

---

# Strategic Planning Processes and Hospital Financial Performance

*Amer A. Kaissi, PhD, assistant professor, Department of Health Care Administration, Trinity University, San Antonio, Texas, and James W. Begun, PhD, James A. Hamilton Professor of Healthcare Management, Division of Health Policy and Management, University of Minnesota, Minneapolis*

.....

## EXECUTIVE SUMMARY

Many common management practices in healthcare organizations, including the practice of strategic planning, have not been subject to widespread assessment through empirical research. If management practice is to be evidence-based, evaluations of such common practices need to be undertaken.

The purpose of this research is to provide evidence on the extent of strategic planning practices and the association between hospital strategic planning processes and financial performance. In 2006, we surveyed a sample of 138 chief executive officers (CEOs) of hospitals in the state of Texas about strategic planning in their organizations and collected financial information on the hospitals for 2003. Among the sample hospitals, 87 percent reported having a strategic plan, and most reported that they followed a variety of common practices recommended for strategic planning—having a comprehensive plan, involving physicians, involving the board, and implementing the plan. About one-half of the hospitals assigned responsibility for the plan to the CEO. We tested the association between these planning characteristics in 2006 and two measures of financial performance for 2003.

Three dimensions of the strategic planning process—having a strategic plan, assigning the CEO responsibility for the plan, and involving the board—are positively associated with earlier financial performance. Further longitudinal studies are needed to evaluate the cause-and-effect relationship between planning and performance.

For more information on the concepts in this article, please contact Dr. Kaissi at [amer.kaissi@trinity.edu](mailto:amer.kaissi@trinity.edu).

**F**ormal strategic planning requires a sizable investment of organizational time and other resources, and strategic planning is commonly believed to be important to the effective functioning of organizations, including healthcare organizations. However, evidence on the practice of strategic planning is scarce. Which organizations are more likely to plan? Do healthcare organizations that plan exhibit better performance in the marketplace? What characteristics of the planning process are particularly important to better performance? Does better performance stimulate more or less planning over time? This research contributes to an evidence base for healthcare organizations to more optimally apply the commonplace management and leadership function of strategic planning. More specifically, it aims to assess the extent of strategic planning processes and the association between hospital strategic planning processes and financial performance.

In a previous study, we interviewed 20 hospital chief executive officers (CEOs) and vice presidents of strategic planning in the Twin Cities, Minnesota, area and in San Antonio, Texas, to explore strategic planning practices (Begun and Kaissi 2005). The findings from the interviews suggested that strategic planning generally is viewed as a key value-added function of leadership in healthcare organizations. All but one of the organizations had a formal strategic plan. In the respondent organizations, physicians were moderately involved in the planning process, and the plan was reviewed and/or approved by the governing board. In addition, the importance of executing the plan was stressed

by the respondents. However, because of the small sample and data limitations, we did not empirically assess the association between strategic planning and performance.

Other empirical evidence on the extent and variety of strategic planning in healthcare is highly limited and rarely includes findings that link planning to organizational characteristics. Most of the reports derive from case studies or small samples (e.g., Dubbs 2002; Lemak and Goodrick 2003; Sollenberger 2006; Wells et al. 2004). Zuckerman (2006) reports healthcare strategic planning practices based on a survey of 440 planners, finding widespread support for strategic planning but does not present the associations between planning and hospital characteristics.

## CONCEPTUAL BACKGROUND AND PROPOSITIONS

Against this backdrop, we studied several common strategic planning assumptions and practices that are promoted in the health administration literature. Some of these practices are also supported by particular organizational theories. The first practice relates to the organizational decision to produce a strategic plan.

Leaders generally support the perspective that strategic planning is a key component of their role as strategic managers. This is based on the belief that organizations guided by correct strategies perform better and that organizational leaders make better strategic choices if they are able to more accurately read their internal and external environments (Luke, Walston, and Plummer 2004; Swayne, Duncan,

and Ginter 2006; Zuckerman 2005). The benefits of strategic planning include the creation of organizational focus, mobilization of stakeholders, and motivation of the workforce, in addition to the development of better strategy (Begun and Heatwole 1999).

Theoretically, strategic planning receives some support from the structural contingency perspective, which argues that organizational structures need to change in concert with environmental change (Donaldson 2001). The accurate reading of environmental change, presumably, is enhanced by strategic planning. Institutional theory adds another argument for having a strategic plan. Having a formal plan legitimates the organization in the eyes of important stakeholders, such as the community and accrediting organizations (Scott 2000). Based on common practice and the structural contingency and institutional theory arguments for planning, we forward Proposition 1.

**Proposition 1: Having a strategic plan in place is positively associated with financial performance.** Having a strategic plan is not enough in itself, however, because plans differ in breadth and depth and may or may not be implemented. For planning advocates, the most useful plans are those that are fully developed, including external analyses of the environment and internal analyses of the organization as well as strategic goals and objectives that guide the organization toward the implementation of the plan. This belief is best illustrated by the Baldrige criteria for strategic planning, which provide a comprehensive framework for the

“ideal” strategic plan (Baldrige National Quality Program 2006). Again, structural contingency theory and institutional theory support the notion that more comprehensive plans are more likely to be useful to the organization. Therefore, we submit Proposition 2.

**Proposition 2: Having a more fully developed strategic plan is positively associated with financial performance.** However, even the best-developed strategic plans are useless unless they are actually implemented by the organization. The importance of implementation is well documented in the business literature (e.g., Bossidy, Charan, and Burck 2002) and was stressed in interviews with healthcare leaders in an earlier qualitative study (Begun and Kaissi 2005). As noted earlier, structural contingency theory assumes that planning activities are useless unless implemented. Based on these arguments, we offer Proposition 3.

**Proposition 3: Fully implementing the strategic plan is positively associated with financial performance.** The responsibility for developing the strategic plan varies within organizations. In some organizations, only the CEO has that responsibility, while in others, the responsibility is delegated to a vice president (or director) of strategic planning or is shared by all members of the executive team. No evidence suggests which structure is more conducive to better performance. Classic hierarchical organization theory will argue that assignment of any activity to the CEO elevates its importance in the organization. Assigning the CEO responsibility

for the plan also raises the likelihood that the plan will be well resourced and implemented. Therefore, we present Proposition 4.

**Proposition 4: Assigning the CEO the responsibility for strategic planning is positively associated with financial performance.** The importance of the role played by boards of directors in strategic planning is well documented in the governance literature. The board's involvement ensures that stakeholder input is incorporated in the strategic planning process and that organizational goals are driven by stakeholders' needs and expectations (Orlikoff and Totten 2006). This involvement ensures that the agency relationship between the governing board and the organization is monitored and strengthened. According to the health administration practice literature, this involvement demonstrates that the executive team, the physicians, and the board are all focusing on the same goals, which gives everyone involved the confidence to move toward achieving those goals and improving performance (Rice 2006). Therefore, we submit Proposition 5.

**Proposition 5: Involving the governing board in the strategic planning process is positively associated with financial performance.** In addition to the governing board, a key stakeholder group in the strategic plan of any hospital is physicians. Traditionally, physicians' involvement in hospital strategic planning was limited to formal or informal interviews conducted with key physician leaders, invitations to select phy-

sicians to strategic planning retreats, or presentations of strategic planning process results and recommendations to a physician advisory group (Rovinsky 2002). However, these approaches may be insufficient to enhance physicians' support of the strategic plans and its recommendations. Analysts have suggested that when physicians have a meaningful role and when their needs and expectations are well incorporated in the strategic planning process, the organization is more likely to improve its market position and financial performance (Rovinsky 2002; Van Kooy and Ettinger 2002). Alexander (2006, 40) asserts that "strategic planning cannot drive an organization to success without real partnering with physicians on process, critical issues, vision, and strategy development." Proposition 6 is based on these aforementioned arguments.

**Proposition 6: Involving physicians in the strategic planning process is positively associated with financial performance.**

## METHODS

### Specification of Variables

*Hospital performance.* Hospital performance is a multidimensional concept, as outcomes typically pursued by hospitals include such dimensions as employee engagement, community health, clinical quality, operational efficiency, and financial performance. In this study, we focus on the dimension of financial performance. In analyzing the financial performance of hospitals in this study, three outcome measures were originally

employed: net income, profit margin, and return on assets (ROA). These are among the wide range of financial indicators that have been used in previous studies in healthcare (e.g, Burns, Gimm, and Nicholson 2005; McCue and Kim 2005; Menachemi et al. 2006; Song and Smith 2007).

We sought to capture indicators of the ability to control expenses, generate revenues, and use assets wisely, as all are likely targets of strategic plans. Net income is calculated as revenues minus expenses; profit margin is calculated as net income divided by revenues; and ROA is calculated as net income divided by total assets. In the analyses we conducted, however, the models for ROA did not achieve overall statistical significance, so ROA was dropped as a measure of financial performance.

*Strategic planning process.* Characteristics of the strategic plan and the strategic planning process are measured by six variables:

1. Does the hospital have a strategic plan? (No/Yes)
2. Extent to which the strategic plan is fully developed (1–7 scale, based on the Baldrige criteria)
3. Extent of actual implementation of strategic plan (1–7 scale)
4. Who is assigned the responsibility of strategic planning? (Others, CEO)
5. Extent of involvement of the governing board in the last major revision of the strategic plan (1–7 scale)
6. Extent of involvement of physicians in the last major revision of the strategic plan (1–7 scale)

Four other variables are employed as control variables in the analyses: organizational ownership (private for-profit; private not-for-profit; government), system membership (no/yes), location (urban/rural), and hospital size (total number of beds).

#### **Data Sources**

The two main sources of data are (1) Texas hospital financial data obtained from the Centers for Medicare and Medicaid Services for the most recently available year—2003, and (2) a strategic planning process survey conducted in Texas in May through June 2006. We limited the survey to Texas hospitals to maximize the response rate and to control for interstate differences. The sample consisted of all 390 general acute care hospitals in Texas, as listed in the *US News/American Hospital Association National Directory* website (see [www.usnews.com/usnews/health/hospitals](http://www.usnews.com/usnews/health/hospitals)). We developed a mail survey instrument based on the themes that emerged from interviews with healthcare leaders in 2004 (Begun and Kaissi 2005). The survey instrument was reviewed by seven CEOs and strategic planning experts, and their comments were incorporated to derive the final set of questions.

Surveys were mailed to CEOs of the 390 Texas hospitals in the summer of 2006. The protocol used was approved by the Institutional Review Board of Trinity University in San Antonio, Texas. After two mailings, 138 surveys were received, for a 35 percent response rate. This response rate is similar to that achieved by many other surveys of top leaders, who typically do not consider

completion of optional surveys a high priority. For example, response rates for recent surveys of senior hospital executives (Finley, Ivanitskaya, and Kennedy 2007), board members and CEOs (McDonagh 2006), and nursing home administrators (Calhoun, Banaszak-Hall, and Hearld 2006) were 26 percent, 31 percent, and 44 percent, respectively. No differences were observed in hospital characteristics between the hospitals whose CEOs responded to the survey and the sample population, except that system hospitals and not-for-profit hospitals were slightly overrepresented among respondents.

### Statistical Analyses

Associations between the strategic planning process characteristics and net income (Model 1) and profit margin (Model 2) were examined using multiple linear regression analysis. For each of the two regression analyses, hospitals with net income or profit margin values more than three standard deviations from the mean were excluded from the analyses (six hospitals for net income and three hospitals for profit margin). Correlations among the independent and control variables were all below .40, except for board involvement and physician involvement in strategic planning, which were correlated at .71. A series of interaction terms between system membership and the strategic planning characteristics was tested, based on reasoning that system membership may lead to different relationships between performance and strategic planning for individual hospital members, as compared to nonsystem members. Only one

interaction term contributed to overall model significance—system membership and board involvement, and it was added to Model 2.

### FINDINGS

Table 1 reports descriptive statistics for the sample hospitals. The large majority of the CEOs (87 percent) indicated that their hospitals have a strategic plan. Overall, the CEOs rated their plans as partially or fully implemented in their organizations (mean score of 5.55 on a 1–7 scale). In 54 percent of the surveyed hospitals, the CEO is assigned the responsibility for strategic planning.

CEOs in Texas indicated that their hospitals have moderately to fully developed strategic plans (mean score of 5.3 on a 1–7 scale). The level of involvement of the governing board in the last major revision of the strategic plan varies by hospital, with most CEOs indicating moderate to high board involvement (mean score of 4.9 on a 1–7 scale). Consistent with the findings of Zuckerman (2006), the involvement of the physicians in the last major revision of the strategic plan is slightly lower (mean score of 4.6 on a 1–7 scale). Profit margin for these hospitals is 1 percent, which is significantly lower than the industry average of 5 percent (Gapenski 2005).

The results of the multiple linear regression analysis for net income (Model 1) and profit margin (Model 2) are reported in Table 2.

### Model 1: Net Income

The regression model for net income performs reasonably well, with 40

**TABLE 1**  
**Descriptive Statistics (N = 138 hospitals)**

Variable	Mean or Percentage	Standard Deviation
<b>Control Variables</b>		
Ownership		
Private not-for-profit ownership	41.3%	—
Private for-profit ownership	21.0%	—
Government ownership	37.7%	—
System member	45.7%	—
Number of beds	142.46	160.42
Urban location	52.2%	—
<b>Strategic Planning Processes</b>		
Have a strategic plan	86.9%	—
Extent of implementation (1-7 scale)	5.55	0.94
Fully developed strategic plan (1-7 scale)	5.28	1.16
Responsibility for the strategic plan		
CEO	53.6%	—
Others	46.4%	—
Level of governing board involvement (1-7 scale)	4.86	1.71
Level of physician involvement (1-7 scale)	4.62	1.53
<b>Dependent Variables</b>		
Net income	\$1,728,277	\$6,255,342
Profit margin	0.01	0.11

percent of variance in net income explained. Three variables are related to financial performance in Model 1. Among the control variables, larger size is associated with higher net income. The individual assigned responsibility for the strategic plan and the level of involvement of the governing board are also associated with net income at a statistically significant level. More specifically, assigning the responsibility for strategic planning to the CEO is

positively associated with net income. This finding is consistent with Proposition 4. Consistent with Proposition 5, higher-performing hospitals report more involvement of the governing board in the last major revision of the plan. No support is found for Propositions 1, 2, 3, and 6.

**Model 2: Profit Margin**

Model 2 explains less of the variance in the dependent variable, with an

**TABLE 2**  
**Regression Analysis Results**

Variable	Model 1 Dependent Variable: Net Income (N = 132)		Model 2 Dependent Variable: Profit Margin (N = 135)	
	Unstandardized Coefficient (1,000,000)	Standard Error (1,000,000)	Unstandardized Coefficient	Standard Error
<b>Control Variables</b>				
Not-for-profit ownership	2.33	11.54	-.01	.02
For-profit ownership	.68	1.93	-.02	.02
System member	2.76	1.40	-.06	.04
Number of beds	.02	.00***	.00	.00
Urban location	.57	1.56	.01	.02
<b>Strategic Planning Processes</b>				
Have a strategic plan	8.82	5.83	.19	.07**
Extent of implementation	-.13	.73	-.01	.01
CEO responsible	2.49	1.19*	.01	.01
Fully developed plan	-.26	.67	.01	.01
Board involvement	1.20	.54*	-.01	.01
Physician involvement	-1.09	.57	.01	.01
Board involvement-system member interaction	—	—	.02	.01
Constant	-11.76	7.21	-.17	.09
Overall F		5.29***		1.90*
R <sup>2</sup>		.40		.21

Note: Reference category for the ownership variables (for-profit ownership, not-for-profit ownership) is government ownership.  
\*  $p < 0.05$ ; \*\*  $p < 0.01$ ; \*\*\*  $p < 0.001$

R<sup>2</sup> value of .21. Depending on the interaction terms entered in the equation, overall model significance wavered around the .05 confidence level. Only one variable—having a strategic plan—was consistently significant in its association with profit margin. As reported in Table 2, having a strategic

plan is significantly related to a higher profit margin.

### DISCUSSION

As reported by CEOs, most Texas hospitals conduct strategic planning as it is typically explained in textbooks, with 87 percent having a formal plan that is

comprehensive, largely implemented, and developed in concert with physicians and the governing board. Substantial variation in practice was observed in the dimension of assignment of responsibility for the plan, with about one-half of hospitals assigning responsibility for strategic planning to the CEO.

Six propositions that relate these characteristics to financial performance were tested in the analyses. Proposition 1 (having a strategic plan), Proposition 4 (assigning responsibility for the plan to the CEO), and Proposition 5 (involving the board) were supported, although for only one of the two financial outcome measures for each. The three confirmatory findings have important implications, although the fact that the performance measures are dated 2003 and the strategic planning process measures are dated 2006 restricts the interpretation of the findings. Hospitals with a strategic plan in 2006, hospitals that assigned the CEO responsibility for the plan in 2006, and hospitals that involved the board more in strategic planning in 2006 are more likely to have performed better in 2003. The three strategic planning processes are positively associated with past financial performance. Whether the findings hold for concurrent and future hospital performance, however, awaits future longitudinal analysis. For the time being, the positive findings are limited to the association of three dimensions of planning with past performance.

Having a strategic plan in place in 2006 is positively associated with hospital profit margin in 2003. Hospitals with higher profit margins have lower expenses relative to revenues. Having ex-

penses under control may indicate commitment to a planning process, because a strategic plan allows the organization to focus on activities that maximize internal capabilities (Swayne, Duncan, and Ginter 2006). This finding supports the perceptions of the respondents in our earlier qualitative study, who described strategic planning as "worthwhile," "critical," and "one of the most important processes" in a healthcare organization (Begun and Kaissi 2005).

The extent to which the strategic plan is fully developed, and the extent of actual implementation of the strategic plan, are not associated with either of the financial outcome measures (Propositions 2 and 3). As shown in Table 1, the variance in both the extent of development and the extent of implementation measures is low, and absolute levels of both measures are high (more than 5 on a 1-7 scale). Most leaders consider their plans to be comprehensive and implemented. This may have contributed to the lack of a significant finding.

Hospitals with higher net income are more likely to have assigned the CEO the responsibility for the strategic plan (Proposition 4). While it may be important for the CEO to involve others in the planning process, some advantage may come from having the CEO assume the lion's share of the responsibility for the whole strategic planning process. Parrington (2006) argues that characteristics of the strategic planning process are less important than leadership's commitment to change. Note that this structure does not necessarily equate to a dictatorial leadership style or micro-management by the CEO; it simply indicates that the CEO is ultimately

accountable to the board for the development and for the results of the strategic plan.

Involvement of the governing board is positively associated with hospital net income (Proposition 5). The governing board represents the needs and the expectations of the important stakeholders in the organization, and its involvement may reflect greater pressure to perform well. Physician involvement, however, did not have an independent association with financial performance (Proposition 6). While physician involvement in strategic planning may be critical to the development of strategies that enhance the quality of care delivery in hospitals, physician participation may not necessarily be associated with better financial performance.

Trying to draw implications for practice from this study illustrates the generic issues around developing evidence bases for management practice (Kovner and Rundall 2006). First, interpretation is in the eye of the beholder. Proponents of planning could argue that given the methodological challenges in this study, it is remarkable that any performance indicators at all were found to be associated with planning. Detractors could argue that the findings overall are so weak that the value of planning as evidenced in this study is neutral at best.

Second, drawing implications from one study is dangerous, particularly from a study with a small sample and a limited explanatory model. We see this study as one among a number that will unfold over a several-year period and contribute to a more robust evidence base. In fact, a major purpose of this research is to stimulate more com-

prehensive research. We hope it will encourage others to undertake similar research that assesses strategic planning and other common management practices.

### **Limitations and Future Research**

The research design and data reported here present several limitations. The financial data used in this study were for 2003, while the strategic planning process survey data were collected in 2006. We cannot assess whether strategic planning leads to better performance. Longitudinal research designs, with performance data before and after strategic planning, are needed to ferret out these issues of causality.

Choice of outcome measures is important in assessing performance. The measures of hospital performance we used capture only selected financial outcomes and do not include indicators of the quality of care provided (which were not available for these hospitals) or other dimensions of performance. Future research should strive to include additional measures of financial performance and other measures of hospital performance, such as quality and employee satisfaction.

Additional improvements in study design include having multiple respondents for each organization for the strategic planning survey and having more objective (less perceptual) measures of the planning process. As noted, the hospital population in the study was limited to Texas. In comparison to all U.S. hospitals, Texas hospitals have a higher proportion of for-profit ownership, which limits generalizations of results (AHA 2004). National survey and

performance data will provide a stronger evidence base. Finally, measures of the market environment, such as degree of competition faced by each hospital, may provide clues to additional sources of systematic variation in planning processes.

## CONCLUSION

Strategic planning is a basic management function undertaken in most hospitals and, in this study, the vast majority of 138 Texas hospitals. The impact of planning and variation in the planning process on future hospital performance remains a matter of conjecture, although having a strategic plan, assigning the CEO responsibility for the plan, and involving the governing board in the planning process in 2006 are all associated with higher financial performance in 2003. The retrospective performance measures and the modesty of the findings in this study reinforce the need for further research that employs a longitudinal design, a more comprehensive explanatory model, and multiple dimensions of hospital performance.

## References

- Alexander, K. 2006. "Advancing Strategic Planning." *Frontiers of Health Services Management* 23 (2): 39-41.
- American Hospital Association (AHA). 2004. *AHA Hospital Statistics 2005 Edition*. Chicago: American Hospital Association Company.
- Baldrige National Quality Program. 2006. *Health Care Criteria for Performance Excellence*. Gaithersburg, MD: Baldrige National Quality Program.
- Begun, J., and K. B. Heatwole. 1999. "Strategic Cycling: Shaking Complacency in Healthcare Strategic Planning." *Journal of Healthcare Management* 44 (5): 339-51.
- Begun, J., and A. Kaissi. 2005. "An Exploratory Study of Healthcare Strategic Planning in Two Metropolitan Areas." *Journal of Healthcare Management* 50 (4): 264-75.
- Bossidy, L., R. Charan, and C. Burck. 2002. *Execution: The Discipline of Getting Things Done*. New York: Crown Business.
- Burns, L., G. Gimm, and S. Nicholson. 2005. "The Financial Performance of Integrated Health Organizations." *Journal of Healthcare Management* 50 (3): 191-211.
- Calhoun, J. G., J. Banaszak-Hall, and L. R. Hearld. 2006. "Current Marketing Practices in the Nursing Home Sector." *Journal of Healthcare Management* 51 (3): 185-200.
- Donaldson, L. 2001. *The Contingency Theory of Organizations*. Thousand Oaks, CA: Sage.
- Dubbs, N. L. 2002. "Organization Design Consistency: The PennCARE and Henry Ford Health System Experiences." *Journal of Healthcare Management* 47 (5): 307-18.
- Finley, F. R., L. V. Ivanitskaya, and M. H. Kennedy. 2007. "Mentoring Junior Healthcare Administrators: A Description of Mentoring Practices in 127 U.S. Hospitals." *Journal of Healthcare Management* 52 (4): 260-69.
- Gapenski, L. C. 2005. *Healthcare Finance: An Introduction to Accounting and Financial Management*, 3rd Ed. Chicago: Health Administration Press.
- Kovner, A. R., and T. G. Rundall. 2006. "Evidence-based Management Reconsidered." *Frontiers of Health Services Management* 22 (3): 3-22.
- Lemak, C. H., and E. Goodrick. 2003. "Strategy as Simple Rules: Understanding Success in a Rural Clinic." *Health Care Management Review* 28 (2): 179-88.
- Luke, R. D., S. L. Walston, and P. M. Plummer. 2004. *Healthcare Strategy*. Chicago: Health Administration Press.
- McCue, M. J., and T. H. Kim. 2005. "Association of Market, Mission, Operational and Financial Factors on Hospital Acquisition Prices: 1999 Through 2001." *Health Care Management Review* 30 (1): 24-31.
- McDonagh, K. J. 2006. "Hospital Governing Boards: A Study of Their Effectiveness in Relation to Organizational Performance." *Journal of Healthcare Management* 51 (2): 377-89.
- Menachemi, N., J. Burkhardt, R. Shewchuk, D. Burke, and R. G. Brooks. 2006. "Hospital Information Technology and Positive Financial Performance: A Different

- Approach to Finding an ROI." *Journal of Healthcare Management* 51 (1): 40-58.
- Orlikoff, J. E. and M. K. Totten. 2006. "Strategic Planning: Maximizing the Board's Impact." *Trustee* 59 (7): 15-20.
- Parrington, M. 2006. "Match Planning Sophistication to Organizational Evolution." *Frontiers of Health Services Management* 23 (2): 43-46.
- Rice, R. T. 2006. "The Board's Role in Strategic Management." *Trustee* 59 (7): 28-29.
- Rovinsky, M. 2002. "Physician Input: A Critical Strategic Planning Tool." *Healthcare Financial Management* 56 (1): 36-39.
- Scott, W. R. 2000. *Institutions and Organizations*, 2nd Ed. Thousand Oaks, CA: Sage.
- Sollenberger, D. K. 2006. "Strategic Planning in Healthcare: The Experience of the University of Wisconsin Hospital and Clinics." *Frontiers of Health Services Management* 23 (2): 17-31.
- Song, P. H., and D. G. Smith. 2007. "Financial Preconditions for Successful Community Initiatives for the Uninsured." *Journal of Healthcare Management* 52 (6): 411-23.
- Swayne, L. E., J. E. Duncan, and P. M. Ginter. 2006. *Strategic Management of Health Care Organizations*, 5th Ed. Malden, MA: Blackwell Publishing.
- Van Kooy, M. A., and W. H. Ettinger. 2002. "Involving Medical Staff in Strategic Decisions Is Key to Success." *Physician Executive* 28 (4): 38-42.
- Wells, R., S. D. Lee, J. McClure, L. Baronner, and L. Davis. 2004. "Strategy Development in Small Hospitals: Stakeholder Management in Constrained Circumstances." *Health Care Management Review* 29 (3): 218-28.
- Zuckerman, A. M. 2005. *Healthcare Strategic Planning*, 2nd Ed. Chicago: Health Administration Press.
- . 2006. "Advancing the State of the Art in Healthcare Strategic Planning." *Frontiers of Health Services Management* 23 (2): 3-15.

## PRACTITIONER APPLICATION

*Thor W. Nelson, FACHE, director, Cardiovascular and Imaging Services, Mercy Hospital, Allina Hospitals and Clinics, Coon Rapids, Minnesota*

**T**his article supports what many of us who have done strategic planning believe to be true: Strategic planning done well is associated with higher performance. As the authors describe, little quantitative evidence shows exactly what it means to do strategic planning well. This article is a step in the right direction to empirically prove the link between specific characteristics of a strategic planning process and higher performance.

The authors conclude that higher-performing hospitals (in 2003) exhibit three distinctive planning characteristics (in 2006)—having a strategic plan, assigning the CEO responsibility for the plan, and involving the board. I suspect that these planning characteristics both contribute to and are reinforced by higher performance. While these planning steps may be intuitive, hospitals face challenges when making them happen.

Having a strategic plan requires a significant commitment of time and resources. In hospitals, the natural motivation is to have goals in areas such as quality and financial performance. Many of our day-to-day priorities are in these areas and are shaped by processes for regulatory compliance, quality measurement, and budgeting. The result in many cases, however, is that goals are often short term (one year)

and may best be described as operating goals rather than strategic goals that have a longer-term horizon. The ability to take a longer-term view requires, among other things, research of industry trends, market analysis, and benchmarking. Finding the time to do this work is not easy amid the daily pressures that hospital leaders face.

This pressure of time and resources also relates to the challenge of assigning responsibility for the plan to the CEO. Assigning responsibility for the plan cannot mean that the CEO manages the process alone. Based on my own experience, the CEO is most effective when he or she can lead the strategic plan while another person acts as the facilitator of the process. Involving the governing board requires different processes than does involving other leaders, staff, or clinicians. The overall process needs to be tailored for the different stakeholders. Doing this well requires significant preparation and work that a CEO cannot realistically manage alone.

The CEO's responsibility for the plan is inherently related to successful involvement of the board. Strategic planning needs to be built into the board meeting calendar as the CEO and board chairperson set the agenda. The board may also need to give additional time in the form of additional or extended meetings. A board's willingness to commit this extra time requires a higher degree of preparation and the resources to conduct a highly effective board session.

Strategic planning must be a priority for hospital leadership. The authors take an important step in providing evidence on the link between strategic planning and improved hospital performance. While many priorities compete for a leader's time and for organizational resources, a commitment to strategic planning is vital. The commitment must start with the CEO and the organization's willingness to assign the appropriate resources to the strategic planning process.