Chapter 6)

Q-Sort

A ranking procedure that forces choices along a continuum in situations where the difference between the choices may be quite small. (Chapter 7)

Quality Improvement

Focuses on continuous enhancement of products/services rendered to organizational stakeholders. (Chapter 1)

Quantitative Management

Application of scientific analysis and data collection to the solution of management problems. (Chapter 1)

Quantitative MBAs

A management fad (theory) emerging after WWII and an educational focus of Master of Business (MBA) education in the 1970s that assumed that much of management could be reduced to data, formulas, mathematical models, simulations, and statistics to improve decision making; quantitative management in the 2010s has a more distinct focus on information systems, management science, and operations management; most business education takes a more balance approach mixing both quantitative and qualitative methods moving toward the 2020s. (Chapter 1)

Reactor Strategic Posture

Typically, the lack of a strategy or plan that results in inconsistent and unstable responses to external changes, markets, and competition; occasionally, a strategic choice to be a follower of a dominant industry leader. (Chapter 6)

Realized Strategy

A planned approach to the business that subsequently works out successfully (as planned). (Chapter 1)

Reconfigure the Value Chain

Changes the activities or sequence of activities an organization performs to change the way value is delivered to the customer; changes the way the customer is served; a new business model. (Chapter 6)

Red Ocean Strategy

Plans to compete in industries currently in existence. The marketplace is known, the industry boundaries are defined, and the competitive rules are established and well understood. (See also Blue Ocean Strategy) (Chapter 7)

Red Queen Effect

You have to “run as fast as you can just to stay where you are” in a highly competitive industry segment. An iterative process, where achieving competitive advantage is usually matched or exceeded by competitors, requiring yet another competitive response. (Chapter 4)

Reduction of Scope Strategy

Strategies to decrease the size and reach of operations through divestiture, liquidation, harvesting, and retrenchment. (Chapter 6)

Re-engineering

A total re-thinking/re-designing of organizational processes to achieve dramatic improvements in measures of performance. (Chapters 1 & 7)

Related Diversification

Adding new, somewhat similar products/services (businesses) that are outside the organization’s core business. (See also Concentric Diversification) (Chapter 6)

Relative Strength or Weakness

Resources, competencies, or capabilities that are not obvious and can only be determined in relationship to the resources, competencies, or capabilities of

primary competitors. (Chapter 4)

Resource-Based Theory

A proposition that valuable, expensive, or difficult-to-copy resources provide a key to sustainable competitive advantage. (Chapter 4)

Resources

Stocks of tangible and intangible factors that are available for use in producing goods and services. (Chapter 4)

Retained Earnings

Earnings not distributed to stockholders. (Resource 2)

Retrenchment

A plan to reduce the scope of operations, through redefining the target market, cutting geographic coverage, reducing the segments served, or reducing the product/service line; may be a preamble to other strategies. (Chapter 6)

Return on Investment

Measures the efficiency with which an organization employs capital contributed or invested in the organization and reinvested through the retention of earnings. (Resource 2)

Rivalry

The intensity of competition for a product/service category in a service area influenced by the number and diversity of competitors, segment growth rate, fixed costs, switching costs for customers, capacity investments, strategic stakes, and exit barriers. (Chapter 3)

Scanning (External Change)

A process of identifying and documenting a number of external organizations and activities in the general environment, health care system, and service area in search of pertinent, current, and emerging trends/issues. (Chapter 2)

Scenarios

Probable visions, stories, or pictures of the future based on forecasting the impact of current trends, events, and issues that may affect an organization. (Chapter 2)

Secondary Providers

Individuals and organizations that provide health care resources (example: pharmaceutical companies); not directly involved in patient care. (Chapter 2)

Self-managed Teams

Members of the group share leadership, accountability, responsibility, and authority over its work; sometimes called holacracy, circles, or organic organizations. (Chapter 9)

Sensemaking

Understanding the context of a situation so that complexity can be better explained. (Chapter 2)

Service Area

The geographic area from which an organization draws the majority of its

customers/patients. For some service categories the service area may be quite large (organ transplant) whereas for other service categories it might be quite small (emergency room). (Chapter 2)

Service Area Competitor Analysis

A process to define the geographic region from which the organization draws the majority of its customers/patients, understand its rivals in the region, and anticipate their potential moves. (Chapter 3)

Service Area Structural Analysis

Five forces framework for analyzing the attractiveness of an identified geographic region for a product/service category considering the threat of new entrants, intensity of rivalry among competitors, threat of substitute products/services, bargaining power of customers, and bargaining power of suppliers. (Chapter 3)

Service Category

A distinct health care offering that may be defined very broadly (hospital care) or very narrowly (pediatric hematology) depending on the level of analysis. (Chapter 2)

Service Delivery

The primary way organizations create value through the health care they provide to the customer/patient using a variety of activities (pre-service, point-of-service delivery, and after-service). (Chapter 4)

Shared Assumptions

A common understanding in the organization of “who we are” (mission) and “what we are trying to accomplish” (vision and strategic goals) as well as the belief in the values of the organization. (Chapter 9)

Shared Values

An understanding or perception of the “way we do things” (underlying principles) that may or may not reflect the actually stated “rules” of the organization. (Chapter 9)

Situational Analysis

A process of understanding and documenting the external environment an organization faces now and into the future, current internal systems, and directional strategies (mission, vision, values, and strategic goals). (Chapter 1)

SPACE Analysis

Acronym for Strategic Position and Action Evaluation – an analysis method and graphic depiction that indicates the appropriateness of strategic alternatives based on factors relating to the service category strength, external stability, the organization’s relative competitive advantage, and the organization’s financial strength. (Chapter 7)

Stakeholder Analysis

The systematic identification and evaluation of external and internal individuals, groups, and organizations that have an interest (or stake) in the success or failure of an organization. (Chapter 2)

Stakeholders

Individuals, groups, and organizations that are directly or indirectly

impacted by the success or failure of the organization. (Chapter 2)

Statement of Cash Flows

Identifies sources and uses of funds for an organization. (Resource 2)

Statement of Financial Position

Document showing assets, liabilities, and net assets of a not-for-profit organization; equivalent to the Balance Sheet of a for-profit organization. (Resource 2)

Status Quo

A maintenance of scope strategy seeking to maintain relative market share within a market and to retain services at their current level. (Chapter 6)

Stockholders' Equity

The value of an organization attributable to its owners. (Resource 2)

Strategic Awareness

Thoughtful detection and interpretation of subtle and not-so-subtle external signals of change. (Chapter 2)

Strategic Business Unit (SBU)

A semi-autonomous division-level entity within a larger organization that produces a physical product (see also SSU). (Chapter 1)

Strategic Capability

The ability to effectively and efficiently coordinate resources and competencies to achieve integrative synergies through leadership and management. (Chapter 4)

Strategic Control

An aspect of managing strategic momentum that regulates the implementation of strategic plans; not only measures the organizational success against the plan but also considers changes in the external environment, incorporating thinking and learning as the strategy unfolds. (See also Management Control) (Chapter 10)

Strategic Goals

Benchmarks or end results related to critical success factors providing more specific direction in accomplishing the mission and vision. (Chapter 5)

Strategic Group

Organizations within a service area that are most similar and compete directly against each other on the same competitive dimensions. (Chapter 3)

Strategic Information System

A decision support system that collects unorganized data and converts the data into useful information to enable managers to make better decisions than others in its competitive group. (Chapter 9)

Strategic Issues

Trends, developments, dilemmas, and possible events that affect the organization and its position within the industry/service area. (Chapter 2)

Strategic Management

The process of strategic thinking, strategic planning, and managing the strategic momentum of an organization to provide direction and change to achieve the organization's mission and vision. (Chapter 1)

Strategic Momentum

The management processes of implementing the organization's competitive plan to position itself through day-to-day activities directed toward achieving its overall desired end results (goals). (Chapter 1)

Strategic Planning

The periodic process of developing a set of steps for an organization to accomplish its mission and vision using strategic thinking. (Chapter 1)

Strategic Posture

A description of how organizations behave within their service area (or industry when the service area is large); includes defenders, prospectors, analyzers, and reactors. (Chapter 6)

Strategic Resources

Assets of value for an organization such as financial, human, informational, technological, location, brands, and operations. (Chapter 9)

Strategic Response

Likely changes necessary to be competitive; the next strategic moves of competitors (that bear monitoring). (Chapter 3)

Strategic Service Unit (SSU)

A semi-autonomous division-level entity within the larger organization that produces an intangible that one party offers to another that is not a physical product (see also SBU). (Chapter 1)

Strategic Technologies

The look, feel, and location of facilities, the type and sophistication of equipment including software and hardware, and management of technology within the organization that enable it to be competitive in its marketplace. (Chapter 9)

Strategic Thinking

An intellectual activity that is perceptive to emerging changes, strategic implications and develops transformative responses; includes the activities of awareness, anticipation, analysis, interpretation, synthesis, and reflection. (Chapter 1)

Strategic Thinking Map

An intellectual process guided by a logical plan of action (set of guidelines); used to describe approaches, guidelines, or analytical methods to ignite cognitions leading to a strategic plan or components of a strategic plan. (Chapter 1)

Strategy

The consistent behavior of an organization in coping with its technological, social and demographic, economic, legislative/political, and competitive issues; a consistent, relatively enduring approach to achieve a goal or objective; the result of the strategic planning process that effectively positions the organization in its environment. (Chapter 1)

Strategy Formulation

The process of developing strategic alternatives, evaluating alternatives, and making strategic choices that are competitively relevant. (Chapters 1 & 6)

Strength

An organizational attribute or characteristic (resource, competency, capability) in which the organization believes that it excels. To be competitively relevant, the strength has to be valuable to the stakeholder, be relatively rare among competitors, difficult to imitate, and sustainable by the organization. (Chapter 4)

Stretch

Significantly moving the organization toward its strategic goals – accomplished through resource leveraging or systematically achieving more than normally expected to be possible from available resources. (Chapter 4)

Structure

The organization of the management processes necessary to accomplish the strategy. (Chapter 9)

Subjective Strengths or Weaknesses

Resources, competencies, or capabilities possessed by an organization expressed by someone's opinion (not fact-based). (Chapter 4)

Support Activities

Value created for the organization through its culture, structure and financial, human, information and technology strategic resources. (Chapter 4)

Surplus

For a not-for-profit organization, funds left over after payment of all expenses (comparable to net income in a for-profit organization). (Resource 2)

Sustained Competitive Advantage

An enduring value differential between the services of one organization and that of its competitors. A long-term strength that is rare in the service area, difficult to imitate by competitors, and can be sustained by the organization. (Chapter 4)

Switching Costs

The economic, logistic, and emotional costs for consumers in selecting and adopting an alternative product/service over their present product/service. (Chapter 3)

SWOT Analysis

A systematic investigation to consider an organization's internal strengths and weaknesses and its external opportunities and threats; often displayed in a two-by-two matrix. (Chapter 7)

Synergy

A concept where value and performance combined will be greater than the sum of the separate individual parts. (Chapter 4)

System

A perceived whole whose elements hang together because they continually affect each other over time and operate toward a common purpose. (Chapter 1)

Systems Perspective

A way of understanding a phenomenon by perceiving the whole as well as its interactive elements (subsystems); a system's subsystems continuously affect each other and operate toward a common purpose. (Chapter 1)

Target Market

An identified segment believed to be an organization's best customers; the primary focus of marketing activities. (Chapter 8)

Telehealth

Remote health care delivery via monitoring; phone monitoring of the implementation of scheduled and prescribed encounters; the collection and transmission of vital signs and clinical data through electronic information-processing technologies. (Chapter 8)

Theories X and Y

Assumptions underlying human nature in motivation theory popularized by Douglas McGregor. Theory X assumes people are lazy and must be controlled. Theory Y assumes people are mature individuals who want to work and produce thereby requiring less control. (Chapter 1)

Theory Z

Sometimes thought of as Japanese Management, emphasizes individual trust, group decision making, and lifetime employment. (Chapter 1)

Threshold Condition

The minimally required resources, competencies, or capabilities (organizational strengths) necessary to successfully compete within a product/service category in a given service area (market). (Chapter 4)

TQM/CQI

Total Quality Management/Continuous Quality Improvement. Often thought of in the context of Japanese management where the emphasis is on both for continuous improvement (getting a little better each day). (See also Kaizen) (Chapter 1)

Unit Action Plan

(See Action Plan). (Chapter 10)

Unit-Level Strategy

An overall plan for individual departments within an organization that supports higher-level organizational strategies. (See also Action Plan) (Chapter 1)

Unrealized Strategy

A course of action or strategic plan that did not work out as envisioned or planned. (Chapter 1)

Unrelated Diversification

Adding new products/services (businesses) that are unlike (dissimilar to) the organization's core business or current market. (See also Conglomerate Diversification) (Chapter 6)

Value

The degree of satisfaction received relative to the price paid and the expected result; balancing price relative to satisfaction. (Chapter 4)

Value-Adding Service Delivery Activities

Pre-service, point-of-service, and after-service processes essential to customer satisfaction and the effective and efficient delivery of health care products and services. (Chapters 4 & 8)

Value-Adding Service Delivery Strategies

Objectives and plans focusing on improving the delivery of better than expected results to customers during pre-service, point-of-service, and after-service. (Chapter 8)

Value-Adding Support Activities

Organizational culture, organizational structure, and strategic resource processes essential in the effective and efficient implementation of broader strategies. (Chapters 4 & 9)

Value-Adding Support Strategies

Objectives and plans focusing on improving the effectiveness and efficiency of an organization; includes the plans for the organization's culture, structure, and strategic resources. (Chapter 9)

Value-Based Reimbursement

The health insurance payment system that pays providers based on the actual benefits achieved from the health care delivered rather than the number of visits or tests ordered – thus paying for the benefit of improved health versus the number of patients treated (value rather than volume). (Chapter 8)

Value Chain

An illustration of how and where satisfaction is created in organizations. Generally, satisfaction is created through service delivery and organizational support activities. (Chapter 4)

Values

Fundamental or guiding principles that are held dear by members of the organization and shape the organization's culture. (Chapter 5)

Venture Capital Investment

An expansion of scope strategy that provides funding to an organization with a developing technology, product, or market enabling the investing organization to participate (have a share) in its growth (profitability). (Chapter 6)

Vertical Integration

A strategy to grow (add members) along the channel of distribution; may be backward or forward (toward suppliers or toward patients); or stages in the continuum of care. (Chapter 6)

Vision

An expression of hope for a desired future state – a description of what leaders want the organization to achieve when it is accomplishing its purpose or mission. (Chapter 5)

Vision-Led Approach

Leaders are committed to a philosophy that strives for the highest levels of performance that are inspiring, despite not yet being achieved. (Chapter 5)

Weakness

An organizational attribute or characteristic (resource, competency, capability) that the organization assesses as an area that it does not excel in (needs to improve) and it is competitively relevant; the attribute is valuable to the consumer, relatively rare among competitors, difficult for the organization to imitate, and sustainable by the competitors. (Chapter 4)

Zero-Based Budgeting

A budgeting technique that builds from spending nothing in a category (the “zero” base) each fiscal period; requires justification to include any spending on programs, products/services, marketing, and so on. (Chapter 1)

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directors *see* boards of directors
direct primary care model
disruptive capabilities
disruptive innovations
distribution/logistics, pre-service
diversification
diversity, organizational culture
divestiture
divisional-level strategy
divisional structure
doctors
 hospital alliances
 primary care physicians
 website use
dogs (product/service category)
Drucker, Peter F
dynamic capabilities

EBM *see* evidence-based management
economic changes
e-detailing
EENT *see* eye, ear, nose, and throat medicine
EHRs *see* electronic health records

Eisenstat, Russell
electronic health records (EHRs)
electronic medical record (EMR) system
emergent approach
emotional culture
EMR *see* electronic medical record system
end-of-life care
enhancement
environmental stability, SPACE analysis
equity/net assets
errors, medical
ethics
evidence-based management (EBM)
executive and standing committees
expansion of scope strategies
expenses, prepaid
expert opinion
extended portfolio matrix analysis
external analysis
 advantages/disadvantages of techniques
 assessing
 brainstorming
 Delphi method
 dialectic inquiry
 expert opinion
 external information categories
 focus groups
 forecasting
 future studies
 general environment
 goals
 individual focus
 information sources
 issue impact

issue maps
key terms
lessons
limitations
monitoring
multiple service areas
nominal group technique
organizational focus
organizing the process
probability prioritization
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scenario analysis
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service area competitor analysis
service categories
stakeholder analysis
stakeholder maps
strategic thinking framework selection
external conditions, market entry/exit strategies
external information categories
external/internal strategy matrix
external issues
external scanning
external trends/issues
eye, ear, nose, and throat (EENT) medicine
facilities
facilities management
failures, medical
faithful dogs (product/service category)
fast market exit strategies
Federal Emergency Management Agency (FEMA)

Federal Health Centers (FHCs)
Federal Medicare Prescription Drug Improvement and Modernization Act
federal poverty level (FPL) pay
Federal Tort Claims Act (FTCA)
fee for service (FFS) models
FEMA *see* Federal Emergency Management Agency
FFS *see* fee for service models
FHCs *see* Federal Health Centers
finance
 accounting
 assets
 asset turnover
 balance sheet
 cash flows statement
 equity/net assets
 financial forecasting
 financial performance analysis
 financial position statement
 financial reporting
 financial statements
 income statement
 leasing
 liabilities
 off-balance sheet financing
 statement of activities
financial leasing
financial resources
financial strength, SPACE analysis
first-mover advantage
Five Forces framework (Porter)
fixed-rate bonds
focused factories
focus groups
focus strategies

follow-on activities, value-adding
follow-up activities, value-adding
forecasting
 external issues
 financial
forward vertical integration
FPL *see* federal poverty level
franchises
Frederick Regional Health System, Inc. (FRHS)
Fresenius Medical Care
FRHS *see* Frederick Regional Health System, Inc
FTCA *see* Federal Tort Claims Act
functional structure
future studies

GAAP *see* generally accepted accounting principles
GASB *see* Governmental Accounting Standards Board
general environment
 external analysis
 issue maps
 scanning
generally accepted accounting principles (GAAP)
generic strategies
geographic information systems (GIS)
Ghoshal, Sumantra
GIS *see* geographic information systems
glossary of terms
governance, boards of directors
governing boards *see* boards of directors
Governmental Accounting Standards Board (GASB)
government health care insurance
gray rhinos
Greenwich Hospital
group process, strategic planning

groupthink

Hammer, Michael

harvesting

Harvey, Jerry B

HCA *see* Hospital Corporation of America

HCA Holdings Inc. (HCA)

HCAHPS *see* Hospital Consumer Assessment of Healthcare Providers and Systems

HCSM *see* Health Care Sharing Ministries

health care acronyms

Healthcare Effectiveness Data and Information Set (HEDIS)

health care gaps

health care industry

- changes in

- strategic management in

Health Care Sharing Ministries (HCSM)

health care system

- issue map

- organizations in

- scanning

health information exchanges (HIEs)

health insurance

- government health care insurance

- reference pricing

- reimbursement provision

- value-based reimbursement

Health Insurance Portability and Accountability Act (HIPAA)

health maintenance organizations (HMOs)

- enrollment of

- private health insurance

health policy

healthy children (product/service category)

HEDIS (Healthcare Effectiveness Data and Information Set) database

helicopter operations

- Henderson, Bruce
- hierarchies
 - organizational
 - strategy
- HIEs *see* health information exchanges
- Hill-Rom, Inc., case study
 - competitive advantage
 - diversification
- HIPAA *see* Health Insurance Portability and Accountability Act
- Hispanic population
- HMOs *see* health maintenance organizations
- HNDN, organizational culture
- HNDY
 - competitive advantage
 - organizational culture
 - pre-service activities
- HNEN, competitive advantage
- HNEY, competitive advantage
- holistic medicine
- home patient monitoring
- horizontal integration
- hospices
- hospital bed industry
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey
- Hospital Corporation of America (HCA)
- hospitals
 - community hospitals
 - physician alliances
 - quality data
 - ranking of
 - rural areas
- HRH *see* Humber River Hospital
- human resources

Humber River Hospital (HRH)

HYDN, competitive advantage

HYDY

- competitive advantage

- organizational culture

- pre-service activities

HYEY, organizational culture

IASB *see* International Accounting Standards Board

Icarus Paradox

ICS *see* incident command structure

ideology *see* organizational culture

IHS *see* Indian Health Services

implementation plans

implementation strategies

- action plans

- alternative strategies

- case analysis

- challenges

- value-adding service delivery strategies

- value-adding support strategies

incident command structure (ICS)

inclusion, organizational culture

income statement

independent living facilities

Indian Health Services (IHS)

individual focus

inevitable surprises

influenza pandemics

information

- about competitors

- case analysis

- overload

- resources

- sources
- websites
- see also* data
- information systems (IS)
- information technology (IT)
- innovation
 - clinical process innovation
 - disruptive innovations
- insurance *see* health insurance; malpractice insurance
- intangible resources
- integration
- integrative medicine
- interlocking directorates
- internal analysis
 - capabilities
 - competencies
 - competitive advantages/disadvantages assessment
 - evaluation
 - external analysis review
- key terms
- lessons
- organizational strengths/weaknesses
- process
- resources
- service area competitor analysis review
- service delivery activities
- strategic thinking maps
- support activities
- value-adding service delivery strategies
- value-adding support strategies
- value chain

internal development

internal ventures

International Accounting Standards Board (IASB)

internet, health care information
inventory, assets
inversion
investments
Iowa, multiple service areas
IS *see* information systems
issue impact
issue maps
IT *see* information technology

Janis, Irving
Johns Hopkins medical center
Johns Hopkins University
joint ventures (JVs)

Kanter, Rosabeth Moss
Kaplan, Robert S
keeper of the vision
Kennedy, John F
key performance indicators (KPIs)
Kotler, Philip
Kouzes, James
KPIs *see* key performance indicators

Lakeland Regional Medical Center
leadership
 competitive advantage
 importance of
 mission statement development
 mythopoetic leaders
 organizational roles
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Lean Six Sigma
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 Federal Medicare Prescription Drug Improvement and Modernization Act
 Federal Tort Claims Act
 Health Insurance Portability and Accountability Act
 Medicare Access and CHP Reauthorization Act
 Public Company Accounting Reform and Investor Protection Act
 Sarbanes–Oxley Act
 tax
leverage, financial
leveraging
liabilities
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licensing agreements
liposuction
liquidation
liquidity
logistics, pre-service
long-range planning
long-term care industry
Lorange, Peter
losses, realized and unrealized
Louisiana State University (LSU) hospitals
loyalty, organizational
LSU *see* Louisiana State University
McDonald, Robert A
MACRA *see* Medicare Access and CHP Reauthorization Act
maintenance of scope strategies
malpractice insurance

- managed care
- managed care organizations (MCOs), service purchasing
- management
 - approaches
 - control
 - evidence-based management
 - glossary of terms
 - preconceptions
 - vision
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 - competitor mapping
 - concept of
 - issue maps
 - Patient Satisfaction Strategy Maps
 - stakeholder maps
 - strategy maps
 - use of maps
 - see also* strategic thinking maps
- market
 - consolidation
 - determinants
 - new entrants threat
 - see also* service area competitor analysis
- market development
- market entry/exit strategies
 - advantages/disadvantages
 - alternatives/choice evaluation
 - alternative strategies
 - external conditions
 - organizational goals
 - strategic momentum
- marketing
- market research
- marketwide strategies

- mass customization
- Matrix, Porter's
- matrix structures
- Matthews Plastic Surgery
- Mayo Clinic
 - brand equity
 - culture
 - value statement
 - vision statement
- MD Anderson Cancer Center
 - mission statement
 - value statement
 - vision statement
- Meade, Margaret
- Medicaid
- medical device industry
- medical failures
- medical information, online
- medical tourism
- Medicare
- Medicare Access and CHP Reauthorization Act (MACRA)
- Medi-Share
- mergers
- metadata
- Miller, Danny
- Mintzberg, Henry
- mission
 - mission creep
 - mission drift
 - mission statements
 - characteristics
 - components
 - questions raised by
 - writing of

mobile health care units
monitoring of external issues
Morton, Michael F. Scott
multinationals, inverted
multiple service areas
multispecialty group practices
Mylan, Inc
mythopoetic leaders

national associations
National Center for Complementary and Integrative Health (NCCIH)
National Committee for Quality Assurance (NCQA)
NCCIH *see* National Center for Complementary and Integrative Health
NCQA *see* National Committee for Quality Assurance
needs/capacity assessment
nested systems
net assets
new entrants threat
newness liability
nominal group technique (NGT)
norms, behavioral
Norton, David
not-for-profit organizations
 alternative strategies
 financial reporting
 program priority setting
not-for-profit title-holding corporations

Obama Care *see* Patient Protection and Affordable Care Act
off-balance sheet financing
online applications (apps)
organizational capacity
organizational culture, value-adding support strategies
organizational focus
organizational goals, market entry/exit strategies

organizational-level strategy
organizational strengths/weaknesses
organizational structure, value-adding support strategies
organizational units, guidance to
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Pack Health
palliative care
pandemics
partial market exit strategies
partnerships
pathfinding
patient portals
Patient Protection and Affordable Care Act
patient satisfaction
Patient Satisfaction Strategy Maps (PSSM)
Patton, George
payments, prospective payment system
PCPs *see* primary care physicians
pediatric care
penetration strategy
personal selling
Pfeffer, Jeffrey
pharmaceutical companies
philanthropic governing boards
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physicians
 hospital alliances
 primary care physicians
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pioneering organizations
pipeline businesses
planning

- contingency planning
- continuity of operations planning
- implementation plans
- long-range planning
- organizations
- strategic planning
- plastic surgery, case study
 - competitor actions/responses
 - competitor analysis
 - critical success factor analysis
 - multispecialty practices
 - service area structural analysis
 - service category
 - strategic group analysis
 - strategic response
 - synthesis of analyses
- platform businesses
- PLC *see* product life cycle analysis
- point-of-service
 - service delivery strategies
 - value chain
- point-of-service plans (POS)
- political changes
- population changes
- Porter, Michael E
 - cost leadership
 - value chain
- portfolio analysis
- POS *see* point-of-service plans
- positioning strategies
- Posner, Barry
- posture *see* strategic posture
- PPS *see* prospective payment system
- preconceptions, management

predictable surprises
preferred provider organizations (PPOs)
Premier Plastic Surgery Center
pre-service
 distribution/logistics
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 promotion
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Press Ganey
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 pre-service pricing decisions
 reference pricing
primary care physicians (PCPs)
primary providers
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probability prioritization
problem children (product/service category)
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product life cycle (PLC) analysis
professional associations
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profitability measures
program evaluation
program priority setting
program Q-sort evaluation
Promise Healthcare, mission statement
promotion, pre-service
prospective payment system (PPS)
prospector strategic posture
PSSM *see* Patient Satisfaction Strategy Maps
Public Company Accounting Reform and Investor Protection Act
public health

alternative strategies
program priority setting
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United States
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Qliance
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Quinn, James Brian
ranking of hospitals
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Red Queen effect
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 see also legislation
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- remote health care
- reports, case analysis
- reputation
- resource-based theory of competitive advantage
- resources
 - action plans
 - competitive advantage
 - financial resources
 - human resources
 - information resources
 - market entry/exit strategies
 - positioning strategies
 - strategic posture
 - strategic resources
 - value-adding support strategies
- retrenchment
- return on investment measures
- risk
 - case analysis
 - information overload
 - medical tourism
 - positioning strategies
- rivalry
- rural areas
 - see also* community hospitals
- St Jude Children's Research Hospital
- Sarbanes–Oxley Act
- SBU*s see* strategic business units
- SBU*s*/SSU*s see* semi-autonomous strategic business/service units
- scanning
- scenario analysis
- scope strategies
 - expansion of

maintenance of
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secondary providers
segmentation, markets
semi-autonomous strategic business/service units (SBUs/SSUs)
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 competitive forces
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 strategic group analysis

- strategic response
- strengths/weaknesses of competitor
- substitute products and services
- supplier bargaining power
- synthesis of analyses
- service categories
 - defining
 - plastic surgery
 - SPACE analysis
- service delivery activities
 - see also* value-adding service delivery strategies
- service failures
- service purchasing
- shared values
- shining stars (product/service category)
- Shriners Hospital for Children
 - mission statement
 - vision statement
- SIS *see* strategic information systems
- situational analysis
- skilled nursing facilities (SNFs)
- slow market exit strategies
- SNFs *see* skilled nursing facilities
- social changes
- social choices
- social media
- SPACE (strategic position and action evaluation) analysis
- spas
- sports medicine
- SSUs *see* strategic service units
- stakeholder analysis
- stakeholder maps
- standing committees
- stars (product/service category)

- statement of activities
- statement of cash flows
- statement of financial position
- status quo strategy
- strategic alliances
- strategic alternatives *see* alternative strategies
- strategic assumptions validation
- strategic awareness
- strategic business units (SBUs)
- strategic choice *see* choice evaluation
- strategic control
- strategic decisions, action plans
- strategic goals
- strategic group analysis
- strategic information systems (SIS)
- strategic issues
- strategic management
 - benefits of
 - dimensions of
 - external nature of
 - foundations of
 - in health care industry
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 - organizational levels
 - versus health policy
 - what it is not
- strategic momentum
 - action plans
 - adaptive strategies
 - alternatives/choice evaluation
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 - competitive advantage
 - competitive strategies

- directional strategies
- market entry/exit strategies
- value-adding service delivery strategies
- value-adding support strategies
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- strategic resources
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 - see also* external analysis
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 - alternative strategies
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 - mission statements
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 - value-adding service delivery strategies
 - value-adding support strategies
 - vision statements
 - see also* strategy mapping
- strategy
 - definition
 - formulation
 - hierarchy
 - level and orientation
- strategy mapping
 - alternatives/choice evaluation
 - Balanced Scorecard
 - see also* strategic thinking maps

Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis
stretch
structure, support strategies
Stryker Corporation
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substitute products and services
suppliers, bargaining power
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sustained competitive advantage
Sutton, Robert
SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis
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systems perspective
Taleb, Nassim Nicholas
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tax legislation
teams
technology
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telemedicine
telemonitoring
Thomas, Danny
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Toffler, Alvin
tourism, medical
trademark licensing
TRICARE
Trinity Health

trustees *see* boards of directors

Uber

unbundling strategy

uninsured people

unit-level strategy

University of Texas MD Anderson Cancer Center

- mission statement
- value statement
- vision statement

unrealized strategy

unrelated diversification

validation of strategic assumptions

value, definition

value-adding service delivery strategies

- after-service
- billing activities
- branding strategy
- clinical operations
- decision logic
- evaluation
- implementation strategies
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- key terms
- lessons
- organizational unit guidance
- point-of-service
- pre-service
- process
- requirements/potential identification
- strategic momentum
- strategic thinking maps
- strategy requirements

value-adding support strategies

- decision logic
- evaluation
- implementation strategies
- internal analysis
- key terms
- lessons
- organizational culture
- organizational structure
- organizational unit guidance
- process
- requirements/potential identification
- strategic momentum
- strategic resources
- strategic thinking maps
- strategy requirements
- value-based purchasing (VBP) plans
- value-based reimbursement
- value chain
 - implementation strategies
 - reconfiguration
- values
- value statements
- VBP *see* value-based purchasing plans
- venture capital investment
- venture teams
- vertical integration
- vision
 - characteristics of
 - combination strategies
 - directional strategies
 - health care environment
 - and internal capacity
 - organizational history
- vision-led approach

vision statements

writing of

Voci Center

WebMD

Weiss, Alan

Welch, Jack

word-of-mouth (WOM) communication

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