# STRATEGIC PLANNING IN A SMALL COMMUNITY HEALTH CARE SETTING

By

NORMAN M. HATLEVIK

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to the required standard

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Dr. Vance Mitchell

_____

Dr. C.J.G. MacKenzie

_____

Mr. L. F. Detwiller

THE UNIVERSITY OF BRITISH COLUMBIA

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Department of Health Care & Epidemiology

The University of British Columbia
1956 Main Mall
Vancouver, Canada
V6T 1Y3

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ABSTRACT

This study provides an overview of the strategic planning process and presents the hypothesis that strategic planning is not only applicable to a small, community health setting but essential. The paper discusses the present situation which hospitals, especially small community hospitals, find themselves in and attempts to determine if the strategic planning process can offer advocacy prescriptions and a format for survival.

It is aimed a encouraging a practical interest in the theoretical strategic planning process. While this is not a "model-building" exercise, the issues discussed are of concern to both the theory builder and the practitioner. An attempt is made to go beyond the existing literature on strategic planning to a discussion of the intrinsic, indirect or "invisible" factors peculiar to the process and to hospitals, factors which are critical and require the attention of boards and administrators.

While the study attempts to simplify the strategic planning process, the additional discussion and emphasis on these "indirect" factors may appear to make the attempted transition from theory to practice more foreboding a process than it is.

This study is developed by way of a literature review and case study analysis. The Case Study describes how one small community hospital became concerned about their capabilities

of dealing with the political and economic forces that would affect the future of their facility and how they developed a strategic planning approach designed to ensure the survival of their community organization. The dominant role for both the Board and Administration became one of strategic planners.

Part One provides an overview of the health care system and the current issues that are confronting the system. Part Two briefly describes the hospital industry and discusses the complexity of hospitals. Part Three describes the characteristics of small community hospitals. Part Four discusses the "state of the art" of planning in the hospital industry. Part Five provides a definition of strategic planning and describes special considerations. The reader is taken through the strategic planning process in a step-by-step manner. It is in this section during discussion of the roles of the main players that the many "invisible" factors are illuminated. Part Seven presents the Case Study and attempts to apply theory to practice. Part Eight provides concluding comments on the application of the strategic planning process in a small, community hospital.

The main hypothesis of this study is that theoretical strategic planning is indeed applicable and implementable in a small, community health care setting. It was proposed and found that theoretical strategic planning can and does allow an organization to predict and influence its future.

Signed _____

Dr. Vance Mitchell, Professor

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# Health Care in Canada

As the health care system in Canada has improved the services offered are viewed as a right, not a privilege. This expectation has resulted in increased demands on the system that often exceed the ability to deliver. The economic situation of our country continues to deteriorate and a reversal does not seem imminent. The economic realities are not leaving the health care system unscathed. Health care budgets, specifically those of institutions, are being cut throughout the country. One thing that can be said for sure is that tomorrow and next year, things will never be the same again in the health care system.

Governments are in great financial difficulties. The magnitude of government deficits is becoming unmanageable. The capacity of governments to levy more taxes has reached a limit and governments are faced with extremely difficult priority decisions. While Federal and Provincial governments have come under public pressure for the current situation, so too has it become commonplace to criticize hospital governments - the boards of directors and hospital managements - the senior administrative group. Health care costs are sending clear messages indicating the need for lower cost health care alternatives and higher productivity.

Combined with the demand/supply is the fact a new era of health care is upon us. The potential implications of the rising over 65 population, which is projected to be at 20% by the year 2030, may indicate an emergence of chronic disease as the dominant pattern of morbidity. Our convential infectious disease technologies may be ill-suited to cope with this shift. This will create a greater need for long term care facilities and approaches, and more emphasis on geriatrics. This problem will be exacerbated by the shrinking of the nuclear family and the increase in lobbying potential of this group. Also in this new era is a shift in emphasis from curative care to preventative care and from inpatient care to outpatient care which has created a growing demand for home health services and to help people stay out of hospital whenever possible and as long as possible.

The traditional reliance on high cost technology may continue unabated even though the results of scientific advances may be diminishing. That is, many health authorities believe that more doctors and more hospitals will have no more effect on good health overall than the way people live, their lifestyle. The next major advance in health may result only from what each individual person is willing to do to avoid deleterious practices such as smoking, excessive drinking, etc. This belief is described as the Health Field Concept in Marc Lalonde's (1974) "A New Perspective on the Health of Canadians", and is supported by Dr. Thomas McKeown's (1975) massive historical study of the levels of health in England and Wales. This individual health consciousness may be

be brought into play by economic default sooner than by political planning and social change.

With the economic pressures and changing needs, health care organizations, and hospitals in particular, have been coming under increasing scrutiny to ensure that they are aimed in sound directions. Provincial governments, in legislating the health field, have undertaken the major and important responsibility of adequately funding the health care system and increasingly, these funding sources are demanding stricter accountability from health care organizations.

A problem arises when a provincial Ministry articulates its goals as increasing the efficiency and effectiveness of the health system but does not have the management capabilities nor data bases to provide the means whereby these goals can be realized. The emphasis then becomes focused on ensuring that costs are contained (which is not necessarily the same as either effectiveness or efficiency). The funding agencies paying for health care costs are assuming a more active role in attempting to contain health care costs. These agencies, which are extensively involved in paying, have watched demand soar and are now paying as much attention to costs as ensuring communities have an optimal mix of health care service available. They are beginning to raise penetrating questions such as: what results have been achieved; and even is there a real need for the services provided by the organization? In addition, business, industry, and labour are becoming increasingly concerned about the costs of health-related

employee fringe benefits.

These pressures have created a rate of change in the health care industry which is greater and accelerating at a more rapid pace than at any time in recent history. They have combined to create a period of discontinuity in the health care system and indicate there are major problems ahead in dealing with the environmental forces, forces that may affect the very nature of the health care system. The need to plan to stabilize these environmental forces is obvious.

In past years, many "opportunities" to deal with these pressures and forces have been missed. By missed opportunities I refer to the fact that all institutions and hospitals in particular do not change focus or direction when things are going well. Planning does not readily occur in times of tranquility. Change generally emerges from problems and crises. With the crisis comes the opportunity to plan or to once again be missed out by assuming that we have muddled through so many similar problems for so long that we cannot recognize that the crisis is real. This type of coping is no longer adequate nor appropriate.

## The Hospital Industry

"Every organization much achieve some primary goal, otherwise society will not, in the long run, support the organization. All organizations are chartered by society to perform an economic mission: to produce some good or service which is wanted by people "outside", and to produce at a level of efficiency and effectiveness that is acceptable externally. Internal efficiency, as important as it may seem, is simply a means to a larger end - social productivity. This is particularly true of a hospital which must render quality patient care at a level of efficiency satisfactory to patients and governing boards." (1)

Hospitals, as organizations, can be characterized as extremely unique in having a very political environment. It has often been said that hospitals are labour or people intensive but that they are also very ego-intensive. With the types of individuals found in the organization: administration, professional staff and boards of directors, all of whom are convinced that they all have the proper answers, the tendency for jurisdictional disputes are almost everywhere. Besides the inherent aspects of the life-and-death struggles that go on in hospitals, it is also a place where staff's emotions are subject to stress at all times.

A hospital's milieu is unique and so are the variety of problems faced by employees. The following issues either occur more frequently or uniquely in the health care industry compared to other industry:

1. Psycho-medical reactions: hypertension, "burn-out", depression, psychosomatic illness and abuse of chemicals, specifically sedatives, barbiturates, opiates, and stimulants.
2. Rotating shift work.
3. Organizational change due to funding, technology, and programs.
4. Social conflict as a product of stress among patients and staff.
5. Women's issues: working mothers, sexual harassment, struggles in career management and professional development.
6. Potential for violence as part of job: emergency department, psychiatric and chemical related illness.
7. Death and illness as normal factors. (2)

A hospital is a difficult place to work, an almost impossible place to get consensus, and a tough place to manage and maintain direction. (3)

Hospitals, by virtue of their mission; their uniqueness as organizations; the largest, most expensive and most visible segment of the health system, are open to considerable scrutiny, and are most susceptible to change. This is understandable also as hospitals consume the largest part of the health care budget and they are the single greatest item in virtually all provincial

budgets, In B.C., from 1971 to 1981, the annual expenditure in health has grown from $337 million to $2 billion, an increase of 600%. Hospitals and physician services account for 85 percent of this budget.

For decades they have been the centrepiece of the health care system, and now their position is threatened as "traditional" ways of dealing with problems, both fiscal and service, are not likely to work and are often inappropriate. Hospital administrators and trustees are being charged daily, relentlessly, and with malice to do more with less, to do better for little economic or social return, to a point where they regularly apologize for actions taken in the best interests of the communities they serve.

The concerns and efforts by boards and administration to reduce high cost inpatient services and to deal with dwindling utilization rates have resulted in confusion about these traditional hospital roles. This confusion may simply be the final blow sealing a fate that was predestined by improper strategic positioning or repositioning in the 1950's, 60's, or 70's, a period when there was still growth and time to manoeuver.

In the 1950's the strategic problem for many hospitals was simply to reaffirm that they were in the acute care hospital business and from time to time assess their weaknesses. Changes in the environment were quite predictable, and those that did occur impacted on activities which management and board had always been concerned with such as: raising money for capital expenditures, developing new programs, and attempting expansion. The

management tools that were used for dealing with these environmental changes were not particularly different from those they had always had. However, in the 1960's and 1970's the changes that began to take place were often totally unexpected, and the time to react to them was short. No one can predict with certainty what is going to happen in the 1980's and 1990's, but it is a reasonable hypothesis that changes in the environment are going to occur, particularly political and economic changes.

In the 1980's we will continue to see the trend that started in 1970 with hospital costs steadily increasing and occupancy rates across Canada steadily declining. This condition of low utilization or "death beds" is crippling some hosital more than others and for small community hospitals too many empty beds for too long can signal their doom. This declining census does not always reflect failing health care for the problem may lie in tired and out-dated hospital policies and poor communication with employees, with doctors, with its community, and with the Ministries of Health.

Professional literature and the mass media are constant with their criticisms of health care's lack of a system to respond to changing societal needs. Most medical health facilities seem to react to changes rather than to anticipate trends or the future. Too many decisions are apparently made without thorough analysis of the long-term impact of those decisions, causing a prevailing posture of playing "catch-up" all the time. There are charges and counter-charges about the excess of hospital beds, about duplication of expensive equipment, about unnecessary tests and surg-

ical procedures, about excessive lengths of stay, and about how all of these contribute to questionable patient care and the unquestionable spiraling of costs. In turn, health care administrators, boards of trustees, and health associations describe their role as one of putting out one fire after another, not quite sure what to expect from any of them. Often, we end up with a plethora of new programs, many of which are introduced simply to keep up with other health providers in the industry.

Hospitals often respond by resigning themselves to fate, and predict large numbers of unemployed, unserved health needs and economic ruin. It becomes an easy out to blame the government, blame the union movement, blame the schools for turning out poor professionals - blame everything except where the blame properly should rest: in themselves for lacking the skills of strategic planning. Hospitals can adopt a "seige" mentality and a strategy of consolidation, retrenchment, and preservation of "basics" as the first priority. One could say that hospitals are programmed for stalemate. Their attempt to keep the demand for service at high level may not be appropriate when all logic tells us that effective health care ought to reduce demand.

Survival and growth, even for those who are strong and mature, cannot be taken for granted. Even the most dynamic organizations in terms of delivering today's services can quickly find themselves out of business if they neglect the skills of assessing and responding to the changing needs of their service areas.

If hospitals are to escape becoming the next victim of

"marketing myopia" they must develop management responses that will be new and different from those used in the past. Indeed, by the mid 1980's it may become apparent that a major task of boards and management for the remainder of the 1980's is going to be to defend the legitimacy of the hospital as the principal supplier for health care services to society. It may well be that boards and management have to develop strategies for survival of their own hospitals dealing with the economic, social and political environments that are quite different from any used before. Choosing the appropriate strategies to deal with government and other parts of the environment is truly one of the greatest challenges for management in the next decade. This approach calls for a different response, one which is proactive and less emotional and asks how to combat these changing conditions. Hospitals must strategically position themselves to adapt to changing needs in their community or patient market and become catalysts responsible for alternative delivery systems rather than just a place people go to die. Hospitals must be more aggressive in trying to capture the opinions of the various publics with which they deal. They can be the vector or the victim of slow productivity, competition, and regulation. It all depends upon their knowledge of the needs of their patient market and their willingness, desire and capability to respond to these needs.

In summary, hospitals are complex and dynamic systems; always subject to a mixture of political, economic, social and technological forces. Such systems do not run by themselves,

they must be understood, designed, improved, administered, and controlled. It requires planning, either formal, or informal, but always conscious and deliberate. The crisis facing them is basically a combination of: a prolonged, perhaps permanent, period in which resources are decreasing; funding agency allocation decisions with respect to these resources are not shifting toward hospital based activities; changes in medical practice; expansion of allied health professionals; changes in technology; changes in population composition; and inflation.

The way out of the crisis and around the first repsonse of the defensive position is to take the offensive and lead the way in developing strategies to increase efficiency, effectiveness and productivity, not simply of hospitals, but of the entire health care system.

Will and can hospitals respond to the changing health care needs of an aging population, increasingly characterized by chronic disease and disability and the absence of traditional family supports, and to the need for appropriate preventative services and long term care in a combination of medical and social services, all in the face of dwindling resources? Or will the group requiring care be continually forced into the increasingly inappropriate and unnecessarily expensive acute care system?

Hospitals must seriously consider their role and this can only be done through strategic planning. While large, more mature hospitals may be able to cope and adapt, the impact will be greatest on the small community hospital.

## SMALL COMMUNITY HOSPITALS

A small, public, community hospital, for the purposes of this study, is defined as having 50 beds or less; approximately 5000 bed days per year; and is situated within 50 miles of a larger treatment facility.

These small facilities provide an integral link and are an essential and valuable component in the Canadian health care system. They represent 421 facilities or 56% of Canada's total; and 10,120 beds or 9% of the total of 115,388 beds available. In B.C., small public community hospitals represent 51 institutions or 49% and 1195 beds or 8%.

Such hospitals are often characterized by the following aspects: (in no order of frequency or priority)

- a long, proud history which is supported by considerable community emotion
- board attendance is usually between 50 - 60%
- no review of their role in totality but rather have watched and reacted to declining population
- downward trend in
    - acute patient days
    - % occupancy
    - inpatient E.C.G., Lab, X-Ray, Surgery
- often upward trend in
    - length of stay due to long term care patients
    - out-patient services
    - number of part-time staff

- the board has direct and/or perceived involvement in day-to-day operation rather than adhering to a policy-making role. They often handle praise and criticism rather than redirecting to the administration.
- poor administrative structure. Department heads are not given authority and responsibility for departments. There is little or poor delegation. Department heads obtain no budget information and have no control over their cost centres.
- many family-related staff and often board members have relatives working also
- performance evaluations are not in place or are not up to date, particularly for the C.E.O.
- no specific goals or objectives stated
- policy manuals are inadequate and there is a lack of written policies, procedures and job descriptions
- older staff at top of pay scale and benefits
- many items of reporting and recording done by rote rather than from understanding
- medical staff may have mixed feelings towards the hospital but agree it operates the way they desire
- strangely enough, there may be a pattern of surplus, possibly due to past funding mechanism rather than utilization and management. This may indicate certain areas are being neglected.
- highly active auxiliary
- concentration of local patients
- referral patterns and especially relationships with nearest major health facility are not totally co-operative

- at middle or lower end of regional or provincial statistical comparisons.

The communities these hospitals are located in are generally characterized by the following traits:

- slow or negative growth with population projections that are low or negative also
- slow or static birth rate and increased death rate
- decline in school age children
- decline in labour force
- increase in 65+ population
- decline in number of households and size of households
- decline in family size
- facility usually plays a significant employment role
- regional hospital district does not play an active role in health care planning. They often see the provincial government as the sole planning and funding body. This results in a perceived centralized control at the provincial level.

The small hospitals are potentially at greater survival risk than other community or urban hospitals because of their size and management depth and because often provincial governments do not take their special conditions into account. The problems facing small hospital administrators when sorting out the future of their institutions are quite extensive. The small hospital must typically meet the needs of an area that is underserved, or conversely, may be experiencing over utilization because of

aging population as it may service an ever-greater proportion of older persons; have a staff of older physicians and a limited number of skilled personnel; it must come to grips with external regulatory pressures (government, unions) that are removing management prerogatives. Small hospitals provide the community with the first and often the only contact with the health system. While they have special problems of geography and size restrictions, they are as responsible as any for providing acute care, inpatient and ambulatory care and should not be exposed to substantially more risk than the hospital in an urban environment. Health care and the services provided by the small community hospitals are no exception as they struggle against the limitations experienced by institutions of every size. The following are special problems that impact upon the small hospital:

- increasing quantities of legislation and regulation by government and the professional associations that increase the demands for higher standards in facilities and personnel employed
- along with labour demands for higher standards have come the high cost of salaries and benefits and inpatient care
- the age of specialization will make it economically difficult and unfeasible for the small hospitals to retain a full range of specialists. At the same time, difficulties in recruiting specialists will be compounded by the inability of these facilities to provide ample access to higher education. Specialists will regard the small, rural area as a dead-end in their

career path

- because of the spillover from the United States court cases, Canadian doctors will want to protect themselves with tests and procedures which put an often unnecessary burden on the finances of the small hospital
- physicians trained with modern medical procedures and sophisticated equipment will want the technical support, personnel and facilities of the large, urban hospital rather than the small facility
- small hospitals desperately need back-up and sophisticated management services, but when seeking affiliations or relationships with regional hospitals discussions too often centre around a complete take-over or the development of a clinical service. Shared management services or support can be a major factor in survival while at the same time such services can build the regionalized system that is necessary for cost-effective areawide health service delivery.
- the small hospital must have a commitment to overcoming both traditionalism and provincialism by exposing their staffs and their community leadership to new ideas, new concepts, and new methods for dealing with the problems that occur with the imposition of limits
- there must be a painful but realistic self-appraisal. Does the hospital truly need to exist as a separate entity or should it be part of a larger system or merge with neigh-

bouring facilities? Multi-hospital systems are proving, in many cases, that there are cost benefits and patient service benefits in pooling resources for the provision of health services

- the small hospital could well represent the facility with the greatest investment of money in equipment and facilities and the largest employer. It then has the responsibility to take a leadership role in not only serving the community in the pursuit of health status but also leadership in the socioeconomic sense of quality of life, diversity of service and the optimal use of resources.

One of the most critical needs of small hospitals is to hire or have access to competent financial managers who are familiar with the special problems of these hospitals. The fiscal manager probably should be considered the main support person to the planning team. Unless a small hospital has strong fiscal management and strong fiscal planning, it probably will not do well in strategic planning. Consideration should be given to using fiscal consultants and data services or seek to share the skills of a financial manager or to purchase them through multi-organizational arrangements to help upgrade fiscal management methods if they are lacking in the organization.

The accountant is the newest specialist on the community hospital staff. As a diagnostician they are assessed on the

basis of their reporting, rather than on their recording. They must therefore be more concerned with interpreting than with the mere accumulation of historical data. A hospital is more than an institution in which medical care is given; it is also a significant business organization affecting the entire community. As a non-profit business, it offers no cocoon to the accountant with a 'pencil-pushing' mentality. As the catalyst on the administration team the accountant must be imbued with a sense of their management responsibility.

A thorough understanding of hospital finance and trends and the creative ability to use fiscal opportunities to the benefit of organizational interests are necessary elements of successful strategic planning. No longer can the hospital trustees expect the chief executive officers, office managers, or local accountants to rely on their own skills in handling highly technical and sophisticated financial operations. Many small hospitals will face the need to spend increasing amounts of money on their physical plants and on capital equipment. Allocating these expenditures will become increasingly complex, so small hospitals will have to become increasingly sophisticated in financial management.

It must be cautioned that a hospital can have the best financial systems in place and still be headed for disaster. It is important to remember that proper operations must feed proper financial systems but the reverse is not necessarily true. Becoming obsessed with perfecting the financial reporting

system early on rather than stressing the needs for accurate operating data, can be a mistake.

Besides having special problems, there are other obstacles that stand in the way of strategic planning in small community hospitals:

- they generally do not have the expertise to tackle the planning process by themselves, or they are unable to afford expensive outside help
- the homogeneity of board members is likely to discourage effective planning. A study of board composition has indicated that the more homogeneous the board is, the less innovative it will be. (4)
- partly because of the conservative nature of small communities and partly because of the age of most board members, community hospitals tend to resist change or at least not plan for it
- the members of the medical staff can be a major impediment to strategic planning. Physicians may be leery of competition, tempted to place their own interests above the hospital's, and are inexperienced in long-range planning. Yet when it comes to the tough decisions, board members often defer to physicians because of their medical knowledge.

It is obvious that the small community hospital, which includes more than half of the hospitals in Canada, may not survive its present role, location, or service configuration, despite its importance to its community, unless planning is immediately adopted as a major management function.

It is ironic that the small hospital, which has fewer resources than its larger urban counterpart, should be faced with the imperative of implementing a planning process when in fact very few hospitals of any size have completely mastered the skill of strategic planning.

# HOSPITAL PLANNING

The philosophical base of planning lies in the conception that any organization, be it family, business, military, government, or a hospital, can more effectively obtain its objectives if it engages in systematic planning. "Planning philosophy presupposes that man must influence his future to some degree by present actions to survive. This planning effort is considered ethically desirable and presumes the existance of goals sufficiently definite for planning." (5)

As well accepted as the notion of planning is the term itself which has many meanings, depending on such factors as who is involved, how planning is carried out, and what it is to accomplish. The term "planning" covers a wide variety of activities ranging from the simple to the complex, from the solution of current problems facing management to determination of action that an organization must consider in coping with an uncertain future.

The following are some of the definitions found in the literature that have been applied to the activity of planning:

- providing some type of structured direction and guidance to a health care provider regarding its <u>future</u> directions and viability based on an analysis of its current and anticipated situation
- deciding <u>in advance</u> what is to be done. Basically an intellectual

process which involves decision-making and requiring mental predisposition to think before acting. To act in the light of facts rather than on guesses and generally seeking to do things in an orderly fashion

- sensing that something needs to be done and deciding firmly who does what, when; an activity much broader than compiling and analyzing information or dreaming up ideas about what might be done. It is more than logic or imagination or judgement. It is a combination of all these that culminates into a decision, a decision about what must be done.

The common theme in these definitions is that planning has always been an activity in which there is a need for decisions which determine courses of future action. These can be immediate or far-reaching in their consequences. Also, regardless of the emphasis, planning is generally recognized as the decision-making process that enables an organization to activate and produce results at some future date.

The planning process should ideally embody the following aspects:

- be purposeful, and always start with a statement of goals and objectives
- a continuous process consisting of a series of interrelated steps or phases, not a single act
- an integral part of the process of managing
- be hierarchal in nature and consist of a system of plans, rather than an individual plan
- have an organizational identification. In other words, plans are caused by and made for certain parts of an organization.

- allow for the socio-political environment of the organization
- should be deliberate, rational, and objective. An important point of reference for planning is the current or organizational profile and capability
- deal with the future, and as such, requires an input of forecasts or trends
- state standards which become the basis of the monitoring system
- elements of flexibility must be built into the design of a plan since internal requirements and external influences can change over time
- pervasive and take place at all levels and in each part of the organization
- a top management function as the ultimate responsibility for planning rests at this level
- be creative problem solving although this is difficult because there are not necessarily standard solutions and answers
- a blend of art and science
- provide the basis for informed and improved decision-making
- involve the tasks of educating and compromising to reach agreement and understanding
- require an integration of the programmatic, organizational, physical, financial, and environmental dynamics of an institution.

Planning is no more than a conscious, rational process of deciding upon a desired future state and committing resources to achieve it to avoid always reacting to immediate problems. Normally, by the time the problem is immediate, the solution is

already long overdue. Planning allows the identification of the problem before it becomes a crisis and allows the development of an effective course of action to provide an on-going solution instead of stopping for temporary fixes, or from "muddling-through". When speaking about planning we can make several differentiations. One distinction is between informal planning, which everyone does, and formal planning. Even the most unsophisticated manager gathers and organizes data, makes assumptions about the specific situation, establishes goals and objectives, and sets priorities for activities. This is usually extemporaneous and carried out with little attempt to be systematic or orderly. Most people and most organizations neither analyze the contents nor the effectiveness of this type of planning process. Informal planning differs from formal planning in that in the former, the manager makes the decisions alone, the act (rather than the process) lacks a multidisciplinary perspective, and has no rigorous methodology. Formal planning is the reciprocal of this activity.

Another distinction is between incremental planning (troubleshooting) and developmental. Incremental is when a problem is identified, evaluated, responses are co-ordinated and endeavours made to control the situation. Developmental begins by researching choices and changes and evaluating feedback. (6)

Another distinction has been made at the macro and micro levels. At the macro level, the major objective of health care planning is to produce a comprehensive and co-ordinated network of all health providers resulting in the

organization and delivery of optimum health. This is necessary as a single hospital or provider cannot be expected to provide the entire spectrum. At the micro level, the objective is to better manage the internal workings of health care facilities.

Planning is not an adjunct to normal hospital operations, nor can it be done in isolation from the life of the facility. It is not the dust-covered Master Plan developed years ago by a consultant or management and never implemented. It is an integral function of hospital management and a necessary tool for survival that should significantly contribute to the following results:

- more productive commitment of organization resources to areas that maximize strengths and opportunities and that meet needs.
- availability of future options.
- increased organizational integration and support through better conflict resolution, decision-staging and sense of mission.
- improved positioning of the organization for future gains in relation to external demands, such as those posed by regulatory agencies and competitors
- ongoing organizational evaluation and growth.

The evolution of hospital planning appears to have three generations. The first generation of hospital planning is considered as facility planning. This was heavily orientated to design and construction of physical facilities. The focus on facilities occurred in periods of hospital growth, characterized by capacity shortages, unionization, and technological expansion. Government funding initiatives such as the

National Health Grant Program and Hospital Construction Grants were introduced. Architects and engineers were key participants. The second generation of hospital planning would be institutional planning. This was and is characterized by a broader focus on planning the programs and departments of the hospital. Annual or long-term objectives for the major existing programs are set. To varying degrees, hospitals tie budgeting to these objectives and explore new types of related health care services that the hospital could provide. This institutional planning is often oriented to responding to external initiatives as resource constraints began to be felt. It was during this generation that many hospitals hired directors of planning to deal with the external forces and to develop hospital master plans.

The hospital industry, with few exceptions, is currently tottering between the second and third generations of hospital planning. This is in between institutional and strategic planning.

Successful evolution into third-generation planning will be judged by a hospital's ability to do more with less and to find opportunities within the constraints. According to some observers the effectiveness of planning efforts in the health care field in all generations has in the past and perhaps in the future been constrained by the lack of a conscious, definitive methodology to guide efforts. Planning was often accomplished on a sporadic or periodic basis following an informal consensus that facilities must be expanded, new equipment needed, or new services should be provided. This planning was only concerned with the details of co-ordinating the const-

ruction project. The lack of planning emphasis has also been constrained by the fact there is little pressure or incentive to plan, the complexity involved due to many "immeasurables", comprehensiveness and diversity, and with an insatiable demand for services there were rarely any questions as to an institution's viability.

Some hospitals use few if any quantitative tools with which to steer their activies. With the exception of statutory or government requirements, many of the small organizations do not even prepare annual statements or other reports. Moreover, they seldom use quantitative methods to measure their achievements or to track their progress toward specific goals. This may be due to the fact that the health care field is marked by people who are, by nature, doers and who are under day-to-day pressures to get things done. A more detailed discussion will be given in the next section as to why hospitals have not made the full transition into the third generation of strategic planning.

Hospitals are obligated, morally and legally, to strategically plan. They don't really have a choice. They can plan for and anticipate the problems or they can sit back and react, waiting for others to control their destiny. The option of not planning is not open to most hospitals and all should realize that. Planning is essential if governing boards are to exercise control over the destiny and development of their organizations, particularly in these times of unprecedented change.

Fortunately, we are learning that the potential of planning is much greater and that planning is a process - that

describes a human interaction which produces a commitment to a course of action that requires many people to change at the same time. Hospitals, with their traditional lack of strategic planning, actually rely considerably on a collective approach to change, partly because of the complex nature of the hospital, partly because of the social emphasis which characterizes much of their endeavours, and partly because of the professional background of the leading participants. In a hospital or medical care setting, planning is a process of questions raised and answers sought, of ideas exchanged and debated, of support received and withheld, conflict and resolution of issues, persuasion and compromise of solutions accepted, all involving people of varied interests and backgrounds and all who share a commitment to the hospital's goals.

In summary, the structure, accountability and governance of hospitals have come under close scrutiny, with the dual goal of improving delivery and cutting the cost of services. Increasing competition for limited resources by a growing variety of providers, and confusing, changing government structures have sparked an interest in strategic planning as a key tool for hospitals to survive and to thrive. Even with these incentives observers are particularly critical of the lack of policy and planning in hospitals. Generally, hospitals don't do planning usually because they don't know how to do it or it is not an all-out effort. For instance, a U.S. nation-wide survey of 614 acute general hospitals revealed that although 96% claimed to have engaged in

comprehensive planning, about one-third of these efforts were one-time exercises and not part of an on-going, iterative process. (7) While this was in the U.S. setting, the results could be generalized to the Canadian health industry.

Not only have hospitals failed to reach the strategic management stage of development of the third generation, but many of them have failed to reach even the strategic planning stages that for-profit enterprises initiated 15 to 20 years ago.

The arena in which the hospital must now compete and survive can be equally demanding as the environment in which its profit-seeking counterpart operates. The task of survival is perhaps even more difficult since management of an organization dependent upon government funding is often without the benefit of even the most basic equipment in its arsenal of strategic and tactical weaponry. More and more, however, the tools applied by the profit-oriented manager in climbing his way over the "return on investment" hurdle and winding his way through markets jammed with utterly differentiated products are becoming available and being applied by the non-profit organization manager. Since the management technology has evolved in response to the necessity of decision-making in the face of uncertainty, competition and scarce resources, conditions prevalent in both spheres of operation, the hospital should find that this technology is easily tranferable and readily applicable. Some areas of management technology have been more readily assimilated by managers in non-profit organizations

than others. For the most part, that which has been adopted appears to concern itself with the management of the internal organization. This internal focus on management results in another area of equal importance being neglected. Faced with the rapidly changing environment which characterizes the period of time in which both the profit and non-profit sectors find themselves operating, the external environment is requiring more and more attention. Many factors in the uncontrollable environment of the non-profit organization are changing, all calling for corresponding changes in the ways with which the organization deals with changes.

The ideas of business planning are as relevant to health care organizations as they are to corporations. The concepts of strategy, expansion, diversification, mergers, acquisitions - the whole range of terms, techniques, and tools - can and should be brought to bear in a conscious manner in the management of health care facilities. One could speculate that an important factor in rising health costs during the last decade has been a lack of implementation of strategic planning ideas and tools.

## STRATEGIC PLANNING

For the better part of a decade, strategy and strategic planning have been solely the business buzz-words of competitive industries as they lay out strategies for the future. Strategic planning has been adopted by corporate management for two major reasons. First, the concept is straightforward and easily understood. Second, it allows managers to assume more control over the futures of their organizations. (8) Now hospitals must also adopt this type of thinking for there is an obvious need to accommodate the economic, political and social forces that are stimulating questions and resource allocation concerns in the health care industry. Without it they will behave like any large, unwieldy bureaucracy when they could be nimbly meeting community needs.

Boards of directors, when they discuss corporate strategy, must have some common idea of what is meant by the term. As suggested before, it can be considered the evolving pattern of decisions that both determines and makes clear what a hospital's purposes, goals, and principle policies are.

Approaches to hospital strategic planning are as varied as the number of institutional planners, consultants and academics engaged in the process. Even with the differences in approaches certain elements are common to every approach, such as definition and evaluation of the organization's "line of business", assessment of the environment, examination of the institution's mission and role, and identification and analysis of strategic options.

Strategic planning is an essential component of effective hospital management. It involves all levels of management, medical staff leadership, the board and various external publics in assessing the community need. It assists us in determining the current and future health service and related needs of the community, in relation both to the organization's strengths and weaknesses and to the programs of other local health service organizations. Strategy integrates an organization's major goals, policies, and actions into a cohesive whole. At the same time, it helps allocate the organization's scarce resources based on its competencies and shortcomings, anticipated changes in the environment, and contingent moves by its regulators and competitors.

Strategic management links the rigor of formal planning to vigorous operational execution. The heart of the strategic process is the generation of alternatives - combining in new ways opportunities, community needs and hospital capabilities. In order for strategic planning to take place, there must be a planning process that stimulates entrepreneurial type thinking and an organizational value system that reinforces board and management's commitment to the hospital strategy. The value system that the hospital must adopt should consider four common themes:

1. The value of teamwork which leads to task-oriented organizational flexibility.

2. Entrepreneurial type drive or the commitment to making things happen.

3. Open communication rather than the preservation of confidenciality. By open communication, it is not necessary for senior management to divulge everything, but as a minimum all staff in the hospital should know the strategy purposes that their actions serve.

4. A shared belief that the enterprise can largely create its own future rather than be buffeted into a predetermined corner by the winds of environmental change.

A strategy that meets these specifications is always the proper subject of discussion by the management and board, for strategy in a changing world of hospitals should always be evolving with experimental offshoots and informative forays. Plenty of room exists in the course of these determinations for incremental processes and intuitive judgement.

What board members must realize is that significant strategic shifts in large organizations take years, if not decades, to accomplish. Consequently, it is rare for a single person to mastermind a complete change in a major organization's total strategy - although this can occur in a time of crisis or when an individual's tenure is exceptionally long. What one sees in the short run as an important strategic shift very often turns out under investigation to be part of a much longer continuity that has been building for some years and will later gently mutate and evolve into quite a different form than it now poss-

esses. Those who wish to shape strategy in large organizations must learn to live with and manage this continuously evolving, sometimes ambiguous, consensus-creating systematic use of planning as a management tool to best position the corporation to set and meet its goals in both the short and long term. One of its most important traits is a deep-rooted reorientation in thinking throughout the organization toward strategic management as a socially oriented business. The understanding and commitment of the C.E.O., board of directors, and, in a hospital setting, of the top physicians, are critical ingredients in strategic planning.

Contrary to the opinion voiced by writers, and others, strategic planning does not involve itself in any way with the setting of objectives, even long-range ones. Strategic planning and long-range planning are not the same thing. The major differences between these two types of planning are both dramatic and far-reaching, especially in health care organizations. Long-range objectives cannot and should not be set until strategic planning has been completed. The example often cited is that you first decide on your vacation destination before commencing your planning on how to travel or what to take. Strategic planning concerns itself with establishing the major directions of the organization, eg. what is its purpose/mission, major clients to serve, major programs to pursue, major geographical area, and major delivery approaches. It is broad and concerns itself with both ends and means. Until these directions have been

carefully thought through and decided upon, it is foolhardy for an organization to determine what it is going to do.

Basically, strategic planning is distinguished from traditional planning by three characteristics:

1. Strategic planning examines the organization in the context of its environment. As hospitals face increasing competition from each other and from new types of providers, this approach is essential in identifying options for the future.
2. Strategic planning recognizes that business organizations are made up of a number of sub-units, or lines of business, each of which may play a different role in contributing to the achievement of overall corporate goals. This concept is particularly appropriate to hospitals, whose roles are becoming increasingly diversified.
3. Strategic planning emphasizes that resources are limited. An achievable strategic plan must assign priorities to each line of business.

In organizations one major goal is aimed at bringing about organizational or behavioural change in one form or another. Obviously this type of change does not occur overnight. The longer the period of time it takes to accomplish, the greater becomes the importance of strategic planning to help ensure that the organization is aimed in the proper direction or directions. This is the primary role of strategic planning.

The following is a brief and common list of characteristics of strategy. It must be understood that not all these charact-

eristics will be found in every strategic decision but many of them will be. These characteristics include:

1. Tends to change the nature of the organization (its purpose or direction)
2. Involves unusual risk in the event of failure
3. Involves unusual benefits in the event of success
4. Involves unusual commitment (time, money, effort for prolonged period of time)
5. Involves high-level approach
6. Usually involves a series of decisions
7. Frequently handled by a senior committee or task force
8. Once set in motion they cannot be easily reversed.

Strategic planning is more of an art than a science. Not everyone can do it and the educational process can be frustrating. The process of strategic planning is what is interesting. While the term is not used, one could not help but imagine a "zero based planning" model, where before looking inward to determine "where to from here?" and priorities, we must look to our external environment to determine what is needed. Strategy is a living concept, with certain fundamental character-determining purposes remaining essentially unchanged.

In addition, it is important to consider that strategic planning, like all planning, must cease to be a management exercise which one commissions every three to five years. There is a need for day-to-day awareness of the limiting effect of today's decisions on an organization's long-term options.

The question has often arisen as to whether one can create a planning process and be planning without producing a plan.(8) And also, how explicit this plan should be stated. Too often, in all generations of planning, we have fallen into the trap of considering planning to be a sophisticated quantitative method, a written document, or a set of regulatory requirements. This apparent dichotomy between planning processes and written plans show that strategic planning is on a spectrum. At the one end you have hospitals that are process-oriented where planning processes are inherent throughout board and administrative structures and activities. The process planner keeps himself informed about a wide range of operating decisions being made at different levels in the hospital. The process involves a series of activities which create collectively a strategic guidance system to move the facility towards its future. The creation of a "plan" is not stressed. Carried to an extreme we find boards and managements that save their energy for those few issues, decisions, or problems to which they should give their personal attention. They are sensitive to the power structure in their organization, work through people in different parts of the organization who have ideas they like, and develop a hazy set of goals, a hazy timetable, and a hazier notion of how they can reach these goals and find ways to bypass opposition. This type of planner must know how to satisfy the organization that it has a sense of direction without ever getting himself committed publicly to a specific set of objectives. Practising the art of imprecision, they communicate objectives over time by promoting a consistency or pattern in operating decisions and

avoids management by objectives and other policy straight-jackets. This method assumes a futility in trying to push total packages of purposes and policies through an organization.

At the other end of the spectrum are hospitals which are plan-oriented, where the focus is on the preparation of a comprehensive long-range plan as the necessary document for that institution's decision-makers. The institution which is plan-oriented reflects the belief that a comprehensive long-range plan is a necessary tool to help management keep the institution cognizant of its mission and goals, through the analysis and documentation of the institution's environment, service areas, facilities and programs, utilization experience, etc. The plan-oriented planner produces highly formalized strategic plans, a process which may be viewed as sterile, but one which is promoted by professional planners.

In recent years, there has been an increasing chorus of discontent concerning this type of strategic planning. Many managers are concerned that despite elaborate strategic plans and planning system, costly staffs for this purpose, and major commitments of their own time, their most elaborate strategies never get implemented. These executives and their boards have generally fallen into the classic trap of thinking of strategy formulation and implementation as separate sequential processes. They have relied on the awesome rationality of their formally derived strategies and the inherent power of their positions to cause their organizations to respond. When this does not occur, they become bewildered, if not frustrated and angry.

Somewhere in the middle of this spectrum is an alternative model of strategic planning in which both process orientation and the plan orientation are represented and where the organizations can apparently benefit from the best of both worlds. This approach allows the managers who operate with a certain amount of logical incrementalism to build the seeds of understanding, identity, and commitment into the very processes that created their strategies. By the time the strategy begins to crystalize in focus, pieces of it are already being implemented. Through their strategic formulation processes, they have built a momentum and psychological commitment to the strategy, which causes it to flow toward flexible implementation. Constantly integrating the simultaneous incremental processes of strategy formulation and implementation is the central art of effective strategic management. Astute managers combine and restructure the separate proposals before them to move partway toward their objectives. They identify opportunities and relationships in the stream of operating problems and decisions.

Quinn (1980) finds that managements "arrive at their strategic goals through highly incremental processes, rather than through the kinds of structured analysis often prescribed or 'required' according to management dogma."

This point of view has wide support, especially among students of organizational behaviour. Henry Mintzberg, author of "The Nature of Managerial Work" (1973), and of three HBR articles, believes that strategy is a pattern in a stream of decisions and can be quite divorced

from intent. Strategy emerges from behaviour and, if articulated, may so constrain creative members of the organization that the stream of innovation will dry up.

How explicit and articulate should be the pattern of purposes and policies that flow from this incremental process that defines the business of a hospital and the kind of hospital it is and should become? The uses of ambiguity are sensed by every politically wise administrator, who by definition is sensitive to the ways in which the purposes and perceptions of individuals divert or even disrupt co-operative action. But unless a board of directors knows what the purposes and policies of the hospital are, it can hardly review or take part in the subtle processes that produce them, approve the outcome, or have confidence in the wisdom of the risks being undertaken. For a board the opportunity to consider an articulated strategy, whatever shape it is in or whatever uncertainty it still has not addressed, can be a productive way to perform its twin functions of supporting and evaluating the performance of its C.E.O. and his immediate senior associates. The main reason for attempting to make strategy explicit is to identify areas of indecision and expose indecisiveness to reasonable discipline. "The master who knows but won't tell is no worthier than the pretender who doesn't know and therefore can't tell." Neither gets the benefit of counsel from his associates in management or on the board. Opposition is sometimes better faced in open argument than manipulated in accordance with a hidden and perhaps confused agenda. Candor is becoming recognized more and more widely as administratively

useful and also informative. (9) If the goals of the organization and the principal means for getting there can be communicated, then people of like mind, attracted and held to a hospital because of what it seeks to be, can commit their energy and creativity to it without forever being told or having to improvise what to do.

It has been said for strategic planning to be successful, hospitals must involve appropriate power bases in the process. These groups include trustees and physicians, staff, business, labour, patients, community groups, legislators, and many others. The appropriate power bases vary among hospitals so each hospital must identify the most important ones in its own specific situation.

If the appropriate power bases affected by the change have an opportunity to participate in the process as early as possible, are aware of the process, and fully knowledgeable of the end result, success is more likely to be achieved. In this process the financial, technical, material and human resources can be planned for and sought out in advance and the organizational structures and systems will then be dominated by the hospital's general purpose rather than by the special purposes of a few.

If the strategy is challenging, members of the organization can be stimulated to respond with more than routine performance, with new ways of reaching goals, and with solutions to problems encountered on the track. A band of people casually gathered to work for a livelihood can be made into an institution embodying values, creating loyalty, and providing non-material rewards, to say nothing of profiting from efficient or first-class performance. If the strategy is known, rather than obscured in incre-

mental wandering or muddling-through, where only the leader (and often not even he) knows what is really going on, then its evolution cannot really be monitored. A changing organization will have untold difficulty in coming to terms with a changing environment.

Successful "strategic planning" in health care will depend on our ability to overcome the natural tendency to begin the process with old assumptions and beliefs which tend to limit objective and meaningful assessment. They also depend on a purposeful move towards a leadership position.

Given the apparent importance of strategic planning for hospitals, why has it not been utilized?

Ironically, most obstacles are self-imposed. They arise either because the purpose of planning is poorly understood, or because the participant's organizational mission (mythologies) about what their health care institution should be do not mesh with market (demand) realities. Too often, hospital planning has been supply-driven rather than based on patient demand. This is a backward approach to planning. In listing these obstacles it appears the most prevalent are:

1. Lack of acceptance of strategic planning as a necessary governance and management tool. This requires bringing together the divergent needs of profitability and an even cash flow with the traditional strong sense of community responsibility. Often the latter outweighs an appreciation of fiscal realities.
2. Resistance to the adoption of a strategic process and program. This can be overcome if planning goals clearly are understood

and participation is encouraged in plan development.

3. Lack of adequate management information systems. In many small hospitals this is not affordable and a vital support for decisions is lost.
4. Poor decision makers. The planning committee must be a select group of individuals who have consistently addressed problems and issues and have handled them in a systematic and thoughtful manner.
5. Poor demand forecasts. Shifts in demands and any environmental change must be anticipated and quantified (whenever possible) in order to match demands, goals, and resources.
6. Lack of realistic and measurable planning objectives. One of the hardest tasks is staying on course. Planning objectives should be related to a program with a defined timetable and a calendar of review.
7. Lack of candor and objectivity. Some participants may be too close to a program to view its results objectively.
8. Lack of follow-through and evaluation. Usually more effort and resources are committed to development of the strategic plan than are invested in its evaluation. Accountability and control rests on the early development of performance measures, definition of responsibilities and scheduled reviews. Equally important is delineation of a means of amending the document itself.

It is these such obstacles that must be overcome and by indicating the step-by-step procedure of strategic planning, the reader will

see it is not as formidable as thought.

As strategic planning is continuous in nature with no natural beginning or end, it is logical to view strategic planning as a process or cycle having the following steps or phases:

1. Recognize the need and make the commitment.
2. Organize for planning.
3. Determine, collect and analyze data on organization and environment. This involves making forecasts and predicting trends and indicates where we are .
4. Determine the organization's purpose - where we want to be.
5. Steps 3 & 4 are combined to determine a "distance" between where we are and where we want to be. To close this distance we must analyze our data base in terms of weakness, opportunities, threats and strengths.
6. Goals are articulated to close the distance and objectives are designed and specified to achieve the goals. At this stage alternatives are selected and courses of action chosen.
7. The plan is marketed and implemented.
8. The plan and process is monitored and evaluated. (page 50)

Depending upon which article is first grasped, a different set of terminology can be identified for each approach. Nowhere is this confusion more demonstrated than in the multiple and interchangeable usage of the common terminology such as mission, philosophy, strategy, goals or objectives. At this point specific definitions for these concepts are presented in order that their difference (and interrelatedness) in the process may be demonstrated.

To eliminate confusion and to create consistency I have departed from the literature and sought asylum in the dictionary.

PHILOSOPHY/PURPOSE/MISSION

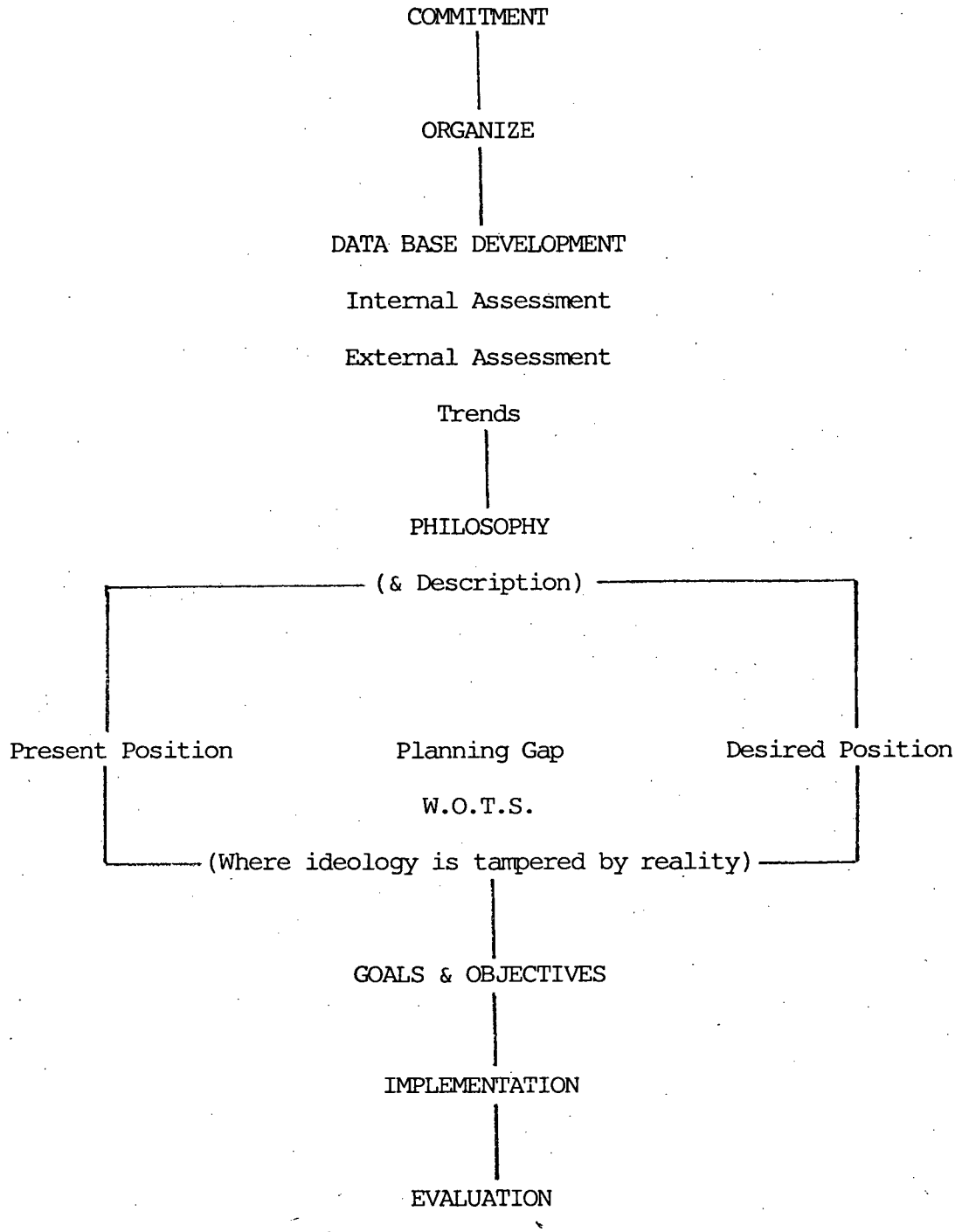
The dictionary suggests that these terms may be and should be used interchangeably. It states that a Philosophy is the guiding principles followed in a particular activity or field of knowledge. In this case - health care. Purpose adds to this the ideas of resolution or determination to carry out what one proposes. It is used to guide board policies. It is often idealistic and quite generalized.

Goals statements are derived from the mission or philosophy statement of the organization. While still idealistic and remote, these statements are more specific than the statement of purpose. They are used to guide individual policy issues or to make decisions. They allow for discriminatory decision-making when alternative decisions or policies are presented to the organization.

Strategy statements are derived from the periodic assessment of the organization and its environment in terms of its current position, the trends which are moving it forward into the future, and the desired position to which the organization wishes it to evolve in the future.

These statements usually identify, describe and articulate the areas of the desired future. The making of decisions or the setting of policy is governed by these statements, i.e. policy is set or decisions are made to the extent to which they work toward the content of these statements.

## THE STRATEGIC PLANNING PROCESS



"Objectives" refers to an end or goal with the implication that it can be reached. The objectives are annualized statements of measurable and attainable programs, services or produce changes which are selected from among alternative programs and services in a manner consistent with the goals and support of the movement of the organization toward the attainment of one or more goals.

As mentioned in the previous section, strategic planning is not a single act. It is a process of cycles consisting of many interrelated and interdependent stages or steps. There is no natural beginning or end. It is a whole series of interrelated activities that must be segmented into related, workable components. It matters little how these activities are divided, as long as the components of any phase are interrelated and lead to making the next phase more productive. The task of the planning committee is to manage these phases, their components, and the decision-making process so that the outputs are relevant and productive for future decision-making phases.

Regardless of the type or scope of strategic planning, the following steps must be completed:

1. Strategic Planning Commitment (recognition of the need)

Planning itself requires planning and good planning occurs only when management makes a conscious effort to incorporate it as an ongoing part of administration.

The first problem in seizing the opportunity to develop strategies is for the key decision-makers to make a commitment to the belief that planning is worthwhile. This commitment should be

in the form of a formal policy statement. Even in those few hospitals currently doing strategic planning, this commitment should be restated as often the origins of the need have been forgotten. The ideal situation is for the C.E.O. and the board chairman to state at the next board meeting - "We are today going to commit ourselves to the commencement of strategic planning." This is the easiest and least painful beginning. Unfortunately, the demands of the future press less urgently than those of the past and present, so this step is not taken in this manner. Board and management time and talent is so focused on delivering care that preserves present needs that planning for the future is often postponed.

Often this recognition of need comes about from a crisis situation and usually the telltale signs of crisis are everywhere. The initial problem, identification of the situation, is the need for someone to recognize the general and specific signs indicating that a crisis is facing the organization and to create a real understanding of the need to do something about the crisis.

When an organization is in a crisis and is able to recognize that crisis, the board's role will be that of attempting a turn-around of the hospital. The word crisis implies a serious need for improvement in any organization and a turn-around is needed. It suggests that, for one reason or another, a hospital requires a one shot effort to remove or reverse certain entrenched situations and practice which, if permitted to continue, would lead to the eventual failure of the organization. There are hospitals in situations which by nature are terminal and the only cure for them is to close or do a complete reversal. To decide whether a turn-

around is feasible, a strategic planning process must be initiated. Whatever situation an organization is in, be it a crisis or good times, which will be fewer in the future, the proper time to start on strategic planning is the present. There is only one time, and that is now. As imperfect and unready and untrained as all the participants may be, the perfect time to start is at the present. (10)

Eckstein (1956) observed that however imperfect the planning techniques are, it is the will to plan that matters.

2. Organize for Strategic Planning (Establishment of the Committee)

Once committed, the hospital's trustees and management should be willing to become involved in all appropriate planning activities. The first aspect should involve a measuring of their own (the board's) performance or effectiveness. Boards need to examine themselves periodically to maintain or improve effectiveness. This self-examination should ensure all members of the Board participate. The starting point is to determine what are the Board's duties that need to be evaluated. (Appendix 1) This evaluation is a two step process. The first step is to assess performance or obtain information on performance. The second is to place that performance against some standard to determine its adequacy. It is expected that in the evaluation of any group or individual, strengths and weakness will be identified. The purpose of the evaluation is to permit and encourage those concerned, to capitalize on their strengths and to compensate as much as possible for their weaknesses. In evaluating a board of directors, it needs to be examined in two perspectives. The first is a collective, a group of people with given group tasks. The second is a collection

of individuals, each with given tasks. The chairman is an individual with an additional set of tasks, who assumes the leadership role, so that every act is intended to help accomplish the tasks of the board as a group.

The evaluation process should include the following questions:

1. How effective is the board? This will be determined by the degree to which the board achieves its stated goals.
2. How efficient is the board? This will be best answered by the Board's use of its resources, materials, manpower, facilities, and equipment.
3. How acceptable or creditable is the board? The response to the question is found in attitudes expressed by individual board members, hospital staff and members of the community.

Credibility would appear to be a direct function of the board's ability to identify problems and issues affecting the attainment of the stated goals of the hospital, to plan and implement programs reducing or eliminating problems, and in general to make decisions and act upon them.

If we want the board to be effective, efficient, and credible in its work, by implication we expect individual board members to meet the same criteria.

A board wishing to examine its own work should set aside several days on an annual basis. With a record of the policies, objectives and goals, information would be collected to establish the strengths and weaknesses which were preceived by several members of the board. In this case, subjective informaiton will play an important part in assessing the performance of the collective group.

An alternative would be to hire an external consulting firm which is

familiar with the process of evaluation, and would proceed to conduct the needed studies, to collate the information, and to provide a summary concluding with recommendations for the board. New board appointees should know that an evaluation process exists, and should look on it as a positive process which aims to maintain the highest quality of standards for the institution. I have suggested that boards of trustees should be evaluated on a regular basis including the collective and individual membership. It is evident that this particular topic has not been explored in any depth or to any extent, as I found little in the literature that discussed the issues or described methods and approaches that might be considered. I feel this is due to the fact that concentration has been on the operational aspects of the institution, with various professionals and organizations within the institution having high priority, and little thought has been given to the need to appraise and evaluate the board of trustees.

However, one must always be sensitive to the fact that in most cases, trustees are volunteers and contribute their valuable time and effort with little, if any, remuneration. One individual in particular should be evaluated - the chairperson of the board. Perhaps one of the key positions in the hospital today is that of the chairman of the board. In the past, the position has often been an honorary one that did not entail much in the way of time or detailed involvement with hospital activity. The increasing scrutiny by the public, generally through the media, of public institutions now makes this position one of great importance and responsibility. A suspicion on the part of the public that many individuals employed or working in the hospital

have vested interests that preclude their fairness in judgement and decision-making, has made the position of chairman of the board of increasing inportance.

In evaluating the work of the chairman of the board, we need to assume that he exhibits the skills and performs the tasks listed for individual board members and that, in addition, he serves as chairman on behalf of the board. The individual is totally accountable to the group, and his performance should then be judged on his ability to help the board accomplish its goals. In addition, the chairman's competence in the following roles should be evaluated by the members of the board, as they have the clearest and broadest perspective of the chairman's activities:

1. As a leader, in developing goals he must steer the board towards new challenges, but away from shoals and quagmires;
2. As a communicator, he will need to be direct with other members of the board, the hospital administrator, and the constituencies the board represents;
3. As an evaluator, he will assess the effectiveness of individual board members;
4. He will act as a facilitator and negotiator for members of the board and on behalf of the board with external institutions and agencies; and
5. As a counsellor for other board members, he will offer his perceptions and advice.

The C.E.O. should also be evaluated at this time. However, this will be discussed under a separate section.

Selection of the strategic planning committee may be the single

most important action the board's chairman can take.

COMMITTEE STRUCTURE:

- Size

The literature varies on this aspect; however, a range of 7 - 12 appears common and depends on what is required to represent all the elements of the highly diverse constituents. An average number may be 10. A common mistake is to make a committee too large in an attempt to ensure every viewpoint is represented. All major interests should be represented but the committee should be small enough to allow for exchange of ideas.

- Composition

All the key groups must be represented: board, administration, medical staff, senior staff, nursing, and the hospital auxiliary. It is only the inclusion of the last group that may require some explanation. The governing board must authorize the auxiliary so it can identify with and function on behalf of the hospital. If the hospital is ultimately responsible for the activities of the auxiliary then they (the hospital) must keep the auxiliary informed and involve them in planning. Whatever the auxiliary's role; be it fundraising or volunteer services, if they are to function as trusted members of the organizational team and to function with effectiveness, they need to be apprised of current issues facing the facility, and the health care system. They need to be aware of the facility's expectations and goals and to be involved in strategic planning discussions. This can be accomplished in many ways:

- the C.E.O. can attend auxiliary meetings
- a member of the auxiliary can be appointed to the board
- a member of the auxiliary can be appointed to the board strategic planning committee.

The best approach is for all of the above to occur.

The literature indicates the need for community representation with a consumer perspective. This is subject to discussion as one can say all the board members already on the committee "reflect" the needs of a small community. They are already consumers. The consumer perspective can be obtained through other input vehicles without creating additional members of the strategic planning committee. It is preferable to have more than one medical staff representative. The medical staff would intuitively include the chief-of-staff, however, you should try to pick doctors who have a considerable stake in the hospital. All members must be allowed sufficient time to absorb subject matter and to do their work properly. Time must be commensurable with the task given them.

- Chairperson

The chairperson of the committee must be a member of the board. Literature indicates that the committee chairman should not be the chairman of the board but rather someone who is impartial to the process. In a small, rural hospital, to reduce proliferation of different committees and to place importance on strategic planning and to internalize it, the chairman or vice-chairman of the board could be the chairman of this planning committee. He must be a strong-minded, knowledgeable person

who is capable of directing, deliberation and able to develop sufficient time to be well-informed. He must work closely with the C.E.O. and staff in reviewing materials and preparing agendas. The chairman of the planning committee should be a person who is a facilitator and able to lead the committee to a plan that is best for the hospital. They must participate while maintaining traditional neutrality. They must be able to provoke productive discussions or identify more debatable issues.

- Consultants may be used on the committee and a fuller discussion on this will be found in a separate section.
- Role
  - to make recommendations for long-term objectives
  - to serve as an advisory committee to the board on topics concerning future directions
  - to serve as a collective voice of the community regarding health needs of the population
- Mandate

  The purpose of this committee should be well-recognized from the start. It is not the production of a thick report titled "The Strategic Plan" or "Five-Year Plan". The objective of this committee and of all strategic planning is action. This is the result you are after. Once all the major issues are in the open and have been discussed and a consensus has been reached, things will begin to happen and change will become visible. This committee, once formed, must be given a clear mandate that should be written and circulated for all staff to see what is going on. An example

of such a mandate can be seen in Appendix II.

The strategic planning committee shall make recommendations for long-range goals and objectives for the hospital. It shall attempt to be aware of all developments in the health care field and trends in society and to interpret the effect of these developments and trends on the hospital. A principal function of the committee shall be the development of a written statement describing the hospital's specific role in the community in relation to all other health care facilities.

The mandate should include a planning calendar - Appendix III. Strategic planning is best accomplished over a relatively short period to ensure continuity of purpose and participants and to maintain the momentum that the planning process generates in its early phases.

No planning program should exceed 12 months in duration before a strategic plan is developed, although the planning process is continuous and ongoing. The amount of time and the number of meetings needed to evaluate the various services and programs will vary, depending on the needs of each institution. A degree of flexibility should be maintained throughout the project, but a time frame should be established at the beginning. Monthly meetings of approximately two hours duration should be sufficient to accomplish the committee's work provided adequate preparation is made, the committee meetings are well-planned and the tasks of each member are clear to all members.

While the committee has a mandate that indicates action, it is critical to remember that the committee derives its authority

from the board of trustees and like any other committee it is responsible and reports back to the board. It has no decision-making power of its own. However, the committee should have power to delegate work to staff for fact-finding and digging out of statistics. Having adequate support that produces good information keeps the committee from dealing with trivia and opinion. The C.E.O. must assess the staff for the necessary talent to assist the chairman.

The committee's time frame is explicitly long-range. It should stay out of current operations and administrations and out of the way of the other board committees, which are working on current business most of the time.

The committee's job is to consider major issues of all sorts, major projects, and priorities, and to make recommendations to the board. Major expenditures should usually be considered first by this committee and next by the finance committee.

The mandate implies that the committee has the further duties and obligations to:

1. Develop a framework for orderly decision-making, through a defined community role called the "Mission Statement", a set of long-term goals and objectives, a strategy for achievement, and a timetable for recommended progress.
2. Ensure that all recommendations coming from this and other committees fit within the hospital's defined role facilitate achievement of its goals and objectives, and follow the strategic plan. It is a continuing obligation of the committee to keep the hospital on course with its plan

(strategy) or to change the plan as new facts and conditions dictate.

3. Develop a sense of priorities in its examination of issues and projects so that the hospital's limited resources of time and money are spent on those projects that take it the furthest in achieving its defined role in the community.
4. Act as additional vehicle for good communication among the board, the medical staff, and the administration.

Long-range planning cannot be effective if it is the work of a single chairman for he will not be aware of the hospital's and the community's values and culture nor have a feel for board members' attitudes. It is also helpful if trustees and management hold many of the same values.

When selecting trustees for the committee, do not overlook the power of economics, the power of prestige, and self-esteem as motivators for involvement. Remember, of course, that you need a balance of skills and resources for the board. The following aspects should be kept in mind when selecting the committee members:

- sense of duty (dedicated, faithful)
- overall interest (big picture)
- enthusiasm for facility
- general strengths and specific abilities (mix and match)
- inform them of importance and workload of function
- the benefit of a skeptic or doubter on board.

Notify trustees, preferably in writing, as to the number of hours or days per month that they should allocate

to the committee, defining work and activities. Let trustees know you expect an honest commitment to time schedules and that strategic participation means more work, more time, more thought, and probably at times, more uncertainty, frustration and concern. The strategic planning committee's work should be an issue- and action-oriented effort to establish a strategic plan for the participation of problems and their resolution. Strategic planning addresses issues that often are discussed in public, and the planning committee must operate as a seeker of truth. Once the committee has been formed, a definite educational process must begin. While this is focused directly at the committee, the full board should be included. This is an educational effort that will be tedious and hard and must be developed over time and started off slowly. To help move a recalcitrant board in this direction, the board chairman might even consider adding carefully selected new, additional members to the board prior to forming the strategic planning committee. The effort must be purposefully designed to have all players overcome the hope that everything will return to normal. Part of the effort must also clearly indicate that while it may be a crisis situation, it is also a time of great and probably unique opportunity. It is at this precise moment in a hospital's history when strategic planning will truly pay off. A planning check list may help in indicating the present state (or lack) of planning. Appendix IV.

This responsibility belongs to the hospital administrator and an appointed board member who must determine the most appropriate course of action, depending on the level of the board's awareness, interest, and commitment to planning.

Orientation and education should include:

1. Introduction to the strategic planning process, stressing planning as the key to assuring a viable future for the institution within the framework of area-wide plans and to assuring the appropriate allocation of available resources.

   The C.E.O. or board chairman can develop participation and encourage board involvement in strategies through trustee education by way of a series of persuasive case histories. Cases will help to express the very nature and form of strategy and give a better appreciation.

   The C.E.O. or the board might bring an outside consultant in to educate board members on the concept and practice of strategic planning. If it is feasible, the C.E.O. might even consider a retreat for members of the board and selected members of the hospital staff during which a consultant would lead them through appropriate group process techniques to heighten their awareness of planning and to motivate them to get into the planning function.

2. An overview of national trends affecting health care delivery, with emphasis on those trends specifically affecting small facilities.

3. An overview of regional and area-wide trends affecting the local communities and the local facilities.

4. Inherent in this educational orientation are moral and ethical obligations for not only committee members but all trustees. These obligations are:
   - to be well-informed about the ever-changing health care environment
   - to seek the truth regarding present and future needs and to question the relevancy of the programs, services and operation of the facility
   - to challenge statements about the facility's accomplishments and capabilities and to ask the hard, often unpleasant questions about the future or survival of the facility.

This educational process is consistent with planning itself as planning is a learning process; a process in which the learner is encouraged to let his perceptions of today interact with his ideas about the future. Once the process is started each member of the committee will grow. As the poet Emerson wrote: "A mind stretched by a new idea never returns to its original shape." Finally, the chairman must encourage a team spirit among trustees, the executive director and other professional staff, and all volunteers. Hospitals must have committed people at all levels; and professionals and volunteers alike must be well led to maximize their success.

During the committee's education, they must be made aware that there are some unique aspects to problem and issue recognition and solution. Some of the old-time cliches should be disbanded.

1. If you can figure out the problem, then it is almost solved. This isn't always, or even very often, true. You can figure

out a problem that you are going to be $90,000 in a deficit position by year-end, but figuring out the solution is another matter.

2. All problems have a solution. This isn't true. You will avoid a lot of work if this is accepted from the beginning. It is often helpful to separate problems that are solvable and unsolvable and accept the fact that there are some problems we must live with in reasonable comfort as we cannot solve them.
3. There are always answers. Sometimes, there are no answers and the committee must learn to live with ambiguity. It has been said the success in strategic planning will be in direct proportion to the ability to handle the ambiguity that exists in hospitals. The classic example of no answer and ambiguity is when you are confronted by a community individual who insists that you keep costs down but also insists that you have all the necessary equipment when his family needs it.

The outcome of the discussion of some cliches is that we cannot always reach consensus or force conclusions from our planning process. We should not push prematurely for solutions that will only give us the wrong answer.

Another aspect the committee must keep in mind is not to re-invent the wheel. It is fairly common knowledge that most of the problems that hospitals have are well-known and have already been dealt with in other hospitals. The role of the committee, therefore, is to correctly match the problem and the solution, not to invent innovative solutions or to discover problems never known before.

As the committee will be involved in considerable discussion

before reaching a consensus, there are several techniques to make this process more comfortable and productive. These are listed below and can be researched in any of several books on groups, meetings, or interviewing.

(a) Meeting in the proper room with appropriate and comfortable furniture.

(b) Arrange length of meeting.

(c) Meetings should be conducted with a clearly stated purpose for it and the committee should never leave without arriving at a conclusion to the problem under discussion. Always lay down a system of controls to assure that those assigned to follow-up on items actually do so.

(d) The meeting must be designed to assure all members of the committee participate in the discussion.

(e) Staff reports must be carefully read with discussion focused on issues that need resolving.

In closing, the first constructive thing that the committee must do is to stop blaming the government (although there is no question that government interference has become one more impediment to efficiency), to stop blaming labour unions (though valuable time and energy is consumed in bargaining, grievances and arbitration), but to devote the time to investigate, analyze, and decide the kind of health care the people of our communities are going to receive in the years ahead.

3. Data Base Development (getting the facts together)

This all-important fact-gathering phase is sometimes referenced in different terminology as "market research", "situation analysis", "environment assessment", and "organizational assessment", to name a few. Essentially, the objective of this phase is the preparation of a complete assessment of all relevant internal and external facts, issues and considerations bearing on the organization's current status and forecasting trends that will impact on its future status.

Few can deny the importance of information in the planning process. Data as used in planning are a synthesis of past trends and current conditions that provide a basis on which to predict future happenings.

The level and depth of data necessary for a specific planning process depends on many factors - the most important of which is their pertinence to a particular problem. Other factors to consider are the committee's ability to analyze and utilize them; how the data are collected and the cost of collection; and their accuracy and preciseness.

It is paramount to remember that data are merely an aid to decision-making. They do not and cannot, in themselves, provide a solution. For the purposes of this study, three broad categories of data can be identified, and the committee is wise to use aspects of all three:

- recurring data (regularly gathered on own organization)
- repetitive studies (periodically undertaken within a given timeframe)
- special studies (conducted on a one-time basis).

The list of information to be obtained is as long as the committee wishes; remembering that too much information is as detrimental as too little.

During this step, the following "profiles" should be developed:

Organizational Assessment (internal Profiles)

The task at this stage requires a self-appraisal that should reach every level and part of the organization. It is cautioned that it is here that health care organizations suffer from their most serious difficulties - their product or output is difficult to assess and measurement has long been regarded as virtually impossible.

Items to be included in this section can be found in the already available documents such as:

| | | |
|---|---|---|
| Ministry of Health, B.C. | HIA 35 | Appendix #5 |
| Federal Year End Report | HS 1 & 2 | Appendix #6 & 7 |
| Quarterly Federal Report - Statistics Canada | | Appendix #8 |
| Comparative Statements (B.C.H.A) | | Appendix #9 |
| Peer Group Indicators (Ministry of Health, B.C.) | | Appendix #10 |
| Accreditation Questionaire & Survey Results | | Appendix #11 |

Environment Assessment (External Profiles)

It is usually considered that a statistical survey of patient origin is the most important aspect of this data base. This is generally not so for a small community hospital, even if they have a highly specialized unit, for the cost of the survey far outweighs the results. The minimum that should be considered here is: an understanding must be gained of your service area, or put in commercial terms "the consumer base". You must look at the community needs and who you are serving to find out what is going on and what is likely to happen in the future.

This information relates directly to the marketing of your plan. It is quite helpful at this point in the process to review a map of your area and to gain census tract information from provincial and federal governments. A review of any natural barriers is also helpful. At this point, the committee should be asking the critical questions, such as "will our service area shrink or grow; will this population get younger or older; will the population change ethnically; will new barriers or access, like highways, be introduced and significantly change traffic patterns? What do recent vital statistics show for births, deaths, mortality rates, disease patterns? What are the social indicators, such as human resource rates, housing conditions, crime and delinquency rates?"

In all aspects of planning, nothing is as basic to the process as the service area and the service area's population. Potential

in-patient populations must be defined and acknowledged they can be different in origin than an out-patient or emergency population, depending on our services available and the admission practices.

The Committee must become "tuned into" the community. A Committee must have a feel for what is going on around the hospital. It must be in communication on an on-going basis with the community and the individuals who live there. To do this, one must develop sensitive listening-posts in the community. There are several techniques that can be used here to be in tune with the community:

- consumer attitude research, using a very basic questionaire that can be developed by the committee or use existing ones from other hospitals. The objective of this is to
    - measure your progress
    - determine how patients view you
    - compare your profile with that of hospitals near you
    - gain some indication of how patients of other hospitals perceive you.

Such surveys should be done on an annual basis. That way, each successive year is a follow-up and will tell you if you are making progress.

Another technique is to reverse the historic approach with service clubs. Instead of trustees and administrators going to the service clubs and telling them about the hospital, it would be better if a hospital representative were to listen instead of talk. One way to achieve this is with a brief questionaire to be handed out

to service club members and to be returned prior to the meeting. An example of such a questionare may be "list three things you like about the hospital; list three things you dislike." These letters should be reviewed prior to the representative attending the service club.

This has not happened in most cases and the results are obvious. As stated earlier, the principal reason so many hospitals are being highly scrutinized by the political process is that the politicians were more sensitive to what the community was saying than the hospital was.

Other Providers:

While it is considered somewhat demeaning in the hospital world to refer to other health care institutions as competitors, it is an essential step in the strategic planning process. This is so because the concept of competition is valuable, although it is possible for competition to be carried too far. In the literature review, I have found no single reference where competition, even in the U.S. setting, has been considered to be carried too far. If the committee doesn't review and understand the competition, we will be making poor decisions about adequate service, duplication of services, and costs, and we will not be able to determine where the gaps are in the services. In reviewing the competitors, we must also review their strategies. We must determine what levels of care are available in the region, what plans are there to change these levels, what they are good at, what they expect to build, and where they are also going. The

governments also would be interested in a competitive approach as it may ensure that the limited resources are being spent wisely and not wasted on matching competition. A technique used to review competition or gaps in service is a simple Matrix (Appendix 12 (a) and (b)). A question that may arise is how do we obtain this information. One way is to merely ask for it. Most health providers are quite readily willing to exchange such information. It is also published in their annual reports and by the provincial governments. The most successful way would be through regional planning groups such as hosital districts or hospital advisory committees.

A logical explanation of the review of competition is to look at inter-institutional relationships. Some basic questions that the committee should ask are - what health service agencies to we work with - what other facilities do we exchange information with - how do we work together to lower costs. Again, there is a basic technique that can be used to determine this and the general outcome, to everyone's surprise, is the length of sharing arrangements. A simple Matrix can also be used (Appendix 13).

The examples of areas we are looking at here are either joint ownership or purchase services of laundry, linen, lab services, computer services, educational programs, group drug purchases, etc. The offshoot of this is that it clearly indicates to the local communities and to the Ministry of Health individuals that we are developing co-operative ventures and joint planning rather than a duplication of service.

Some other elements of the external profiles can be found in Appendix #14.

In order to develop these strategies, the board and management must have an understanding of the public policy implications of what the hospital does. Moreover, they must have a fundamental interest in dealing with such implications. It will be essential that the board and management have good, accurate and preferably early information about the forces external to it which are at present or in the future going to affect the manner in which the hospital operates. This may involve political analysis so that emerging issues and trends can be identified. While some major changes that may dramatically influence the future of the hospital cannot be forecasted, most major governmental policies are a considerable time in development. Indeed, the public policies of tomorrow can often be seen in the works of the researchers, academics, and the scholars of today.

To be successful, a board and management have to monitor the environment defined in the broadest sense possible. It goes without saying that the board must know the way in which government makes its decisions and who the significant policy-makers are. This is not always obvious, particularly in the last decade since many new players and new systems of decision-making have often been put in place at the provincial level.

Once the necessary or indicated data has been collected, the arduous task of analysis begins. This analysis will aid the hospital in answering the questions

- what is our present purpose?
- what services do we really provide, to whom?

This analysis requires the committee to switch its orientation back and forth from internal efficiencies to external forces. The

end result of the analysis must be to provide the most accurate possible picture of the opportunities and threats the future will pose for the organization and the environment in which the organization must manage and compete.

The implications of this step is that it forces the committee to reconsider and define their hospital as part of a "system". Sights are now raised from tactical planning to that of strategic planning of the system. This fact gathering yields the information needed to develop the strategy.

In the analysis of the data hospitals, even small ones, may have access to data processing services. While this may ease the workload and speed the process, electronic technology can never replace management effectiveness. Vital as it is for acceleration, it is useless for direction.

A critical aspect of developing a data base designed to close the planning gap is that of forecasting trends (crystal ball gazing). It is this point that frustration usually reaches the highest level. We hear "How can we predict what medical breakthroughs will be in the next 10 years"; and "How can we predict what politicians and unions will do"; and "We're different, we can't plan like in business". All these statements have a grain of truth but uncertainty can be dealt with by building in flexibility. A method of building in flexibility is to list expected consequences of the determined trends. Trends are not all mysterious and doping out the future is somewhat more predictable than what many people would like it to be. Whatever will happen in the future is already happening. Trends in society start small and build gradually over a long span of years, they are not sudden at all, they

just appear that way because of our unpreparedness. What we are doing in predicting trends in planning is attempting to figure out what the future holds by being good students of the past and present. For example, the committee can review what is happening to occupancy rates of other hospitals in the community, province, or even the nation. Information on new techniques used in medical schools is readily available. Professional papers and trade magazines clearly indicate trends.

For example, the planning committee should try forecasting the trend of increasing government conrol of the quantity and cost of health care, and to extrapolate (guess) what future consequences the trend will have on the hospital in the next 5 - 10 years.

Illustration:

- Consequence 1. The board of trustees will become less of a decision-making group and move to a recommender role, because a government agency will make the final decision.
- Consequence 1. The hospital will not get projects approved by the Ministry unless it responds to their "requests". You should figure out what those requests will be.
- Consequence 3. Whether the government pays an increasing or decreasing share of all bills incurred by patients, such payments are generally going to be slower and will require more handling. The hospital will therefore need more working capital and improved cash flow.
- Consequence 4. The hospital will need to further enlarge its staff to respond to government requests for data and to process forms and papers.
- Consequence 5. More agencies of government will inspect the hospital.
- Consequence 6. A key management job will have to be established to

co-ordinate all responses and activities that result from government inquiries.

- Consequence 7. Overhead or staff costs will probably go up faster than direct patient care costs because of consequences 3-6.
- Consequence 8. Doctors will continue to yield ground to "planned medicine" and will steadily lose their cherished freedom.
- Consequence 9. Doctors' bills will be monitored, and greater forms of regulation may occur. Hospital rates are regulated now; the doctors' portion of health care costs will not be exempted for long.
- Consequence 10. Doctors' offices will be further affected by the rising tide of forms and data requests from the government. This will result in doctors forming into collectives or groups in order to afford the management and clerical systems needed to cope.
- Consequence 11. The government may attempt to push some of regulatory scorekeeping of doctors' incomes and practices onto hospitals. Hospitals and doctors will need to be careful not to get caught on opposite sides of the fence.
- Consequence 12. About 10 years ahead, our health care systems may develop into a two-tier system. One tier will be hospitals for patients who want to escape the "system" and for doctors who want to avoid the red tape of government. The other will be hospitals for everyone else. Your board will need to think about which way your hospital would lean, if such a split developed. (11)

4. Philosophy or Statement of Purpose

This stage translates the potential areas of organizational responses to needs, demands, wants, opportunities, into a specific framework. It is the cornerstone of the organization. Sooner or later, when an

institution looks at itself and its future, it must ask some fundamental questions about its reason for existance. Most medical care institutions were organized for a specific purpose, but with the passage of time it is often only half remembered or even distorted in the memory of a few founders or long-time employees. In many cases, institutions have added so many new programs to meet new demands, and to keep abreast of medical advances that their original purpose is subordinate. And yet, unless an institution has a clear idea of intent, it cannot hope to progress very far in its planning.

A concise statement is needed articulating the basic principles or purpose that differentiates your hospital in some way from all its competitors and stems from a perception of present and future community needs, (market) opportunities, distinctive competence, competitive advantage, available resources, and board/management personal aspirations and values. It is the "best fit" between services that are consistent with the organization's available resources and the community's needs.

It reconciles what a hospital might do in terms of these opportunities, what it can do in terms of its strengths, what its management wants it to do, and what it thinks is ethical, legal, and moral. This concept of principles involves economic, social, and personal purposes. Although it evolves with the development of profiles, strengths, and values, a hospital principle marks out a deliberately chosen direction and governs directly the service decisions, organizational structure, community relations, and indeed the essential character of the hospital. It embodies a unity of purpose, a purpose which to be powerful

must be clear and worthy of the commitment of energetic and intelligent people.

It reflects qualitatively what kind of business organization the hospital intends to pursue and/or excel in for all its constituents - trustees, employees, physicians, and the community. Aspirations of quality, style, tone and social responsibility belong in this determination. This kind of summary statement of purpose should be clear enough not to prevent the generation of innovative, detailed action programs and the participation of people who are motivated by their perception of purposes that have opportunity and attraction for them. It shouldn't be so vague as to provide no direction, nor so restrictive as to stifle the strategic planning process, nor should it be so all-encompassing as to substitute for the final planning document. In times of rapid change and in emergencies, details can and will be bypassed; it is this recognition of purpose for each action which holds the entire organization together.

Such a statement makes an important contribution to management. It forces continuous sensitivity to changes taking place in the hospital's environment and resources. It requires the managers to lay conflicting personal and often "invisible" agendas on the table and to look beyond immediate opportunities toward long-term growth and development. The statement summons up imagination, innovation, and a zest for risk. The concept

of a "Statement" has its shortcomings, as well, for it demands tough, high-risk commitment to a choice of direction. It can often be subject only to judgement, not to definitive evaluation in advance of its validity.

This is the first and foremost strategic decision an organization must make. This represents the "big picture" of the facility's future. Failing to determine this and determine it well leaves the organization with no focal point or central thrust for lining up the organization's energies and resources to accomplish the most desirable ends. The natural result of this failure is the dissipating or scatter-gunning of efforts in many diverse directions typically evidenced by a myriad of different programs which do not meet the needs of community and some programs which may actually conflict with others.

The Statement is but a tool designed to communicate both internally and externally what the hospital stands for. It is the beginning point of discipline that will allow you to evaluate the appropriateness of present activities, future directions, and assists in appraising requests for new staff, equipment, and to consider new facilities. The Statement of Purpose is the beginning of the plan and should start with an accepted social value. Literature indicates that 9 out of 10 hospital trustees, administrators, and doctors are unaware whether a Statement of Purpose exists, let alone what it says. Traditionally, the problem that most hospitals encounter is that they do not answer any questions that may be raised. They

state "that the mission of this hospital shall be to provide the provision of health care at the lowest cost for all who enter". The statement should answer certain questions and concerns raised by any of the key players of the community, such as "what does the hospital stand for; where is it going; what can the hospital afford to do; what do patients expect of the hospital; what medical procedures is the hospital qualified to perform; who does the hospital serve; how should it serve its community?" The statement that is general is basically useless, as it provides no direction and is so vague that it merely creates no reactions also.

How clear it is in words or practice, how consistent it is with organization competence and resources (both present and projected) and how internally consistent it is can all be submitted to qualitative analysis. How much it reflects the values and aspirations of the key persons in the hospital, how much it constitutes a clear stimulus to effort and creativity, and whether in ethical and moral terms it inspires commitment and the required quality can also be estimated in the light of relevant, if unquantifiable, evidence. The fitness of the match between resources and opportunity and its potential can be quantified.

A sample statement that adequately describes your hospital is found in Appendix #15.

It should be noted at the onset that an organization does not determine its purpose. The community which it serves

makes this determination for the organization. An effective Statement of Purpose always proceeds from the outside (patient and environment needs) to the inside (a hospital's response to these needs). If one needs to test this premise, you need look no further than the countless number of organizations which have failed in the past because they (not the client) determined their purpose. After gearing up to carry out their purpose, they found they were trying to provide programs and services which the community did not need or want.

The purpose and role of an institution are matters of policy to be determined by its governing board. It is rare, however, that the board, either on its own initiative or through its planning committee, actually spells out purpose and role. Rather, they are usually defined, in part, by a series of actions taken and policies made over a period of years. Much of the planning conducted at the board level proceeds on tacit assumptions of what the institution should do and what the community expects it to do. The assumptions may not always be clear or rational. Planning has been described as a means of clarifying these assumptions and sharpening their rationality.

This stage should answer the question "where do we want to go?" It specifies the <u>end</u> towards which the hospital would <u>like</u> to move during a specified period of time.

One of the most difficult aspects of this stage is that it requires the hierarchal structuring of goals and objectives within a complex, dynamic and interdependent framework. Cyert

and March (1963); and Ansoff (1969); have written extensively on organizational goals and it is beyond the scope and intent of this study to deal with this matter other than to caution committees that considerable attention must be paid to reaching consensus on specific targets (goals and objectives).

It may come as a shock to the committee that, upon reviewing everything and making your statement of purpose, that your hospital is indeed not the greatest, nor the leader in some fields that you have expected. While the statement can be dressed up for external use, it is important that it be expressed in plain terms. If the committee finds that there are shortcomings in the hospital with some of the programs and low utilization, one must not be afraid to view certain programs and services with an eye to euthanasia. It is a big responsibility for the committee to take the suggestion or recommendation to the board that they have reviewed the facts and some things are not working. Failure of a program or service is not to be interpreted negatively. It is a natural consequence of out-dated programs or new ideas that are not adequate in the present tough environment that we exist. It makes no sense to do everything right if we are not doing the right things. If the board is reluctant to act upon trends that may indicate, however slightly, that certain services should be eliminated, then certainly a future evaluation is necessary. The starting point should be some benchmarks that will be evaluated one or two years down the road, such things as:

1. a definition of success e.g. occupancy rate should be at such a level

2. a timetable of events e.g. the number of procedures we expect to perform
3. a projection of surplus or deficit
4. a definite statement of action courses on new programs. The principle to this exercise is very simple: the survival of your hospital depends on you concentrating your resources on the facilities and programs that are most demanded by the community you have decided to serve and this means eliminating failing efforts.

Developing such a statement is an ambiguous and controversial exercise. There has to be dissent and controversy before a viable definition can be found, because you serve such a variety of constituents. You have to satisfy the patient, the doctors, the nurses, the technical staff, and other employees, the patients' families, the taxpayers, the donors, and other third party payers who provide the bulk of the support of most hospitals. Until you have such a statement agreed to by your managers, financial supporters, board members, employees and all other constituents, you are not ready to approach suggestions for change.

5. The planning gap. After the statement of purpose is drafted, the next step is to determine whether it coincides with the reality as determined by a review of your data base; the plans of other hospitals in the community; community perceptions; plans of health planning agencies; demographic data; and anticipated changes in the practice of medicine. How closely it coincides determines the extent of your "planning gap". To help close the gap we must now assess our current organizational capabilities (present)

position) in light of the statement of purpose (desired position). The strengths are assets and are building blocks for the future. Your weaknesses, of course, are on the negative side. Both are to be appreciated. To discover them there are two steps to be taken in the strategic planning process:

1. Ensure the committee members all have the Statement of Purpose in front of them, for without the Statement, they cannot tell the weaknesses and strengths. For example, if Statement declares that the hospital's role is to specialize in day care surgery, and you have a large program for geriatric day care, the program for the elderly will not be a strength, even if it is medically and financially successful, because it neither fits the Purpose, nor enhances it. What you once thought of as a strength is in reality one more thing to be corrected or the Statement of Purpose should be changed.
2. The strengths and weaknesses must be explicitly articulated and written down. As stated in the example of the geriatric day care program, if the Statement is in conflict with the major strength of the hospital, either the strength must be abandoned by declaring it no longer consistent with the hospital's purpose, goals and objectives or the Purpose must be changed. With planning in place, the board and management should be alert to the need for change long before outside forces press for action. Under no circumstances should the hospital try to live with the inconsistency.

Drucker (1977) stresses two traits that are necessary both for an effective executive and for an effective organization:

1. building on your strengths, and
2. concentrating on the few major areas in which superior performance will yield outstanding results.

The importance of this lesson in the hospital field will increase. If your hospital is going to stand out in the crowd and position itself to provide the services that are most appropriate, you first need to recognize your hospital's unique strengths and to focus your planning efforts on building on them. In conducting its assessment of the level and the scope of services to provide, the hospital needs to consider services that are required to sustain needs rather than services required to deal with acute illness. This may well be a new approach to health care delivery for many small or rural hospitals. These two steps make it obvious that realistic goals and objectives cannot be established without knowing your current capabilities.

The review of strengths and weaknesses should be analyzed, along with the data base, in terms of constraints. The awareness of constraints, both absolute and relative, in becoming increasingly important in developing a meaningful process. Constraints are placed in the sequence of planning because they help establish parameters that must be observed or obstacles that must be overcome. Subsequent planning activities must acknowledge the barriers or ground rules that the internal organization or the environment imposes.

Constraints should not dictate planning activities, but they provide a framework for idea germination. It is necessary to recognize the realities of the current health care environment.

At this point also the committee should review their strengths and weaknesses in conjunction with any problems or issues that can be identified. The planning committee should develop a list of problems and issues the hospital faces and it must address. The first step of course is to collect and identify the issues. This procedure should not be complex and should not be overworked because there is often a redundancy in relation to the identification of the hospital strengths and weaknesses. However, this does discuss similar areas from a slightly different angle and will have the effect of narrowing the margin of error and increase the probability that what ails the institution has been correctly identified. Often the best procedure is for each committee member to work independently on a list of problems and perhaps, using two lists of current problems the hospital will face. It will become obvious that many of the problems listed can be grouped into clusters and basically have one issue underlying many problems.

In attempting to deal with crises, and gain the opportunity they provide, one must look behind the crises at the issues and problems. The difference between an issue and a problem is that the issue is the underlying cause of the problem. It is the thing that will keep causing problems if it is not corrected. An issue is a problem generator. Resolve it and you get rid of many problems. Often board and administration begin their planning efforts with solutions and then look for problems to solve. This is probably a natural tendency for finding and facing issues requires a lot of demanding and

time-consuming work. In attempting to get to the bottom of issues it helps to begin with some key questions:

1. How did things get so far without someone recognizing the issue and problem?
2. How is it possible for a situation like this to go on so long?
3. What other problems and issues are in the organization that we do not know about?
4. Is there a problem with communication?
5. What problems and issues do we need to clear away?

There are a few peculiar things about issues. First, upon investigation they are rarely the same as you think they were at first. Problems and issues are almost never what you were originally told. Secondly, issues are often fairly delicate and unspeakable. This is usually because people do not want to disparage associates and they feel that it is an act of kindness to say nothing. Third, most people in the hospital do not see the whole picture as they work only in a segment and may only see the small problems and not the entire issue. However difficult it is to dig through the problems to find the main issue, it is the board and administration's obligation to show their willingness and ability to tackle these issues.

6. Formulation of Goals and Objectives (Identifying, selecting and designing alternative courses of action)

This stage deals with the specification of organizational goals and designing the objectives by which they are to be achieved.

Subsequent to the institution's identification of potential needs, demand, opportunities, etc., and the decision to pursue a direction, it is critical to examine the various options that direction provides.

After the facts are gathered by consultants, administration and the planning committee, the next step is to dissect and digest them. Careful analysis and study will disclose trends, weaknesses, and issues that should be addressed by the committee.

Organizations must continually evaluate various courses of action throughout the planning process but it is here that a distinct point is reached where major evaluations should occur. Many future problems can be eliminated by rigorous review at this time. This is the most critical phase of the entire planning process. At this point, the committee members have the knowledge - but not necessarily the courage - to put together an effective plan. The economics of running a hospital may be forcing the committee to think in terms of dollars and cents as well as quality of care. Pet projects may have to be axed. Doctor problems may be surfacing as certain directions and decisions become apparent. The committee may be facing the unsettling discovery that the future cannot be predicted, only guesed at, and that some problems may not have apparent solution. The time has come to face the music.

It is at this stage that we are required to project the consequences of the various alternatives laid out in Stage 5.

These courses of action (alternatives) which are not consistent and do not relate to other goals or to the overall mission, are politically not viable or are unrealistic or not achievable, must be discarded. The remaining ones are evaluated in terms of priorities.

This stage narrows the alternatives and may in itself force a single choice. A truly effective strategic plan should facilitate the decision-making process to such a degree that decisions are not agonized over but seem inevitable. This selection stage entails the institution making a decision on a course of action. It represents the "go-no-go" point in the planning process carrying the full weight of the governing body, and, presumably, the endorsement of the institution's management and medical staff.

While the importance of this stage appears obvious and rational to the onlooker, it is one of the critical deficiencies of many hospitals - the inability to make decisions. Selection should mean that there will not be any turning back or rehashing of previous steps unless warranted by new developments. At this point there will be an assigning of responsibilities and a timetable for completion. What is needed at this point is a committee chairman who is determined, with the backing of the board chairman, to see the project through to the end. Having wrestled with the tough issues, the committee now must focus on pulling the ideas together into a strategic plan. Usually, various pieces of the plan are already written but must be brought together into a cohesive document.

In reaching decisions, hospitals differ from most other organizations because of the preponderance of professionals who are inclined to relate on a colleagual basis, and because of the discretness of governance and management. Professionals usually come to agreement by debating, viewpoint sharing and consensus rather than by voting or by an authoritarian approach. Consensus is essential to the implementation of a strategic plan. It cannot be achieved if one or two persons dominate the planning process.

Although it is sometimes possible for one person to influence the destiny of the hospital or organization, planning in most medical care settings usually involves many persons representing diverse interests, who think and work together, come to an agreement on what should be done. The succcess of the process rests on highly motivated participants who communicate well with each other and who are committed to the goals of the hospital. The process is often a "give and take" situation that at many times may defy logic and reason. The need to compromise does not necessarily mean failure, nor does it necessarily defeat the purpose of the activity. In this respect, planning at the hospital level is essentially a consensus forming activity.

This selecting of specific goals and objectives is a mixture of what the committee would like to see accomplished and what it believes can be achieved, provided its forecasts and assumptions materialize. Goals are an amalgamation of

what the committee believes will enable the hospital to carry out its mission (attain purpose) to satisfy specific community needs (desired position).

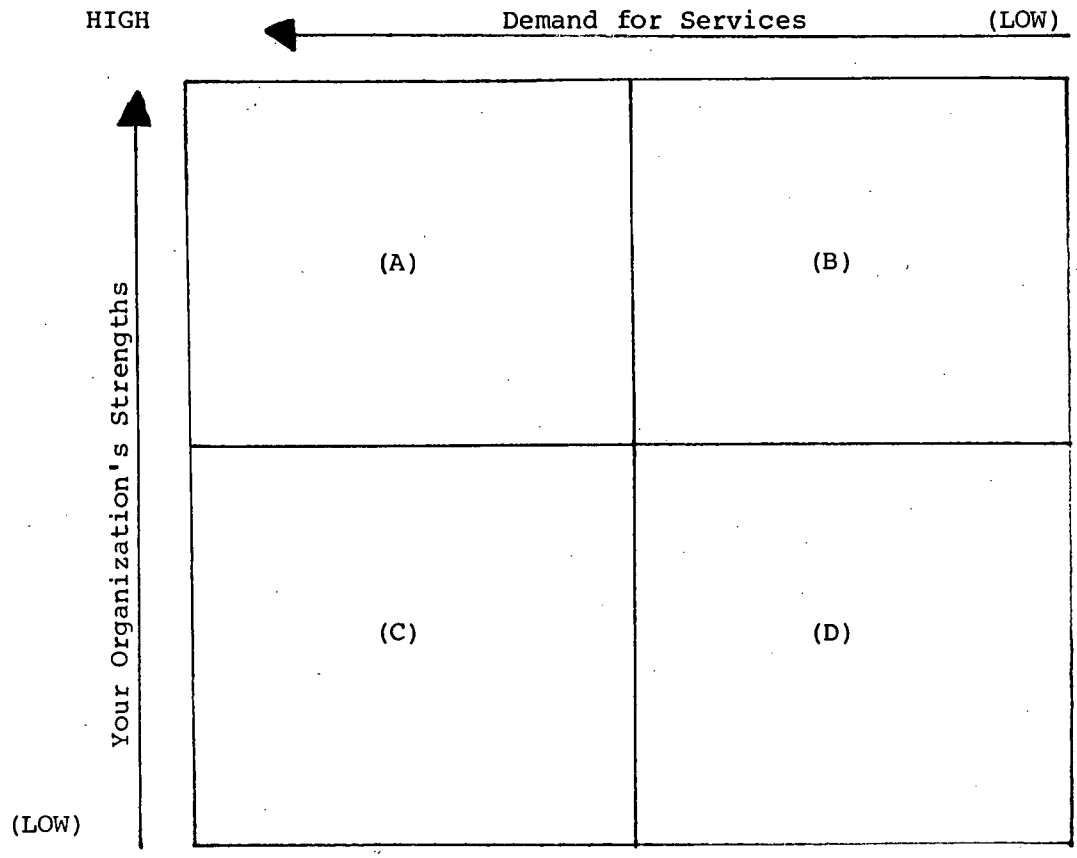
Goals, under the definition used throughout this study, are a situation or end to which the organization aspires. While it is not an actual activity, it should be submitted to the tests of:

- suitability to the principles (purpose)
- consistency or relevancy to community needs
- feasibility (can it be carried out)
- achievability (do we have the resources)
- specificity (is it detailed enough to provide a basis for action)
- effectiveness (will it achieve our desired position)
- acceptability (to all constituents)
- cost implications.

Once goals are set, they must be ranked. The task of ranking one goal over another is primarily one of exercising judgement. And, as stated, at this advanced stage of planning, education, and information, setting priorities is usually not as difficult as it may first appear.

When designing alternative goals (courses of action), several strategic planning techniques are available. One such technique is "positioning" on a strategy grid, another "segmenting". Positioning requires the organization to take each one of its programs or activities and the "position" it

on a strategy grid as described below.




Segmenting recognizes that the essence of strategy is "differentiation". How can an organization make itself different to help it gain an advantage over other organizations in the same field? Various ways by which differentiation can be realized include:

- by users
- by geography
- by age
- by delivery system
- by programs
- by services.

The second aspect of this phase is determining specific objectives to achieve each of our goals which in turn, in aggregate, represent our statement of principles. Setting clear objectives is the essence of strategic planning. Objectives refer to the goals with the implication that they can be reached. Objectives specify and operationalize the overall strategy and should have three inherent characteristics:

- measurable
- a specified time for completion
- the responsible person should be identified.

Examples of goals and objectives are provided in Appendix (16) and also in the Case Study.

7. Implementation (marketing the plan)

This stage is where definite resource allocation commitments are made. Implementation may be easier than expected as there has been an understanding and commitment to the hospital's objectives if all interests have been represented during the planning process. This is true because the planning has been done by a well-representative group from the board, medical staff and administration; as many sides of every issue have been considered; problems have been aired; conclusions reached and decisions made. In addition, there has been much contact with people in the community and there

should be a fair awareness that planning was going on. Also, no doubt that some things have leaked out. However, the rumors on the grapevine should have a high degree of accuracy so there should not be any big surprises in the final recommendations.

Periodic reporting of progress through committee minutes and group briefing sessions is suggested so that rumors are reduced and that the medical staff, especially, sees no surprises in the final plan. The plan should be consistently presented in such a way as to emphasize its goal of strengthening the hospital and the committee's intention not to detract from the practice of any physician.

If we fail to market or sell the plan internally to doctors, the board, nurses, employees, and externally, the process has been interesting and stimulating, but has no payoff for action. It is the responsibility of the board to market or communicate your plan internally and to get the commitment of all those who must act to make things happen. The efforts taken to market your plan will not be all that difficult for the techniques of strategic planning, as reviewed and outlined in this study, are designed to produce a solid plan and to generate commitment. We have seen from the process that step-by-step the plan has emerged and may well market itself when presented.

Therefore, the climate for action and change should be good and the final sell or marketing should not be difficult.

This is of course the way things should be, once in a while they really happen that way. In order to improve the success rate the committee should not overlook the value of a marketing approach.

Many believe that marketing is not a function that hospitals should practice. These who would believe this are barring their organizations from a primary vehicle for improvement. Marketing provides any type of organization - public or private, profit or nonprofit - with the means for securing the answers to the two questions which determine effectiveness:

1. What is the need?
2. How can the need be better met?

The marketing approach pursues the answers by following a planning approach which includes a determination of:

1. Who is the client?
2. Where is the client located?
3. What does the client want and need?
4. How can the organization deliver what the client wants and needs?

Planning and marketing are closely related, both conceptually and operationally. Marketing is the design and management of exchange relations with a hospital's important publics: patients, physicians, employees, other hospitals, trustees, volunteers, the public, regulatory or funding agencies, etc. Marketing should result in relations with these publics that are understood, predicted and influenced through identified

exchanges of values. It employs the same basic capabilities and processes as planning. For the purpose of this study, it is necessary to stress the importance of marketing.

No effort should be spared before, during and after formulation of the plan in selling physicians on the plan's merits. The medical staff has the power to destroy, by negative comments or half-hearted support, any chances the plan may have for success.

The board of trustees should be the easiest group to sell. Although this group originally commissioned the project, the full board may not have been active in the planning process and may not be fully aware of the committee's efforts to date. If the planning process has stirred up controversy, most board members will have received phone messages from "concerned" callers anxious about what the committee is planning for the hospital.

To forestall potential problems, the board needs to receive constant and ongoing feedback so that board members feel part of the resultant plan and are aware of the process and the problems encountered along the way. In this way, the full board will be viewed as approving of the process and will, in fact, be comfortable with its outcome. The plan should be presented to the full board for approval only after proper spadework has been done.

The plan should be sold to the ministry of health with the awareness that the ministry will look at its effect on all

hospitals within the region. The plan should be flexible enough to let ministry members contribute to it without substantially affecting its direction or intent. A plan that dovetails with the ministry's own plans is likely to be readily accepted.

In adopting strategies, a hospital's policymakers must recognize that two major target market groups, potential patients and admitting physicians, make the decisions on where they will seek the medical services that hospitals offer. The hospital's offering of a medical service does not necessarily mean that the public is aware that the hospital offers the service nor that it will choose the service when need arises.

In considering the service area and the population you will be serving (marketing), the long-standing question to consider is the orientation towards this population. The mere fact we refer to patient and not customer or consumer gives us an orientation that may not help our survival in strategic planning. Once the plan is in place and we must market the strategic plan, we are implying a customer, not a patient. The term "patient" and "sick role" that is inherent in the word "patient" is a study of its own. It is sufficient in the context thatwe are using here to bring to the reader's attention that "patient" implies "subordinate and dependent". The word "patient" has connotations that are probably at the heart of much distress and friction that exists between health care professionals and the people who

go to hospitals for help. It implies that the patient waits patiently until we can see them. "Patient" implies that if they were as smart as professionals they would also be a doctor or nurse or trustee. The patient is someone who looks to us for help, the patient is usually seated or lying down when talked to. It is usually considered that a patient is helped, and when they are helped, they should be grateful, thank the professional, and act like a patient.

This perceived role of the patient, combined with the fact that most people who are employed by hospitals have a social service lean, and they desire to be out and above the day-to-day grind of the business world, they merely want to help others. This is often hard to reconcile with the patient when newspapers are packed with stories about nurses going on strike, doctors becoming militant and considering unions, and room rates going up on a regular basis. The notion that all who work in the hospital only for the love of their fellow man no longer has credibility in our society and the image of the hospital as a place of charity just barely exists.

In considering these few facts, it may become obvious that the service population should be treated more like customer although we have said they will be the end user and the medical staff the customer. Taking a "customer" orientation will assist in strategic planning and no matter how hard a time hospital people have swallowing this fact, we are able to provide

service to our community through a commercial-like endeavour and knowing what the needs of the community are. With this orientation, it may be that when a patient leaves, it is the staff and administration who say "thank you".

If the hospital does not know what its customers (patients and medical staff) want and help them satisfy these needs, the hospital could be in trouble. Hospitals that do not take time out to learn what the needs are can probably base their failures on not understanding consumers. Marketing in its broadest sense is essential for hospitals. It is necessary for us to look at a form of market analysis and find out exactly where and what our market is. Hospitals generally ignore all the tried and true marketing techniques. With the great shifts taking place in the population profile, we must consider the impact on the hospital further down the road. Effective marketing can benefit a hospital in several ways. It provides better consumer understanding of how to properly gain access to the system, where problems lie and what services are available. Most people know the hospital is a service but they seldom know what the services provided are.

8. Evaluate

The plan should include a process for evaluating the goals and objectives so that criteria for success or failure are defined before any programs are initiated. The plan also should include a strong cost-containment program.

The final stage of the process merely illustrates the dynamic nature of the endeavour. Monitoring entails the continual review of significant changes in the various planning profiles as well as a review of the progress of various implementation activities. These become the "key indicators" in measuring organizational performance and effectiveness.

We must know when things outlive their usefulness, or when they never do live up to their promise; when that happens we must abandom them. It is difficult enough to get something new started; it is many times more difficult to turn it off.

Any phase of the planning process may need to be repeated in order to adjust to changing circumstances. Strategic plans will have no impact on the organization if they are not kept under proper surveillance and control.

In Summary:

The plan is the key to your hospital's future. Once the strategy or plan has been developed, it can be lost unless we can prepare a meticulous plan of communication to market the plan. The plan should indicate that action and changes will show up in an improved care for more patients and more kinds of problems at lower cost, and it is the obligation of the planning committee to set up measures to ensure that performance standards have been improved. This is achieved through the following process:

1. The need for planning, whatever the basis, must be recognized and the decision made to start - now.

2. The Committee is formed and the mandate is provided.
3. Start your planning by collecting and reviewing facts about your hospital. Survival starts with the facts of the present situation and historical information. Strengths and weaknesses are analyzed. Problems and issues are identified. At this point, solution should be the farthest thing from the committee's mind. The objective of the planning committee is to anticipate the future and to provide action that will reduce uncertainty. Therefore, in digging out facts we will be looking seriously for trends. This can be accomplished by projecting the hospital's statistical data and a good basic question to kick this off is "if we do nothing to modify our behaviour, if the social climate remains constant, if our competitors stand still, and if no one comes up with a medical breakthrough, this is what we can expect." (12) This basic statement assumes you are living in a change-free environment and while it is worthy of a basic statement, you can now start changing some of the key elements around, such as the social climate, competitors, and technology, along with trends in society and government.
4. Make a clear mission statement for the hospital. The mission statement can be viewed as the job description for your hospital, only stated in community terms, considering community needs, the hospital's capabilities, and the financial ability to serve.

5. Alternative action courses for survival are presented as goals and objectives.
6. The chosen courses of action are implemented.
7. The plan and the courses of action are monitored and evaluated.

The strategic plan that evolves from the planning process should provide a framework for orderly long-range planning and decision-making and should make it possible for problems, issues, and projects to be examined with a sense of perspective. The planning process itself should be responsive to input from other hospital committees and interested parties.

Once you have drafted and implemented your strategic plan, is that the end of your responsibilities as a board member, administrator, or physician, with regard to planning? Not if we accept the definition of the strategic plan given by the Stanford Research Institute:

> " The strategic plan is the long-term means which top management uses to guide an organization toward a desired future position. This plan determines the nature and scope of all other plans and reaches beyond them in time. "

This would suggest we need a state of strategic thinking, because the plan should never be frozen or the process considered concluded. Effective strategic planning requires all organizations to establish a dynamic planning approach to cope with the rapid state of change.

In Conclusion, it is clear that strategic planning in small hospitals, despite its critical importance, faces an uphill struggle. The initial roadblock is the acceptance of strategic planning as a necessary governance and management tool. This acceptance may be the critical factor in initiating and implementing the strategic planning process.

The hospital with knowledgeable board members who are enthusiastic about strategic planning has taken a giant step towards the achievement of this most critical of organization needs.

## ROLE OF THE CHIEF EXECUTIVE OFFICER

As a function of management, planning is interwoven with the other management functions, such as organizing, staffing, directing, and controlling. Planning then becomes the responsibility of all managers at all levels of an organization, although this responsibility will vary significantly among the different levels.

Effective planning by the organization's managers cannot exist without the support and involvement of the chief executive officer (C.E.O.). This basic principle should be obvious but often is not. Management experts cite the role of planning in the management process but frequently do not articulate the role of the CEO in planning. A management expert who does recognize the role of the CEO in planning is Peter Drucker, who notes:

"Management has no choice but to anticipate the future, to attempt to mold it, and to balance short-range and long-range goals.... the task of thinking through the mission of the business, that is, of asking the question 'What is our business and what should it be?' This leads to the setting of objectives, the development of strategies and plans, and the making of today's decisions for tomorrow's results. This clearly can be done only by an organ of the business that can see the entire business; that can make decisions that affect the entire business; that can balance objectives and the needs of today against the needs of tomorrow; and that can allocate resources of men and money to key results." (13)

In short, the CEO manages management and is ultimately responsible for the strategic planning and decision-making process. Often

the responsibility is handled informally. People generally believe that they do plan and are planning, even without a formal process; perhaps the CEO believes the same. Nonetheless, the following matters fall within the purview of the CEO's decision-making authority, whether or not he acknowledges them: (1) the manner in which the organization's strategy is formulated (with or without a formal planning system) and (2) the way in which opportunistic issues and threats are met.

The CEO has the primary responsibility for designing and following a course that leads the organization in the formulation of strategies and strategic planning. The design must also be created to suit his management style and needs. Unless he is comfortable with the manner in which strategies are formulated and strategic planning is done, he probably will not use it as part of his decision-making process. If may be best that the formulation of strategies be a component of a formulized planning system, but this is difficult to achieve if the CEO acts informally as a manager. The CEO sets the management tone of the organization; if he is informal, so is his approach to planning, and so is the way that subordinate managers plan.

As stated, the manner in which strategy is formulated in an organization depends on the management style of the CEO and his aspirations for the organization. CEOs should recognize their personal limitations and regularly tap the minds of others. It is often helpful to team different managers and their styles together, e.g. a detailed oriented, quantitative-oriented

manager with a qualitative-oriented manager. (14) CEOs will tend to hire management personnel whose value system and philosophies are similar to their own and those of their organization. People with the same value systems tend to react similarly to situations.

The CEO's personality, therefore, will be strongly reflected in the formulation of strategy. A futuristic, risk-taking, intuitive CEO will strongly influence the strategic direction that the organization takes. Although a CEO who tends to operate intuitively (informally) is harder to accommodate in a formal planning system, the importance of a CEO who successfully leads by "gut feelings" cannot be ignored. Indeed, it can be said, "Strategies or objectives arrived at by judgement ('educated gut feel') are just as valid (or more valid than) those arrived at by suitability, feasibility, or acceptability studies" (15)

Other CEOs favor a team approach. This approach often is more formal, with the CEO frequently meeting with key members of the medical staff, board of directors, and administrative staff to discuss strategic direction, setting of long-term and short-term goals, and evaluation of opportunities and threats. Such a "team player" CEO can adapt better to a formalized planning process, which usually is very structured and systematic. Often a written planning manual should be used to guide managers in their translation of the organization's strategies into appropriate goals.

Although intuitive and systematic thinkers certainly differ, their approaches can complement one another. Indeed, a formal

planning system, by giving an organization a more defined strategic direction, can save time spent on putting out fires and, thereby, help managers sharpen their intuitive skills. This fact often is overlooked by CEOs who won't consider formalizing the planning process. An informal manager can work in a formal mode. However, a CEO rarely can conduct the planning process alone. (16)

As Steiner has noted, "A CEO's duties are spread over a wide range of substance and, even ceremony. The CEO must be a leader of people; a skilled judge of human character, motivation and capability; a business statesman in dealing with government and community leaders; a thoughtful person who can look ahead and know how to get there; a person of action who can make decisions; an architect of the company management system; an innovator; and a vigilant seeker of opportunities who is willing to come to grips with and take risks." (17)

In many organizations including the very small, the CEO must share planning tasks with staff, consultants, and committees. Nonetheless, it is important that the CEO ensure that the planning system is designed and managed in a way that is consistent with his management style and intentions. He maintains the ultimate responsibility for planning, so that his function should operate as an extension of his office. In other words, he should retain "ownership" of the process. (18)

"Without the Chief Executive Officer's support and commitment to the hospital's planning and development program, the function is futile." (19) The CEO need not be actively involved in each step of the process, but, particularly in the introductory stages of a new planning system, his deep commitment to the process

must be communicated to the managers of the organization. Without this commitment, the formalized planning system probably is courting disaster. Indeed, if the CEO does not actively support the planning system, the organization's managers are likely to meet it with hostility and complaints. Therefore, the CEO must recognize the potential problem of anti-planning biases and act as an educator in the start-up period by explaining the importance of the system.

A CEO plans, organizes, motivates, and controls his institution as its primary manager. Many CEOs fail to recognize that they are involved in the planning process even when they intuitively decide or manage. Consequently, they frequently overlook their responsibility to integrate this informal planning into a structure to be used beneficially by the entire organization. How to formalize this process can only be determined after the CEO recognizes the need to do so.

Small organizations are often characterized by having one person who provides the power and direction - the CEO. Because of the lack of available manpower to conduct long-range planning, many administrators of small hospitals are finding that segments of the planning process can be assigned successfully to the various department heads. This approach not only aids the administrator in completing the plan, but also commits the department heads to the outcome of the planning. It also allows the CEO to utilize all the talents in a hospital. The CEO must ensure that the different opinions are recognized, understood and amended by properly interpreted facts before positions and judgements are hardened. For in order to develop effective strategies, the CEO

must have a high degree of input and participation from all levels of management.

Help must be given department heads to develop management skills and sufficient technical capability to allow them to manage their specific daily internal operations of the institution. The CEO of a small hospital needs to be freed from these routine operational responsibilities so that he can engage in policy-making that will have long term consequence for the institution. Often the administrator must decide how to staff the nursing department, how to handle physician demands, whether to use outside contractors to provide cleaning services and so on, ad infinitum. In addition to these perpetual operational problems, the administrator experiences the feeling that the world around him is shifting dramatically and as a result, the solutions of yesterday are no longer adequate to ensure success in today's fast-chaning environment. Environmental change demands a change in the CEO's priorities and time allocation. More internal operating decisions for the hospital must be delegated to others to allow the administrator time to look ahead and steer successfully through the shifting winds and tides of changing circumstances. A massive delegation of operating responsibilities by the CEO is necessary to allow time for strategic leadership.

A common major mistake is to give an employee both line responsibility and also a planning function. A line job will always consume more time, leaving little or no time for planning.

When discussing the importance of delegation to free the CEO and to involve department heads we must also touch briefly

on the importance of management decision-making. We can briefly classify organization practices on three levels: authoritative, consultative, and participative. It has been argued that the most effective are participative. Many writers have suggested that the more an organization encompasses broad participation in decision-making, the higher the productivity and overall performance it will achieve. Such organizations have been shown to display higher levels of motivation, better communication and greater member co-operation. All of these are essential in developing strategies.

It should be apparent that group decision-making involves a greater amount of participation, but that such a method is required only under certain circumstances. When we are dealing with development of strategies, we find most of the conditions where greater participation is necessary.

1. The objective quality of the decision cannot be readily measured at the time the decision is made. In other words, the decision requires judgement rather than assembling facts.
2. Group acceptance and understanding of the problem and its solution are required.
3. Implementation of the decision requires acceptance by the group members.
4. The quality of the decision is enhanced by the group interaction.
5. Professional development of the group members is important.

Group decision and participation is extremely useful in policy-making, goal-setting and strategy development since such decisions cannot be readily verified when they are made but do require acceptance and understanding if they are to be implemented.

Participation is useful in situations of strategy where diverse interests or perspectives are represented. For this reason, decisions involving vested interest of physicians, nurses, administrators, board and community must be made jointly.

Using participative management or group decision-making, one must pay attention to the different needs of the group members and alternatives to the problem before the group decides on the best solution. As department heads are given authority and responsibility and as they develop, the semblance of a sound management team will begin to take shape. It may not be ideal, but it should be an improvement and a promising start. The emphasis will have to be on teamwork and co-operation. A good CEO should be prepared to give more control to the functional line managers, allowing them to extend themselves even at the risk of failing to perform. Hospitals wishing to improve their positions in the health care industry need to establish long-term programs to develop their middle management and senior personnel. By regarding the development of superior human resources as an essential aspect of strategic plans, the CEO should be able to attract very capable people. A group of loyal productive employees is an organization's chief asset. Strategic planning will be ineffective in the long run unless it is considered in close co-ordination with human resources planning.

Once the management team is in place the CEO is freed from much of the day-to-day pressure and can concentrate on his major role in strategic planning, that is, to keep the board informed

of environmental changes and recommend strategies that will ensure the long-term viability of the hospital and its continued service to citizens in the area. This responsibility cannot be delegated. The CEO must do it, but he must also have adequate help. The department heads and staff provide him with the internal information and assistance he can use in making operating decisions. Similarly, the CEO needs someone to bring him intelligence on external realities and to help structure the strategic decision-making process. This may be a specially assigned staff, board members or members of the strategic planning committee.

The CEO of a small organization is probably the best person to nurture the community relationships. However, once the organization grows or becomes more active, a committee of the board may be struck to assume responsibility for this function.

At the administrative level, the risks involved in strategic planning are quite high. The risk is compounded by the confusion that is created by the "three-legged stool" model of power in hospitals. The balancing of power among trustees, medical staffs, and the CEO often promotes the absence of a unified hospital. The CEO, as the chief strategist, should also be the chief spokesman and the single focal point of authority for hospital matters. This is so because of the increased complexity, unionization, and regulations of modern health care. It has been estimated that the average CEO spends between 60 - 70 percent of their time in such activities as planning and review of external changes. While physicians function best on a one-to-one basis and only provide

secondary allegiance to a hospital, they still have considerable reservations about "handing everything over to the administrator." At the present, the three legged stool is not near collapse, but the pressures of today are making it extremely wobbly. To make the triumvarate function better perhaps a type of leadership comparable to that of industry should be attempted. To accomplish this it may be necessary for CEO to have membership on the hospital board and perhaps even on the medical staff's executive. They would also be on the board's nominating committee.

This level of risk, likely to be adjustable, should be determined jointly, and shared, by the board and management. Often the governing board sleeps through initial warnings of hospital disaster only to promptly wake up and fire the CEO. The CEO is being forced to be more of a risk taker just to carry out his professional commitment to keep the hospital afloat (solvent) and on course (purpose). Boards have an obligation to support their main risk taker and must be made to understand that the CEO is now caught in the middle; between the external forces insisting on more cost containment and the internal forces from the medical and nusring staff; and are extremely vulnerable. Or, if a board is going to sign off a strategy, it is sharing its risks with the CEO and must not turn on him as a scapegoat at a later time only for the reason that the plan was wrong.

These risks are brought about by the complexity of the strategic planning process. The CEO must be prepared for a variety of repercussions once he or she starts the planning process. Planning

begins to make accountability much more evident. Once one begins the planning process and things don't go as anticipated, people begin to ask why. Once members of the board become involved in planning, they are likely to want to be more involved in policy decision-making and will require more justification for activities that do not follow the agreed upon goals and objectives. Priorities can change and the once favored departments might need to share scarce resources with their previously less favored peers. Once committed to planning, a CEO might find that he or she must become much more competitive with a previously antagonistic rival. In short, planning not only sets a course, but also causes organizational behaviour change in the instuitution. All of this can probably cause discomfort, at least initially. The CEO must maintain support for planning, monitoring, and correcting the process through all of these difficult changes.

Effective planning leads to action and action involves change. At that point, it will again fall upon the CEO to create a climate that is receptive to orderly but timely change. The days are gone forever when a long, leisurely gestation period was acceptable. Increasing government and competitive pressures will often force a faster response time and a higher degree of risk taking than would have been necessary in the past if the strategy is to succeed. Those CEO's who have achieved excellence in their institutions, whether in service, quality or financial restraint, have done so by concentrating time, attention and resources on identifying and solving their problems. Successful planning and execution of

strategies to meet the rapidly changing environment requires the same level of commitment and focus from the CEO. While all chief executive officers face realitites brought on by the decision to put together a planning function, they have a tendency to underestimate the amount of time and resources that are necessary for developing an adequate plan. It has been said that as a broad, general guideline, any hospital that has more than 75 beds needs to have staff members who devote at least part of their time to planning. Any institution that has more than 200 beds should have a full-time planner.

As stated in the opening of this section, most CEOs are not ready to set up formal committees of the board to review strategy. This may be appropriate for perhaps informal discussions of the CEOs and directors to review alternative strategies should come first. Such sessions may stimulate CEOs to move faster than they might otherwise to consider basic strategy questions; and should assure them of their board's support and willingness to take part in periodic discussions leading eventually to conclusions. The astute executive, however, senses what is ready for discussion and what is not. He knows the value of a single idea not thought of before. He is aware that the more he knows about the way his managers and directors think about strategic problems, the more liekly he is to arrive at a solution that is politically acceptable as well as economically sound. Rather than inscrutably keeping his peace, he has the opportunity to open up the process, to raise questions, to encourage but not to force the facing of strategic reality, and to lead a process of decision that can enlist the

total strength of management and the support and detached insight of the board.

Because of the role and importance the position of CEO has within a small hospital, the board should carefully evaluate not only the performance but also the personality. Such an evaluation can be carried out using the H.A.A. of B.C. format (appendix #17). Frequent checks must also be made to ensure that management (CEO) is "out on the floor" and not seeking shelter somewhere or ignoring realities. The CEO should make daily patient rounds - this serves to counteract the common image of the administrator as one who clutches the financial statement like a security blanket or too often defers matters involving patient care to the medical staff or to the nursing service. What should a board look for in a CEO? Planning requires a blend of scientific analysis, human judgement, and experience. In the words of Branch (1966), many of the requisites of the successful CEO and planner - flexibility, inclusiveness of thinking, deductive ability, intuitive perception, sensitivity to human considerations and capacity to learn - depend as much on the emotional maturity as specific business experience or professional training. Stuehler (1976) identifies the three key roles of the hospital planner - facilitator, co-ordinator, and catalyst. Another role is also important - teaching. Writing, verbal and other communication skills, conceptual ability, evaluation skills, analytical skills, leadership in group process, and, if possible, training or experience in planning all will help with these roles. They should be a generalist, able to draw up priorities, weigh the risks, and make quick decisions. They should also be prepared

to question everything and take nothing for granted, preferring to go back to basics as much as possible. People's skills are essential. They must also strive to be tough, consistent, and above all, fair in making decisions, making judgements, and arriving at decisions. They should be neither over-confident about their chances of success nor too optimistic. Rather, it is often best to work from the negative position, being inquisitive and energetic and maintain a sense of balance about what is to be accomplished.

Individual directors and the CEO challenge each other, and their relationships are strengthened by associations developed in such situations as off-site discussions. They should explore things informally as well as more seriously.

There must be careful selection of the CEO for rural areas. They should be able to handle the greater visibility of their personal lives and the inevitable judgements that will be made about them by community members. Perhaps of great importance is that the CEO should have a rural background, familiar with similar cultures, and be able to maintain a low personal profile. These factors should assist in encountering more acceptance and co-operation.

## THE ROLE OF THE BOARD OF DIRECTORS

As an introductory comment, I offer a quote from Dr. Gordon Butes, founder of the Health League of Canada:

"No government, however intelligent or energetic or benevolent can cover the whole area of social needs. Voluntary effort and individual effort is more important than ever because the tasks of the state are so vast that without voluntary assistance, they cannot be accomplished and after all is that not the true meaning of democracy? Democrary means far more than merely that the citizen has the power, by his votes, to determine the personnel of his government. It also means the citizen should have a change of himself, actually assisting the work of public administration, for without that you do not realize the great idea of self government."

Implied in this quote are some basic assumptions:

1. Trustees are important to their hospitals. Many trustees don't really believe it, but they are legally in power, legally responsible and accountable. Trustees have big-time responsibilities that cannot be delegated.
2. Trustees need more information about the health care process. Trustees are generally knowledgeable about their own business affairs, but for the most part they do not know much about the complex business of providing health care. It is a highly regulated and technologically advanced industry and trustees need to know about law and about medicine and medical gadgetry.

3. The economics are tough. More and more often the government tells the hospital what its costs are, no matter how the books add up.

4. The economic consequences of decisions made in hospitals are never "clean"; some of the best decisions the hospital makes lose money, but they save lives. That's the problem; every decision is a trade-off between that which is medically desirable and that which is economically possible. The situation isn't simple to begin with and it changes monthly, daily, and worse, often retroactively.

5. Trustees are often part of the problem as they are not sufficiently informed about the issues or the mechanics of health care but with their large vote, they contribute to the problem rather than the solution.

6. Trustees can be bigger contributors to solutions because: doctors, nurses, administrators, government planners, and educators are all deeply enmeshed in their own corners of the health care field, which is not only complex, but so big that no one person knows any more than a fragment. No one has a better chance to see it all and to see it in perspective than informed trustees. They come with their outside experience and a detachment that is almost impossible for insiders to achieve. To be part of the solution, trustees need background and they need constant updating on the changing ground rules.

A trustee is the one person in the hospital who is neither so narrowly trained nor so thoroughly embedded in the present system

that they can't see the whole institution in the context of the community it serves. They are the one generalist around, the one person in the whole place who can ask questions without fear of appearing dumb, the one person who can demand that complex issues be explained simply so they can understand - and thus everyone else will understand better.

Health care trustees are always having their role and responsibilities defined, outlined and described. One would think they should be clear by now, but possibly the subject will always be of interest, since trustees by their very nature change on a regulated and fairly short term basis. This is particularly true at this time in B.C.'s history as the very nature and structure of hospital boards is being carefully scrutinized by the Ministry of Health, the professionals, and the public. It is therefore important to keep redefining the role of the trustee. There are at least three major areas of responsibility for a health care trustee. One of these is operating the institutional program for which the appointment of trustee made. A second major area is assuring that the quality of care is adequate within acceptable current standards. A third major responsibility is the assessment of health care requirements. This responsibility involves the trustee directly with a responsibility for planning.

Are hospital boards involved in this planning aspect? One research study into the board of directors of business corporations posed this question: "It was found that boards of directors of most large and medium-sized companies do not establish objectives, strategies or policies, however they are defined. The study

indicated that these roles were performed by company managements and that presidents and outside directors generally agreed that only management should have these responsibilities. Typical outside directors do not have time to determine an organization's objectives, strategies and directions as these require considerable study. At most, they can approve positons taken by management and the approval is based on scanty facts and not time-consuming analysis." (20)

This lack of policy and stragegy formulation by a board of directors is probably true in the hospital sector, although there appears to be a lack of research on the topic. Many factors may account for the small amount of literature on governing boards and their role in strategic planning. These groups are not easily accessible for indepth analysis and often the minutes of meetings rarely reflect the deliberation process.

Whether the planning role is carried out or not, it remains. This role requires that the board relate the organization, its resources, and programs to relevant external components and is the most important function of all governing boards of trustees. A clue to this planning aspect is found in the words themselves. "Governing" clearly implies that the board is the top of the internal management hierarchy. It is therefore ultimately responsible for all programs and activities of the hospital. While the daily operational decisions are delegated to subordinates through a chain of command, the board is where "the buck stops". But there is another part of the title, "trustees, which has several legal and moral implications. The thrust of these is

is that the board has a community to serve and relate to. This is where the hospital-community, organizational-environmental theory becomes a reality.

This boundary-spanning role between the organization and its environment has prompted some theorists to examine this process. Several authors have defined boundary management as the concern of trustees in defining the desired state of environmental relations. For any organizational unit to fulfill this role, information from and about the environment is needed. Since governing boards are structured most often into committees for task accomplishment, these work groups become an integral part of the boundary management process.

While the ultimate purpose of a board is to make policy and program decisions, a key prior step is the planning process through which this decision-making body recognizes the need to make those selections. This awareness issue is a mandatory step. Early problem recognition is better than late problem recognition. If an organization can learn of a problem before it becomes a crisis, then there is lead time for decision-making and coping strategies. Fire-fighting on a continual basis is almost antithetical to planning.

If the governing board is seen as the major organizational link to the external environment, then it should be anticipating and staying abreast of trends as they develop, not after they have already had an impact on the hospital. This reinforces much of the current criticism leveled against health care boards. This study confirms much of this relatively

reactive posture.

The historical growth and change in the hospital and its governing board provides one logical explanation for this posture. The past can be characterized by a gradual, yet rather consistent, erosion of governing board power in the daily administration of the hospital. Once based on financial concerns, governing board contributions have been replaced by insurance funds, government monies, and other sources of revenue. This past history has also witnessed a shifting of power to a more professional administrative structure, and a more involved and concerned medical staff. The future will, according to many, be noteworthy in a more equal division of power and influence between these three parties. One role that emerges for a board is to consciously not become overly involved in the routine of hospital functioning to the point that it detracts from policy-making.

The hospital has evolved over the years from a place where the homeless came to die to an institution of quality. The question is, how will the hospital be regarded in the future? The central part of the answer lies in the ability to reach predetermined goals and objectives because, "Information must permeate the organization's boundaries before a decision can be made." (21)

The adaptability of hospitals is an important issue for contemporary health institutions. In an era of rising costs, public concern about the quality of care and governmental analysis of medical care, as well as the ability of the hospital to regulate and guide itself, is important. If the hospital is not guided by

its top trustees, then the potential exists for other to step in and assume these responsibilities. Literature seems to indicate that:

- the seeking and use of environment data by governing boards is positively related to problem recognition at an early stage.
- the ration of externally to internally focused committees of the board is positively related (a) to the use of external data in recognizing problems, and (b) to problem recognition at an early stage.
- the occurrence of major, non-routine events in organization is positively related to early problem recognition.

To fulfill these responsibilities there must be a fuller engagement of the board of directors in design and execution of a hospital's strategic plan. Effective board participation in strategic processes can make an important long term difference in a hospital's performance and contribute to the longevity and pride in achievement of the administrators. When the board chairman opens the door to discussion of strategy, the other directors begin to participate. There are several unresolved problems which delay this participation and the board becoming productive in strategy formulation and implementing. These are:

1. It is not the board's function to formulate but to review and to monitor the process that produces it.
2. What is meant by strategy and how clearly it is set forth are not generally understood.
3. The hospital administrators are used to thinking that the board's principle function is to select, support and replace them and will

approach enlargement of the board's strategic role with much hesitation and little experience.

4. Directors are very busy and are not usually well-informed about the strategic recommendations they may be asked to evaluate and approve.
5. Central decisions that will determine the hospital's nature and performance ten and twenty years into the future are laden with risk, uncertainty and contention.

We do not have to look far to find out why. Many a C.E.O., rejecting the practicality of conscious strategy, preside over unstated, incremental, or intuitive strategies that have never been articulated or analyzed and therefore could not be deliberated by the board. Others do not believe their outside directors know enough or have time enough to do more than assent to strategic recommendations. Still other may keep discussions of strategy within management to prevent board transgression onto management turf and consequent reduction of executives' power to shape, by themselves, the future of their hospitals.

The foregoing leads to three observations. First, many trustees do not participate in strategic decisions because they find it difficult to infuse their values into the strategic process. Second, the neutralization of their values tend to reinforce the executive director's value system. Third, the time factor militates against involvement. Trustees are not always willing to spend the necessary time to do the necessary homework. These trustees, because of their busy schedules, must rely on the executive director for a flow of information, definition of their role and, frequently

evaluation of the organization's achievement of its goals. Thus, the major role of any trustee (this is policy formulation) is usually lost or forgotten. The result is that the formulation of goals and policies is then automatically relegated to the executive director, and therefore he or she practically has the power of the C.E.O. and the board all in one. Moreover, conflict between executive directors and trustees is all too common in hospitals, especially in middle-sized and small hospitals (where differences may become personal).

Even if strategy were not such a sensitive topic, invoking latent tension between C.E.O. and independent directors, it would require more time and sophistication than chairmen or outside directors, however willing, could easily summon to the task. At best, original contributions by outside directors is limited and infrequent. Nonetheless, the forces shaping hospital governance, including restlessness among independent directors, are pressing boards toward greater participation in determining the future direction and character of their organizations.

Administrators, staff and medical staff should not take the approach of wondering whether they are expecting more of the directors than most can provide in terms of time and talent. There is usually ample of both.

All in all, the strategic management void created by an unwieldy and ever changing board is compounded by executive directors whose job survival requires satisfying trustees within a limited term. The administrators must recognize that they depend more than only obliquely on their boards of directors for guidance on hospital

strategy. The board must also determine if their administrator is a strategic thinker. If he is, they must be aware of the fact that he will seldom be inhibited by anyone; but will work closely with his other top managers, the board of directors, outside professional planners, or the government.

Combined with the above stated problems, one of the greatest hindrances to strategic planning at the board level and the administration is the protection of the future against the overwhelming pressures of the present. These pressures are often easy to specify as essential but bringing about the trade-off and surviving requires judgement on the part of the board and administration. Often, no one can describe the judgement applied to future/present trade-offs but strategic thinkers know it when they see it. Similarly, the board of trustees also needs to reflect a corporate board style. This approach will assist trustees as reorganization will probably involve greater emphasis on policy formation, evaluation, and accountability; development of less casual attitudes on the board and its committees; more openness; and a variety of steps to ensure that deliberation and decisions of the board provide an appropriate balance of provider and consumer interest." The board and its committees no longer can afford to spend time reviewing daily internal activities of the hospital. Instead, the board must take a far more global perspective, plotting the hospital's role with the intent to ensure the hospital's future viability.

## THE ROLE OF PHYSICIANS

As stated, planning deals with the future and is somewhat unpredictable. One of the elements of the unpredictability hospitals have to wrestle with is how strategic planning affects and will be affected by the practice of medicine. I can say without contradiction, that a major issue in hospital strategy formulation is the role of the medical staff, a group which seldom participates formally in the institution's management decisions. The following are some explanations for the absence of the medical staff participation:

- physicians are usually viewed as resistant to change
- physicians have limited time to get involved
- physicians are fearful of becoming involved in decision-making because they will be held more accountable for the results
- the medical staff, even in a small hospital, is usually a large and diverse group. It is difficult to have wide participation and representatives do not necessarily speak for or represent a broad cross-section of the staff.
- administrators are fearful that if physicians are formally involved in decisions, they will relinquish some of their power
- there is an inherent mistrust among administrators, physicians, and nurses which creates barriers to joint efforts. Whether or not these reasons are valid or accurate, there are significant differences between the medical staff and the administrative/

board component of the hospital, differences which present real barriers to participation. For example, the power and authority of the medical staff are based on expertise. For the administrators, the power is often designed by the organization. Further, physicians are orientated to the professional specialties and patients rather than to the hospital for their sources of career rewards. Administrators, on the other hand, are orientated to the hospital for their career reward and advancement. In addition, relationships among physicians are more likely to be colleagual and informal. For administrators, relationships are more formal and based upon the structure of the organization. Physicians' goals are treatment-centred, administrators' goals focus on organization maintenance and efficiency. Finally, the work-flow of physicians is intensive - it incorporates a variety of skills necessary to treat an individual patient. In contrast, the workflow of administration is diffuse with disparate values, goals, resources and strategies.

Even with the most affable of medical staffs the potential for conflict with the board and administration is strong. A beneficial aspect of this is that such conflict may be necessary, organizationally healthy, and socially useful.

It seems likely that all these reactions, and probably others as yet unforeseen, will continue to be encountered as time goes on, varying from place to place and in some cases, from doctor to doctor. In attempting to bridge some of these existing

differences, a number of hospitals of medium and large size have established a position of medical director. However, this may not be sufficient to overcome barriers of participation, generally because the medical director is often seen either on one side or the other. The above stated reactions and differences such as training and outlook, are basically those of turf, economics, and vested interests and are therefore negotiable.

However far hospitals are forced to stray from their accustomed past due to restraint and competition, it is likely the hospital will remain essentially a place where doctors work. It must be remembered that a lot of physicians have a hard time in the practice of medicine, excluding the pressure of making it financially. The reason has to be that above everything else, physicians value the professional freedom to make their own decisions about their own patients and their own practice. Some of this freedom has already vanished into the hospital where collective decisions are made about technology, utilization and money, and that makes the freedom that remains the more to be cherished and the more reluctantly to be surrendered.

The board and administration must realize that the physician must be able to satisfy their pre-eminent loyalty to their profession by taking leadership in their area of medical expertise and knowledge. The board and administration must view their role as the vehicle through which physicians relate this knowledge and expertise to the performance and results of the organization.

It must also be remembered that the practice of medicine is a bond between two persons, both of whom bring and take away feelings as well as information. Inevitably, the patient-physician bond is stretched and strained by the unavoidable technological and economic complexities of government regulations and hospital management, and it will be further stretched and strained in an era of restraint.

In addition to professional freedom and patient care responsibilities, physicians have an implied right to influence hospital management in its performance of that care. Physicians seek a role in management to fulfill their obligations to their patients, to meet their personal legal liability, to have control of the use of their time, and to retain control over technology. The physician seeks access to management for a feeling of influence over their destiny.

Based on their professional position, patient care responsibilities, and "implied rights", the physician is the principal medium through which the resources of the hospital are made available to the patients and as such are an effective strategic weapon. Physicians play three important advocacy roles:

1. on behalf of their patients
2. on behalf of good medical practice
3. on behalf of the community in defining and meeting the health care needs.

To ensure physician's co-operation and loyalty, the hospital needs to ensure the presence of those things that move

the physician speedily and effectively through the hospital. Since hospitals do not directly charge physicians who use hospital services, it is easy for hospitals to overlook and neglect paying attention to the "price" of services that physicians offer to hospitals. Physicians' basic commodity is their professional time, so a hospital's particiaption requirements, such as committee work, as a function of medical staff membership, are a direct cost of business for physicians. A hospital must determine how it can minimize this cost for physicians. Perhaps it can in terms of the time required, of convenience afforded to the physicians, or of public or other recognition for efforts made in participation.

Such things as parking privileges, convenient dictating facilities, and well-scheduled operating room times are critical. Accessibility, evidence of follow-through and feed-back, and a clear indication of receptiveness to physician input are musts to ensure the reciprocal obligations of maintenance of clinical competence, the assurance of appropriate communications, and the meeting of hospital "citizenship".

Physicians name nursing as the number one service that they expect hospitals to provide. The difficulty of structuring this service to meet physicins' needs is complicated by the differences between physicians' and nurses' perceptions of nursing.

Another way is to give careful consideration to its activities that might be perceived by its medical staff as engaging in direct competition with their private practice of medicine.

Traditional hospital outpatient clinics generally are not perceived as being in direct competition with medical staff

members. However, if a hospital engages in primary care, it is going to be perceived as being engaged in direct competition with its own staff members. Diagnostic and treatment services constitute a potential area for conflict between a hospital and its medical staff members. Relatively few physicians in private practice are going to invest in high technology and capital-intensive services, such as C.T. Scanners, in their private office settings. However, some physicians, particularly those in group practices, are investing in an increasing array of diagnostic and treatment services of medium capital intensity as allowed by regulations on private laboratories. In what ways can the hospital, with its heavy investment in these services, make it attractive for the physicians to continue to buy them from the hospital rather than to build them into their practices? Inpatient care may seem to be an unlikely area for competition between the private practitioners and the hospital. However, private practitioners might see the growth in numbers and variety of specialists who have privileges with the hospital as direct competition between office-based medical practice and hospital care. Fifteen years ago, a hospital may have had relationships with anaesthesiologists, radiologists, and pathologists. Now, it may have such arrangements with not only more of these specialists, but also with emergency department physicians; cardiologists; pulmonary disease specialists; specialists in nuclear medicine and rehabilitation. This array of specialists may account, in part, for the decreasing number of hours that office-based physicians report they are practicing in hospitals. (22)

Physicians will be more or less satisfied with the

hospital depending on the satisfaction of their patients, their own assessment of the hospital environment, how easy they are able to associate with the hospital, and their comfort with administration's management style.

Because of their treatment skills and knowledge, physicians will retain a paramount position in the provision of health services for at least the next 10 years. Physicians determine who will receive health services; when, how and where treatment will be provided; and what kind of treatment will be provided. They are the primary "customers" of health services, whereas patients are the "end" users. Thus, physicians' judgements will determine resource allocations in vertically integrated health care systems. In fact, no health care organization can prosper unless it has recognized that, although its managers make pronouncements, its physicians make the ultimate decisions as part of their professional commitment.

It goes without saying that the medical staff should be carefully prepared regarding the planning process. The C.E.O. should use their managerial skills to see that the appropriate staff member is selected as the medical staff representative on the planning team. This physician must have the respect of her or his peers and be willing and objective enough to fully participate in the planning process. To help make this participation possible, some consideration could be given to paying the physician for staff time contributed to the planning process. Make no mistake, the medical staff will be a powerful force either in hindering or helping the hospital's planning process.

There has never been a greater need for co-operation between hospitals and medical staff. Doctors need hospitals and hospitals need doctors. This has been true for a considerable time, and will be true into the future. The relationship between the hospital and its medical staff is a symbionic one; if the hospital is to survive and prosper, so must its medical staff. Hospitals in today's troubled environment can no longer take their medical staff for granted and must do everything possible to improve their sometimes tense relationship with them. Adversary relationships will only weaken the organization and leave it unable to confront the problems and issues facing it. At this point, there will be no winners between board, administration and medical staff disputes. If the delivery of health as we now know it is to be preserved, physicians, trustees and administrators must work together more effectively and put aside any differences. The organized medical staff is the most vital mechanism in the hospital, existing as a source for self-governance and a means of communication. It is only through a strong, organized, and interested staff that effective communication and action can take place.

One prediction seems safe: any change will be introduced more successfully where the strategic plan had investigated and judged the response of the physicians and had most carefully prepared for it.

## ROLE OF THE CONSULTANT

At times it may be necessary to enlist the aid of a consulting firm in order to assist with strategic planning, either at the starting point or at some later date. When to bring in a consulting firm depends on the availability of skilled staff, and the peculiarities of the institution's own problems and planning process. In this section, I will assume that the use of a consultant is indicated and that a hospital planned and budgeted for this assistance with its strategic planning.

In selecting a consulting firm, several observations are relevant:

- what is the firm's reputation?
- whom has it worked for and how well has the client done?
- are they known and recognized by your provincial health association and the Ministry of Health's consultants assigned to your hospital?
- who are their staff members to be assigned to your project?
- how well does the firm's personality match with your institution's personality?
- are the consultants willing to teach and develop your staff and institution to further your own sophistication and capability in planning?

Hospitals should interview more than one consulting firm. There is a lot of consulting talent available so make sure your dollars buy the best for your institution.

An aspect to remember in enlisting the aid of a consultant is that you may want to consider it an ongoing arrangement. When a consultant is given the opportunity to work with a hospital over a period of time, their value increases. To give a consultant only a few weeks to produce written plans is to force them to spend time on documentation rather than analyzing, informing, assisting and challenging. A consultant needs ample time to help the hospital face reality.

The first task of the consultant is always to assess in-place management. A quick but thorough analysis of key personnel is essential to gaining an opinion of their individual capabilities. All functional areas should be reviewed for weaknessess and strengths. The problems as people view them should be identified and rated according to their seriousness.

The purpose of the consultant's role is to provide assistance in reaching the consensus that is necessary for the hospital's strategic planning. There are some general rules that should apply when a consultant is involved. It is important that whatever is done, there is visibility and a consultant must establish themselves quickly. Most planning is only accomplished from a base of sound information which, if not available, must be sought out. The consultant should be asking hundreds of questions of the administration, board and the community.

In summary, consultants can play many legitimate roles, but a hospital should be cautious about using a consultant to design and install a planning system and to prepare plans. Generally, this approach will neither assist the hospital's management process nor develop a sense of commitment to and ownership of the plans.

Consultants should be used as sounding boards but they should not do your planning for you. Once the plan emerges, it must be the committee's or the board's. It must be viewed as an original, authored by your hospital and believed in by your staff and community.

## THE ROLE OF POLITICS

### "A Question of Decentralized VS Centralized"

An important generality that probably has not yet been fully grasped is that health care is no longer just the art of healing the sick or preventing the well from getting ill. To provide health care effectively now requires a hospital to appreciate that it is deeply enmeshed in politics. It is no longer possible for a hospital to provide good health care without having good relationships with various government departments and politicians.

Funding and regulatory agency staff often are as confused and concerned as hospitals are about how to best resolve planning dilemmas. You will be most successful in hospital planning if you recognize that this situation is an opportunity and if you attempt to create an environment for receptivity to your ideas and to offer good, alternative ideas. Creating an environment for receptivity includes being perceived as a respected resource by the agencies and being politically adept. Board and management must have the capacity, responsibility, and authority to be able to approach the government on any problem or issue. However, it is desired by government health officials to meet with organizations representing a number of hospitals rather than with individual hospitals, therefore the board has a responsibility for developing good working relationships and information flows with its association. We must remember that government officials are in need of good, solid, factual material and ideas about how to deal with problems. They are totally uninterested in any type of special pleading approach that is not associated with a solution to a problem.

Students and practitioners of management who have closely analyzed the relationship of hospitals to government argue that one of the greatest problems that management exhibits in its dealings with government is that it does not have any strategy at all. Too often hospitals cannot decide whether or not to respond to government initiative and often by the time they decide they should do something, it is too late to be effective.

A word of caution is that the central government will do everything we hesitate to do. Because Canadian hospitals operate in a government /taxpayer funded environment, they can either influence government or wait for government to influence them. It is essential that hospital people learn to plan well before the government planners get the message because someone has to fill any vacuum in planning.

While it is essential that strong political ties be developed and maintained, it is critical that strategic planning be beyond the political tides. Strategic planning must remain with the individual hospital or regional hospital district rather than becoming a centralized function at the provincial health level.

If strategic planning and planning in general are implemented at a provincial level, they may not be able to compensate for the diverse local and community needs. A uniformly structured program may not be sensitive to the needs and focus of individual communities.

Simply put, should the hospital board and regional hospital districts with their understanding of local conditions have the power to make decisions for their hospital and community, or should

the government with its provincial perspective, be allowed to impose decisions on the hospital and district?

At this time of restraint and changing health needs, some local communities have become sensitive to the importance of health planning. The importance of a strong voluntary planning process linked with local decision-making structures has increased because of the potential for an alternative that is a highly regulated planning system. The sensitivity is that no planning structure, no matter how adequately funded or empowered through statutory or other means, can stimulate a cost-effective allocation of health resources unless it is accepted by the local community and unless it can support the planning process of individual hospitals.

Strategic planning for a small community hospital can be designed to help correct the deficiencies in current health planning and to reduce the need for centralized planning. The local nature of planning should be stressed through the recognition that any local health planning mechanism must be designed by and at least partially funded by the community it serves. The leaders and decision-makers of the particular community should be involved in deciding what type of health planning mechanism, if any, will exist in their community. A community's planning mechanism and authority should be based on its effectiveness in responding to the community and on the credibility of its leadership. To be effective, the community-based planning mechanism must be integrated with the existing socioeconomic and political structures of the community and perceived as acceptable by the community's leaders and decision-makers. The regional hospital districts are an existing and nearly

ideal mechanism to use. What is needed to complete the process it the enlistment of the "non-institutional" groups or the community-based services such as public health, mental health, long term care, homemaker, etc.

Hospitals must be able to work with the community-based planning mechanism to achieve cost-effective allocation of resources. The commitment by the provincial government should be to the over-riding principle that community-based planning and other mechanisms should stimulate and support the individual hospital's strategic planning efforts to meet quality, access, and productivity objectives on a community or regional basis. Accepting this places a great deal of responsibility on the individual facility to effectively plan and co-ordinate plans with other health care providers in the community.

This need to co-ordinate and co-operate is a common sense point, but one to which adherence is the exception rather than the rule. Obviously, unity among hospitals on all issues is impractical and is probably not beneficial. However, to the extent that hospitals recognize how they often weaken their position when they publicly disagree with one another, more agreement in more circumstances is likely to occur. There are many important reasons for hospitals to strive for maximum unity, particularly in public areas and on regulatory issues. In some cases, public disagreements allow regulators to play one hospital off against another in order to achieve their objectives without having to be accountable or having to build a sufficient case to justify their objectives. The overall positions of the hospital industry is weakened because the regulators

discount future position statements on behalf of the industry. It is important for hospitals to be united as much as possible because, particularly in joint planning, unity can minimize external regulation. The question of when unity among hospitals is possible is much more difficult to answer than the question of why unity is important. Some issues are so inconsequential that hospitals are not going to reach agreement with their major competitors under any circumstances. The starting point for increasing unity is to identify areas in which it is more possible and then to promote those areas. The following criteria are a starting point for determining issues that lend themselves to a unified public posture by hospitals. In other words, the potential for unity increases as:

- the impact of the issue is more long term
- it is not clear specifically which institutions will be affected and in what exact way
- it appears that the impact will be arbitrary so that all hospitals have relatively equal chances of being affected
- the issue is "less tangible". For example, hospitals more likely will support bottom-up planning than a particular bed number developed by their ministry of health
- efforts are proactive attempts to build new ideas into the system rather than strictly reactive responses to current threats
- the issue threatens the financial viability of health care institutions in general.

It is also felt that planning and regulatory processes should be formally separate. Thus, if the provincial government is providing the regulation and funding, they should not be involved in the planning.

The desire to create effective relationships with governments must not preclude the fact that there are times when hospitals must abandon the more gentlemanly, reasonable tactics and turn politically aggressive; aggressive enough to gain public support and force the government to back down on closures or budget restrictions. It may be the time that hospitals learn the lesson that if they expect to win any concessions from the political arena, they are going to have to play the game by the political rules. Hospitals may have to present their side of the problem to the public because the public, or more accurately, the voter, is the final judge. If the politician believes the public does not approve his actions, he should review history.

When national health care came in, it was an election vote getter, but there is another side to this political coin that can lose votes. If hospitals close beds, and the public is unduly disturbed, it means a loss of votes. Why this isn't obvious to hospitals and why they don't take advantage of this situation is quite simple. Most hospitals are under increasing budget pressure and are interested in only one thing: survival. They have their own internal political problems without taking on the government, and they usually react as individuals rather than as a group through their association.

Whatever political stance is taken, it must be remembered that when developing strategies to meet social, political and economic policies set by the senior government, the guiding principle must always be, if at all possible, to keep the goals of the hospital in reasonable congruence with the goals of society.

In summary, the primary loyalty of any community-based planning mechanism must be to the community at large and not to any one facility or special interest group. Even in an era of restraint, limited resources, and sometimes increased competition, the community has an interest in the outcome of health services and that interest revolves around what happens to all of the people in the community, and the health care system's role in the community's economic and political structure.

It must remain clear in the trustees' eyes that their responsibility is to see that the purpose and the motivating force of the hospital are and remain the improved health and well-being of the public and that all of their goals and objectives associated with the hospital are subordinate to that purpose. When this occurs, the rest of the hospital will understand that the trustees must be able to function as public representatives and must put the hsopital's mission, that being better public health, ahead of its own survival.

## INVISIBLE FACTORS

Inherent in every planning decision is an element of choice. Managers realize that there usually are many options open to an organization for dealing with change and that each option has certain advantages and disadvantages. Like so much of life, good management and sound planning depend on knowing how to choose well; but, as everyone knows, making a good choice seldom is easy. It is particularly difficult when it involves selecting the best option to guide an organization that is as complex and as socially relevant as a hospital is. Choosing wisely implies somthing more than rationality or selecting an action that is best suited to achieving a desired result, or appraising the risk that a proposed action in terms of what can be done to respond to opportunities and threats. Choosing wisely has an ethical aspect that reflects not only the personal preferences and values of the individuals who make the choice but also the shared beliefs, moral standards, societal responsibilities, and acknowledged obligations of the organization in which they operate. The basic question simply is "What should the organization do?" or better still, "What is the 'right' thing for it to do?"

Ethical considerations, either individual or organizational, rarely are discussed in the literature on hospital strategic planning. Instead, much of the literature that supports this study has focused on the rational elements of the process - use and limitations of data, determination of community need for hospital beds and services,

identification and roles of various participants, and other important matters that determine how the process is carried out in a hospital setting. This focus is not enough - there are overriding ethical and societal considerations that must be held by trustees, administrators, and other participants in managing a hospital's strategic planning efforts.

In hospital planning and management, consideration of individual, organizational, and societal values is crucial to ensuring that institutions individually and collectively fulfill the expectations and meet the health care needs of the communities that they serve.

Organizations themselves have value systems and goals. These systems and goals both foster and limit an organization's actions. They determine how the organization operates (its style) and how it intends to deal with the future (its strategy). All organizations are responsible for the social consequences of their actions and are held accountable for actions that violate society's prevailing ethical codes. Because of the nature of their services and their unique role in society, hospitals are expected to adhere to higher standards of ethics, responsibility, and accountability than are business or other less altruistic organizations.

The provision of hospital services traditionally has been based on and motivated by the concepts of "charity" and "gift giving". These concepts constitute a traditional value structure (often termed the Judeo-Christian ethic) that drives the provision of basic goods and services that individuals require

to survive. Throughout history, society has organized what sociologists term "sustenance organizations" in order to provide these needed goods and services. As sustenance organizations, hospitals have an essential social mission and purpose - to ensure the public's general health and well-being through the provision of health care and related community health improvement services.

At this time in Canadian history, the provision of hospital services has an obvious economic dimension. The availability and use of hospital services are being affected by economic considerations. Unprecedented advances in medical technology can save lives, but this too produces complex ethical questions for hospitals, patients, the community, and government. What is the value of human life? When, if ever, is a life not worth saving? Many renowned writers have extensively addressed these issues and the discussion still prevails. This study only briefly considers the question and presents the positon that a hospital as a "moral agent" cannot consider the topic of cost benefit analysis in ethical questions. Any policy statement or strategic plan involving same would be "morally indefensible". A hospital's ethical policy should be embodied in the services it chooses to offer or deny. For example, you will offer hemodialysis to <u>all</u> patients, or not to any. However, this fact does not mean that society's view of the role of the hospital has shifted from the charitable ethic to the exchange ethic that governs most goods and services in a competitive, free market.

In view of recent economic developments, will hospitals change so much that they must adopt other values, such as the exchange ethic, in order to survive? Would such a shift in values be acceptable to the publics that they serve? Because these questions are so important in the planning and future management of hospital services, they merit discussion.

Most public opinion studies show that, despite persistant complaints about hospital costs, food, schedules, and other operating matters, the public continues to have a high regard for hospitals and what they stand for. It also continues to view hospitals as sustenance organizations and there are no signs that this view is changing significantly. (Both the C.H.A. and A.H.A. guidelines were developed by and for the hospital industry, but they do seem to reflect widely accepted societal and community values.)

However, this information does not resolve the issue of whether hospitals must now adopt some other ethic in order to survive in what promises to be a more financially restricted and difficult environment. This question is more difficult to answer, and, in doing so, it may be helpful to consider some recent writings on this subject.

Titmuss has explored the issue of medical care being construed as a commercial service rather than as a sustenance service. He noted that treating blood tissue as a commercial commodity raises some important ethical considerations:

"The moral issues that are raised extend far beyond theories of pricing and the operations of the marketplace. More-

over, they involve the foundations of professional freedom in medical care and other service relationships with people, the concept of the hospital and the university as non-profit-making organizations, and the legal doctrine in the United States of charitable immunity. Charity in that country would be subject to the same laws of restraint and warranty and have the same freedoms as businessmen in the private market." (23)

Kinzer echoed this view in his recent commentary on cmpetition as a strategy to contain hospital costs. (24) Even more recently, in his review and examination of the ongoing debate on competition in health care, Ginzberg said that whatever gains may result from the pro-competition proposals are "problematic" and that "rather than seeking to transform the multi-segmented health care market into one that resembles the idealized model of perfect competition, health care reformers should focus on the important challenges facing the health care field - speeding the shift of resources from inpatient to ambulatory care settings, ensuring that the poor do not become victims of governmental cutbacks, developing alternatives to dumping the aged into nursing homes, and finding alternative sources of financing so that health science centres and R & D receive essential resources to advance the frontiers of knowledge and therapeutics. " (25 ) Ginzberg concluded that hospitals and the public continue their past commitment and match it with resources that society can afford to invest in needed health care services.

None of this discussion implies that sound financial support and performance are not essential to ensuring that hospitals effectively serve their communities. Hospitals can go broke if they are not managed in a fiscally sound manner, and going broke may not be in their communities' best interest, but this implication does not mean that hospitals must be driven solely by financial considerations or by bottom-line performance.

Before developing strategies and decisions, a hospital must first determine whether its goal is to maximize its financial well-being solely or to promote its community's more general benefit in the use of the hospital. Explicit consideration of the community's benefit helps to ensure that societal values and expectations are considered in the decision-making process.

Values permeate a hospital's decisions not only concerning which services it will provide but also concerning which patients it will serve. Values affect the competitive/co-operative decisions that hospitals make in relation to other hospitals and health care providers. The charitable ethic that governs the provision of health care services traditionally has emphasized the importance of co-ordination among providers to maximize their communities' benefit from the services that they render. Few hospitals are willing to take actions that would destroy or seriously cripple neighbouring institutions.

What is the relevance of this discussion for hospital management and strategic planning? Essentially, it is easy for an institution to forget about values and their importance when

it faces mounting economic pressures, countervailing technological pressures, and community demands for increased services. Nonetheless, values are integral to ensuring the ongoing "legitimacy" of each health care institution.

The concept of "legitimacy" is aimed at defining the behavioural bounds within which a hospital, as part of a larger socioeconomic system, continues to have relevance and meaning within that system. A hospital generally has little or no influence over societal values and expectations; however, it has complete control over how well it performs in satisfying these values and expectations. A hospital can become "illegitimate" - that is, it can fail to be relevant to the larger socioeconomic system if its performance of its purpose is unsatisfactory or its purpose is contrary to society's values and expectations. Loss of legitimacy usually results in declining public support and eventually results in loss of physicians, employees and patients.

Hospital managers often must make decisions in which society's expectations must be taken into account. Now, economic pressures are causing an increasing number of hospitals to face "institutional survival" issues as well. However, a hospital's legitimacy may be affected when institutional survival itself becomes the end, rather than the means to the end (community service).

In 1930, Rufus Rorem noted, "Ninety-one percent of the hospital capital has been provided by the public, without expectation of repayment or business return on the investment." (26) From this charitable beginning, the manner of meeting the

financial requirements of hospitals has shifted from informal, local community sources to more formal and impersonal. This shift and the rapid increase in the complexity of hospital organization perhaps have contributed to desensitizing hospitals to their community roots. Where these roots are still strong, they are strained by the mounting economic pressures confronting hospitals.

In the long run, however, regardless of economic pressures, hospitals' survival as viable social institutions will be ensured only through maintaining legitimacy - that is, by keeping sight of societal values and expectations. While these values increasingly emphasize the importance of efficient management, they also continue to be firmly rooted in traditions of charity in the provision of hospital services.

When hospitals are able to match societal values with the organizational goals, and when these values are supported by the personal preferences and values of the hospital's board and management, hospitals are well-prepared to deal with the many opportunities and threats that they certainly will face in today's turbulent environment.

Everyone will agree that predicting whether a hospital will grow and prosper is a high-risk game. Successful hospitals will give off certain clues as to the extent of such things as a written strategy, a standing committee for strategic planning, detail planning mechanism, a demanding board of directors, and strategic thinkers within the organization.

The successful hospital will develop strategies that will prevent it from being at the mercy of its environment, that tend to stabilize the environment and provide the hospital with some measure of control over key environmental factors all the while meeting societal values and expectations.

## CASE STUDY

The community and hospital used in this study are factual.

The City of Rossland, population 4000, is located approximately 8 km. west of Trail, population 11,000. It is a bedroom community for Trail with about 40% of the labour force working for Cominco, the world's largest lead and zinc smelter. The community of Trail supports two major medical groups (95% of the local physicians are included) that have a history of competition. Rossland supports two small groups (a one physician practice and a group of three), both of which have direct ties to the Trail Clinics. Rossland was originally incorporated in 1897 and had a population of over 10,000 during the heyday of the mining industry.

Since that time, the Rossland population has been steadily declining with intermittent periods of growth. The decline in recent years has not abated as between the two census years 1966 to 1976 the population declined from 4,264 to 3,716. However, this trend may be reversing itself as the most recent estimation of population as of 1978 was approximately 3,900. This may be due to the cost of housing and the usable land within the Trail area, making Rossland an attractive alternative to younger families and retirees who formerly went to the Coast, but who can no longer afford to. There are small communities in the

Kootenay-Boundary Hospital District and while there have been some population shifts among the communities, the region has experienced a static growth pattern.

Since 1961, there has been a steady decline in the pre-school (0-4) and elementary school (5-9) age groups, a gradual decline in the secondary school (10-19) age group since 1966, and a gradual decline in the labour force (20-64) age group. In contrast, there has been a steady increase in the senior citizen (65+) age group since 1961. Birth rates have remained almost static, but the death rate has increased slightly, as would be expected with an aging population. Compared with the remainder of the region and the Province, the rates are not significantly different. In overall terms, neither changes in death or birth rates are sufficient to affect net migration, but the aging of the population is of interest in terms of the type of services that will be required.

The history of the Mater Misericordiae Hospital has been part of Rossland's life ever since its inception in 1896. It was in that year when the local parish priest wrote to the St. Joseph's Convent in New Jersey requesting that Sisters be sent to establish a much needed hospital in this new mining camp. Two Sisters did arrive and for a time were the only females in the camp. A small hospital was established and maintained by fees from patients, a one dollar a month payroll deduction from each miner, and occasional collections. The caring and sharing relationship between town residents and the hospital was established from the beginning. In the Spring of 1897 construction began on the present site; and the

new hospital was opened in June, 1897. Land acquisitions and fund raising allowed for additions to be built in 1899 and 1921. The present 41 bed facility and the Nurses Residence were initiated in 1938 with the new kitchen and laundry wing being built in 1953. New administrative space was added in 1965.

In 1969 the Rossland Hospital Society was formed to take over the running of the hospital following the departure of the Sisters. At the 1982 Fourteenth Annual Meeting, the membership stood at 296. Since its modest beginnings 86 years ago, the hospital has provided invaluable service to the community. It has also remained as a significant source of economic stability, being the fourth largest employer with an annual payroll in excess of $1.5 million. The first Hospital Auxiliary was formed in 1938, joined the B.C. Hospital Auxiliaries in 1947, and has now grown to 67 members in 1982. They have been responsible for raising a considerable sum of money over the past years of service and have donated a long list of equipment and supplies. The Auxiliary is an extremely active and supportive group which has the ability of generating community support, and raises sizeable sums of money through various activities and the operation of their Thrift Shop. The Auxiliary President becomes a voting member of the Board of Trustees.

The Board of Trustees of the Mater Misericordiae Hospital were proud of their record of recognizing community needs and actively initiating changes accordingly. While they believed that planning is primarily a board's responsibility, they are also proud of their record of support and assistance in the implementation of

past Ministry's recommendations:

- In 1968 the obstetrics, and neo-natal care were moved to the Trail Regional Hospital because of the recognized potential for serious complications and reduced utilization rates.
- In 1977 nineteen of the Mater Misericordiae Hospital acute beds were converted to 15 extended care beds, again to meet community and regional needs. At this time our rated bed capacity was reduced from 45 to 41.
- Also in 1977, the outdated laundry facility was dismantled. The available space provided the opportunity to plan, develop and implement a much needed physiotherapy department which now services the increasing inpatient and outpatient needs. The laundry requirements are now provided on a purchase services basis from the Trail Regional Hospital.

All these responses and changes were made by the Board of Trustees and staff to meet the needs of the community and the Region, and to adapt to advancing medical technology, meanwhile continuing to maintain an active acute care service for the Rossland community.

In March, 1980, the pending retirement of the administrator and the continuing effects of the 1979-1980 five percent fiscal cutbacks - which were fully complied with - provided the Board with a unique opportunity to evaluate:

1. The organization structure and effectiveness.
2. The community needs.
3. Mater Misericordiae Hospital's role.

Following the retirement of the administrator, the Ministry of Health "suggested" to the Board of Trustees that they retain a consulting firm to provide interim administration and to conduct an Administrative Overview and Role Study, with funding provided by the Ministry.

- The Administrative Overview would assess the internal organization.
- The Role Study would assess community needs, clearly indicate potential future roles for the Rossland Hospital and combined with the Administrative Overview, would develop the methods to implement the determined role.

  During the early stages of the Role Study, the consulting firm recommended that the interim administration be replaced by a shared administrative arrangement with Columbia View Lodge, an 84 bed Intermediate Care Home situated in Trail and owned by the Trail Intermediate Care Home Society.

On June 13, 1980, the Role Study was completed and submitted to the Board of Trustees. Several specific meetings which included Board Members, Administration and Medical Staff were held and the recommendations of the Role Study were evaluated in considerable depth. It was the Board of Trustees' feeling that although it was not in total agreement with all the recommendations, the time for discussion had passed and the time for action had arrived. This need for action resulted in the Board, Medical Staff and Management taking on a strategic planning function.

Phase One of the process had occurred by way of the "suggestions" from the Ministry and the recommendations of the Role Study. The Board was forced to recognize the need to plan; there was no other viable alternative.

The Board, without realizing, embarked upon Phase Two by organizing itself into a planning committee. This was achieved more by a change in focus rather than structure. Because of the size of the existing Board (9 members) and the desire to keep everyone involved and informed, the entire Board assumed the role of the planning committee. The existing Board Chairman assumed the role of Committee Chairman and additional members, which included the Medical Advisory Committee and Senior Management were brought onto the Committee. It was felt that given the size of the community that the Board was reflective and representative of the community and no consumer member was required. The Committee, which as in fact the full Board with added representatives, was already mandated as a decision-making Committee, not an advisory one. Several of the above aspects were departures from the theoretical process. The reasons for this are threefold:

1. It eliminated one step in the decision-making process.
2. It reduced the amount of medical staff required.
3. At this point the Committee did not know it was involved in any specific theoretical planning process.

Phase Three was well established for the Committee as the development of a data base had formed the basis of the Administrative Overview and the Role Study. Ample information had been

compiled and the results analyzed. It was at this point where the Committee realized it must develop some formal method of handling the data base and for "re-analyzing" it and the consultant's report. Strategic planning awareness had been created. Several meetings ensued to discuss what strategic planning is and how it is carried out. The question of "how we got to Phase Three without knowing it" became obvious as the process and the phases were studied. The Board involved itself in an educational program to study the strategic planning process and its applicability to its own peculiar situation - a small community hospital. This educational process came under the responsibility of the shared administrative C.E.O. and due to the urgency of the situation, a very limited bibliography was used. These books were supplemented by Board Members and Management attendance at one Conference sponsored by the A.H.A.'s Centre for Small and Rural Hospital.

- Norman H. McMillan

- Joseph P. Peters

From this cursory review two aspects became obvious. One, strategic planning, in a simplified form was a process that could help the Board rationalize and formalize their thought. Two, they agreed with the three basic assumptions presented in the McMillan (1978) book which resulted in the Board's planning being advocacy and prescriptive in nature. These assumptions are:

1. "The diversity of hospitals (small and large; rural and urban) should be preserved as a source of ideas and innovation. The greatest good will be served and costs the lowest when diverse methods are allowed to serve the diverse needs of our society,

and we should not decrease our diversity without clearly proven alternatives in sight."

2. "While government agencies usually become involved in planning through a hospital's default, they do not have an impressive planning record and their efforts should be viewed with caution."
3. "Hospitals' planning records are also less than impressive and they must begin to fill the vacuum they have created over the years by not anticipating the future."

These three assumptions indicate that this study is advocacy in nature. The author agrees with Gilbert and Specht's (1974) suggestion that there are three different roles of professional planners, one being - as an advocate accountable primarily to the consumer group that purchases his services and operating with a view of the public interest derived from consumer preference.

Armed with an awareness of the strategic planning process, the Committee now began a review of the data base compiled by the consulting firm and determined what trends were obvious. The data base that was developed was very simplistic but it generated ample information for discussion and planning. From reviews of the normal reporting mechanisms the following internal and external assessments were made, several problems/issues identified, and trends developed.

At this point the Committee now had to assume the task of developing a Statement of Purpose (Philosophy, Mission) for the Hospital (Phase 4). The approach taken was that while such a development was dependent in part on the data base and trends, it was also

independent and could be modified in subsequent phases. The Description and Philosophy developed are found in Appendix XV. With the data base developed and reviewed and some trends determined it was now possible for the Committee to plot their present position (where we are and where we are headed). The creation of the philosophy now provided the Committee with a desired position (where we want to be). The distance between the two positions, "the planning gap", gave an indication of the reviews and work that remained to be performed.

In closing the gap (Phase 5) it was now necessary to review the data base information and the philosophy in terms of WOTS (Weaknesses, Opportunities, Threats and Strengths) as something is only a strength or weakness in relation to a given. The reference point is the philosophy and unless the WOTS are consistent with this mission the mission must be changed. This is of course required on a regular basis as a Strength today may be a Weakness tomorrow given the changing environment.

The following is a description of the Committee's findings:

Threat - the District conformed to the pattern of both the Province as a whole and also other somewhat similar hospital districts. All have seen a gradual decrease in the number of days that the acute care population stays in hospital, this in spite of the fact that now the case-mix is likely to represent more complex medical and surgical problems than it did in the mid-sixties (this is because of the development of home care services which deal with more minor problems thereby

reducing the need for hospitalization). (The number of acute patient days has decreased significantly between 1977 - 1978 but the male/female mix has been constant.) Also in line with the remainder of British Columbia the average length of stay for acute patients has dropped over the period and in 1978 was 6.4 days.

Weakness - The Hospital has been in the community since 1896 and has not changed or reviewed its role in totality. Rather, it has been watching and reacting to internal and external changes.

Weakness - The Regional District of Kootenay Boundary has played no role in the planning of health care for the district but rather has acted as purely a fiscal agency. The Regional District appears to be trying to divorce itself even more from its role as a hospital district and wishes to transfer all funding responsibility to the Provincial Government Ministry of Health instead of raising ¼ Mill funds.

Threat - The Hospital's occupancy rate had shown a steady decline for the past three years. The acute care occupancy (55%) must be considered low even for a small hospital such as Mater Misericordiae. 70 - 75% occupancy would be regarded as "full" given the complications of dealing with infections, male/female accommodation, and post-surgical cases which may need individual rooms when only four bed rooms are available.

Threat/ Weakness - The lack of availability of an anaesthetist would likely mean a decline in surgery. The use of the surgical facilities

for one day per week might throw into question continued existence given the current costs of staffing.

Opportunities - There had been a gradual decline in requirements for support services (laboratory, electro-cardiograms and radiology) on an inpatient basis, with the exception of physiotherapy (reflecting a need in the extended care area.) However, there was a rise in out-patient activity, which reflects both the changing style of medical practice and also a valuable function served by the hospital facilities in the community. Radiology here remains the exception having stayed relatively stable.

Weakness - It became clear that from the acute care separations the majority of patients originate from Rossland; but it was noted that if the Hospital were not used by other than Rossland residents its acute bed occupancy would be very low indeed. For extended care, the Hospital clearly serves as part of a wider system of health care and mainly caters to non-Rossland resident.

Threat - The Hospital had an aging physical plant and outdated technology.

Opportunity - On the active staff was a young orthopedic surgeon with a keen interest in arthroscopic menisectomies (knee surgery).

Threat - There remain strong "suggestions" that the Hospital move towards a Diagnostic and Treatment Centre type service, with more extended care and/or psychogeriatric beds. The occupancy rate lended to reducing acute beds in accordance with the R.H.D. projections:

ACUTE CARE BEDS PER 1000 POPULATION

RHD 2A 1976 - 1986

ACTUAL AND PROJECTED REQUIREMENTS

| Year | Beds/1000 Population |
|---|---|
| 1976 (actual) | 8.04 |
| 1977 (actual) | 7.44 |
| 1980 (with 5 bed decrease) | 7.20 |
| 1981 (projected) | 6.66 |
| 1986 (projected) | 6.56 |

The most common ailments affecting patients receiving treatment represents both diagnoses and procedures:

Weakness - signs and symptoms (general investigation) rank very highly over all years indicating that the physicians use the Hospital for surveillance of patients for whom observation is necessary.

Trend - the proportion of patients using the Hospital for respiratory disorders has declined steadily.

Trend - dental surgery, once highly ranked, no longer is performed at the Hospital.

Strength - surgical procedures, in general, rank highly, especially in the musculo-skeletal area.

Opportunity - over the years 1972 to 1978 a steadily increasing proportion of the total separations is represented by the six top ranked discharge diagnoses (1972 = 36.7%,

1978 = 50.6%) indicating a concentration of activity in the Hospital, particularly in the surgical area. Again, the absence of a resident anaesthetist may result in a changing pattern in 1979/80.

Weakness - the pattern of emergency care was inconclusive as both outpatient (non-emergent) and emergency services were entered in the same book.

Trend - the level of full-time nursing staff had been gradually decreasing (probably due to availability) and a substitution through the use of part-time workers was made.

Threat - the analysis showed a direct involvement of the Board into the day-to-day operation of the Hospital.

Threat - the ratio of physician to population is in line with the provincial standard of one physician per approximately 566 residents. It appeared the medical staff realized the limitation of the Hospital and do not use the Hospital beyond the medical capabilities of the existing staff. However, due to the decline in various types of cases coming to the Mater Misericordiae Hospital, further referral patterns to the Trail Regional Hospital had been established. This has been hastened by the lack of an anaesthetist available to the Mater Misericordiae Hospital.

Opportunity - the analysis at this point moved towards an area of softer data where, rarely if ever, figures are available to make a case. The data is, however, of considerable importance because, in a small way, it represents a sampling of opinion about Mater Misericordiae Hospital's

current functioning and its potential for serving the community in the future. In health planning there is a necessity to recognize that a number of rationalities come into play when any decision-making is underway.

In the case of the lay persons that were interviewed there was, quite predictably, considerable emotion displayed about the Hospital. It was cited as representing itself a sense of community, as providing warm, personal care, to the point that the townspeople may even be spoilt. In the case of general sickness, the Hospital was seen as providing a sense of security: this especially was viewed as important in the care of older people who needed to maintain contact with their relatives and friends. Here the unlimited access which the Hospital provides is much appreciated.

Threat - one negative note came through on a number of occasions concerning the receptiveness and openness of the Board of Trustees. It was felt that much could be done to improve the formal relationship between the Board and other organizations and representative bodies in Rossland.

Threat - professional feelings tended to concentrate around a concern that the Hospital, over the years, was gradually being downgraded. Professionals who are dependent upon the Hospital for employment would like to see a return of surgical activities but note the difficulty without more anaesthetic capability. Other professionals question the

appropriateness of care for patients represented in the already low occupancy levels, suggesting a considerable proportion of medical cases could be discharged at any one time, and that home care services could be used quite easily and effectively. It was felt to be a useful facility, which engendered considerable public interest and support. However, on the practical side, there were questions as to whether or not the Hospital could or should be continuing as an active surgical facility. Opinion by professionals outside of Rossland centres on lauding the extended care unit whilst questioning the need for acute care facilities. Some even questioned the Hospital's viability as an acute care facility, suggesting that Trail Regional Hospital should take over all services. Even in terms of out-patient activities, particularly physiotherapy, it is felt that Trail is more appropriate, especially for Cominco workers from the Rossland area. In general terms, Mater Misericordiae Hospital is regarded as duplicating services unnecessarily.

Opportunities - at a very practical level, a number of the lay persons recognized an important current function of the Hospital as a centre of employment in Rossland. In treatment terms it was recognized as a useful facility in the instance of people needing a few days of observation under medical supervision. Considerable comment was made on the utility of the emergency services provided by Mater Misericordiae

and this, together with difficulty of access to patients in the Trail Hospital, brought forth a number of comments about transportation. In the case of Mater Misericordiae Hospital, this was not felt to be problematic (although better sidewalk clearing in winter would be appreciated!), but public transportation to Trail (often relied upon by older people) was judged inadequate. It is understood however, that an increase in service is imminent. Concern was expressed also about the need to close Rossland's acute care beds and winter access to Trail was cited as a problem (the R.C.M.P. were not, however, able to confirm the difficulty noting that access was very rarely impaired).

Strength - (Opportunity) a number of programs were highly though of, particularly rehabilitation services, the extended care unit, and meals on wheels.

Threat - (Opportunity) concern was expressed in regard to the lack of anaesthetic services in that it was felt physician orientation would turn more and more to Trail. Further, the relationship of Trail Regional Hospital to Mater Misericordiae Hospital was felt to be one based on inequality, one where services had gradually gone from the Rossland Hospital. Much negative feeling existed about the prospect of using Trail Regional Hospital as an alternative acute care facility: it was felt to be inflexible in providing service; there was perceived to be a delay in obtaining treatment; and the

waiting lists were described as long.

Opportunity - suggestions, or statements of wants in this area, were rather limited, tending towards a requirement that services that currently exist be not further reduced. The lay respondents felt especially that emergency services should be maintained at the current level and that acute care beds would continue to be needed especially for sick tourists and older persons and retirees. Some persons mentioned they would like to see a return of maternity facilities, as well as an increase in surgery.

Opportunity - professional responses were consistent and came mainly from the physicians. There was felt to be a need for the future to maintain the emergency capacity of the Hospital, but mainly for minor emergencies; however, it is recognized that acute beds would be required if the Hospital were to offer these services. Further, it can be observed that if there were no acute beds the X-Ray and laboratory facilities could not be justified. It was not felt that it would be reasonable to reintroduce maternity care, but restoration of orthopedic work would be possible in the event of anaesthetic capability being available.

Threat - The Trail-based professional view of the future for the Hospital centred upon its use as a long term care facility exclusively serving the Trail overflow.

Weakness - in the review of the administrative structure of the Mater Misericordiae Hospital, it was found that there was little

delegation of authority or responsibility from the administrator to the department heads. Individual department heads were not aware of their budgets nor were they given full authority and responsibility to purchase, control staff hours, or to co-ordinate and direct their departments. Rather, there was a continual direct interference with the day-to-day operation by the administrator with the department heads which did not aid in the co-ordination of the Hospital in total.

In reviewing the administrative files and operation, it was found that there was a lack of written policy/procedures within the Hospital and many of the administrative support staff, especially the secretarial and business office staff, have been under-utilized and misutilized.

Weakness - there had been no evaluation of the administrator nor specific goals or objectives he was to achieve. This lack of objectives and evaluation eventually ended with the Board and the Hospital staff working around the former CEO. This created both a difficult situation with the former administrator, and the department heads, as no individual could work for two masters.

In summary, the Mater Misericordiae Hospital was at a crossroads. This crossroad presented the Hospital with probably the greatest challenge that it had ever faced in its 83 year history. There was an atmosphere within the institution that change must occur

for survival of the institution. The institution had played a significant role within the community of Rossland and it may continue to play a significant role in its future if planning and change occurred. It was viewed as important that the Board of Trustees maintain an open mind and act quickly and decisively to guide the Mater Misericordiae Hospital through its needed transition. It was agreed that the Board will have to play a highly visible and public role in accomplishing this change within the community that has only known the Mater Misericordiae Hospital as a hospital in a traditional sense.

The Committee was now at a stage to develop their Goals and Objectives, the timetable for action and the assignment of responsibilities (Phase 6).

Preamble:

The Board of Trustees desired to set a course for the Hospital, and wished to declare it to the Community, the Region and the Ministry, stating where the Mater Misericordiae Hospital is going in terms of programs, facilities and equipment. The intent is to plan and influence our future, to monitor our success and eliminate our failures. Our goals and objectives are to develop the following specific role described in our philosophy in full consideration of our existing strengths, our relationship to other health care facilities, and the Ministry's economic parameters.

Goals:

1. To maintain historical commitments to provide a comprehensive range of acute inpatient and outpatient health care services

for the local community.

Objectives:

1. To maintain at least the existing levels of medical and surgical inpatient services based on occupancy, not beds set up.

2. To expand efforts to increase the hospital's recognition.

   i. Increase public relations by liaising closely with City Council, Chamber of Commerce, church groups, etc. This will be done through a standing committee of the Board, to be established immediately.

   ii. Provide community education programs with emphasis on early detection and prevention, personal health care education and the effective use of health care services and facilities through the provision of information and instruction. These activities tend to keep people well and out of hospitals and provide opportunity for hospital employees to teach community members important aspects of health maintenance. This will be overseen by the Community Relations Committee.

   iii. To develop working relationships that will make explicit the belief that the Hospital is an important component of a wider system of health care which includes both facilities and community-based services. To encourage hospitals and other health care institutions to co-ordinate and consolidate services and to share support services. This will be initiated through meetings with

the facility administrators.

3. To increase outpatient activity. This is consistent with existing trends.

   i. Increase day-care surgery procedures (arthroscopic menisectomies) by 100% in the next 12 months, utilizing the interest and expertise of the orthopedic surgeon. This will require an expenditure of $20,000 and the Hospital Auxiliary will be asked to sponsor the project.

   ii. Develop a dental surgical suite that could attract a specialist from the Okanagan. Increases in #i & ii may attract the much-needed anaesthetic service.

   iii. To cancel our contract physiotherapy service with the Regional Hospital in favour of our own full-time therapist within 6 months. This therapist will be C.A.R.S. trained to develop services to the large population of arthritis sufferers.

4. To maintain our emergency department services.

   i. To upgrade our facility within the next 12 months. This will be overseen by the joint action of the Planning & Development and the Physical Facilities and Properties Committees.

   ii. To reduce the number of non-emergency conditions through patient education.

   iii. The Community Relations Committee will distribute Patient Questionaires to all Emergency Room patients to assist in

analysis of perceived quality of care within 6 months.

iv. Continue to evaluate the quality of Emergency Room care through monthly Medical Staff Emergency Room Committee case evaluations and medical care audits.

5. To promote cost-containment.

i. To develop pre-admission testing.

ii. To develop discharge planning.

iii. To develop a working liaison with the Home Care Service.

6. To develop various levels of care based on community need.

i. Redesignation of 3 acute care beds to extended care. Discussions with the Ministry will commence immediately.

ii. Review the need for Meals on Wheels with the desire to increase numbers.

7. To explore some form of utilization for the vacant Nursing Annex. Such uses may be:

- administration offices
- private practice offices
- alcohol treatment centre
- hospice care
- psychogeriatric unit.

8. To improve the image of the Board.

i. It will be important not only that the Board not be involved in the day-to-day operation but that there be a perception within the Hospital that they are not involved with the day-to-day operation. This is especially important as many of the Department Heads felt they were working

directly for the Board of Trustees and not within the administrative structure of the Hospital. This will be a large task to turn around in the minds of the individual Department Heads and it will be important that that Board be beyond reproach in re-establishing this administrative hierarchy.

ii. It is important that the Board review its policy concerning having Trustees who also have relatives working within the institution. It is hard in a small community to recruit Board members for the Society without some type of family relationship working within the Hospital. However, the Board should be cautious in having any direct family working within the institution.

iii. Just as the Board of Trustees must be seen not to interfere with the institution internally, it is also important that the community perceive the Trustees' role better. The Board of Trustees act as Trustees of the Society which is made up of residents of the community. It is difficult in a community the size of Rossland not to have direct discussions and communications concerning the Hospital and quality of care. It is therefore important that the Board emphasize with the community the role of the administration and the re-directing of complaints and praise to the administrative component of the Hospital. It will be important that individual problems which are raised with the Board of Trustees be re-directed by the Board members to the administrator.

This will be overseen by the Executive Committee.

9. To develop improved working relationships with the Regional District and other health providers.

   i. implement pre-op assessment and post-op care to service the Rossland public and to assist the Regional Hospital.

   ii. moves by the Regional Hospital District to be exempt from their planning role should be opposed by the Hospital as it will, if accomplished, completely centralize all funding in the Ministry of Health, thus removing local autonomy.

10. To develop a maintenance upgrading program and schedule.

   i. Replacement of existing HVAC system within 12 months. Negotiations will commence immediately with the Ministy as preliminary calculations indicate a 3 year payback on new boilers.

   ii. Painting of Hospital within six months.

   iii. Perform an equipment and technology review within 3 months.

These projects may delete the existing Plant Fund but are considered of such necessity they must be commenced.

11. To make the Ministry more aware of the future role of the Hospital.

   i. Prepare a Brief for submission to the Ministry within six months.

12. To review and improve the organizational structure.

   i. Update organizational chart, policies and procedures.

   ii. Perform a human resource assessment and update on all evaluations.

   iii. Decentralization and delegation to be implemented.

   iv. Develop an educational program for staff to indicate their relation to the Board.

Summation of Goals and Objectives:

The changing role of hospitals within the health care delivery system requires institutions to recognize and modify their services to meet increasing demands for non-inpatient services. The Board of Trustees must be aware of the Ministry's desires "to provide leadership to the Hospital industry in developing a full range of hospital sponsored or hospital associated non-inpatient services which would be responsive to community, economic and service needs." The Board must also agree with the Ministry of Health's commitment "to shift the emphasis from acute inpatient care in hospital beds to a full range of integrated care and to day-care and home-care in the belief that the latter are both better for the patient and less costly." The Rossland Hospital had done this in the past and was attempting to pursue this process in the future.

The Committee was now faced with the task of selecting courses of action (priority) from the many Goals and corresponding Objectives. As stated in the section on "processes", the task was easier than anticipated.

The maintenance of the acute role was paramount. The Committee "keyed" on those goals relating to acute hospital functions. All of the goals and corresponding objectives resulted in the developing of more extensive individual strategies such as the preparing of briefs, timing, communications, budgets, etc. However, most of the information was readily available.

The Committee found that most of the goals were interrelated and could/should be worked upon simultaneously. The assignment of responsibilities was relatively easy as most goals fell comfortably

into the mandate of the existing Standing Committees, or on the responsibility of Senior Management. In developing the timetable for implementation (Phase 7) ample "lead-time" was allowed.

The Committee now entered Phase 8 - the need to develop an evaluation mechanism or system.

Since this document and Case Study are current, no actual evaluation has occurred. In consideration of this aspect I will include some additional general comments on Phase 8 and refer the reader to Appendix 18 where the Evaluation Questions are set out.

In evaluation the Board must remeber that actual progress is an insufficient guide to accomplishment. Of course, it is essential that if a plan move from concept to reality, from a piece of paper to desired goals, actions must occur. However, the actions must be evaluated to determine if they are accomplishing what was intended. Even though evaluation is merely a way of comparing actual performance with intended effort, it is undoubtedly the most difficult and, at times, the most distasteful of the planning process. Few committee members or CEOs relish the discovery that their long deliberations and labours did not produce the desired results. Not only does evaluation involve self-criticism, but it also demands a discipline that makes individuals answerable for carrying out assigned tasks as planned. It is therefore not surprising that evaluation is often overlooked and that everyone assumes that the plan has a life of its own and is achieving what is expected.

## CONCLUSIONS

This document is limited to strategic planning, which is described as a process that directs an organization's attention to the future, thereby enabling it to adapt more readily to change and to determine the direction in which it chooses to move. By its very nature, strategic planning is an umbrella-like activity that sets the tone and direction for the various other planning efforts that take place within an organization. This document does not aspire to be comprehensive and deal with the entire range of planning that occurs (or should occur) with a health care facility. The document and the Case Study are presented as being unabashedly prescriptive and advocative. It also offers some secrets:

1. Keep it simple. This is the best advice given in this study although the writer fully realizes that the simplicity may be lost as consideration has been given to so many factors. However, strategic planning is not complicated.
2. It can be carried out incrementally (evolution) by taking one small step at a time.
3. It is highly unlikely that any great mistakes will be made if the Committee is willing to involve enough people.
4. It is better to take the risks involved in planning than to do nothing.

Another aspect, or secret, is that there is no concensus on how strategic planning should be practiced in any specific situation because planning means different things to different people. However, it should not be supposed that advice cannot be

offered on how to plan.

Above all, hospitals must develop the ability to question and, if necessary, change traditional (and often parochial) assumptions and policies when these seem no longer adequate for present or future conditions. If questions are asked and planning attempted, any hospital will learn that good planning comes about only with experience. The first step in this experience is creating a favourable climate. A Study indicates that a change in top management is the event most likely to initiate the process and to spur action or at least provides the opportunity (27).
This is also borne out in the Case Study.

The outcome of developing this ability to question and creating the climate to plan is the requirement to produce a unique and durable strategy, to review it periodically for its validity, to use it as the reference point for all other board decisions, and to share with management the risks associated with its adoption. In doing this the lines between management and board authority must remain clear, but the more communication across them the better.

This type of communication calls for a form of participative management which is consistent with a small hospital's budget and resources. This method calls upon board members, management staff and physicians to acknowledge their diverse interests and perspectives and to accept their responsibility for charting the future course of the organization.

With the climate created it is easy to review, through our data base, what we have been doing, where we are, and where we are headed. We must now look outside to determine if our "heading" is

is consistent with the society/community we serve.

The hospital field is now facing a challenge and an opportunity. Hospitals, and even groups of hospitals, that want to start over and try to do a better job of it now have that chance. Their best hope will be in defining more clearly the role of health planning in their institutions and in their communities, and in understanding that these two entities are utterly intertwined. If small hospitals; indeed, all hospitals of any size, are to survive, then their plans must be responsive to the community and must be based on good information about that community. Most of all, hospitals have a choice in involving themselves in community planning or having a real mess on their hands. Either we respond to community expectations or the community will cease to accept us. If the hospital is abandoned by their community, it can suddenly find that its favorable political environment and financial support can disappear overnight. The local environment can be more hostile than any hospital could realize.

To eliminate this possibility, and create congruence between the community and the health provider, strategic planning is essential. Because there is nothing so constant as change, a service organization must accept a position of continually planning and evolving. The need for careful and comprehensive strategic planning is indicated by each of the many challenges that will face small or rural hospitals in the 1980s: changing populations and changing services designed to accommodate the needs of chronic disease and the special needs of the aged, altered patterns of

health care delivery, innovative use of human resources, and adjustments in hospital organization and management. This is the worst possible time to put a freeze on new programs. If ever in the history of our health care system we needed innovative policy and administration, it is now. What is most exciting is that small or rural hospitals, because of their size, are best equipped to shift gears and to be innovative in responding to the challenges that the future can and will bring.

As this entire study is based upon being one of advocacy and prescriptive, I will not hesitate to offer predictions on the future state of strategic planning based on current comments. In most hospitals, less mangement effort will be expended on the creation of explicit, formal strategy development processes. Rather, it will be more widely accepted that strategies evolve gradually and informally as hospitals identify their values and attempt to reflect these values in their services and programs.

The key challenge for hospital managers will be to maintain or create a climate supported by value structures emphasizing excellence in programs and services. In a 1982 hospital planning review, James B. Webber (28) predicted a "growing disillusionment with the concept of strategy that is predicated on the ability to predict trends and to prepare for them."

Based on research in the corporate sector, Walter Keichel (29) observes that the concept of corporate strategy is experiencing difficulty as a viable business management approach. Thomas J. Peters and Robert H. Waterman Jr. (30) note that many of the

companies studied to not have planning staffs. Where planning staffs exist, formal planning processes are used to recognize change as it takes place and not as a major input to the decision-making process. They observe that "those who implement the plans must make the plans." (31)

In another study, James Brian Quinn found that, in major businesses, formal planning processes often are separated from decision-making processes, with the result that strategic decisions are made, more often than not, outside the formal planning process. "Real strategy," he notes, "tends to evolve as internal decisions and external events flow together to create a new, widely shared consensus for action." (32)

Quinn's (1980) study, coupled with supporting anecdontal evidence from hospitals, has stimulated a recent study of hospitals that, in part, looks at the role of formal planning in the decision-making processes of those hospitals. Joseph P. Peters and Simone Tseng and their associates conducted in-depth interviews at 10 hospitals that were distinguished as having successfully managed some form of major change. Their preliminary findings generally are consistent with those of Quinn. (33)

The uncertainty of a risky environment argue for strategic planning but also for making strategic commitments in the manner that one pays taxes: as little and as late as possible.

We will find that management will require more intuitive skills

than the development of technically correct approaches. This places greater emphasis on the role of the Board, Management and Medical Staff as strategic planners. This change may be more ideally suited to the small health care facility than the large facilities with their planning department. These intuitive skills are important now and will take more importance in two areas of planning. One, choosing wisely from alternatives involves understanding community expectations of the hospital, a hospital's historical role and mission in providing specific services and serving specific population segments, and related values, beliefs, and expectations held by boards of trustees and key medical and management staff members. (34)

Two, implementation aspects of alternates draw heavily on an understanding of values, especially those held by a hospital's work force. If a work force is devoted to excellence of patient care, management advocacy of a hard-hitting, cost-containment campaign may fail in practice if it lacks support for employees' commitment to excellence. This leads to the importance of understanding, as well as managing, a hospital's culture. Terrence E. Deal and Allan A. Kennedy (35) define a corporate culture as "a cohesion of values, myths, heroes and symbols that has come to mean a great deal to the people who work" within an organization. As Webber (36) states "the next conceptual wave lapping at the shores of the health care field may be strategic management."

Whether strategic planning eventually becomes embodied in something referred to as strategic management is for future considerations. For now, it is sufficient to say that strategic planning is critical to the health field.

In the light of information collected, reviewed and analyzed during the course of developing this document (Parts One through Five) and the insights gathered from the Case Study (Part Six), I offer the following conclusions:

Theoretical strategic planning is indeed applicable and implementable in a small, community health care setting.

This statement takes on even more credence when one views that the first several phases of "planning" in the Case Study actually occurred without the Board's knowledge. This indicates that not only is strategic planning applicable, it may well be an evolutionary process that one cannot escape during an orderly response to a crisis. It may also indicate that the answer (strategic planning) in dealing with an uncertain future is right in front of us and that we are only bound and constricted by our inability or unwillingness to participate in the apparent demands of innovative thinking that are, in fact, made simpler by using the structured and orderly format of strategic planning.

# Functions of the hospital trustee — part 1

Do you ever wonder just what it is that a trustee is supposed to do, what the chief executive officer (CEO) and the medical staff do, and how the three fit together? The first topic in the Trustee Development Program will focus on these questions.

This first unit will identify nine functions of a trustee. Although these functions may differ somewhat from hospital to hospital, they do in general define the role and legal responsibilities of a hospital trustee.

To facilitate your learning — or reviewing — these functions, we will present them in two parts. Here are the first four functions.

**It is the function of the board of trustees to:**

A. Establish and maintain procedures for conducting the business of the board.

B. Establish and update goals and policies for the hospital.

C. Develop and continuously update a long-range plan for the hospital and ensure that decisions are made in accordance with that plan.

D. Monitor and evaluate plans and programs to ensure that they meet hospital goals and policies and the objectives of the long-range plan.

| Function: | Description: | Examples: |
|---|---|---|
| A. Establish board procedures for conducting business. | The board develops and follows procedures for conducting board meetings; these should be spelled out in the hospital bylaws. | Follow parliamentary procedures. Hold regular meetings. Keep minutes of meetings. Establish committee structure. |
| B. Establish goals and policies. | The board generates or reacts to proposed *goals* (the purpose of the hospital, as stated in the constitution, bylaws, and long-range plan) and *policies* (general statements governing hospital actions). | Provide high-quality medical care for the entire community (goal). Refuse to perform abortions (policy). Examine the establishment of a new medical specialty in the hospital (policy). |
| C. Develop and update the long-range plan. | The board ensures the existence and yearly updating of a three-year or longer plan indicating the goals, policies, and programs of the hospital to meet community needs. The long-range plan examines trends in medical care and diseases as well as community characteristics. | Make current decisions in line with the long-range plan. Evaluate trends in medical care and delivery. Identify services to be offered and those not to be offered. |
| D. Monitor plans and programs that implement goals, policies, and the long-range plan. | The board defines and/or approves specific actions or services that implement goals, policies, and the long-range plan. | Approve affiliation with another hospital. Approve acquisition of major medical equipment. Review proposal for addition of burn unit. |

# Functions of the hospital trustee — part 2

Here are the last five functions of a hospital trustee.

**It is the function of the board of trustees to:**

E. Ensure the hospital's financial stability, and a harmonious relationship with government and allied agencies.

F. Select the CEO, define his duties and responsibilities, and evaluate his performance.

G. Approve selection of medical staff and ensure that it is properly organized.

H. Provide a process for evaluation of all phases of hospital performance, including the quality of medical care.

I. Ensure that the community the hospital serves is well informed about the goals and performance of the hospital; ensure that the hospital is meeting the community's needs.

| Function: | Description: | Examples: |
|---|---|---|
| E. Provide for financial stability. | The board is responsible for the approval of budgets and the financial management of the hospital; it reviews the effects of government budget allocations, inflation and new policies and programs on finances, income sources, and investments. | Ensure funds are wisely spent. Review hospital occupancy. Make decisions concerning lease or purchase of equipment. Plan development program and engage in fund raising. |
| F. Select and evaluate CEO. | The board selects the CEO, defines his responsibilities, and evaluates his performance. | Identify selection criteria. Conduct formal performance review. |
| G. Approve selection of medical staff and its organization. | The board is responsible for the actions of the medical staff; the board approves medical staff appointments, privileges, and bylaws; it also approves standards set by the medical staff, requests support information for recommendations, and approves disciplinary actions. | Approve addition of surgeon to medical staff. Award privileges to physicians. Approve recommended reappointments. Approve utilization review reports. |
| H. Evaluate all phases of hospital performance. | The board is responsible for knowing areas in which standards are important (including both operation of the hospital and quality of medical care), and it ensures that established standards are met. | Approve ranges for efficient departmental operation. Question high rate of normal tissues removed. Ensure compliance with various codes and standards. |
| I. Ensure hospital is meeting community health needs and that community is informed. | The board must assess community needs and must seek solutions to community health problems through the offering of appropriate services. It must keep the community informed of available services, long-range plans, and hospital rate structures. | Survey community health care needs. Provide for special health needs of the hospital's community. Represent varied community groups. |

# The Long-Range Planning Committee's Charge

One hospital has labeled the long-range planning committee the challenge committee. Whatever its name, the committee should not begin work until its function has been agreed upon. Here is a suggestion for the charge:

> The long-range planning committee shall make recommendations for long-range goals and objectives for the hospital. It shall attempt to be aware of all developments in the health care field and trends in society and to interpret the effect of these developments and trends on the hospital. A principal function of the committee shall be the development of a written statement describing the hospital's specific role in the community in relation to all other health care facilities. The chief executive officer of the hospital shall be on the committee, and the hospital administrative staff, under the CEO's direction, shall assist the committee in its work. There shall be at least two members of the medical staff on the committee.

This charge will serve as a model and give you a start on writing your own. Use it also as a resolution to modify the bylaws of your hospital in order to give the committee official status.

Now let's examine the charge. It makes clear that the long-range planning committee derives its authority from the board of trustees. That means that, like any other board committee, it is responsible to the full board and reports back to it.

The committee's time frame is explicitly long range. It should stay out of current operations and the administrator's hair and out of the way of the other board committees, which are working on current business most of the time.

The committee's job is to consider major issues of all sorts, major projects, and priorities, and to make recommendations to the board. Major expenditures should usually be considered first by this committee and next by the finance committee.



The charge implies that the committee has the further duties and obligations to:

- Develop a framework for orderly decision making, through a defined community role called the mission statement, a set of long-term goals and objectives, a strategy for achievement, and a timetable for recommended progress.
- Ensure that all recommendations coming from this and other committees fit within the hospital's defined role, facilitate achievement of its goals and objectives, and follow the long-range plan. It is a continuing obligation of the committee to keep the hospital on course with its plan (or strategy) or to change the plan as new facts and conditions dictate.
- Develop a sense of priorities in its examination of issues and projects so that the hospital's limited resources of time and money are spent on those projects that take it the furthest in achieving its defined role in the community.
- Act as a vehicle for good communication among the board, the medical staff, and the administration.

That is the charge the long-range planning committee needs from the board to get started.

| SESSION | PEOPLE INVOLVED | ACTIVITIES | EXPECTED OUTCOME |
|---|---|---|---|
| I | Administrator<br>Outside Consultant | -General orientation to planning<br>-Role of Planning Committee<br>-Planning Tasks<br>-General Discussion of Hospital-related info., stats, trends<br>-Introduction of Community Survey<br>-What do we do next? | Promote discussion of planning<br>Answer questions about hospital, planning, external agencies<br>Initiate thinking about strengths and weaknesses |
| II | Administrator<br>Planning Committee | -Information/Educational Item *<br>-Brief Review of Role and Tasks of Planning Committee<br>-Strengths/Weaknesses Assessment<br>-Discussion of Mission Statement<br>-Review of a draft "Community Survey"<br>-What do we do next? | Listing of Strengths<br>Listing of Weaknesses<br>Develop appreciation and understanding of Mission Statement<br>Gain Consensus on Survey |
| III | Administrator<br>Planning Committee | -Information/Educational Item<br>-Review Strengths/Weaknesses Listing<br>-Prioritize top 5 Strengths to build on<br>-Prioritize top 5 Weaknesses to address<br>-Relate to a future Mission Statement<br>-Finalize Community Survey<br>-What do we do next? | Prioritization of areas to address<br>Consensus on Survey<br>Draft of a Future Mission Statement<br>Identify what is to be addressed at next meeting |
| IV. | Administrator<br>Planning Committee | -Information/Educational Item<br>-Discuss preliminary results of Survey<br>-Discussion of "Issue" (see format)<br>-Discussion & development of Institutional Goals<br>-What do we do next? | Reach consensus on a recommendation pertaining to "Issue #1"<br>Identify further informational needs |
| V, VI, VII | Could take same format as #IV or until all major issues have been addressed | | |
| VIII | Administrator<br>Planning Committee | -Finalize Mission Statement<br>-Review draft of the Written Plan<br>-Discuss additional areas of concern or interest that may not be of immediate concern to Committee, i.e. what should we be considering after this? What should future goals be?<br>-What do we do next? | Finalize the plan and prepare to present to Hospital Board<br>Identify future role of the Planning Committee |
| IX | Administrator<br>Planning Committee | -Finalize above from Session VIII | |
| X | Administrator<br>Planning Committee<br>Hospital Board | -Present to Hospital Board for approval. | |

# PLANNING CHECKLIST

## The Status of Your Need for Planning:

1. Where is your long-range planning document?
2. What is the composition and function of your Long-Range Planning Committee? Do you have one?
3. Is the nature of the area around the hospital changing in any significant manner (composition of population, availability of health facilities)?
4. What staff resources are devoted to the hospital planning process?
5. What are the population trends in your service areas and what are your plans to accommodate the population and meet the need for services required by that population?
6. Does the hospital know the regulatory requirements affecting its future plans?
7. What new programs or services are you planning to provide in the next year? Next three years? Next five years?
   - How were these ideas identified?
   - Does your medical staff agree with them?
   - What impact will they have on existing services and programs?
8. What external factors do you consider when developing your plan and your budget? What internal (e.g. cost containment) factors?
9. What are your specific goals and objectives for the next year and over the coming five years?
10. Are there presently any functional deficiencies in the existing site and buildings? Do all functional features conform to current minimum standards?

Planning Checklist - Continued

11. Are the existing location and allocations of space for each department adequate in relation to the present and future objectives of the organization?
12. Are there any other physical plant problems or deficiencies which detract from efficient building operation (e.g. mechanical, electrical and ventilation systems, etc)?

Province of British Columbia

Ministry of Health
HOSPITAL PROGRAMS

FINANCIAL REPORT FOR THE _____ HOSPITAL NUMBER _____

_____ MONTHS ENDED _____ 19____ _____ B.C.

| | ACTUAL YEAR TO DATE | |
|---|---|---|
| **A. INCOME** | | |
| 1. HOSPITAL PROGRAMS-INPATIENT | | |
| 2. HOSPITAL PROGRAMS-CO-INSURANCE | | |
| 3. HOSPITAL PROGRAMS-OUTPATIENT | | |
| 4. HOSPITAL PROGRAMS-SUB TOTAL | | |
| 5. LONG TERM CARE-INPATIENT | | |
| 6. OTHER-INPATIENT | | |
| 7. OTHER-OUTPATIENT | | |
| 8. ROOM DIFFERENTIAL (100%) | | |
| 9. CAFETERIA | | |
| 10. OTHER INCOME | | |
| 11. SUB TOTAL (1 TO 10) | | |
| 12. ROOM DIFFERENTIAL (40%) | | |
| 13. NET INCOME (11 LESS 12) | | |
| 14. EXCLUDABLE INCOME | | |
| 15. OPERATING INCOME (13 LESS 14) | | |
| **B. EXPENDITURES** | | |
| 1. SALARIES & WAGES | | |
| 2. PROFESSIONAL FEES | | |
| 3. EMPLOYEE BENEFITS | | |
| 4. MEDICAL / SURGICAL SUPPLIES | | |
| 5. DRUGS | | |
| 6. DIETARY FOOD & SUPPLIES | | |
| 7. PLANT MAINTENANCE | | |
| 8. LINEN & LAUNDRY | | |
| 9. PATIENT CARE, DIAGNOSITC & THERAPEUTIC | | |
| 10. ADMINISTRATIVE & GENERAL SUPPORT | | |
| 11. PLANT OPERATION & HOUSEKEEPING | | |
| 12. OTHER | | |
| 13. BAD DEBTS | | |
| 14. SUB TOTAL (1 TO 13) | | |
| 15. EXCLUDABLE EXPENDITURES | | |
| 16. OPERATING EXPENDITURE (14 LESS 15) | | |
| 17. SURPLUS / DEFICIT | | |

PROJECTED YEAR END SURPLUS / DEFICIT _____

NOTES _____

NAME (PLEASE PRINT) _____ TITLE _____ SIGNATURE _____ DATE _____

HLTH 1838B (HIA 358) REV 82/04

Province of British Columbia
Ministry of Health
HOSPITAL PROGRAMS

SUPPLEMENTARY FINANCIAL REPORT FOR THE _____ HOSPITAL NUMBER _____

_____ MONTHS ENDED _____ 19____ _____ B.C.

## A. AUTHORIZED CHARGES (CO-INSURANCE) INPATIENT (HOSPITAL PROGRAMS DAYS)

| | ACUTE/REHAB | EXTENDED CARE | LONG TERM CARE |
|---|---|---|---|
| CHARGED TO HOSPITAL PROGRAMS | | | |
| CHARGED TO PATIENTS, ETC. | | | |
| TOTAL | | | |

## B. HOSPITAL PROGRAMS ADVANCES

| | DEBIT | CREDIT |
|---|---|---|
| BALANCE END OF CURRENT MONTH | $ | $ |

## C. STATEMENT OF WORKING CAPITAL -

| | OPERATING A/C | CAPITAL A C |
|---|---|---|
| CURRENT ASSETS | | |
| 1. CASH | | |
| 2. INVESTMENTS | | |
| 3. ACCOUNTS RECEIVABLE BCHP | | |
| 4. ACCOUNTS RECEIVABLE OTHER | | |
| 5. INVENTORIES | | |
| 6. PREPAID EXPENSE | | |
| 7. OTHER | | |
| 8. TOTAL | | |
| CURRENT LIABILITIES | | |
| 9. BANK LOANS / OVERDRAFT | | |
| 10. SALARIES & WAGES PAYABLE | | |
| 11. EMPLOYEE DEDUCTIONS PAYABLE | | |
| 12. ACCRUED HOLIDAY & SICK RELIEF | | |
| 13. OTHER ACCOUNTS PAYABLE | | |
| 14. OTHER | | |
| 15. TOTAL | | |
| 16. WORKING CAPITAL | | |

## D. CASH FLOW PROJECTION — OPERATING FUND

| | MONTH | MONTH | MONTH |
|---|---|---|---|
| 1. CASH ON HAND, BEGINNING OF PERIOD | | | |
| RECEIPTS | | | |
| 2. HOSPITAL PROGRAMS | | | |
| 3. M.S.P. | | | |
| 4. OTHER | | | |
| 5. TOTAL CASH AVAILABLE | | | |
| PAYMENTS | | | |
| 6. PAYROLL | | | |
| 7. EMPLOYEE DEDUCTIONS PAYABLE | | | |
| 8. ACCOUNTS PAYABLE | | | |
| 9. OTHER | | | |
| 10. TOTAL CASH DISBURSEMENTS | | | |
| 11. CASH ON HAND, END OF PERIOD (1+5-10) | | | |

PREPARED BY: _____ DATE: _____

TITLE: _____

Province of British Columbia

Ministry of Health
HOSPITAL PROGRAMS



STATISTICAL REPORT FOR THE _____ MONTHS ENDED _____ 19 ___

HOSPITAL NAME _____ NUMBER _____

LOCATION _____ B.C.

## A. BEDS, ADMISSIONS, PATIENT DAYS, ETC.

| | ACUTE/REHAB 1 | EXTENDED CARE 2 | LONG TERM PATIENTS 3 | NEWBORN 4 | LONG TERM CARE PROGRAM 5 |
|---|---|---|---|---|---|
| 01. PATIENT DAYS-HOSPITAL PROGRAMS | | | | | |
| 02. PATIENT DAYS-OTHER | | | | | |
| 03. ADMISSIONS | | | | | |
| 04. SEPARATIONS | | | | | |
| 05. TOTAL DAYS STAY-SEPARATIONS | | | | | |
| 06. AVERAGE LENGTH OF STAY | | | | | |
| 07. RATED BEDS (APPROVED) | | | | | |
| 08. BEDS SET UP | | | | | |
| 09. PERCENTAGE OCCUPANCY | | | | | |

NOTES _____

## B. TYPES OF CARE

| | PATIENT DAYS 1 | BEDS SET UP 2 |
|---|---|---|
| 10. MEDICAL | | |
| 11. SURGICAL | | |
| 12. MEDICAL/SURGICAL UNDIFFERENTIATED | | |
| 13. PAEDIATRIC | | |
| 14. OBSTETRICAL | | |
| 15. ICU/CCU | | |
| 16. OTHER CRITICAL CARE (SPECIFY) _____ | | |
| 17. PSYCHIATRY | | |
| 18. REHABILITATION | | |
| 19. OTHER (SPECIFY) _____ | | |
| 20. TOTAL | | |

NOTES _____

## C. LABORATORY UNITS

(ENTER STANDARD LABORATORY UNITS FOR TECHNICAL AND NON-PROFESSIONAL WORKLOAD - DO NOT INCLUDE UNITS FOR PROFESSIONAL COMPONENT OF WORK SUCH AS MEDICAL INTERPRETATION, ETC.)

| | INPATIENTS 1 | OUTPATIENTS 2 | REFERRED IN (INCL. PUBLIC HEALTH) 3 | ROUTINE HEALTH EXAMS, QUALITY CONTROL ETC. 4 | TOTAL UNITS 5 |
|---|---|---|---|---|---|
| 21. STANDARD LAB UNITS DONE BY OWN HOSPITAL | | | | | |

| | NUMBER OF TESTS REQUESTED FOR | | TOTAL TESTS REQUESTED ON SPECIMENS REFERRED OUT 3 | NUMBER OF TESTS REQUESTED FROM | | |
|---|---|---|---|---|---|---|
| | INPATIENTS 1 | OUTPATIENTS 2 | | PROV. OWNED LABORATORIES 4 | OTHER HOSPITALS, RED CROSS 5 | OTHER LABORATORIES 6 |
| 22. NUMBER OF TESTS REQUESTED FOR SPECIMENS REFERRED OUT | | | | | | |

NOTES _____

Province of British Columbia — Ministry of Health, HOSPITAL PROGRAMS



STATISTICAL REPORT FOR THE _____ MONTHS ENDED _____ 19____

HOSPITAL NAME _____ NUMBER _____

LOCATION _____ B.C.

## D. SERVICES WHICH MAY BE PROVIDED BY LABORATORY, RADIOLOGY, OR A SEPARATE ORGANIZATIONAL UNIT OF THE HOSPITAL (DO NOT INCLUDE UNITS REPORTED IN SECTIONS C or E)

| | NUMBER OF EXAMINATIONS OR TREATMENTS | | NUMBER OF STANDARD UNITS | | NAME OF ORGANIZATION CARRYING OUT THE SERVICE |
|---|---|---|---|---|---|
| | INPATIENTS 1 | OUTPATIENTS 2 | INPATIENTS 3 | OUTPATIENTS 4 | 5 |
| 01. ECG | | | | | |
| 02. EEG | | | | | |
| 03. ULTRASOUND | | | | | |
| 04. NUCLEAR MEDICINE | | | | | |
| 05. OTHER (SPECIFY) _____ | | | | | |

NOTES _____

## E. RADIOLOGY

| THERAPEUTIC RADIOLOGY | BY HOSPITAL | | BY OTHER AGENCIES FOR PATIENTS OF THE HOSPITAL | | TOTAL |
|---|---|---|---|---|---|
| | INPATIENT 1 | OUTPATIENT 2 | INPATIENT 3 | OUTPATIENT 4 | 5 |
| 06. NUMBER OF TREATMENTS | | | | | |

| SCANNING (C.A.T.) | INPATIENTS 1 | OUTPATIENTS (INCL. ROUTINE EXAMINATIONS-STAFF) 2 | TOTAL 3 | TOTAL | |
|---|---|---|---|---|---|
| | | | | DONE BY HOSPITAL 4 | DONE BY OTHER AGENCIES 5 |
| 07. NUMBER OF EXAMINATIONS | | | | | |
| 08. NUMBER OF STANDARD UNITS | | | | | |
| DIAGNOSTIC (INCLUDING FLUOROSCOPY) | | | | | |
| 09. NUMBER OF EXAMINATIONS | | | | | |
| 10. NUMBER OF STANDARD UNITS | | | | | |

NOTES _____

## F. PHYSICAL MEDICINE AND REHABILITATION

| PHYSIOTHERAPY | BY STAFF OF PHYSICAL MEDICINE AND REHABILITATION UNIT | | BY OTHER HOSPITAL STAFF OR OUTSIDE AGENCY FOR PATIENTS OF THE HOSPITAL | | TOTAL |
|---|---|---|---|---|---|
| | INPATIENTS 1 | OUTPATIENTS 2 | INPATIENTS 3 | OUTPATIENTS 4 | 5 |
| 11. NUMBER OF PATIENT ATTENDANCES | | | | | |
| 12. NUMBER OF WEIGHTED UNITS | | | | | |
| OCCUPATIONAL THERAPY | | | | | |
| 13. NUMBER OF PATIENT ATTENDANCES | | | | | |
| 14. NUMBER OF WEIGHTED UNITS | | | | | |
| OTHER THERAPY | | | | | |
| 15. NUMBER OF PATIENT ATTENDANCES | | | | | |

NOTES _____

## G. RESPIRATORY TECHNOLOGY

| | INPATIENTS 1 | OUTPATIENTS 2 | TOTAL 3 |
|---|---|---|---|
| 16. NUMBER OF TREATMENTS AND DIAGNOSTIC PROCEDURES | | | |

NOTES _____

Province of British Columbia — Ministry of Health — HOSPITAL PROGRAMS

STATISTICAL REPORT FOR THE _____ MONTHS ENDED _____ 19____

HOSPITAL NAME _____ NUMBER _____

LOCATION _____ B.C.

## H. SURGICAL SERVICES

| | INPATIENTS 1 | OUTPATIENTS: SURGICAL DAY CARE 2 | OUTPATIENTS: ALL OTHER OUTPATIENTS 3 | TOTAL 4 |
|---|---|---|---|---|
| 01. NUMBER OF VISITS DURING WHICH OPERATIONS, TREATMENTS OR EXAMINATIONS WERE CARRIED OUT IN THE SURGICAL SUITE. | | | | |
| 02. NUMBER OF HOURS—OPERATING ROOMS | | | | |
| 03. NUMBER OF HOURS—P.A.R. | | | | |

NOTES _____

## I. EMERGENCY UNIT

| | INPATIENT VISITS 1 | OUTPATIENT VISITS 2 | TOTAL VISITS 3 |
|---|---|---|---|
| 04. NUMBER OF VISITS TO EMERGENCY UNIT (INCLUDE ALL URGENT & SHORT STAY VISITS. DO NOT INCLUDE SURGICAL DAY CARE OR ORGANIZED OUTPATIENT CLINICS.) | | | |

NOTES _____

## J. AMBULATORY CARE

| | NUMBER OF VISITS: INPATIENTS 1 | NUMBER OF VISITS: OUTPATIENTS 2 | NUMBER OF PATIENTS: INPATIENTS 3 | NUMBER OF PATIENTS: OUTPATIENTS 4 |
|---|---|---|---|---|
| 05. PSYCHIATRIC DAY / NIGHT CARE | | | | |
| 06. DIABETIC DAY CARE | | | | |
| 07. RENAL DAY CARE | | | | |
| 08. PSYCHIATRIC OUTPATIENT | | | | |
| 09. DIETETIC COUNSELLING | | | | |
| 10. GENERAL & SPECIAL CLINICS | | | | |
| 11. OTHER OUTPATIENT | | | | |

NOTES _____

## K. DIETETICS (MEAL DAYS)

| | INPATIENTS 1 | OUTPATIENTS 2 | STAFF AND VISITORS 3 | SUPPLIED TO OTHER INSTITUTIONS 4 | TOTAL MEAL-DAYS 5 |
|---|---|---|---|---|---|
| 12. PREPARED BY HOSPITAL | | | | | |
| 13. PURCHASED FROM OTHERS | | | | | |

NOTES _____

## L. LAUNDRY (SOILED WEIGHT - KILOGRAMS)

| | DONE IN HOSPITAL 1 | SENT OUT 2 | TOTAL 3 |
|---|---|---|---|
| 14. DONE FOR OWN HOSPITAL | | | |
| 15. DONE FOR OTHER HOSPITALS / INSTITUTIONS | | | |
| 16. TOTAL | | | |

NOTES _____

Province of British Columbia

Ministry of Health
HOSPITAL PROGRAMS



STATISTICAL REPORT FOR THE _____ MONTHS ENDED _____ 19 ____

HOSPITAL NAME _____ NUMBER _____

LOCATION _____ B.C.

## M. NURSING PERSONNEL

| | GRADUATE 1 | TOTAL 2 |
|---|---|---|
| 1. MEDICAL | | |
| 2. SURGICAL | | |
| 3. MEDICAL/SURGICAL UNDIFFERENTIATED | | |
| 4. PAEDIATRICS | | |
| 5. REHABILITATION | | |
| 6. ICU / CCU | | |
| 7. OTHER SPECIAL CARE SPECIFY _____ | | |
| 8. OTHER SPECIAL CARE SPECIFY _____ | | |
| 9. OTHER SPECIAL CARE SPECIFY _____ | | |
| 10. OBSTETRICS | | |
| 11. PSYCHIATRY | | |
| 12. EXTENDED CARE | | |
| 13. SUB TOTAL—INPATIENT (1-12) | | |

| | GRADUATE 1 | TOTAL 2 |
|---|---|---|
| 14. LABOUR & DELIVERY | | |
| 15. NURSERY | | |
| 16. SURGICAL SERVICES | | |
| 17. P.A.R. | | |
| 18. EMERGENCY | | |
| 19. AMBULATORY CARE | | |
| 20. OTHER NURSING | | |
| 21. SUB TOTAL (13-20) | | |
| 22. OTHER NURSES | | |
| 23. NURSING ADMINISTRATION | | |
| 24. TOTAL (21-24) | | |

NOTES _____

## N. OTHER PERSONNEL

| | PARA-PROFESSIONAL 1 | TOTAL 2 |
|---|---|---|
| 25. LABORATORY | | |
| 26. E.C.G. | | |
| 27. E.E.G. | | |
| 28. NUCLEAR MEDICINE | | |
| 29. PHARMACY | | |
| 30. RADIOLOGY | | |
| 31. PHYSIOTHERAPY | | |
| 32. OCCUPATIONAL THERAPY | | |
| 33. OTHER THERAPY | | |
| 34. RESPIRATORY TECHNOLOGY | | |
| 35. DIETETICS | | |
| 36. SOCIAL SERVICES | | |
| 37. MEDICAL RECORDS | | |
| 38. SUB TOTAL (25-37) | | |

| | TOTAL 2 |
|---|---|
| 39. ADMINISTRATION | |
| 40. MATERIALS MANAGEMENT | |
| 41. LAUNDRY & LINEN | |
| 42. HOUSEKEEPING | |
| 43. PLANT OPERATION & SECURITY | |
| 44. PLANT MAINTENANCE | |
| 45. OTHER (SPECIFY) | |
| 46. OTHER (SPECIFY) | |
| 47. SUB TOTAL (38-46) | |
| 48. SALARIED MEDICAL STAFF | |
| 49. STUDENTS-MEDICAL | |
| 50. STUDENTS-NURSING | |
| 51. STUDENTS-PARA-PROFESSIONAL | |
| 52. STUDENTS-OTHER | |
| 53. SUB TOTAL (49-52) | |

NOTES _____

## O. TOTAL PERSONNEL

| | FULL TIME EQUIVALENTS |
|---|---|
| 54. NURSING (LINE 24, COLUMN 2) | |
| 55. OTHER PERSONNEL (LINE 47) | |
| 56. MEDICAL STAFF (LINE 48) | |
| 57. SUB TOTAL (LINES 54+55+56) | |
| 58. STUDENTS (LINE 53) | |
| 59. TOTAL (LINES 57+58) | |

NOTES _____

STATISTICS CANADA

# WORKSHEET ONLY

HEALTH AND WELFARE CANADA

## 1982-83 ANNUAL RETURN OF HEALTH CARE FACILITIES – HOSPITALS (01)
## PART ONE

Name of hospital _____

Street and number _____ Postal address _____

City, town, etc. _____ Province _____ Postal code [ ][ ][ ] [ ][ ][ ]

### CLASSIFICATION OF HOSPITAL – Check or specify all appropriate items (as at end of period)

**TYPE**

| | | 1 |
|---|---|---|
| 01. | Public (incl. Voluntary, Prov. & Munic.) | 011 ☐ |
| 02. | Proprietary | 021 ☐ |
| 03. | Federal | 031 ☐ |

**SERVICE**

| | | |
|---|---|---|
| 04. | General – without long term units | 041 ☐ |
| 05. | – with long term units | 051 ☐ |
| | Specialty: | |
| 06. | Pediatric | 061 ☐ |
| 07. | Other (specify) _____ | 071 ☐ _____ |
| 08. | Rehabilitation (incl. Convalescent) | 081 ☐ |
| 09. | Extended Care (incl. Chronic) | 091 ☐ |
| 10. | Other (specify) | 101 ☐ _____ |

**SIZE**

| | | |
|---|---|---|
| 11. | Rated Bed Capacity (Adults and Children) | 111 [ ][ ][ ][ ] |

**OWNERSHIP AND OPERATION** (check one only in each column)

| | | Ownership 2 | Operation 3 |
|---|---|---|---|
| | Voluntary | | |
| 12. | Lay corporation | 122 ☐ | 123 ☐ |
| 13. | Religious organization | 132 ☐ | 133 ☐ |
| 14. | Red Cross | 142 ☐ | 143 ☐ |
| 15. | Municipal (union or hospital district) | 152 ☐ | 153 ☐ |
| 16. | Provincial | 162 ☐ | 163 ☐ |
| 17. | Federal | 172 ☐ | 173 ☐ _____ |
| 18. | Proprietary | 182 ☐ | 183 ☐ |

### CERTIFICATION

I hereby certify that to the best of my knowledge the data contained in this return represent a true statement concerning the facilities, services and expenditure of this hospital.

_____
Signature of Hospital Authority

_____
Title

_____ _____
Date Tel. No.

This return has been completed in accordance with the Statistics Act and with the requirements of the Hospital Insurance and Diagnostic Services Act, the Regulations thereunder, and the Agreement, and is approved.

_____
Provincial Authority

_____
Date

### SUPPLEMENTARY INFORMATION

Special explanatory notes on significant changes during the year, as described in the Instructions and Definitions- ( if not sufficient space please complete supplementary page: Explanatory Notes):

### FOR OFFICE USE ONLY

Date Rec'd _____
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Prof. Edit Done _____
Queried _____
Reply Adj. _____
Arith. Check _____
Final Insp. _____

8–2300–13.1

PART ONE – P. 1 of 18.

STATISTICS CANADA

# WORKSHEET ONLY

HEALTH AND WELFARE CANADA

## 1982-83 ANNUAL RETURN OF HEALTH CARE FACILITIES – HOSPITALS

## PART TWO

Name of hospital _____

Street and number _____ Postal address _____

City, town, etc. _____ Province _____ Postal code |_|_|_|_|_|_| (51)

### HOSPITAL CERTIFICATE

I hereby certify that to the best of my knowledge the data contained in this return represent a true statement of the financial operations of this hospital.

_____ 19 ___ _____

Date Signature of Hospital Authority

_____ _____

Tel. No. Title

### AUDITOR'S/AUDITORS' REPORT

I/we have examined the Balance Sheets of the above-named hospital as at _____, 19 ____, and the Summary of Operating Expense, Statement of Income, and supporting statements, schedules and analyses for the year then ended. My/our examination included a general review of the accounting procedures and such tests of accounting records and other supporting evidence as I/we considered necessary in the circumstances.

Qualifications:

In my/our opinion, subject to the qualifications set out in the preceding paragraph, the attached financial statements present fairly the financial position of the Hospital as at _____, 19 _____ the results of its operations for the year then ended, in accordance with generally accepted hospital accounting principles applied on a basis consistent with that of the preceding year.

Auditor/Auditors

_____

Name

_____

Address

_____

Date

_____

(Signature of Auditor/Auditors)

FOR OFFICE USE ONLY

Date Rec'd ..... _____

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Reply Adj. ..... _____

Arith. Check ..... _____

Final Insp. ..... _____

Statistics Canada Statistique Canada

# *Quarterly Hospital Information System*

Statistics Canada
Canadian Hospital Association

**HOSPITAL WORKING COPY**

Please return copy with address label to Institutional Statistics Section, Statistics Canada in return envelope.

Si vous préférez recevoir ce questionnaire en français, veuillez cocher ☐

(01)

**CLASSIFICATION OF HOSPITAL** – Check or specify all appropriate items (as at end of period)

| TYPE | 1 |
|---|---|
| 01. Public (incl. Voluntary, Prov. & Munic.) | 011 ☐ |
| 02. Proprietary | 021 ☐ |
| 03. Federal | 031 ☐ |
| **SERVICE** | |
| 04. General – no long term units | 041 ☐ |
| 05. – with long term units | 051 ☐ |
| Specialty: | |
| 06. Pediatric | 061 ☐ |
| 07. Other (specify)_____ | 071 ☐ |
| 08. Rehabilitation (incl. Convalescent) | 081 ☐ |
| 09. Extended Care (incl. Chronic) | 091 ☐ |
| 10. Other (specify)_____ | 101 ☐ |

**OWNERSHIP AND OPERATION** (check one only in each column)

| Voluntary | Ownership 2 | Operation 3 |
|---|---|---|
| 12. Lay corporation | 122 ☐ | 123 ☐ |
| 13. Religious organization | 132 ☐ | 133 ☐ |
| 14. Red Cross | 142 ☐ | 143 ☐ |
| 15. Municipal (union or hospital district) | 152 ☐ | 153 ☐ |
| 16. Provincial | 162 ☐ | 163 ☐ |
| 17. Federal | 172 ☐ | 173 ☐ |
| 18. Proprietary | 182 ☐ | 183 ☐ |

11. SIZE – Rated Bed Capacity [111 ☐☐☐]

The rated bed capacity is the number of beds and cribs that the hospital (or a unit of the hospital) has been approved to accommodate, on the basis of established standards of floor area per bed. This capacity would have been approved at the time of:

a) original construction, or
b) after completion of additions or other structural changes.

NOTE – Beds in the following areas should be excluded from the rated bed capacity: labor and delivery rooms; beds in diagnostic and treatment areas designed for patient rest immediately before or after receiving services; beds in outpatient and emergency units; beds in employee quarters including those used for sick staff; post-anesthesia recovery beds; beds in Day and/or Night Care Units.

## GENERAL INSTRUCTIONS

1. Constant reference should be made to the Instructions and Definitions contained on these pages. For more detailed definitions check the Instructions & Definitions (Part I & Part II) for the Annual Return of Health Care Facilities – Hospitals.
2. For items not specified on the form USE lines designated as "OTHER" and provide supplementary information ON THE BACK OF PAGE 7.
3. DO NOT use shaded areas.
4. All data, except beds, must be cumulative year to date, therefore the data for the reporting quarter must be greater than data in previous quarter.

   If the data reported this quarter are less than in previous quarter, please give an explanatory note ON THE BACK OF PAGE 7.
5. Do not report credits. The computer program will not accept credits in expense accounts.
6. Should you have any problems in completing this return please contact Garry MacDonald, Production Manager, Doris Gallinger or Carolyn Lumsden – (613) 995-0991.

Completed by: _____ (Name) _____ (Date)

Telephone Number ( ) _____ Area code

8-2300-18.1: 22-2-82 B101619

BRITISH COLUMBIA HEALTH ASSOCIATION — COMBINED HOSPITAL REPORT — PAGE 03

GROUP: 17 HOSPITAL: 802 - MATER MISERICORDIAE HOSPITAL

| DESCRIPTION | HOSPITAL | | GROUP | | PROVINCE | |
|---|---|---|---|---|---|---|
| A. PATIENT DAYS | | | | | | |
| ACUTE/REHAB | 9,276 | | 113,298 /1425.4 | | 3,116,270 | |
| EXTENDED CARE | 5,401 | | 27,358 /1367.9 | | 1,950,429 | |
| LONG TERM PATIENTS | 836 | | 7,109 /355.5 | | 227,293 | |
| NEWBORN | 0 | | 8,737 /436.9 | | 221,547 | |
| LONG TERM CARE PROGRAM | 0 | | 8,099 /405 | | 204,666 | |
| B. WEIGHTED TOTAL DAYS | 8,276 | | 168,156 /2402.2 | | 5,692,882 | |
| C. AVERAGE STAY - ACUTE/REHAB | 5.3 | | 5.3 | | 7.8 | |
| D. PATIENT SERVICES | INPATIENT | OUTPATIENT | INPATIENT | OUTPATIENT | INPATIENT | OUTPATIENT |
| TREATMENT CLINICS | 1,506 | 2,359 | 17,328 /866.4 | 45,211 /2260.6 | 1,558,284 | 1,179,230 |
| EMERGENCY UNIT | 42 | 1,588 | 2,969 /148.5 | 62,355 /3117.7 | 59,268 | 1,084,948 |
| DIAGNOSTIC CLINICS | 990 | 1,683 | 29,730 /1036.5 | 61,195 /3059.7 | 815,372 | 1,206,603 |
| SURGICAL SUITE | 331 | 140 | 3,674 /183.7 | 2,532 /126.6 | 181,533 | 125,768 |
| E. FULL TIME EQUIVALENT STAFF | FTE STAFF | | FTE STAFF | | FTE STAFF | |
| NURSING | 28.6 | | 469.1 23.1 | | 17,709.2 | |
| OTHER TREATMENTS & DIAGNOSTICS | 12.5 | | 255.3 12.9 | | 8,396.9 | |
| SUPPORT | 12.6 | | 267.8 13.4 | | 8,053.3 | |
| STUDENTS | 0.0 | | 0.2 | | 979.7 | |
| SALARIED MEDICAL STAFF | 0.0 | | 0.0 | | 162.9 | |
| TOTAL STAFF | 53.7 * | | 987.4 * 99.4 | | 35,377.0 * | |
| F. INCOME | AMOUNT | $/WT-DAY | AMOUNT | $/WT-DAY | AMOUNT | $/WT-DAY |
| HOSPITAL PROGRAMS - INPATIENT | 1,592,061 | 181.50 | 28,082,977 | 167.01 | 1,020,565,417 | 167.25 |
| HOSPITAL PROGRAMS - OUTPATIENT | 23,323 | 2.82 | 639,370 | 3.80 | 33,138,713 | 6.03 |
| OTHER INPATIENT | 160,568 | 19.40 | 2,351,095 | 13.98 | 98,974,920 | 16.20 |
| OTHER OUTPATIENT | 124,363 | 15.03 | 3,944,716 | 23.46 | 74,553,735 | 13.57 |
| OTHER INCOME | 39,446 | 4.77 | 973,443 | 5.79 | 47,646,979 | 8.67 |
| LESS EXCLUDABLE INCOME | 0 | 0.00 | 153,277 | 0.91 | 3,075,244 | 0.56 |
| OPERATING INCOME | 1,839,761 | 222.51 | 35,838,324 | 213.13 | 1,269,804,520 | 231.17 |
| G. EXPENDITURES | AMOUNT | $/WT-DAY | % | AMOUNT | $/WT-DAY | % | AMOUNT | $/WT-DAY | % |
| SALARIES & WAGES | 1,287,002 | 155.51 | 68.8 | 23,876,970 | 141.99 | 68.6 | 835,969,203 | 152.19 | 68.3 |
| PROFESSIONAL FEES | 0 | 0.00 | 0.0 | 508,213 | 3.02 | 1.5 | 30,707,019 | 5.59 | 2.5 |
| EMPLOYEE BENEFITS | 155,716 | 18.82 | 8.3 | 2,879,737 | 17.13 | 8.3 | 103,708,975 | 18.88 | 8.5 |
| MEDICAL/SURGICAL SUPPLIES | 40,100 | 4.85 | 2.1 | 799,166 | 4.75 | 2.3 | 51,388,918 | 9.36 | 4.2 |
| DRUGS | 27,878 | 3.37 | 1.5 | 725,726 | 4.32 | 2.1 | 30,749,185 | 5.60 | 2.5 |
| DIETARY FOOD & SUPPLIES | 65,302 | 7.89 | 3.5 | 934,281 | 5.55 | 2.7 | 29,881,706 | 5.44 | 2.4 |
| PLANT MAINTENANCE | 17,008 | 2.06 | 0.9 | 500,989 | 2.98 | 1.4 | 14,921,356 | 2.72 | 1.2 |
| LINEN & LAUNDRY | 52,060 | 6.29 | 2.8 | 390,818 | 2.03 | 1.0 | 15,036,928 | 2.74 | 1.2 |
| PATIENT CARE, D E T | 91,194 | 11.02 | 4.9 | 1,468,662 | 8.73 | 4.2 | 41,576,396 | 7.57 | 3.4 |
| ADMINISTRATIVE & GENERAL SUPPORT | 80,790 | 9.76 | 4.3 | 1,300,259 | 7.73 | 3.7 | 35,525,198 | 6.47 | 2.9 |
| PLANT OPERATION & HOUSEKEEPING | 44,086 | 5.33 | 2.4 | 1,335,921 | 7.94 | 3.8 | 28,033,669 | 5.10 | 2.3 |
| OTHER | 0 | 0.00 | 0.0 | 46,366 | 0.28 | 0.1 | 1,094,756 | 0.20 | 0.1 |
| BAD DEBTS | 10,880 | 1.31 | 0.6 | 94,790 | 0.56 | 0.3 | 4,498,104 | 0.82 | 0.4 |
| SUBTOTAL | 1,871,966 | 226.19 | 100.0 | 34,911,979 | 207.02 | 100.0 | 1,223,092,443 | 222.67 | 100.0 |
| LESS EXCLUDABLE EXPENDITURES | 0 | 0.00 | 0.0 | 133,900 | 0.80 | 0.4 | 1,795,971 | 0.33 | 0.1 |
| OPERATING EXPENDITURE | 1,871,966 | 226.19 | 100.0 | 34,677,579 | 206.22 | 99.6 | 1,221,296,472 | 222.34 | 99.9 |
| SURPLUS/DEFICIT | 22,205- | 2.68- | | 1,160,745 | 6.90 | | 48,508,048 | 8.83 | |
| H. PROJECTED YEAR END SURPLUS/DEFICIT | | 0 | | | 884,996 | | | 16,739,162 | |
| I. DIETARY FOOD COSTS/MEAL DAY | | 5.04 | | | 4.26 | | | 4.19 | |
| J. NUMBER OF HOSPITALS REPORTING IS | | | | | 20 / 20 | | | 103 / 110 | |

MATER MISERICORDIAE (802) PEER GROUP: 50 LAST REPORTED MONTH: MAR
ROSSLAND TEAM: CARIBOO, OKANAGAN, KOOTENAYS

| TAKEN FROM REPORT NO. | INDICATOR | HOSPITALS STATISTIC | PEER GROUP STATISTIC | VARIANCE | VARIANCE AS A % OF PEER GROUP |
|---|---|---|---|---|---|
| 11 | % OCCUPANCY BASED ON RATED BEDS - MONTH | 49.1 | 58.9 | 9.8- | 16.6- |
| | % OCCUPANCY BASED ON RATED BEDS - YTD | 54.0 | 56.7 | 4.7- | 8.0- |
| | % OCCUPANCY BASED ON BEDS SET UP - MONTH | 49.1 | 57.6 | 8.5- | 14.8- |
| | % OCCUPANCY BASED ON BEDS SET UP - YTD | 54.0 | 57.4 | 3.4- | 5.9- |
| | ACUTE/REHAB AVERAGE LENGTH OF STAY | 5.3 | 5.4 | 0.1- | 1.9- |
| | EXPENDITURES PER WEIGHTED PATIENT DAY | 214.31 | 210.50 | 3.81 | 1.8 |
| | WEIGHTED PATIENT DAYS PER FTE | 162.7 | 168.0 | 5.3- | 3.2- |
| 12 | COST PER FTE | 26,866 | 26,990 | 124- | 0.5- |
| | % NURSING FTE TO TOTAL FTE | 53.3 | 46.0 | 7.3 | 15.9 |
| | % GRADUATE TO TOTAL NURSING FTE | 59.1 | 66.6 | 7.5- | 11.3- |
| | WEIGHTED PATIENT DAYS PER NURSING FTE | 305.4 | 365.4 | 60.0- | 16.4- |
| 22 | OPERATING ROOM HOURS PER INPATIENT VISIT | 1.03 | 1.12 | 0.09- | 8.0- |
| | OPERATING ROOM HOURS PER S.O.C. VISIT | 0.86 | 0.83 | 0.03 | 3.6 |
| | % SURG. DAY CARE VISITS TO TOTAL VISITS | 29.7 | 32.2 | 2.5- | 7.8- |
| | STANDARD LAB UNITS PER LABORATORY FTE | 104,548 | 109,732 | 5,134- | 4.7- |
| | STANDARD LAB UNITS PER WTD. PATIENT DAY | 20.4 | 43.3 | 22.9- | 52.9- |
| 20 | KILOS OF LAUNDRY PER LAUNDRY FTE | 0.0 | 24,945.8 | 24,945.8- | 100.0- |
| | KILOS OF LAUNDRY PER WTD. PATIENT DAY | 5.8 | 5.5 | 0.3 | 5.5 |
| | MEAL DAYS PER DIETETIC FTE | 1,600.1 | 1,852.3 | 252.2- | 13.6- |
| | % INPATIENT MEAL DAYS TO TOTAL MEAL DAYS | 81.2 | 66.8 | 14.4 | 21.6 |
| | FOOD AND DIETARY EXPENSES PER MEAL DAY | 5.04 | 4.21 | 0.83 | 19.7 |

TYPE L DETAILED 1982/83 FINANCIAL REPORT

MATER MISERICORDIAE (NO. 802) PEER GROUP 50 LAST REPORTED MONTH: MAR RESPONSIBILITY: DAVID WILKS

ROSSLAND

| CATEGORY | 82/83 YTD ACTUAL ($) | MARCH 31 82/83 PROJ ACTUALS ($) | MARCH 31 82/83 APPR BUDGET ($) | FAVOURABLE/ UNFAVOURABLE BUDG VAR | PROJ % INC OVER 82/83 BUDGET (%) |
|---|---|---|---|---|---|
| HOSPITAL PROGRAMS - INPATIENT | 1,498,948 | 1,498,948 | 1,498,948 | 0 | 0.00 |
| HOSPITAL PROGRAMS - COINSURANCE | 3,113 | 3,113 | 0 | 3,113 | 0.00 |
| HOSPITAL PROGRAMS - OUTPATIENT | 23,323 | 18,740 | 18,740 | 0 | 0.00 |
| HOSPITAL PROGRAMS - SUBTOTAL | 1,525,384 | 1,520,801 | 1,517,688 | 3,113 | 0.21 |
| LONG TERM CARE - INPATIENT | 0 | 0 | 0 | 0 | 0.00 |
| OTHER - INPATIENT | 160,568 | 160,568 | 162,925 | 2,357- | 1.45- |
| OTHER - OUTPATIENT | 124,363 | 124,363 | 113,031 | 11,332 | 10.03 |
| ROOM DIFFERENTIAL (100%) | 8,050 | 8,050 | 9,512 | 1,462- | 15.37- |
| CAFETERIA | 11,534 | 11,534 | 15,960 | 4,426- | 27.73- |
| OTHER INCOME | 23,082 | 23,082 | 3,449 | 19,633 | 569.24 |
| SUBTOTAL (LINES 4 TO 10) | 1,852,981 | 1,848,398 | 1,822,565 | 25,833 | 1.42 |
| ROOM DIFFERENTIAL (40%) | 3,220 | 3,220 | 3,805 | 585- | 15.37- |
| NET INCOME | 1,849,761 | 1,845,178 | 1,818,760 | 26,418 | 1.45 |
| EXCLUDABLE INCOME | 0 | 0 | 0 | 0 | 0.00 |
| OPERATING INCOME | 1,849,761 | 1,845,178 | 1,818,760 | 26,418 | 1.45 |
| SALARIES & WAGES | 1,287,002 | 1,287,002 | 1,310,500 | 23,498 | 1.79 |
| PROFESSIONAL FEES | 0 | 0 | 0 | 0 | 0.00 |
| EMPLOYEE BENEFITS | 155,716 | 155,716 | 131,050 | 24,666- | 18.82- |
| MEDICAL/SURGICAL SUPPLIES | 40,100 | 40,100 | 36,212 | 3,886- | 10.74- |
| DRUGS | 27,878 | 27,878 | 25,650 | 2,228- | 8.69- |
| DIETARY FOOD & SUPPLIES | 65,302 | 65,302 | 58,468 | 6,834- | 11.69- |
| PLANT MAINTENANCE | 17,008 | 17,008 | 24,876 | 7,868 | 31.66 |
| LINEN & LAUNDRY | 52,060 | 52,060 | 37,721 | 14,339- | 38.01- |
| PATIENT CARE, DIAG. & THER. | 91,194 | 91,194 | 82,986 | 8,208- | 9.89- |
| ADMINISTRATIVE & GENERAL SUPPORT | 80,740 | 80,740 | 67,898 | 12,842- | 18.91- |
| PLANT OPERATIONS AND HOUSEKEEPING | 44,086 | 44,086 | 39,607 | 4,479- | 11.31- |
| OTHER | 0 | 0 | 3,772 | 3,772 | 100.00 |
| BAD DEBTS | 10,880 | 10,880 | 0 | 10,880- | 0.00 |
| SUBTOTAL | 1,871,966 | 1,871,966 | 1,818,760 | 53,206- | 2.93- |
| EXCLUDABLE EXPENDITURES | 0 | 0 | 0 | 0 | 0.00 |
| OPERATING EXPENDITURE | 1,871,966 | 1,871,966 | 1,818,760 | 53,206- | 2.93- |
| SURPLUS/DEFICIT | 22,205- | 26,788- | 0 | 26,788- | 1.47- |

MATER MISERICORDIAE (802) PEER GROUP: 50 LAST REPORTED MONTH: MAR
ROSSLAND TEAM: CARIBOO, OKANAGAN, KOOTENAYS RESPONSIBILITY: DAVID WILKS

| CATEGORY | LATEST ACTUAL VALUE | LATEST ACTUAL PROJECTED TO MARCH 31, 1983 | 1981/82 TOTAL (APPROVED) | VARIANCE (2) - (3) | VARIANCE AS A PERCENT OF 1981/82 |
|---|---|---|---|---|---|
| HOSPITAL PROGRAM PATIENT DAYS | | | | | |
| ACUTE/REHAB | 4,091 | 4,091 | 5,004 | 913- | 18.2- |
| EXTENDED CARE | 5,401 | 5,401 | 5,400 | 1 | 0.0 |
| NEWBORN | 0 | 0 | 0 | 0 | 0.0 |
| OTHER PATIENT DAYS | | | | | |
| ACUTE/REHAB | 195 | 195 | 252 | 57- | 22.6- |
| EXTENDED CARE | 0 | 0 | 0 | 0 | 0.0 |
| NEWBORN | 0 | 0 | 0 | 0 | 0.0 |
| UNDIFF. LONG TERM CARE PATIENT DAYS | 834 | 834 | 0 | 834 | 0.0 |
| ACUTE/REHAB ADMISSIONS | 812 | 812 | 852 | 40- | 4.7- |
| A/R AVE. LENGTH OF STAY (ON ADMISSIONS) | 5.3 | 5.3 | 6.2 | 0.9- | 14.5- |
| TOTAL LABORATORY UNITS | 177,817 | 177,817 | 292,896 | 115,079- | 39.3- |
| TOTAL RADIOLOGY EXAMS | 2,302 | 2,302 | 2,460 | 158- | 6.4- |
| OUTPATIENT VISITS | | | | | |
| PHYSIOTHERAPY | 2,359 | 2,359 | 1,848 | 511 | 27.7 |
| OCCUPATIONAL THERAPY | 0 | 0 | 0 | 0 | 0.0 |
| SURGICAL SUITE VISITS | | | | | |
| IN-PATIENTS | 331 | 331 | 348 | 17- | 4.9- |
| SURGICAL DAY CARE | 140 | 140 | 48 | 92 | 191.7 |
| TOTAL | 471 | 471 | 396 | 75 | 18.9 |
| TOTAL EMERGENCY VISITS | 1,630 | 1,630 | 2,004 | 374- | 18.7- |
| OUTPATIENT VISITS | | | | | |
| PSYCHIATRIC DAY/NIGHT | 0 | 0 | 0 | 0 | 0.0 |
| DIABETIC | 0 | 0 | 0 | 0 | 0.0 |
| RENAL | 0 | 0 | 0 | 0 | 0.0 |
| PSYCHIATRIC OUTPATIENT | 0 | 0 | 0 | 0 | 0.0 |
| DIETETIC COUNSELLING | 0 | 0 | 0 | 0 | 0.0 |
| TOTAL DIETETIC MEAL DAYS | 12,961 | 12,961 | 13,284 | 323- | 2.4- |
| TOTAL KILOS OF LAUNDRY | 50,798 | 50,798 | 0 | 50,798 | 0.0 |

DUE TO A CHANGE IN THE MEASUREMENT OF LABORATORY UNITS, THE 1982/83 PROJECTED LAB UNITS FOR AN EQUIVALENT VOLUME OF WORK SHOULD BE CONSIDERABLY LESS THAN THE 1981/82 FIGURE.

Canadian Council on Hospital Accreditation
Conseil Canadien D'Agrément Des Hôpitaux

A.L. SWANSON, M.D., F.A.C.H.A., Executive Director

1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO K1G 3Y6
TELEPHONE: (613) 523-9154

MEMBER ORGANIZATIONS
CANADIAN HOSPITAL ASSOCIATION
THE CANADIAN MEDICAL ASSOCIATION
THE ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA
L'ASSOCIATION DES MÉDECINS DE LANGUE FRANÇAISE DU CANADA
CANADIAN NURSES ASSOCIATION

# HOSPITAL SURVEY QUESTIONNAIRE

Mater Misericordiae Hospital
Name of Hospital

Rossland, B.C.
Location

Dr. H. J. Warrick
Name(s) of Surveyor(s)

~~October 28, 29,~~ 1982
Date and Year of Survey

| Type of Bed | Number and Percentage of Beds for Area * | | | | | |
|---|---|---|---|---|---|---|
| | Your Hospital | Hospital A | Hospital B | Hospital C | Hospital D | Hospital E |
| Mecial | | | | | | |
| Surgical | | | | | | |
| Ob-Gyn | | | | | | |
| Psychiatric | | | | | | |
| Alcoholic | | | | | | |
| Extended Care | | | | | | |

*The area may encompass more than one R.H.D.

## Utilization of Beds

| Type of Bed | Percentage of Beds | | | | | |
|---|---|---|---|---|---|---|
| | Your Hospital | Hospital A | Hospital B | Hospital C | Hospital D | Hospital E |
| Medical | | | | | | |
| Surgical | | | | | | |
| Ob-Gyn | | | | | | |
| Psychiatric | | | | | | |

Working Relationships with Other Hospitals
(Alliance Strategies)

| Activity | Hospital A | Hospital B | Hospital C | Hospital D | Hospital E |
|---|---|---|---|---|---|
| 1 | x | x | x | x | x |
| 2 | x | | | x | |
| 3 | | x | | | |
| 4 | | | x | | |
| 5 | | x | | | |
| 6 | x | x | x | | |
| 7 | | | | | |
| 8 | x | x | | x | x |
| 9 | | x | | | |
| 10 | | x | | | |

Report on Day care Surgery 1980/81 - Research Division, Hospital Programs, Ministry of Health, Province of British Columbia

1980 Canadian Hospital Directory - Buyers Guide, August 1980 Canadian Hospital Association

Statistics of Hospital Cases Discharged During 1980/81 - Research Divison, Hospital Programs, Ministry of Health, Province of B.C.

Hospital Role Study Phase 1, August 1979 - A Discussion Paper on Hospital Services in British Columbia, Ministry of Health

Hospital Role Study Phase I - Addendum - 1981 - A Discussion Paper on Hospital Services in B.C., Ministry of Health

Community Health Services - Annual Report 1981 - West Kootenay Health Unit, Ministry of Health, Province of British Columbia

Changing Statistics for B.C. Health Management - From Program Development to Cost Control, May 1981, Department of Health Care and Epidemiology, University of British Columbia

National Health Expenditures in Canada 1960 - 1973 - Health and Welfare Canada, Health Economics and Statistics Division, Health Programs Branch, Ministry of National Health and Welfare, Ottawa

Vital Statistics of the Province of B.C., 1980 - Ministry of Health, British Columbia

Ministry of Health Annual Report 1979 - Province of British Columbia

# DESCRIPTION OF HOSPITAL

## LOCATION:

The Mater Misericordiae Hospital is located two blocks from the city centre on the corner of Columbia Avenue and Georgia Street. It serves as a small community hospital primarily for the residents of Rossland and the outlying rural area.

## LEVEL OF CARE:

The Hospital has 26 acute care and 15 extended care beds. It is staffed and equipped to provide emergency, primary, and select care services to its community and those referred for minor specialized surgery. These services include inpatient and outpatient medical, surgical, diagnostic, physiotherapy and treatment services, emergency care and extended care.

## SPECIAL STRENGTHS:

The Hospital consistently seeks to maintain its role as a provider of primary and limited secondary care and to contribute to the area-wide health care system in a co-operative and progressive manner. To this end, the Hospital has initiated a standing committee for planning and co-operates with other providers in the area to plan and ensure continuity and an acceptable level of quality care. The Hospital has specialized strength in arthroscopic knee surgery.

## LIMITATIONS:

Patients requiring secondary and tertiary care services are referred to higher levels of care at our referral centre - the Trail Regional Hospital. The Mater Misericordiae Hospital does not intend to provide extensive specialty services, such as obstetrical and intensive care or psychiatric and dependency-related problems, nor to compete with our regional referral centre. Working relationships with other providers have been established to ensure our limitations do not affect area-wide service.

## HEALTH PROVIDER RELATIONSHIPS:

The Hospital has a direct working relationship with Columbia View Lodge, an 84 bed Intermediate Care Home in Trail, through the joint administration of the Shared Services. It also shares an excellent working relationship with the Regional Hospital in areas of laundry, group purchasing, maintenance services and pharmacy. Labour relationships and finance information is freely shared. This relationship

extends to Public Health, the Long Term Care Program and health-related groups by way of direct co-operation and communication.

EDUCATION:

The Hospital seeks to ensure that appropriate orientation, inservice and continuing education are available to health professionals associated with the Hospital. There are no formal affiliations with medical or nursing schools or centres for training allied health professionals. Relationships exist with the Regional Hospital so our staff may participate in their programs.

TECHNOLOGY:

The Hospital strives to make available and maintain to superior functioning such equipment as is appropriate for a provider of primary and secondary care, such as monitoring and diagnostic equipment. It is the Hospital's intention to be an early adapter of new equipment and technology that will ensure our primary role and expand our specialized minor day surgical role. New technology is introduced only at such times as the need has been demonstrated and its cost effectiveness has been determined, either by the Hospital or by other hospitals of equal size and role.

RELIGION:

The Hospital is a nondenominational facility whose background is Christian. It was founded in 1896 by the Sisters of St. Joseph of Newark. The religious order passed control of the Hospital to the Rossland Hospital Society in 1969. Efforts are made to maintain the long tradition of caring and sharing.

Chaplains of all denominations participate in the ministry to the Hospital patients and long-term care residents.

COSTS:

The Hospital is a proponent of cost-containment and implements such cost-control programmes as are possible without sacrificing quality patient care. The priority for doing this is to attempt to provide excellent care for illnesses whose treatment is within the scope of our skills, technological equipment and resources. In addition, the Hospital attempts to provide sophisticated skills and equipment in the narrow list of specialties already defined. The Hospital strives to provide health care services in a cost effective manner which permits a sound and stable financial position for the hospital and reasonable health care costs for the consumer. The Hospital recognizes that the desire for increased services and technology is not always compatible with the desire for reduced health care costs. Therefore, the Hospital endeavours to maintain a realistic balance between cost-containment

efforts and adequately meeting the health needs of the population.

The Board and Administration firmly believe that the key to cost-containment lies with the cost-consciousness of the individual staff and Department Heads.

# P H I L O S O P H Y

The Philosophy of the Mater Misericordiae Hospital is simply stated as "caring and sharing" among ourselves, with patients, and among the community.

The Mater Misericordiae Hospital was founded on a tradition of caring and sharing by the Sisters of St. Joseph of Newark.

It is our privilege and obligation to provide for the patient an atmosphere which will hasten the patient towards optimal physical and emotional health; will consider his privacy, safety and comfort; and will recognize and respect his inherent dignity, rights, worth and uniqueness. To do this, we must always be idealistic in vision and realistic in action.

Through our reflection of this philosophy, we can give purpose and meaning to the lives of others and at the same time greatly enhance our own.

What is a Philosophy:

The guiding principles followed in a particular activity or field of knowledge.

Why a Philosophy:

This is the most important document our Hospital will ever produce, because it establishes our direction, our size, our patient community and our strengths. Our philosophy is the basis of our Mission Statement.

This Philosophy is Formalized as Follows:

We believe that health care institutions and agencies are best governed by an informed group of voluntary trustees, sensitive to the particular needs of the communities, innovative in approaches to meet this need, elected by and accountable to the public, having a concomitant level of authority to meet their responsibilities.

We subscribe to having every Board member on a Committee and all Committees active.

We believe that the health of individuals will be enhanced if they know more about the factors that lead to physical, mental, and social well-being; and take personal and life-long respons-

.../2

ibility for maintaining health. We believe that the Mater Misericordiae Hospital has a duty to assist individuals in meeting this responsibility.

We believe that legislators, board members, executives and direct care professionals must work together to create a climate providing high quality patient care and treatment in a cost-effective and efficient manner that makes innovative use of existing resources.

We believe that the value of any health care institution and agency derives from the quality of health services it provides to the public, and that a recognized accreditation program is the best means of assessing quality and measuring and evaluating services we provide to the public. We believe quality is further ensured through continuing education of staff and Board members.

We believe that regional services should be co-operatively linked to ensure that changes in the level of care are met with minimal inconvenience to the patients and their families.

We believe that the Hospital Auxiliary is a vital and equal part of the care we provide and that their involvement must be maintained.

We believe that the Hospital has intrinsic economic and social values as part of our community.

We believe that the Hospital organization should be structured to provide for communication and input from all levels.

We encourage a planning role for the Medical Staff.

GOAL 1: To assure that the decision making is consistent with the philosophy of the Church and the mission of the hospital.

GOAL 2: To maximize efficient utilization of resoures.

GOAL 3: To develop and maintain a proactive and integrative marketing posture.

GOAL 4: To develop and maintain a proactive and integrative planning posture.

GOAL 5: To operate a high quality and safe level of clinical services.

GOAL 6: To keep the hospital financially healthy.

Objective 1: To complete a comprehensive evaluation of the feasibility of an outpatient surgery program by June 30, 1982, at a cost not to exceed $3,000.

Objective 2: To complete a comprehensive study of the feasiblity of an alcohol treatment unit by June 30, 1982, at a cost not to exceed $3,000.

Objective 3: To establish a board-approved comprehensive, on-going cost containment program to be monitored by a joint committee of the Board, Administration and Medical Staff.

Objective 4: To develop a Primary Care Center in geographic proximity to the Hospital by January 31, 1983, in an underserved area.

4-D

PERFORMANCE GUIDELINES

CHIEF EXECUTIVE OFFICER

1. WORKLOAD: Is the workload planned and delegated where appropriate?

☐ HAS EXCEEDED REQUIREMENT

☐ HAS MET REQUIREMENT

☐ HAS NOT MET REQUIREMENT

COMMENT:

_____

_____

_____

_____

_____

2. ORGANIZATION: Are activities/time well organized and effectively co-ordinated with others?

☐ HAS EXCEEDED REQUIREMENT

☐ HAS MET REQUIREMENT

☐ HAS NOT MET REQUIREMENT

COMMENT:

_____

_____

_____

_____

_____

3. PROBLEM SOLVING: Are problems anticipated/identified? Thought through, solved in realistic and practical way, and where appropriate are effective recommendations made?

4-E

3. PROBLEM SOLVING: Continued.

☐ HAS EXCEEDED REQUIREMENT

☐ HAS MET REQUIREMENT

☐ HAS NOT MET REQUIREMENT

COMMENT:

_____

_____

_____

_____

_____

4. POLICY: Is an active role taken in policy formulation? Are policies maintained in an organized manner and reviewed periodically?

☐ HAS EXCEEDED REQUIREMENT

☐ HAS MET REQUIREMENT

☐ HAS NOT MET REQUIREMENT

COMMENT:

_____

_____

_____

_____

_____

5. SENSE OF RESPONSIBILITY: Are decisions made and is responsibility accepted for those decisions? Is a conscientious and loyal attitude to the position and facility demonstration?

☐ HAS EXCEEDED REQUIREMENT

☐ HAS MET REQUIREMENT

☐ HAS NOT MET REQUIREMENT

4-F

5. SENSE OF RESPONSIBILITY: Continued.

COMMENT:

_____

_____

_____

_____

_____

6. ASSERTIVENESS: How well are ideas presented? How effective is group participation? Is assertiveness used effectively without undue agressiveness?

☐ HAS EXCEEDED REQUIREMENT

☐ HAS MET REQUIREMENT

☐ HAS NOT MET REQUIREMENT

COMMENT:

_____

_____

_____

_____

_____

7. INTERPERSONAL RELATIONSHIPS: Are interpersonal relationships good? Is tact used to maintain good relationships? Is co-operation shown? Is good descretion shown?

a. INTERNAL

VERY GOOD AT GETTING ALONG WITH:

Public/Patients ☐ Board ☐ Medical Staff ☐ Auxiliary ☐ Staff ☐

GOOD AT GETTING ALONG WITH:

Public/Patients ☐ Board ☐ Medical Staff ☐ Auxiliary ☐ Staff ☐

WEAK IN SOME WAYS AT GETTING ALONG WITH:

Public/Patients ☐ Board ☐ Medical Staff ☐ Auxuiliary ☐ Staff ☐

4-G

7. INTERPERSONAL RELATIONSHIPS: Continued.

b. EXTERNAL

VERY GOOD AT GETTING ALONG WITH:

Government Staffs ☐ Press ☐ Allied Organizations ☐ Community ☐

GOOD AT GETTING ALONG WITH:

Government Staffs ☐ Press ☐ Allied Organizations ☐ Community ☐

WEAK IN SOME WAYS AT GETTING ALONG WITH:

Government Staffs ☐ Press ☐ Allied Organizations ☐ Community ☐

COMMENT:

_____

_____

_____

_____

_____

8. LEADERSHIP SKILLS: Is effective direction given to staff? Are adequate feedback and follow up systems in place? Are regular staff meetings held? Are staff concerns dealt with promptly and fairly?

☐ HAS EXCEEDED REQUIREMENT

☐ HAS MET REQUIREMENT

☐ HAS NOT MET REQUIREMENT

COMMENT:

_____

_____

_____

_____

_____

4-H

9. APPEARANCE, MANNER AND GENERAL IMPRESSION: Consider overall bearing, way of talking, manner, and deportment.

☐ HAS EXCEEDED REQUIREMENT

☐ HAS MET REQUIREMENT

☐ HAS NOT MET REQUIREMENT

COMMENT:

_____

_____

_____

_____

_____

10. HANDLING DUTIES WITHOUT STRESS: Is confidence and maturity display on the job or does it appear that undue stress is prevalent?

☐ HAS EXCEEDED REQUIREMENT

☐ HAS MET REQUIREMENT

☐ HAS NOT MET REQUIREMENT

COMMENT:

_____

_____

_____

_____

_____

11. OPEN-MINDEDNESS AND ADAPTABILITY: Interested in and receptive to new ideas and situations?

☐ HAS EXCEEDED REQUIREMENT

☐ HAS MET REQUIREMENT

☐ HAS NOT MET REQUIREMENT

11. OPEN-MINDEDNESS AND ADAPTABILITY: Continued. 4-I

COMMENT:

12. INITIATIVE: Are ideas to improve the facility's services contributed?

13. GENERAL COMMENTS:

FOR EXECUTIVE COMMITTEE DATE

SIGNATURE OF C.E.O.:

DATE:

81/09

## EVALUATION QUESTIONS

1. Is the plan in front of you at each meeting?
2. Were the recommendations of the plan (goals and objectives) actually carried out?
3. If so, when and by whom?
4. Did the actions accomplish what was intended?
5. If so, how do we know this?
6. Did these actions or their results raise other issues or problems?
7. How were these handled or must they be addressed by the Board, Committee or Management?
8. Will such subsequent actions or results require changes in the plan?
9. Were these other issues or problems worth the cost of the actions?
10. Did the assumptions underlying the recommended course of action hold true?
11. If not, how did this affect the actions or the results?
12. If the plan were being prepared or revised anew, would the various recommendations again be proposed?
13. What would be done differently?
14. Are there external developments and/or internal changes that may affect the plan or the assumptions?
15. Are periodic reports being made that help to monitor the plan and evaluate results?

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