



DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

1a. SECURITY CLASSIFICATION OF REPORT N/A		1b. RESTRICTIVE MARKINGS N/A	
2a. SECURITY CLASSIFICATION OF ABSTRACT N/A		3. DISTRIBUTION/AVAILABILITY OF REPORT UNCLASSIFIED/UNLIMITED	
2b. DECLASSIFICATION/DOWNGRADING SCHEDULE N/A		5. MONITORING ORGANIZATION REPORT NUMBER(S)	
4. PERFORMING ORGANIZATION REPORT NUMBER(S)		7a. NAME OF MONITORING ORGANIZATION U.S. Army-Baylor University Graduate Program in Health Care Administration	
6a. NAME OF PERFORMING ORGANIZATION U.S. Army MEDDAC	6b. OFFICE SYMBOL (if applicable) HSDX	7b. ADDRESS (City, State, and ZIP Code) AHS San Antonio, TX 78234-6100	
6c. ADDRESS (City, State, and ZIP Code) Fort Campbell, KY, 42223-1498		9. PROCUREMENT INSTRUMENT IDENTIFICATION NUMBER	
8a. NAME OF FUNDING/SPONSORING ORGANIZATION	8b. OFFICE SYMBOL (if applicable)	10. SOURCE OF FUNDING NUMBERS	
8c. ADDRESS (City, State, and ZIP Code)		PROGRAM ELEMENT NO	PROJECT NO
		TASK NO.	WORK UNIT ACCESSION NO.
11. TITLE (Include Security Classification) The Development and Analysis of a Strategic Planning Process at Blanchfield Army Community Hospital, Fort Campbell, Kentucky			
12. PERSONAL AUTHOR(S) Crook, Kenneth Robert			
13a. TYPE OF REPORT Final	13b. TIME COVERED FROM 7-90 TO 7-91	14. DATE OF REPORT (Year, Month, Day) 91 JUL 1	15. PAGE COUNT 192
16. SUPPLEMENTARY NOTATION			
17. COSATI CODES		18. SUBJECT TERMS (Continue on reverse if necessary and identify by block number)	
FIELD	GROUP	Strategic Planning	
		Hospitals, Military	
19. ABSTRACT (Continue on reverse if necessary and identify by block number) The purpose of this project was to develop and analyze a strategic planning process which culminated in a strategic plan for Blanchfield Army Community Hospital. The process consisted of four phases. Phase one included preparing a Needs and Demands Analysis of the beneficiary population, identifying key stakeholders, and selecting committee members. Phase two was an educational phase in which committee members were oriented to strategic planning and to the specific process to be used. An environmental assessment was also conducted. The organization's mission statement, values, strategic issues, goals, objectives, strategies, outcome measures, and responsible agencies were developed in a two day, off-site planning conference in phase three. The final phase focused on the revision of the strategic planning document. A review and analysis of the planning process revealed three areas for improvement. A discussion of each problem, alternative actions, and recommended solution are provided. Lessons learned are also discussed. Recommendations for implementing the strategic plan are provided. The results of this study provide a template for strategic planning which permits the organization to continuously evaluate and adapt to the changing needs and demands (continued)			
20. DISTRIBUTION/AVAILABILITY OF ABSTRACT <input checked="" type="checkbox"/> UNCLASSIFIED/UNLIMITED <input type="checkbox"/> SAME AS RPT <input type="checkbox"/> DTIC USERS		21. ABSTRACT SECURITY CLASSIFICATION N/A	
22a. NAME OF RESPONSIBLE INDIVIDUAL Major Kenneth R. Crook		22b. TELEPHONE (Include Area Code) AV 635-8048/8040	22c. OFFICE SYMBOL HSDX-DCA

SECRET

MAR 8 1993

DD Form 1473, JUN 86 (Continued)

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93-04869



1988

THE DEVELOPMENT AND ANALYSIS OF A STRATEGIC PLANNING
PROCESS AT BLANCHFIELD ARMY COMMUNITY HOSPITAL,
FORT CAMPBELL, KENTUCKY

A Graduate Management Project
Submitted to the Faculty of
Baylor University
In Partial Fulfillment of the
Requirements for the Degree
of
Masters of Health Care Administration
by
Major Kenneth R. Crook, MS
December 1990

Running head: STRATEGIC PLANNING

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Abstract

The purpose of this project was to develop and analyze a strategic planning process which culminated in a strategic plan for Blanchfield Army Community Hospital. The process consisted of four phases. Phase one included preparing a Needs and Demands Analysis of the beneficiary population, identifying key stakeholders, and selecting committee members. Phase two was an education phase in which committee members were oriented to strategic planning and to the specific process to be used. An environmental assessment was also conducted. The organization's mission statement, values, strategic issues, goals, objectives, strategies, outcome measures, and responsible agencies were developed in a two day, off-site planning conference in phase three. The final phase focused on the revision of the strategic planning document. A review and analysis of the planning process revealed three areas for improvement. A discussion of each problem, alternative actions, and recommended solutions are provided. Lessons learned are also discussed. Recommendations for implementing the strategic plan are provided. The results of this study provide a template for strategic planning which permits the organization to continuously evaluate and adapt to the changing needs and demands of its various customers and environments.

Introduction

Conditions Which Prompted the Study

The future of health care in the United States is not an extension of our past. If the scope and speed of change in the health care industry in our recent history is an indication of what health care providers can anticipate in our future, change is the only characteristic that appears to be relatively certain. Health care organizations that are not proactive in meeting the demands of change will have little or no control over their destiny.

Health care organizations habitually operate in a constantly changing and unstable environment. Dramatic changes within the past 50 years for example, have greatly affected the health care industry.

The Federal Government actively encouraged the growth of the health care industry and construction of hospitals from 1946 into the 1970s through the Hill-Burton Program (Hospital Survey and Construction Act of 1946--Public Law 79-725). The Hill-Burton Program gave rise to major hospital expansion and is credited with financing the construction of thousands of new hospital beds in the United States during the 1950s. Federal funds for the construction of new hospitals (90 cents on the dollar), were available provided that the hospital demonstrated a

need for the hospital and used five percent of its assets to provide care to the medically indigent (Griffith, 1987). The Hill-Burton Program was replaced by the National Health Planning and Resources Development Act (Public Law 93-641) in 1977 in an attempt to regulate growth and drive down health care costs. The drive to achieve efficiency in health care also led to the start of large hospital corporations in the 1970s. (Griffith, 1987)

The enactment of Titles XVIII and XIX of Public Law 89-97 amended the 1935 Social Security Act and brought about Medicare and Medicaid in 1965 in response to escalating health care costs and inequitable access to care. It ultimately made the Federal Government the primary third party payor of all medical expenses in the United States. The 1960s was a period of limited resources and limited growth, and it marked the beginning of increased governmental regulation of the health care industry. (Griffith, 1987)

The most notable effect on the health care industry was brought about by the movement from fee-for-service to a prospective payment system. The Social Security Amendments of 1983 (Public Law 98-21), implemented a payment system that focused on each hospitalization and set prices based upon categories of illness called diagnostic related groups. The prospective payment system

shifted the financial responsibility for the quantity and appropriateness of care provided to each patient to the health care organization. (Griffith, 1987)

Based on the predictions described below, the health care environment appears increasingly turbulent and significant changes are expected to occur in the future. Predictions of change which may dramatically affect the health care industry in the 1990s include numerous organizational, operational, and structural changes in the health care environment.

Battistella (1989) predicts that a national health insurance program will be legislated in response to economic constraints and social considerations. Included in the list of catalysts precipitating the reformation of the government's role in the provision of health care in the near future, Battistella (1989) cites growing health care expenditures. Expenditures were over 12 percent of the nation's gross national product (GNP) for fiscal year (FY) 1989 and continue to grow at rates 50% higher than the GNP (Herzlinger, 1989). Battistella (1989) also lists over capacity of acute care beds, physicians, and most allied health care manpower; and difficulty experienced by an aging population in paying their Medicare deductibles and co-insurance as catalysts.

Coile's (1990) predictions for the nineties include high growth in ambulatory care markets, the forced closure of thousands of hospitals due to rising costs and low utilization, and increased consolidation through mergers as well as sharing agreements with competitors for high-cost or low-use services. Coile (1990) also predicts continued changes in health care policy and that quality of care will become a competitive consideration for customers when choosing providers. Continued growth of managed care organizations such as health maintenance organizations, preferred provider organizations, home health care organizations, day surgical centers, and free standing medical centers which will produce dramatic changes in the health care industry are forecast by Pegels & Rogers (1988).

Rapid advances in technology, which have been largely responsible for the increase in health care expenses, will continue to affect competition, and influence access to care and the manner in which health care is provided (Pegels & Rogers, 1988)

Demographic changes will also significantly affect the health care industry in the nineties--most notably with the graying of America. The Committee on an Aging Society, Institute of Medicine and National Research Council (1985) reports that an increase in the life

expectancy of elderly persons and a decline in the fertility rate which has led to a shrinking 18 year old and under population will produce a shift in the demographics of this nation. They predict that one quarter of the population will be over age 65 by the year 2050.

Changing trends in the social environment such as increasing numbers of teenage pregnancies, increasing numbers of single working parents, an increase in the size of the poverty population, and an aging work force may also result in important changes in the needs and demands of the population served (Battistella, 1989).

These few examples of recent changes in the health care industry and the high probability of significant change for the future clearly indicate that health care organizations cannot simply hope for the best and ignore its responsibility to meet these challenges. They must be proactive in managing the affects of change on their organization.

Organizations must evolve to meet the demands of their changing environments. Those that fail to monitor and adapt to change, and evolve with their environment will enter a state of atrophy and decline, and will not survive (Daft, 1986). In Peters' and Waterman's (1982) search for the criteria of success, they found that

excellent and innovative organizations were especially adroit at continually responding to change of any sort in their environment. Excellent and innovative organizations were able to revamp, adjust, transform, and adapt to shifts in customers' needs, increased competition, government regulation, or social demands.

The demand to demonstrate the same degree of excellence, innovation, and strategic flexibility in the health care industry is no less important. Health care organizations must be actively involved in strategic planning in order to survive and adapt to their changing environment. Flannery and Williams (1990) add additional support to this concept by stating that organizations that can create structure and management which are unencumbered by established procedures and focus instead on the most direct route to improve health care services, will flourish in the nineties.

The environment in which military health care operates is equally as complex, demanding and uncertain as the civilian health care industry. The environment of military medicine not only includes the elements of the civilian health care industry, but is additionally influenced by the combined effects of the external environment (e.g., Congress and the Department of Defense [DOD]), which exerts a high degree of control over the

internal operations of the military system. These include increased limitations on financial resources, programed down-sizing of the personnel force structure, limited ability to control costs or increase revenue, responsibilities to support no-notice mobilization and emergency deployments in support of war time missions, and increasing demands to provide comprehensive health care for retired service members and family members of active duty soldiers.

Strategic planning provides the vehicle for managing the affects that a turbulent environment has on the organization. The U.S. Army's senior leadership has recognized the importance of strategic planning and has recently mandated that strategic plans be developed for its health care facilities (Major, 1990, March 6).

Statement of the Management Problem

Successful organizations must have a plan for the future. Currently, no comprehensive, strategic planning process exists which permits Blanchfield Army Community Hospital (BACH) to identify, evaluate and adapt to the changing needs and demands of its various customers and environments.

Review of the Literature

Strategic planning has many definitions. Kropf and Greenberg (1984) describe it as "the process of making and

implementing decisions concerning the use of resources to achieve an organization's goals and to fulfill its mission" (p. 7). Gray (1986) states that it involves "the allocation of resources to programmed activities which support the achievement of business goals in a dynamic and competitive environment" (p. 89). Both definitions have a reoccurring theme--planning is future oriented. Strategic planning is only one part of strategic management, however.

Pegels and Rogers (1988) define strategic management as "an integrated management activity that identifies where the organization should be heading in the future" (p. xiii). Strategic management is made up of many activities and processes that guide the organizations into the future. The strategic plan serves as the hub of strategic management around which all other management plans and control systems (budget, information, marketing, compensation, and organizational structure), are developed, integrated, and support (Gray, 1986). From effective strategic management the organization develops strategic flexibility--"the ability to reposition itself in a market or industry, change its game plan, or to dismantle current strategies and adopt a new strategic plan" (Pegels & Rogers, 1988, p. xvi).

Although strategic planning in health care institutions covers a period of three to five years in the future, it is not the same as long-range planning or master planning. Thieme, Wilson, and Long (1981) point out that strategic planning differs from master planning in four important respects. First, is a shift from a focus on production to one on people and population groups. Strategic planning in health care organizations addresses the needs and demands of the multiple groups related to and served by the organization. The main purpose of strategic planning is to improve management's ability to diagnose and respond to the needs of the various groups.

Secondly, strategic planning begins with an assessment of the internal and external environments prior to the development of the institutional mission and organizational goals.

Third, master planning is more quantitatively than qualitatively orientated which has often resulted in planning efforts which have failed to be responsive to social needs or institutional values. Decisions made in the strategic planning process are more likely to be selected from realistic options which reflect value judgments in lieu of quantitative assessment.

Finally, the strategic management process must be integrated into ongoing institutional management activities that require broad participation and commitment rather than being contracted out to consultants.

Strategic Planning Models

Four models are presented which offer a slightly different perspective of strategic planning; each has applicability to both corporate and health care industries.

The first model to be examined is proposed by Pegels and Rogers (1988). These authors recommend an idealization approach to the planning process. Retrospective planning attempts to identify and remove deficiencies from past performance of system components. It focuses on what is not wanted rather than what is desired. The idealization approach motivates planning members to think positively and permits them to create any future they want as long as it is technologically feasible, by removing all financial and political barriers (Ackoff, 1974).

Pegels and Rogers (1988) describe seven sequential steps and six parallel tasks for strategic planning. They state that a comprehensive description of the organization must be prepared to ensure that the strategic plan is closely related to the current status of the hospital and

that the planning members have an adequate amount of data about the organization. They state that having objective data about the current status of the hospital can be useful in getting decision makers more involved in the planning process. This description also serves as the foundation for the assessment of internal strengths and weaknesses. The description should include information on the organization's financial status, mission departments and service departments, cost and revenues by mission department and service department, number of employees, specialities and number of medical staff, technological expertise of hospital staff, managerial expertise, operations capability, and historical record of performance in terms of utilization and profitability.

The second step discussed by Pegels and Rogers (1988) is defining the mission. They describe the mission statement as a statement of organizational philosophy and fundamental purpose which should be reflective of the corporate culture and the personality of the organization. It is noted that defining the mission is a critical step in the strategic planning process since it ultimately becomes the tool for assessing corporate growth and progress. Pegels and Rogers (1988) stress the importance of defining the mission before establishing goals since the mission establishes the philosophy or tone that the

corporate goals must follow. They list four criteria of a good mission statement: (a) it should be totally understandable by all possible audiences, (b) it should be applicable over the next five years if no changes in the organizational philosophy occur, (c) it should give an overview of the organization, and (d) it should be phrased to state the purpose of the organization. Want (1986) states that the corporate mission is the starting point for effectively addressing common problems that confront all organizations in the areas of corporate climate, styles of management and control, strategic and tactical planning, lines of communication, corporate structure, and criteria for measuring corporate performance and effectiveness. Want (1986) identifies four primary components of the corporate mission: (a) a statement of overall purpose which provides the company's basic rationale for existence and principle business aims, which link the company's mission to operational level goals, (b) corporate identity, which determines how the organization will be viewed in the market place, (c) policies of the company, which identify the corporate philosophy and style of senior management and their relationship with significant corporate others, and (d) values, which define a clear set of business standards against which the company may be judged. Want (1986) states that it is one

of the Chief Executive Officer's primary responsibilities to develop, implement, and monitor the corporate mission. Mission development and implementation, however, should be done systematically and formally with participation from all levels of the company.

The third step of Pegels and Rogers (1988) strategic planning process is to define the issues that are most critical to the organization's future. The intent is only to create categories for which goals, objectives, and strategies can be developed and structured later in the planning process. The authors caution that many strategic plans fail because of a lack of focus on critical issues. Issues should be action oriented rather than an encyclopedia of issues that make it impossible to address any one sufficiently.

Next, alternative strategies are identified and evaluated based on the issues in the previous step. Each strategy is evaluated with regard to its appropriateness, feasibility, affordability, fit with the mission statement, supportability with current physical and human resources, legality, and regulatory requirements. A set of general strategies is selected that will become the basis for the organization's general strategy. The general strategy is used as the basis for the development of goals and objectives in steps five and six.

Defining organizational goals is step five in Pegels and Rogers (1988) model. They define goals as the "issue-specific aims of the organization that allow for the eventual achievement of the mission" (p. 30). Goals must be realistic, broad agenda-setting statements, which are in agreement with the mission. The goals also serve to establish a time line for the plan. Pegels and Rogers (1988) state that three years is considered long-term planning for health care due to the rapid changing environment, and point out that annual updates are critical to the success of the plan. Every goal has at least one objective.

Developing objectives then, is the sixth step of the strategic planning process. Objectives are relatively specific, time-bound, and action-oriented statements. They are normally stated as one year or multiyear operational plans that support a set of goals. Pegels and Rogers (1988) recommend that the objectives be written in a format that permits the evaluation of progress on any goal. Objectives also serve as the basis for evaluating management's success in a given year.

Refining the general strategy is the final step of the strategic planning process. Goals and objectives that have been formulated are synthesized when refining the general strategy. The general strategy is stated as

functional area plans which provide an overall strategic outlook of how the organization will unfold during the period of the strategic plan. (Pegels & Rogers, 1988)

Pegels and Rogers (1988) also describe six parallel tasks that support the seven steps of the strategic planning process which ultimately provide the data base for assessment of the environment. These six parallel tasks are similar to those identified in other strategic planning models, but have been isolated from the planning sequence itself. They are identified as separate and ongoing tasks that support the seven sequential steps of the planning process.

Environmental assessment includes the internal and external environments. The internal environment is defined by Pegels and Rogers (1988) as "that part of the organization that can be directly controlled" (p. 36). It includes human resources, finances, marketing techniques, services offered, infrastructure, and corporate culture. The external environment include those numerous influences over which the organization has no control such as environmental factors, government regulation, the economic situation, demographic conditions, technological changes, social changes, and most importantly, competition (Pegels & Rogers, 1988).

In the Pegels and Rogers model, analysis of the internal environment is based on three parallel tasks: evaluating human resources, evaluating financial resources, and evaluating internal capabilities. Pegels and Rogers (1988) state that people are the most important resource of a service industry. The evaluation of human resources must identify the short- and long-term strengths and weaknesses of all categories of employees to include the medical staff, nurses, technicians, ancillary providers, and support staff such as housekeepers, maintenance personnel, and dietary workers; as well as volunteers who are often in a direct service capacity. The analysis of medical staff should include missing or under represented specialities, geographic location of physician offices, areas of potential community demand for office practices, physician referral patterns, and the age distribution of physicians by speciality (Pegels & Rogers, 1988).

Evaluating financial resources includes an analysis of the current financial situation of the organization, a projection of the future situation, and an analysis of what the organization's financial future should be.

Evaluating internal capabilities involves all internal capabilities of the organization not already covered in the evaluation of human or financial resources.

These areas include internal technological abilities, marketing expertise, operations management expertise, management control practices, short- and long-term planning practices, and the ability to control costs. The primary purpose of evaluating internal capabilities is to provide a comparison of the organization with respect to other organizations of similar size in similar service areas. This comparison provides information about the organization's competitive position in the community.

Peters and Waterman (1982) provide an organizational model (The McKinsey 7-S Framework) which can be used to assess the internal environment. It encompasses seven variables within the internal structure of the organization which are treated as interdependent: structure, strategy, staff (people), management style, systems and procedures, guiding concepts and shared values, and the present and hoped-for corporate strengths and skills which serve as the central variable linking the other six. Waterman (1982) states that evaluating the effect of strategies in terms of these seven areas can also facilitate implementation of the plan.

In the Pegels and Rogers (1988) planning model, analysis of the external environment is based on the remaining three parallel tasks: analysis of the

environment, analysis of the market and service segments, and analysis of the service area.

Pegels and Rogers (1988) suggest that the analysis of the environment is done using a technique that captures the most important environmental issues and aids in the development of goals and objectives. Environmental areas of concern can be categorized into regulatory, organizational and operational, social, financial, economic, and demographic. Environmental factors can be categorized as opportunities or threats which would help to clarify the issue as well as its potential effect. Projections must also be made on future economic conditions, demographics, manpower availability, technology, and the social environment.

Analysis of the market and service segments includes an analysis of the overall market in terms of expected market growth of the service segment within the service area served by the organization, and analysis of the competitor's strength and projected future strengths in each service segment; an evaluation of the relative competitiveness of each of the services segment niches, and a relative market share evaluation.

Analyzing the service area is usually limited to well-defined geographic borders. The organization must become fully knowledgeable of the service area in order to

project what its needs and the service area's potential will be during the three to five year planning horizon. Familiarization with the service area also permits the organization to exploit profitable opportunities as well as identify potential trouble spots. (Pegels & Rogers, 1988)

The second strategic planning model to be examined was proposed by Kropf and Greenberg (1984). These authors state that there are 12 major steps in the strategic planning process. First, is the development of an initial mission statement of what the mission has been. The mission statement should identify those shared values that the organization places above all others. Peters (1979) adds that functions, levels of care, services, populations, and service area must also be defined in order to provide a focus for the next step in the planning process.

Secondly, the members must examine their environment and analyze the internal and external conditions under which the hospital must operate. Internal analysis evaluates how resources are currently used and defines the capabilities of the hospital. The authors point out that a needs and demands analysis of existing markets for services and technology not currently being provided must also be completed during the internal analysis. The

purpose of external analysis is to identify the hospital's areas of potential growth in terms of market groups (patients and physicians), services, and technologies. Kropf and Greenberg (1984) state that the hospital must assess the effect that external groups such as government agencies and third party payors may have on its current activities and possible initiatives, and evaluate the extent to which the external groups may be able to successfully intervene on its own behalf.

The organization uses the information from the first two steps to assess their present position. Here the hospital's strengths, weaknesses, opportunities, and threats are identified (Kroph & Greenberg, 1984).

The organization's fourth step in Kropf's and Greenberg's (1984) strategic planning model is to develop and evaluate alternative scenarios concerning future events, assigning probabilities of their occurrence, and estimating the potential impact of the scenarios if they were to occur.

The next step for the hospital is to revise the mission statement and develop goals. The revised mission statement should incorporate the unmet needs that the organization is capable of satisfying and describe current activities that are consistent with the hospital's future environment, resources, and capabilities. The mission

statement should be followed by a detailed statement of the goals required for accomplishing the revised mission. (Kropf & Greenberg, 1984)

Kropf and Greenberg (1984) identify the development and evaluation of alternative strategies as the sixth strategic planning step. Changes in function, market groups, and technology are evaluated in respect to whether the hospital should adopt a focused, differentiated, or undifferentiated market strategy to meet its goals; the likely response of competitors, the reaction of important internal and external groups in response to changes, the affordability of making changes; and the availability and accessibility of management, staff, skills, and systems to support the changes. The need for changes in organization structure as a way to facilitate goal achievement are also evaluated in this step.

After developing and evaluating alternative strategies, the hospital must select those that best support the organization's goals and mission--step seven in the planning process. Next, because the hospital cannot develop a strategic plan that adequately covers all contingencies, it must also develop contingency plans. Contingency plans focus on short-term actions which neutralize the most serious scenarios and give the hospital time to modify its strategic plan (Steiner,

1979). Kropf and Greenberg (1984) recommend that trigger points be used to indicate when a contingency plan should be implemented, and responsible individuals should be identified to initiate their implementation.

The ninth step in the Kropf and Greenberg (1984) strategic planning model is the development and implementation of program plans. In this step, the strategic plan is translated into managerial and operational decisions which involve the development of budgets and program plans such as financial plans, marketing plans, and new product plans. Implementation of program plans focus on the effective and efficient management of resources.

The development and implementation of operational plans is the next step of strategic planning. Operational control involves such issues as the utilization of physical space in providing new or changing services, recruitment and training of personnel, changes in management systems, payroll, and inventory; marketing of new or changed services, legal implications of implementing changes in services or organizational structure, and the effects of changes in structure on space, personnel, or systems. Operational plans are less likely to be in the form of a written plan. (Kropf & Greenberg, 1984)

Development of an evaluation, monitoring, and control system is the eleventh step of Kropf and Greenberg's (1984) strategic planning sequence. Here they identify the need for continual evaluation of progress toward the achievement of organizational goals. A formal system is needed to monitor external and internal data on the changes in the environment that affect the hospital and those changes that result from the plan.

Kropf and Greenberg (1984) state that plan revision and implementation of contingency plans is the final step of strategic planning. The authors recommend that a formal review of the plan be initiated at least annually regardless of events. As with contingency planning, responsible individuals are identified to trigger revision of the plan when current goals are met or the internal or external environment make the current plan unusable.

The third approach to strategic planning, proposed by Thieme, Wilson, and Long (1981), identified six elements. These authors support the concept that strategic planning must begin with an analysis of the internal and external environments which then leads to the identification and analysis of critical strategic issues. They state that an accurate environmental assessment is necessary to avoid adopting unrealistic planning goals.

Critical components of the external analysis closely resemble those identified by Kropf and Greenberg (1984), and Pegels and Rogers (1988). They include (a) demographic forecasting to identify the characteristics and analyze the needs and demands of the population to be served, (b) mapping the regulatory environment by developing a matrix of the key provisions of laws and their effects on the individual hospital to assist the institution in focusing their resources and attention on protecting institutional interests, (c) assessing the strengths, weaknesses, opportunities, threats, future plans, and areas of mutual interest of key competitors, (d) identifying and analyzing the needs, demands, and preferences of its many customer groups by using market research techniques such as physician surveys, customer surveys, and focus group techniques, which identify how the system is accessed, customer preferences, how the hospital is viewed in relation to its competition, and competitive factors affecting customer choices, and (e) assessing the impact of trends (technological, social, lifestyle, etc...) in the delivery of health care services. ;

Internal analysis is needed to assess the organization's limitations, strengths, and opportunities. Thieme, Wilson, and Long (1981) recommend that the

internal analysis include descriptive data relating to utilization of hospital services, diagnosis treated, physician characteristics and admitting patterns, financial performance, facilities inventory, and an assessment of the organization's structure and how well it works.

Issue analysis, the identification of critical challenges and opportunities, is derived from the analysis of the internal and external environments. Analysis of the critical issues provides the basis for developing the organization's mission. Goals are developed which specify the strategy for achieving the mission. Finally, objectives are developed which are measurable, time specific, fix responsibility for their completion, and operationalize the strategy. (Thieme, Wilson, & Long, 1981)

The authors argue that an approach that begins with an assessment of the environment is more objective in the development of organizational mission and goals, and is less likely to develop a mission statement which is not based on reality (Thieme, Wilson, & Long, 1981).

The final model to be examined is proposed by Peter Drucker (1974) in which he succinctly outlines five steps for planning in service organizations. These are: (a) define what the business is and what it should be, (b)

derive a clear set of goals and objectives, (c) establish priorities for concentrating efforts on targets, standards of performance, setting deadlines, and accomplishing the work, (d) define performance measures, and (e) review and audit the outcomes to see which are acceptable and to determine where change should be directed.

Sources of Data and Information

Kropf and Greenberg (1984) identify three major categories of sources for gathering data and information on the internal and external analysis and analysis of present position. The first source is the hospital's internal information system. Data and information on a wide variety of internal operations can be obtained through this system. This information is valuable in conducting the internal analysis and in assessing the organization's current position. However, it is designed for routine, short-range, medical or business functions and cannot support the long-range information needs of strategic planning.

Examination of the external environment and the evaluation of alternative strategies requires access to data from external sources. Kropf and Greenberg (1984) state that much of strategic planning is based on data that is derived from external sources to the hospital. Government data are often the main or sole source of data

about the hospital's external environment. It is also very useful because it often covers long periods of time which permit analysis of time trends and projections of future events. The hospital information systems and the many sources of government data available to the planners are often adequate for the strategic planning process.

The final major category of information sources is in shared information systems. Under this type of information system, data from individual hospitals is collected in a central location, hospitals in the system have access to data of other hospitals, and hospitals are often provided with either a customized or common report based on the shared data. Shared information systems have the advantage of offering data to those hospitals that would otherwise not have access to external data. However, as Kropf and Greenberg (1984) point out, the benefits of this system are experienced only by those organizations who are members of the shared information systems.

Defining the Service Area

Kropf and Greenberg (1984) state that both internal and external data sources can be used to determine the hospital's service area. They define the service area as "the combined geographic areas that contain the physicians on which it depends for most of its service volume or

revenue" (Kropf & Greenberg, 1984, p. 186). This can be determined by compiling a complete list of physician office addresses that include information on county, city or town, and zip code. An index of hospital use can then be calculated based on the physician's use of services. Data from external sources can also be used to develop an index of physician investment which would measure the degree that physicians have become dependent on the hospital. Data on discharges, admissions, patient days, or other measures of dependence is combined with data on physician location to provide an index of physician investment for each office location. Kropf and Greenberg (1984) state that using index values and assessing their significance is a more useful method of determining service area than drawing a boundary on a map.

Corporate Vision and Shared Values

Although the models described present a comprehensive approach to strategic planning process, each has omitted or neglected a critical element--the development of a shared corporate vision. Major (1990) defines the vision as "a clear, succinct description of what the organization (and the community) should look like as it successfully implements its strategic plan (p. 13). Byrd (1987) states that people want to be in organizations that share a vision, especially during times of change, and that

commitment to a vision only occurs when people are involved in shaping it. In studying common characteristics of service organizations, Haskett (1987) found that high performing service organizations have an internally oriented strategic vision which focuses on vital groups of employees as well as customers. He states this indicates that management is aware that the health of the organization depends on the degree to which core groups of employees subscribe to and share a common set of values and are served by the company's activities. Shared organizational values are also essential for successful strategic planning.

Pegels and Rogers (1988) state that strategic thinking should be based on a set of shared organizational values. Strong corporate values serve as guiding principles for dealing with uncertainty. Values are standards by which choices are made, they provide standards on matters of principle, offer a vision that members can identify with, unify human resource management policies, unify employees in pursuit of a mission, and help employees to accept change (Byrd, 1987).

Corporate vision and shared values are not only important in the planning process, but are equally essential to successful implementation of the plan.

Implementation

The strategic plan, regardless of how well it is designed, will have little value unless it can be effectively implemented within the organization.

Pegels and Rogers (1984) state that unsatisfactory implementation strategies are to blame for much of the dissatisfaction with strategic planning. They cite an unacknowledged link between strategic planning and plan implementation as a major factor. Hayes (1986) states that strategic planning often is not successful because of the top-down orientation of many organizations. Plans that are developed by outside consultants or internal strategic planning staffs then handed down to line management lack credibility and are viewed as outside interference primarily because they have been excluded from the strategic planning process. One way to avoid this pitfall is to involve line management in the strategic planning process.

It is imperative that the management groups who are expected to implement the changes brought about by the strategic plan have comprehensive participation in the aspects of the planning process that are relevant to them (Hayes, 1986). Line managers should view the plan as their own and be made to feel responsible for its implementation. It is recommended that line managers sign-off on the strategic plan document following a

document review session where the plan is modified as a group. Reaching a consensus agreement on the final document will greatly facilitate its implementation (Pegels & Rogers, 1988). Gray (1986) goes even further in his support to involve line management. He states that strategic planning is a line management function in which staff specialists play only a supporting role.

Secondly, strategic thinking is a necessary condition for successful implementation of the plan. Management must be taught to think strategically in terms of where the organization is and should head in the future. Strategic thinking requires that management think and identify with the entire organization rather than their special area of interest or expertise. In a recent study of the characteristics of high- and low-innovation organizations, Delbecq and Mills (1985) reported that an essential error in the implementation of innovation made by low-innovation organizations is one of parochialism. Organizations with strategically-thinking leadership evolve into consensus-building and participative-management style organizations. Pegels and Rogers (1988) state that strategic thinking training should be made part of the regular management development activities of the organization.

Hayes (1986) states that strategic planning should avoid grand leaps forward and should focus on incremental step-by-step changes and improvements. Grandiose strategic leaps are often the result of the top-down orientation where managers responsible for the implementation of the plan were not involved in its planning or development. Quinn (1980) found support for this incremental approach to strategic change in his study of ten major corporations. He discovered that executives managing strategic change use a step-by-step process to constantly refine and reshape their strategic plan rather than using a highly formalized approach to long-range planning, goal specification, and strategy formulation. Pegels and Rogers (1988) add that an incremental approach to strategic planning is more likely to result in successful implementation of the plan.

Pegels and Rogers (1988) caution that poorly formulated goals and objectives also impede implementation. They state that goals and objectives must be specific and tied into action plans. Well formulated goals and objectives serve as performance indicators and guide line managers in performing actions for which they are responsible. Line managers should be evaluated on strategy implementation as well as satisfactory

performance of existing production, financial, or quality control systems.

Thieme, Wilson, and Long (1981) provide six characteristics of the planning process that are essential to successful strategy implementation: (a) an active planning committee, comprised of influential members who represent the board, administration, and medical staff, (b) the planning committee is a working committee, (c) leadership is provided by a key trustee and by the administration, (d) staff support is provided to gather information and perform initial analysis, (e) persons with special expertise and interests are on the task force to perform in-depth issue analysis, (f) third parties, usually consultants, provide objectivity to the process, and (g) a work plan and time table are followed.

Although the four models described above focus on for-profit organizations and are different in their methodology, their common elements form the core of the strategic planning process.

Conceptual Model

The hypothetical relationship between the strategic plan and other management plans and control systems is shown in figure one. This model is adapted from Gray's (1986), and Pegels' and Rogers' (1988) descriptions of strategic planning in which the strategic plan serves as

the hub of strategic management. Action plans are interdependent and support the execution of the strategic plan. Action plans are developed for each major administrative department, clinical division, service, or functional area. These areas would include information management, budget, organizational structure, facilities, patient administration, marketing plan, human resources, logistics, quality assurance, training, department of medicine, department of surgery, department of radiology, department of psychiatry, department of pathology, department of nursing, nutrition care division, primary care and community medicine, and clinical support division among others. Action plans that support the strategic plan will foster strategic management. Strategic thinking is an integral part of strategic management. Effective strategic management and strategic thinking enables the organization to exercise strategic flexibility. Strategic flexibility permits the organization to adapt strategies that foster continuous improvement. Continuous improvement is the product of an integrated management system for achieving customer satisfaction which involves all managers and employees in order to improve organizational performance (Federal Quality Institute, 1989). The planning process used to develop the strategic

plan is the vehicle that permits the organization to interface with its environment and adapt to change.

Insert Figure 1 about here

Purpose of the Study

The purpose of this project was to develop and analyze a strategic planning process which culminated in a service oriented strategic plan for BACH. As supporting objectives, the needs, demands, and demographics of the beneficiary population were analyzed. Additionally, the development and refinement of the planning process was intended to permit BACH to continuously monitor, evaluate, and respond to the needs and demands of its various customers and to the changes in its environment.

Methods and Procedures

The Author's Role

The author served as the strategic planner for BACH. As the strategic planner, the author designed the planning process, planned and coordinated the activities of the steering committee and the strategic planning committee, provided training to educate committee members on the fundamentals of strategic planning, and facilitated and guided the planning committee through the planning process which culminated in a strategic plan for BACH.

Additionally, the author led the steering committee through an analysis of the planning process used to develop the strategic plan.

Methods

The planning process used in the development of the strategic plan consisted of four phases as depicted in Table 1.

Insert Table 1 about here

Phase I.

Phase one was the pre-planning phase. The author's first task in the pre-planning phase was to develop a needs and demands analysis (Appendix C) similar to the comprehensive description of the organization in the planning process described by Pegels and Rogers (1988). The purpose of this analysis was to provide a brief description of BACH, the beneficiary population, and the health care services provided to that population. Distribution of the needs and demands analysis early in the planning process would assist the members of the steering committee and the planning committee by providing sufficient and objective data about the organization and the beneficiary population which would serve as a catalyst to ensure that the strategic plan was closely related to

the current status of the hospital. The needs and demands analysis also serves as the foundation for the assessment of BACH's internal strengths and weaknesses, and external opportunities and threats (SWOT).

As part of the needs and demands analysis, a catchment area beneficiary profile was developed which described the demographics of the current beneficiary population by number of beneficiaries, age groups, gender, and beneficiary category. Estimates of the catchment area beneficiary population were obtained from the Defense Medical Information System (DMIS), using the Resource Analysis and Planning System (RAPS) Population Reports; estimates provided by Headquarters, Fort Campbell, Kentucky; and estimates provided by the Army's Office of the Surgeon General (OTSG), Medical Corps Optimization Study (Major, 1990, October 3). The catchment area used to determine the beneficiary population was defined in the Catchment Area Directory Zip Code Cross Reference. It is the service area defined by zip codes, which generally conforms to a geographic boundary within a 40-mile radius of Uniform Service Hospitals (i.e. approximately 5,000 square miles), (Defense Medical Information Systems, 1990).

Demands focused on the services actually provided to the beneficiary population for FY89 and FY90. The top

five leading clinical areas, as measured by greatest inpatient bed day utilization, were identified. BACH's outpatient workload and leading clinical areas, by greatest number of outpatient visits, were also identified. Information regarding inpatient and outpatient workload was obtained from the Medical Expense and Performance Reporting System (MEPRS) reports, Patient Administration Services and Biostatistics Activity reports (PASBA), and BACH patient administration division historical records.

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Non-availability Statement (NAS) Reports and BACH patient administration reports of non-availability statements issued were analyzed to determine inpatient and outpatient care provided outside of BACH by clinical area and beneficiary category. CHAMPUS Health Care Summary Reports by Primary Diagnosis were analyzed to describe bed day utilization with and without NASS issued, identify clinical areas of greatest utilization by beneficiary category, and to identify possible trends in utilization patterns and/or beneficiary categories.

Needs were analyzed in terms of potential medical services that could be provided to the catchment area beneficiary population. Projections for the total

catchment area beneficiary population for FY91 through FY95 were obtained from the DMIS using the RAPS Population Reports. DMIS population projections were based on counts of eligible beneficiaries enrolled in the Defense Enrollment Eligibility Reporting System (DEERS) as of September 30, 1988. These projections used an FY88 baseline and were projected based on the total service Program Objective Memorandum (POM), active duty end strength projections, and service specific growth rates of paid retirees reported by the Office of the DOD Actuary adjusted for regional migration patterns computed from historical DEERS data. Projections of the changes in the beneficiary populations were used to identify needed services based on beneficiary categories, age groups, gender, and demonstrated inpatient and outpatient demand.

In order to encourage and promote creativity and innovative thought in developing a service oriented strategic plan, financial considerations were not addressed in the Needs and Demands Analysis, consistent with the idealization approach described by Ackoff (1974).

The second task in the pre-planning phase was to identify the internal and external stakeholders (Appendix D). Blair, Savage, and Whitehead (1989) defined stakeholders as "those individuals, groups, or organizations that have a stake in what the organization

does" (p. 13). The author expanded the definition of stakeholders to include everyone with an interest, influence, or investment in BACH. The author developed an initial list of internal and external stakeholders which was reviewed by members of the command group for additions, deletions, or changes. The command group included the Hospital Commander, Deputy Commander for Administration (DCA), Deputy Commander for Clinical Services (DCCS), and Command Sergeant Major (CSM). The list of stakeholders was also reviewed for final changes by the strategic planning steering committee.

Selection of the steering committee members was the next step in the pre-planning phase. The objective was to have the command group select approximately eight persons from the list of stakeholders who would serve on the strategic planning steering committee. The command group agreed that those selected be key internal stakeholders who were familiar with the function and organization of BACH.

Insert Table 2 about here

The command group selected ten members from the list of internal stakeholders to serve on the steering committee (Table 2). The DCA served as the head of the

steering committee which met regularly to monitor the planning process.

Selection of the strategic planning committee members was the fourth step of the pre-planning phase. The steering committee selected approximately 50 persons from the list of all stakeholders to serve on the strategic planning committee. The objective was to limit the numbers of persons selected to serve on this committee to only about 40 persons in order to keep the committee to a manageable size. However, to ensure that a diverse group was selected which gave adequate representation of the many interests and viewpoints of the stakeholders and instilled a sense of ownership among the numerous groups of stakeholders, the steering committee added members to the proposed list of 40 members.

Committee members selected from the list of internal stakeholders represented senior, middle, and line management from both active and reserve military members (commissioned officers, warrant officers, and non-commissioned officers), and civilian employees from a wide spectrum of administrative and clinical areas. Committee members selected from the list of external stakeholders represented active duty and reserve officers and non-commissioned officers, civilian government employees, family members, volunteer organizations, and community

interests from the Fort Campbell and local civilian communities. The final composition of the strategic planning committee is displayed in Table 3.

Insert Table 3 about here

Phase II.

Phase II of the strategic planning process was the education and orientation phase. Each member of the command group, the steering committee, and the planning committee received a two-hour orientation to establish a base line understanding of the principles and definitions of strategic planning and the process which would be used at BACH. The two hour orientation was provided several times to ensure that all planning members attended.

An outside consultant, who served as the strategic planner for Health Services Command (HSC)--BACH's corporate headquarters, initiated the beginning of this phase during the two initial training periods which captured nearly all members. The consultant defined strategic planning, described why it is important, discussed the utility and benefits of strategic planning, provided the HSC perspective of strategic planning, and gave credibility to BACH's planning process.

The author presented the conceptual model of strategic planning and discussed strategic planning's relationship to other management and control activities such as supporting plans, strategic management, strategic flexibility, and continuous improvement. The author also described how strategic planning is different from long-range planning, why strategic planning is used, the benefits of strategic planning, predictions of change in the health care and military environments, why organizations must continue to evolve from an organizational theory perspective according to Daft (1986), common characteristics of excellent organizations as described by Peters and Waterman (1982), and the planning process to be used at BACH. Finally, the author presented definitions which served as criteria when identifying and establishing organizational values, and determining the mission statement, goal statement, objectives, strategies, milestones, responsible agencies, and outcome measures.

Most definitions were selected from those presented in the literature review which the author determined best described the desired product that the planning committee was to develop. Some terms were presented with more than one definition to help clarify the term or to encompass additional aspects not covered by one single definition.

The author develop definitions and established criteria for unique terms not available in the literature or when definitions were not appropriate for the intended purpose of this project. These definitions were used throughout all phases of the planning process and became the standard definitions when describing terms and the criteria to evaluate the product of the planning committee and working groups. These terms and their definitions can be found in the glossary.

The author reported the findings of the Needs and Demands Analysis and provided one written copy to each committee member. Committee members were also provided a copy of the HSC's strategic planning workbook, provided by HSC's Office of Innovation and Strategic Planning (Major, 1990). A copy of the workbook is provided in Appendix E.

The workbook served as the primary tool for obtaining input from the members of the planning committee. Committee members were asked to complete a five page work sheet in the workbook which was used to solicit their input on the organization's mission, values, environmental analysis (SWOT), and to identify strategic issues.

Internal analysis included that part of the organization that can be directly controlled. External analysis focused on those influences in the environment that the organization cannot control.

In conducting the environmental analysis, committee members were instructed to consider organizational structure, facilities, services offered, corporate culture, internal capabilities, needs and demands of the beneficiary population, political situation, demographics, social, technological, regulatory, financial, human resources, competition, stakeholders' interest, health services industry, and any other areas that the committee members found relevant.

The author consolidated the input that committee members submitted on the work sheets to develop a proposed mission statement and identify organizational values. The author also consolidated and grouped input regarding strengths, weaknesses, opportunities, and threats into general categories and developed a proposed list of strategic issues.

The proposed mission statement, organizational values, SWOT, and strategic issues were presented to the commander and the steering committee for their review, and subsequently to the strategic planning committee (in the next planning phase), for their review, change, and/or approval. The environmental assessment and strategic issues are provided in Appendix F.

The author proposed strategic goals to the steering committee based on the strategic issues identified in the

strategic planning work sheets. The steering committee selected strategic goals which they felt would be required for accomplishing the mission. The planning committee would have an opportunity to validate, modify, add, or delete these goals in the next phase of the planning process. The organizational vision statement was provided by the Hospital Commander.

The next step of the education and orientation phase was to identify, select and train one group leader and one facilitator for each strategic goal area identified. The steering committee decided that the roles of group leaders and facilitators should be performed by members of the steering committee. This decision was based on the assumption that the members of the steering committee were most knowledgeable of the current organization, future direction of superior headquarters, and the planning process to be used. It also reduced the span of control and time required to coordinate the activities and training of an additional six persons if group leaders and facilitators were selected from outside the steering committee. Three group leaders and three facilitators were selected by the steering committee and appointed by the DCA. One group leader and one facilitator was assigned to each of the goal areas of readiness,

sustainment, and modernization based on his/her area of expertise and ability to work together.

Group leaders were officers in the grade of colonel or lieutenant colonel. Group leaders served as the honest broker for their working group. Most importantly, they ensured that the product of their assigned working group met the established criteria. Group leaders also kept the group on schedule and helped to maintain order when necessary.

Facilitators were middle ranking officers in the grade of major or captain. Their primary role was to stimulate discussion, assist the group in reaching agreement, and record the product of their group's work.

To promote standardization between working groups and ensure that each group met established criteria for their group's final product, members of the steering committee (including group leaders and facilitators), were given an orientation to the planning process and the purpose of the strategic planning conference was discussed. The steering committee reviewed the needs and demands analysis, reviewed and was given an opportunity to revise the organizational vision statement, organizational values, SWOT analysis, strategic issues, and mission statement. The steering committee also reviewed the strategic planning process, and discussed and defined the criteria

for goal statements, objectives, strategies, milestones, responsible agencies, and outcome measures. A written copy of each definition and at least one example supporting each definition was provided to members of the steering committee.

The final step in the education and orientation phase was to assign the 50 committee members to serve on working groups for each respective goal area. The author developed a proposed list of committee members to serve on the three working groups, one for each goal area. Working groups were comprised of approximately an equal number of members. The steering committee made necessary changes and reached a consensus on the assignment of members to specific working groups which support the goal areas.

Committee members were assigned to working groups to ensure representation of all categories of internal and external stakeholders from those on the strategic planning committee (i.e. officers, NCOs, civilians, active duty and reserve members, installation staff, volunteers, family members, community representatives, etc...). The author and members of the command group were not assigned to a working group.

Phase III.

Phase III of the planning process began with a two-day conference which was held off-site to develop the

strategic plan. The command group, steering committee, strategic planning committee, working group leaders, and group facilitators attended the conference.

The author began the conference by reviewing the information that was presented during the education and orientation phase. Support for Operation Desert Storm resulted in changing the members of the planning committee. A final review of the material presented in the education phase served to highlight key points for those members who previously attended the orientation and training. It was also necessary to ensure that all participants (especially new members/substitutes), were familiar with and shared a common understanding of the planning process. This review included the definition of strategic planning, the conceptual model of strategic planning, and the relationship of the strategic plan to other management and control systems. Emphasis was placed on strategic planning's relationship to strategic management, and strategic flexibility in attaining continuous improvement; how strategic planning differs from long-range planning, why strategic planning is used and the benefits of strategic planning, predictions of change in the health care and military environments, why organizations must continue to evolve, and common characteristics of excellent and innovative organizations

identified by Peters and Waterman (1982). The author reviewed the BACH's strategic planning process and described the steps that were to be accomplished in the planning conference.

The author reported the key elements which were extrapolated from the strategic planning worksheets, and validated this information through group discussion. The vision statement, organizational values, mission statement, SWOT analysis, and strategic issues derived from the work sheets were presented to the committee. In order to validate the information extrapolated from the work sheets, the author lead the committee through a discussion of each of these key elements. Committee members were provided the opportunity to revise, reject, accept, or replace the information presented. The author led the discussion on these elements until a consensus was reached among the group members regarding recommended changes.

Committee members reviewed the strategic goal areas identified by the steering committee. The author presented the goal areas to the committee and led a discussion which addresses the appropriateness of the goal areas selected. Committee members were given an opportunity to make additions, deletions, or changes to

the goal areas, based on the environmental analysis and strategic issues, subject to the group's approval.

The planning committee was informed of the tasks that they would accomplish once the committee members formed into their respective working groups. The author defined the terms which served as the criteria for development of the strategic plan. Working groups were given the assignment to accomplish the following specific tasks while in their working groups: (a) develop a goal statement for the goal area for which they were assigned (an issue specific aim of the organization that allows for the eventual achievement of the mission), (b) identify objectives which support each goal (specific, time-bound, action-oriented statements which are normally stated as one year or multiyear operational plans that support a goal), (c) develop strategies which support specific objectives (describe the actions necessary to accomplish a supported objective), (d) establish milestones for each strategy (the approximate time that strategies and tasks should be completed in order to meet the time-bound objective), (e) identify responsible agencies (the division, department, branch, service or office responsible for accomplishing and monitoring each specific strategy or task), and (f) establish outcome measures for each strategy and objective (the criteria for measuring

the progress toward the successful achievement of an objective).

Committee members received written copies of each definition/criteria together with an example of an objective with its supporting strategies, milestones, responsible agencies, and outcome measures. The planning committee participated in a discussion of each definition and example to help clarify the criteria and expectations of what their working groups were expected to produce. Committee members were encouraged to be innovative and creative in developing objectives which would provide a strategic organizational focus three-to-five years in the future.

The strategic planning committee was divided into three separate working groups to address the separate goal areas resulting from the strategic issues, and identified by the planning committee. Each working group developed a portion of the strategic plan for their assigned goal area.

Group leaders and facilitators guided the working committee through the development of a goal statement, objectives, strategies, milestones, responsible agencies, and outcome measures. The product of this effort was the combined effort of each separate working group without

influence by the author, steering committee, or command group.

The Hospital Commander, DCA, DCCS, CSM, and the author were not assigned to a specific working group, but rather moved freely between groups. The Commander, DCA, DCCS, and CSM served as observers of the planning process and were free to leave and rejoin the conference. This was intentionally done to limit their influence over the planning committee in the development of objectives.

Committee members were given an opportunity to review the product of each working group in order to validate, or review and restate the working groups' plans. All committee members met together at the close of the second day of the planning conference. Each working group selected a spokesperson to present their portion of the plan to all conference participants. Committee members discussed the portion of the plan for each goal area and reached a group consensus to make necessary changes. Committee members compared the product of each working group against the established criteria for goal statements, objectives, strategies, milestones, responsible agencies, and outcome measures. Milestones, responsible agencies, and outcome measures were also evaluated to determine if they were appropriate for the objective and the strategy supported.

Parallel objectives or those that overlapped between goal areas were combined or eliminated, and when necessary, other objectives were realigned under the appropriate goal area.

Group leaders reconvened their working groups within one month following the conference to validate their input, make the changes identified by the planning committee, and follow-up on incomplete or additional objectives.

Phase IV.

The product of each working group was consolidated into the first draft of the BACH Strategic Plan which began Phase IV of the planning process. The draft strategic plan was submitted to the commander and members of the steering committee for their review. Final output was consolidated into a final draft, submitted to members of the steering committee for their review, concurrence, or nonconcurrence and comments. After nonconcurrences were resolved, the final plan was submitted for the commander's approval. A copy of the BACH Strategic Plan (January 1991), is provided in Appendix G.

The plan was published and widely circulated within BACH. Each department, division, and service chief was provided with a copy of the strategic plan and charged by the commander to ensure that each staff member under their

supervision was familiar with the key elements of the plan. Each member of the strategic planning committee was also provided a copy of the final version of the January 1991 plan. The strategic plan was submitted to the regional headquarters (Dwight David Eisenhower Army Medical Center [DDEAMC]), and to the corporate headquarters (HSC).

The final phase of the strategic planning process is the implementation, monitoring, evaluation, and revision of the strategic plan. This phase was not examined as part of this GMP. Recommendations for implementation however, were presented to the command group and are provided in the conclusion.

Analysis of the Planning Process

An after-action review, which focused on the strategic planning process used to develop the strategic plan, was conducted after the strategic plan was finalized and submitted to higher headquarters. The command group, members of the steering committee, working group leaders, and facilitators were selected to critique the planning process because of their high-level of involvement and familiarity with all phases of the planning process. The author served as the facilitator of the review and analysis process. The author also participated in the

critique based on his observations as the organization's strategic planner and coordinator of planning activities.

The group was asked to identify significant problems associated with the strategic planning process based on their observations and experiences. After a problem list was established, the group was asked to rank-order the problems from most important to least important. The author led the group in a discussion of the facts bearing on each problem and the effect that the problem had on the planning process or final product. The group was also asked to identify alternative courses of action and make recommendations for resolving the problem which would improve the strategic planning process. A summary of the most significant problems identified in the after-action review is provided in the findings.

A summary of the most important lessons learned during the development of the strategic plan is also provided in the findings. Lessons learned are based on the author's observations in the role of the strategic planner and as an observer in the planning process.

Ethical Considerations

Sensitive or privileged information regarding the current status or planned activities of local civilian health care organizations, obtained under the auspices of

graduate education during academic residency, were protected and omitted from the environmental assessment.

The strategic planning conference and working group meetings were conducted in an atmosphere of nonattribution to encourage honesty and candor. Committee members' input on the strategic planning work sheets, other forms of communication, comments, and opinions were held in confidence.

Findings

The top three problems identified in the review and analysis of the strategic planning process and lessons learned are listed below.

Results of the Analysis

Problem 1: Strategic focus.

The first problem to be discussed is that objectives identified in the strategic plan contained little strategic thought and focused too narrowly on on-going and current issues.

The Hospital Commander empowered the members of the strategic planning committee to direct the future of the hospital with an organizational focus of three to five years into the future. The selection of a diverse group of key stakeholders to the planning committee is a primary consideration to ensure adequate representation of internal and external stakeholders, to develop a sense of

ownership among managers who must implement the plan, and for cross fertilization of ideas among group members to foster creativity. Many objectives lacked strategic vision and were designed to resolve current issues at the operational level. Scheduling the strategic planning conference immediately after the mobilization and deployment of thousands of soldiers to Operation Desert Shield/Desert Storm may have affected the committee members' perspective of strategic planning. Their preoccupation with the war may have effected their ability to focus beyond near-term tasks. Additionally, many committee members routinely work at the operational level and may have had little training or experience thinking strategically, and thus were unable to break out of their mind set of routine problem solving. As a result, the strategic plan had little comprehensive strategic value for the organization. Many of the objectives in the strategic plan are ongoing and will be complete before the annual review and revision of the strategic plan in January 1992.

However, this problem may not be as great as it first appears. If we accept the concept that strategic planning is most successful when done incrementally as reported by Hayes (1986), Quinn (1980), and Pegels and Rogers (1988) the objectives identified in this first attempt at

developing a strategic plan can be viewed as one incremental step to reshape and refine more comprehensive objectives and strategies in later revisions of the plan.

Three alternatives were considered as a possible solution to this problem: (a) conduct training in strategic and creative thinking to establish and foster an atmosphere of strategic thought within the organization, (b) develop and promote a strong corporate strategic vision which focuses three to five years in the future and vividly portrays a clear image of that vision to the planning committee, and (c) incorporate only those objectives into the strategic plan which have a strategic focus.

Providing training to all participants which stimulates and encourages creative, innovative and strategic thinking was the solution recommended during the review and analysis process. Providing training which encourages creativity, innovation, and strategic thinking to all participants will foster an environment of strategic thought at all management levels and ultimately produce objectives which are strategically oriented. Training may be provided by an outside consultant or through the use of several video tapes which may be purchased. This solution will benefit the entire

organization as it increases the level of strategic thought and flexibility of all staff members.

Problem 2: Quantitative outcome measures.

The second problem identified was that many outcome measures for objectives and strategies cannot be quantitatively measured. They are stated in qualitative terms, are vague, or are idealistic. Many outcome measures are stated in terms of what the desired outcome should be rather than the criteria for measuring progress toward the successful achievement of an objective. This appears consistent with Thieme, Wilson, and Long's (1981) observations that strategic planning is more qualitatively than quantitatively oriented, and that options are likely to reflect value judgements rather than quantitative assessment.

The inability to quantitatively measure an outcome may limit our ability to evaluate the effectiveness of the strategy or objective it supports. Not all objectives, however, are easily measured using quantitative means. An objective to improve esprit de corps for example, might be measured by surveying unit personnel or by identifying and measuring indicators of performance normally found in organizations with high morale. The question then becomes, how much time should be devoted to devising quantitative measurements or identifying performance

indicators for qualitative objectives and strategies. Any solution must balance the cost-effectiveness of the benefit of devising quantitative measures of qualitative outcomes against the resource devoted to do so.

Three alternatives were considered. The first alternative considered was to require quantitative standards for each outcome measure. Strategies and objectives which were qualitative in nature would be measured by some quantitative standard. The second alternative considered was to increase the training of the group facilitators and provide more specific instructions to group members on how to develop proper quantitative outcome measures. The third alternative considered was to task the responsible agencies with the mission of developing appropriate measurement tools for the strategies and objectives for which they are responsible.

The recommended solution was to provide more training and more specific instructions to facilitators and committee members in the educational phase of the planning process and just prior to the working group meetings. This solution allows the planning committee to identify appropriate measurements for outcomes, and they in turn maintain a sense of ownership in the measurements they develop.

Problem 3: Group size.

The third problem identified was that the size of the strategic planning committee working groups were too large. Facilitators and group leaders expressed difficulty in keeping the group focused on key issues, directing discussions, and in reaching agreement during the development of objectives, strategies, milestones, responsible agencies, and outcome measures.

The target size of each working group was initially intended to be about seven members. However, to ensure adequate representation and a sense of ownership among the many categories of key stakeholders the planning committee grew in size from a recommended 30 members to nearly 60 members. Fifty-one strategic planning committee members participated in the planning conference in addition to the members of the command group who roamed freely between groups. Only three working groups were established to support each goal area. Each working group included the group leader, facilitator, and either 14 or 15 committee members. The addition of members of the command group as observers to the working groups increased the total size of the group to as many as 20 members per working group-- beyond the capability of the untrained facilitator to effectively coordinate their activities.

Three possible alternatives were considered. The first alternative was to refine the selection process in order to limit the number of committee members to a maximum of 30. The steering committee would select only those key stakeholders considered essential to the planning process to serve on the strategic planning committee. The second alternative considered was to subdivide the working groups into two or three smaller groups and assign subtasks to each smaller group once objectives have been identified for each goal area. The third alternative discussed was to subdivide goal areas in order to reduce the number of members in each working group.

Subdividing goal areas into more manageable working groups was the solution recommended during the review and analysis process. Following the conclusion of BACH's conference, Health Services Command expanded their goal areas beyond readiness, sustainment, and mobilization to include two additional goal areas: training and education, and doctrine and development. Additional goal areas would permit the planning committee to retain a sufficient number of members to ensure adequate representation and instill a sense of ownership in key stakeholders, and allow working group size to be reduced to a more manageable number of personnel.

Lessons Learned

Several important lessons learned were experienced during the strategic planning process.

First, differences exist in the reporting periods used for data collection and data reported between the primary data sources used in the development of the Needs and Demands Analysis, making comparisons between data sources difficult.

Differences also exist in the way data is collected and reported. RAPS Utilization Reports appear to understate the actual workload reported when compared to MEPRS and PASBA in both inpatient and outpatient areas. Inpatient workload data was reported as 43,039 bed days by PASBA, 41,017 bed days by MEPRS, and 40,030 by RAPS for FY89. In FY90 PASBA, MEPRS and RAPS reported inpatient bed days as 42,412; 41,017; and 40,032 respectively. RAPS outpatient workload as reported at 476,912 outpatient visits as compared to 669,079 outpatient visits under PASBA--a difference of 192,167 fewer outpatient visits under the RAPS reports. Differences may be due to PASBA and MEPRS data reporting actual inpatient and outpatient workload which includes all 162,000 beneficiaries in the state of Tennessee and 23 counties of Kentucky within and outside of the catchment area. RAPS utilization reports for FY89 and FY90, however, were based on FY87 MEPRS data.

Projections in inpatient and outpatient health care demand is computed based on changes to the base year (FY87) beneficiary population. It does not account for the countless other variables which may affect the health care demand. This may account for the RAPS workload data being understated and makes the accuracy of the RAPS workload projections questionable; especially the farther one attempts to project from the base year.

Secondly, many sustainment and readiness issues have a direct effect on several external organizations' training, manpower, and budget. Objectives which require the hospital staff to train with personnel and equipment assigned to units not under the control of BACH, may not be possible without the support of these external units. It is critically important to have representatives from these units involved in the strategic planning process/conference. Mobilization and deployment in support of Operation Desert Shield/Desert Storm prevented personnel from these organizations from participating in BACH's planning process. Officers assigned to BACH who recently were members of similar units provided insight into the special problems and coordination required to execute these objectives and strategies. Nevertheless, coordination is still required upon their return from

Operation Desert Storm in order to execute those objectives.

The third lesson learned is in regard to membership on the strategic planning committee. Committee members constantly changed during the planning process. The constant turn-over of committee members had a direct effect on the continuity of the education phase and the planning process. The education phase must be ongoing and overlap other phases of the process. Many changes and additions to the planning committee made it necessary to provide a comprehensive review of the strategic planning process at the beginning of the planning phase--just prior to the committee members dividing into their working groups. Without this supplemental training, many committee members would not have had the necessary training to make a contribution to the planning process.

Fourth, there is a noticeable difference in the orientation between members who are clinically oriented and those who largely have field unit experience. These differences become evident when discussing the issues of readiness training. Competition exists between patient care in the peacetime Army--which serves as a measure of productivity for both the care giver and the hospital, and upon which funding for the organization is based; and

supporting military readiness training in preparation for the wartime mission.

Military medicine in a peacetime environment is based on inpatient and outpatient care provided. Maintaining a high state of readiness in preparation for war requires training that distracts from peacetime health care. Funding is not provided for performing wartime training which reduces workload and subsequent funding for the coming years. Likewise, no incentives exist to focus on wellness or preventative medicine issues which could ultimately reduce health care costs, improve the general health of the beneficiary population, and increase wartime readiness of the beneficiary population.

Developing and implementing a comprehensive training program which prepares health care providers to perform the wartime tasks at the expense of productivity, direct patient care, and funding for the hospital's operating budget requires a systems solution that must be supported at the highest levels. To be successful, Congress must fund readiness training, senior Army commanders must be willing to accept fewer peacetime health care services to increase wartime readiness, and leaders within the organization must support the training since these areas are used as indicators of their performance and productivity.

Fifth, facilitators should be chosen carefully with respect to their process versus outcome orientation. It is critical that they understand that their purpose is to facilitate the members of the working group--not lead them to agreement on a set of objectives, strategies or an agenda that they alone have established. Group members appear to resent the top-down orientation of a predetermined set of objectives and strategies. Members may fail to develop a sense of ownership if not allowed comprehensive participation in the development of the plan.

Finally, although mentioned as one of the problem areas in the planning process, it bears repeating. Strategic thinking must be fully integrated into the training and education of the regular management development activities and in the planning process. More importantly, an atmosphere of creativity and innovative thinking must be developed and fostered by top management. Committee members appear comfortable dealing with current issues and topics with which they are most familiar. Innovative and creative thinking must become an integral part of the organizational culture if the committee members are expected to develop a strategic plan that has strategic value. As stated in the literature review by Pegels and Rogers (1988) management must be taught to

think strategically and training should be made part of the regular management development activities of the organization.

Conclusions and Recommendations

The strategic planning process used at BACH was successful in developing a service oriented strategic plan based on the needs and demands of the beneficiary population. With minor modifications, the process can be used as a template at any military or civilian medical treatment facility to develop a strategic plan and establish the foundation for continued planning to meet environmental changes.

Recommendations for Implementation

Effective implementation of the strategic plan is essential if the plan is to be of value to the organization. Recommendations for implementation, monitoring, evaluation and revision of the strategic plan are provided.

The strategic plan should be widely disseminated to all internal and external stakeholders. The plan should be communicated to key stakeholders using as many media as possible. In addition to publication and wide distribution of the plan in written form, stakeholders should receive briefings on the strategic planning process used and the plan itself. An education and information

program should be initiated to present the strategic plan to as many internal and external stakeholders as possible. Internal target groups should include committees comprised of key personnel, and professional development training for all commissioned and noncommissioned officers, civilian employees, and volunteers. All department, division, and service chiefs should be briefed on the planning process and provided with a written copy of the strategic plan. All staff members should be familiar with the organizational mission statement, values, goals, and objectives identified in the plan and internalized into the organizational culture.

Each department and division should develop a supporting plan for their respective area that describes how they will support BACH's strategic plan. Supporting plans should serve as an appendix to the strategic plan. As noted by Gray (1986) the strategic plan cannot achieve its full potential until it is integrated with other control systems in the organization.

The major unit commanders and key staff members on the Fort Campbell installation, commanders of units that are affected by the implementation of the strategic plan, other medical units on Fort Campbell, the Officers Wives Auxiliary of Major Unit Commanders, and local community leaders should receive copies of the strategic plan and be

included in the education and information program for the external stakeholders. Copies of the strategic plan should also be sent to the regional headquarters, and HSC.

The strategic plan should be a living document that adapts to changes in the environment, as organizational goals change, and/or as objectives are accomplished or eliminated. A sustainment committee should be appointed to monitor progress on the strategic plan. The Medical Department Activity (MEDDAC) Executive Committee is identified in Fort Campbell MEDDAC Regulation 15-1 (Headquarters, Fort Campbell, KY, 1989 August 14), as the principle body responsible for the overall planning, coordination and policy making within the hospital. The Hospital Commander, DCA, DCCS, Chief, Veterinary Services; Chief, Department of Nursing; Command Sergeant Major, and the Administrative Resident comprise the executive committee which will serve as the sustainment committee.

The executive committee should monitor the strategic plan through a monthly review and analysis process. Responsible agencies identified in the strategic plan should report their progress on the status of objectives, strategies, milestones, and outcome measures to the executive committee in a monthly in-process review (IPR). The monthly IPR may focus on one goal area each month (readiness, sustainment, or modernization), so that each

goal area is reviewed quarterly. Monthly IPRs should be supplemented by an executive summary which briefly describes the status of each strategy. Responsible agencies should submit executive summaries to the executive committee.

Progress reports should be made to the stakeholders as milestones are achieved and as progress is made with each strategy. Feedback on the current status and progress of the strategic plan should also may be provided to key internal and external stakeholders. Regular updates might also be provided on the local area network and electronic mail systems. Minutes of the strategic planning IPR should be sent to the regional headquarters (DDEAMC), and to HSC.

The executive committee will ensure the strategic plan is updated annually. A strategic planning committee should be formed to reassess the needs and demands of the beneficiary population, conduct the SWOT analysis, and identify strategic issues. Organizational goals, objectives, strategies, milestones, responsible agencies, and outcome measures should be reviewed and updated to reflect changes in the environment, beneficiary needs and demands, and/or organizational goals.

Since the U.S. Army-Baylor University Graduate Program in Health Care Administration provides graduate

level training on the most current strategic planning processes, the administrative resident would be the best qualified to assume the duties of strategic planner for BACH. The Administrative Resident should be responsible for the maintenance of the strategic plan, serve on the executive committee; provide liaison between the executive committee and the strategic planning committee; and coordinate the needs and demands analysis, the environmental assessment, and planning conference.

Institutionalization of the strategic plan can be achieved through the use of management by objectives techniques. Performance evaluations and reward systems should be tied to the development of supporting plans and the accomplishment of outcomes associated with objectives, strategies, and milestones for division, department, and service chiefs; and for responsible agencies identified in the strategic plan.

Once implemented, the strategic plan should function as a cybernetic system as depicted in figure two. This model adapted from Austin (1988), suggests that the elements of the strategic plan are monitored through a review and analysis process and measured against standards embodied in measurable objectives, strategies, and milestones. A control process is established for review and analysis of the plan on a regular basis through the

sustainment committee, command guidance, rewards, cash incentives, performance evaluation reports, and education and training. Corrective signals from the control process allow the plan to be modified to meet changes in the internal and external environments. Output in this model is organizational adaptation, evolution, strategic flexibility, continuous improvement, goal achievement, and accomplishment of the mission.

Insert Figure 2 about here

Recommendations for Future Research

The military health care environment continues to change rapidly. Many changes have occurred in BACH's external environment since the planning committee first met only six months ago.

Three major environmental changes which will have a significant impact on the provision of care and the personnel available to provide it have already begun. First, programmed force reductions will reduce the size of the Army by nearly one-third of its current personnel strength to approximately 500,000 soldiers. Secondly, base realignment and closures, directed by Congress and DOD, have resulted in the scheduled movement of a battalion-size unit (approximately 800 soldiers), and

their family members to Fort Campbell, Kentucky, in FY92. This will significantly increase the size of the beneficiary population. Finally, implementation of the Gateway to Care Program will change the administration and provision of health care in the military to a managed care system. Operation of military health care facilities will more closely resemble a for-profit hospital in the private sector and less like socialized medicine.

Goals and objectives in the strategic plan should be reevaluated in light of these events. Organizational structure must also be evaluated to determine if BACH's internal structure can support the execution of the strategic plan, especially in view of these recent changes. Although these changes are nearly certain to occur, their full effect is yet to be determined. The value of strategic planning for the AMEDD may never have been more timely and important than it is now.

Utility of Results

The development and analysis of a strategic planning process for BACH provides a mechanism to continuously monitor, evaluate, and respond to changes in the health care and military environments, and provides a vehicle for continuous organizational improvement. It additionally focuses the organization's energies by clarifying its mission, goals, and objectives; and makes it more aware

and responsive to needs and demands of its various beneficiaries. The development and analysis of the planning process provides a template to conduct an annual review and revision of the strategic plan and its associated elements.

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Table 1.

Blanchfield Army Community Hospital Strategic Planning
Process

Phase I. Pre-planning

Needs and Demands Analysis, and beneficiary profile

Identify Stakeholders

Select steering committee members

Select planning committee members

Phase II. Education and Orientation

Strategic planning orientation

Process review and education

Report findings of the Needs and Demands Analysis

Environmental assessment

Select and train group leaders and facilitators

Identify working groups members

Phase III. Planning Conference

Process review

Report findings of the environmental assessment

Present the vision statement

Define organizational values and mission statement

Define and prioritize issues

Define goal statements

Determine objectives and strategies

Determine outcome measures and responsible agencies

Phase IV. Draft revision

Table 2.

Steering Committee Members

DCA

DCCS

Chief, Department of Nursing

Chief, Patient Administration Division

Chief, Personnel Division

Chief, Department of Pharmacy

Chief, Personnel Division

Administrative Assistant to the DCA

Administrator, Department of Medicine

Administrative Resident

Table 3.

Strategic Planning Committee Members

	Stakeholders	
	<u>Internal</u>	<u>External</u>
Officers	X	X
NCOs	X	X
Civilians	X	X
Volunteers	X	X
Family Members	X	X
Installation Staff		X
Community Leaders		X
Clinical Staff	X	
Administrative Staff	X	

Figure 1.

Conceptual Model

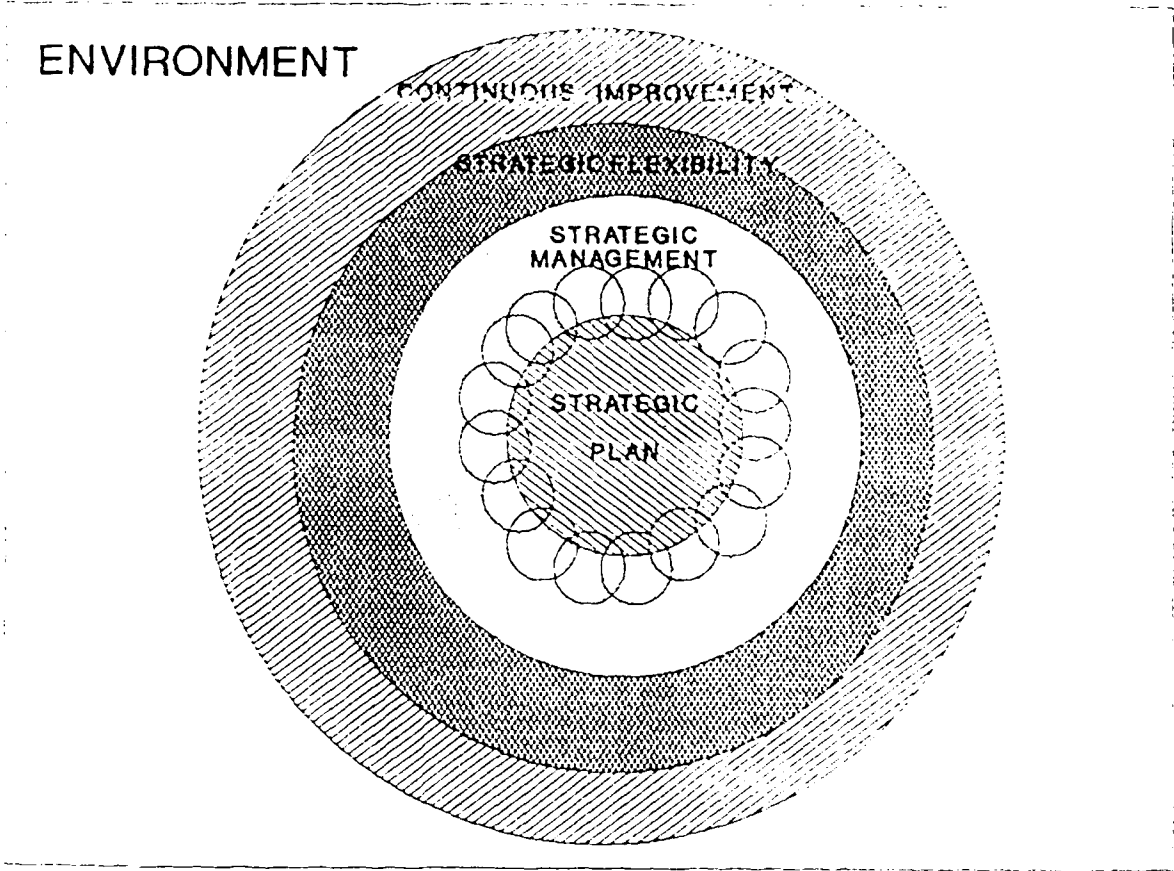
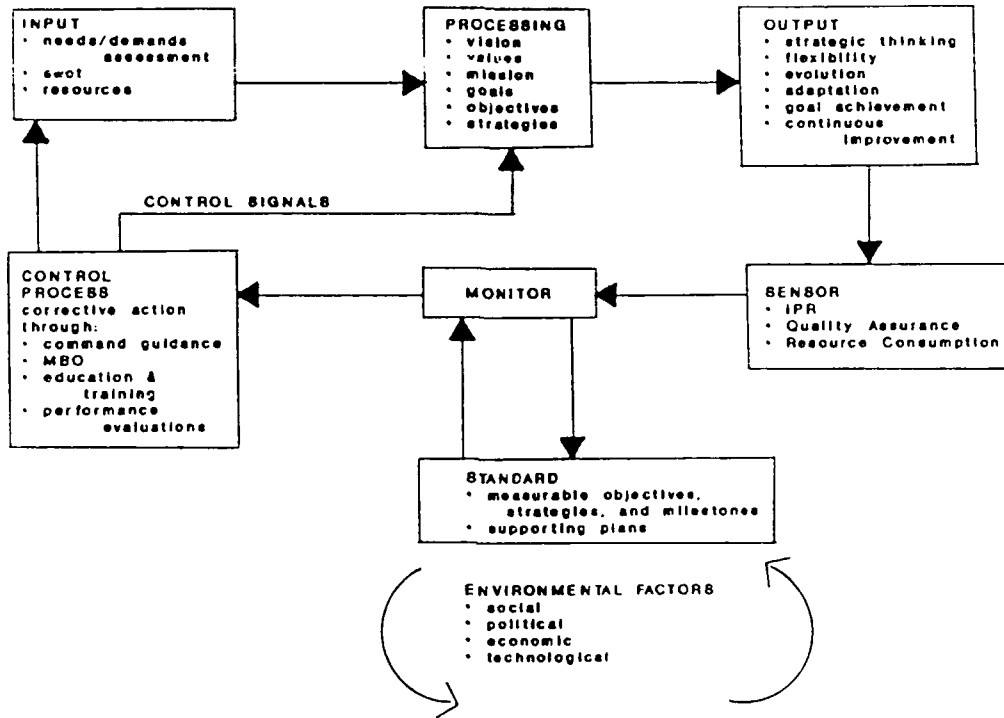


Figure 2.

Cybernetic System



Adapted from Austin (1988)

APPENDIX A

Definitions

Action Plans: Interdependent plans developed by each major administrative department, clinical division, service, or functional area to support the implementation and execution of the strategic plan (Gray, 1986). These areas include information management, budget, organizational structure, facilities, patient administration, marketing plan, human resources, logistics, quality assurance, training, department of medicine, department of surgery, department of radiology, department of psychiatry, department of pathology, department of nursing, nutrition care division, primary care and community medicine, and clinical support division among others. Action plans that support the strategic plan will foster strategic thinking.

Catchment Area: The service area defined by zip codes, which generally conforms to a geographic boundary within a 40-mile radius of Uniform Service Hospitals (i.e. approximately 5,000 square miles), (Defense Medical Information Systems, 1990).

Catchment Area Beneficiary Profile: A portion of the Needs and Demands Analysis which describes the demographics of the current beneficiary population by

number of beneficiaries, age groups, gender, and beneficiary category.

Continuous Improvement: The product of an integrated management system for achieving customer satisfaction which involves all managers and employees to improve organizational performance (Federal Quality Institute, 1989).

Environmental Assessment: Analysis of the needs and demands of the beneficiary population, development of a beneficiary profile, internal strengths and weaknesses, and external opportunities and threats, which lead to the identification and analysis of strategic issues (Thieme, Wilson, & Long, 1981).

Evaluation, Monitoring and Control System: A formal system to continually evaluate progress toward the achievement of organizational goals, and to monitor internal and external data for changes that result from the strategic plan and those in the environment that effect the hospital (Kropf & Greenberg, 1984).

External Environment: Those influences in the environment that the organization cannot control. Includes the political situation, government regulations, finances, demographics conditions, social trends, competition, and technological changes (Pegels & Rogers, 1988).

Goals: "Issue specific aims of the organization that allow for the eventual achievement of the mission" (Pegels & Rogers, 1988, p. 30).

Internal Environment: "That part of the organization which can be directly controlled" (Pegels & Rogers, 1988, p. 36). It includes human resources, finances, marketing techniques, organizational structure, services offered, corporate culture, and internal capabilities.

Milestones: The approximate time that strategies and objectives should be completed in order to meet the time-bound objective.

Mission Statement:

* A statement of organizational philosophy and fundamental purpose which is reflective of the corporate culture and the personality of the organization (Pegels & Rogers, 1988).

* A good mission statement should reflect the organization's ability to conceptualize and project its future; it should be current for five years if no changes in organizational philosophy occur, give an overview of the organization that is understandable by all audiences, and it should be phrased to state the purpose of the organization (Pegels & Rogers, 1988)

Objectives: Specific, time-bound, action oriented statement; normally stated as one year or multi-year

operational plans that support a set of goals. Objectives serve as the basis for evaluating management's progress in a given year (Pegels & Rogers, 1988).

Outcome Measure: The criteria for measuring the progress toward the successful achievement of an objective. Outcome measures describe how we will know if we are accomplishing the stated objective.

Responsible Agencies: The division, department, branch, service, or office responsible for accomplishing and monitoring each specific strategy (Major, 1990).

Stakeholder: "Those individuals, groups, or organizations that have a stake in what the organization does" (Blair, Savage, & Whitehead, 1989, p. 13). This definition was expanded to include everyone with an interest, influence, or investment in BACH.

Strategic Flexibility: An organization's ability to "reposition itself in a market or industry, change its game plan, or to dismantle current strategies and adopt a new strategic plan" (Pegels & Rogers, 1988, p. xvi).

Strategic Issues: An issue that fundamentally affects an organization's mandates, mission, values, products, customers (patients), service level, financing, organizational structure, or management (Major, 1990).

Strategic Management: An integrated management activity that identifies where the organization should be heading in the future (Pegels & Rogers, 1988).

Strategic Plan: A plan which serves as the hub of strategic management around which all other management plans and control systems (budget, information, marketing, compensation, and organizational structure), are developed, integrated, and support (Gray, 1986)

Strategic Planning:

* The process of making and implementing decision concerning the use of resources to achieve an organization's goals and to fulfill its mission (Kropf & Greenberg, 1984).

* "The allocation of resources to programmed activities which support the achievement of business goals in a dynamic and competitive environment" (Gray, 1986, p. 89).

Strategies: Describe the actions necessary to accomplish a supported objective. One or more strategies support a specific objective (Major, 1990).

Values:

* The guiding principles which bind the organization together and serve as the cornerstone of our organizational and individual actions in accomplishing our mission.

* Strong corporate values serve as guiding principles for dealing with uncertainty. They are standards by which choices are made, provide standards on matters of principle, offer a vision that members can identify with, they unify human resource management policies, unify employees in pursuit of a mission, and help employees to accept change (Byrd, 1987).

Vision: "A clear, succinct description of what the organization (and the community) should look like as it successfully implements its strategic plan" (Major, 1990, p. 13).

APPENDIX B

Acronyms and Abbreviations

BACH: Blanchfield Army Community Hospital

CHAMPUS: Civilian Health and Medical Program of the
Uniformed Services

CSM: Command Sergeant Major

DCA: Deputy Commander for Administration

DCCS: Deputy Commander for Clinical Services

DDEAMC: Dwight David Eisenhower Army Medical Center

DEERS: Defense Enrollment Eligibility Reporting System

DOD: Department of Defense

DMIS: Defense Medical Information System

FY: Fiscal Year

GMP: Graduate Management Project

HSC: Health Services Command

IPR: In-process review

MEDDAC: Medical Department Activity

MEPRS: Medical Expense and Performance Reporting System

NCO: Noncommissioned Officer

OTSG: Office of the Surgeon General

PASBA: Patient Administration Services and Biostatistics
Activity

POM: Program Objective Memorandum

RAPS: Resource Analysis and Planning System

SWOT: Strengths, weaknesses, opportunities, and threats

APPENDIX C

Needs and Demands Analysis

NEEDS AND DEMANDS ANALYSIS

Colonel Florence A. Blanchfield Army Community Hospital
Fort Campbell, Kentucky

1. Purpose.

The purpose of the Needs and Demands Analysis is to provide a brief description of Blanchfield Army Community Hospital (ACH), the beneficiary population, and health care services provided to that population to ensure that the strategic plan is closely related to the current status of the hospital. It provides an Area Beneficiary Profile that identifies who and where the beneficiaries are. It describes the actual and potential patient populations served by Blanchfield ACH in terms of categories of beneficiaries and age groups in order to determine their needs and demands. Demands analysis focuses on the services provided to the beneficiary population within the past few years. Needs are analyzed in terms potential medical services that could be provided to our beneficiary population. The Needs and Demands Analysis serves as the foundation for the assessment of Blanchfield ACH's internal strengths and weaknesses, and external opportunities and threats.

2. Background.

a. The United States Army Hospital, Fort Campbell, Kentucky, became operational on August 19, 1942. Medical services were provided in a wood frame structure, using cantonment design. The facility consisted of 53 brick veneered two-story buildings linked by over seven miles of corridors. Spread over 73 acres of land, the facility had an operating capacity of 2,100 beds.

b. A modern facility occupying four levels and 464,175 square feet, was built at a cost of \$61 million. It was dedicated Colonel Florence A. Blanchfield Army Community Hospital on September 17, 1982. The new facility has a capacity of 241 beds, and operates seven outlying troop medical clinics. Blanchfield ACH is capable of expanding to 2,500 beds in support of its war time mission.

c. During FY89 and FY90, Blanchfield ACH maintained an average occupancy rate of 47% (approximately 113 occupied beds per day). There were approximately 27 admissions, an average of 3.6 live births, and 1,705 outpatient visits daily within the various clinics.

d. The clinical specialties include: Allergy/Immunology, Dermatology, Internal Medicine, Ophthalmology/Optomtry, Hearing Conservation and Audiology, Occupational and Physical Therapy, Orthopedics/Podiatry, Urology, General Surgery, Otolaryngology,

Obstetrics and Gynecology, Pediatrics, Preventive Medicine, Neurology, Psychiatry, Social Work, Family Practice, Environmental Health, and Community Health.

e. Several health care programs are in operation which include Family Practice, Partnership Programs, the Exceptional Family Member Program, Primary Care and Community Medicine, and Central Medical Processing for all new arrivals.

f. Blanchfield ACH was operating at 117% of its authorized officer and enlisted strength and 110% of its civilian authorized strength at the end of FY90 (encl A). The organizational structure is depicted in a diagram provided as enclosure E.

g. Blanchfield ACH is accredited by The Joint Commission on Accreditation of Hospital Organizations, The College of American Pathologists, and The Association of American Blood Banks.

3. Assumptions. The Need and Demand Analysis was based on the following assumptions:

a. This project is approached from the concept of Blanchfield ACH's going concern--the idea that the organization will keep going from one year to the next, Blanchfield ACH will continue to operate indefinitely. There are no known plans to close Fort Campbell or Blanchfield ACH.

b. The long range plans for the 101st Airborne Division is redeployment to Fort Campbell, Kentucky.

c. Population projections for 1991 through 1995 would accurately reflect the Fort Campbell population upon redeployment of the 101st Airborne Division.

4. Demographics.

a. Projections for the total catchment area population for FY91 through FY95 were obtained from the Defense Medical Information System (DMIS) using the Resource Analysis and Planning System (RAPS). DMIS populations projections were based on counts of eligible beneficiaries enrolled in the Defense Enrollment Eligibility Reporting System (DEERS) as of September 30, 1988 using an FY88 base line and projected based on the total service POM active duty end strength projections, and service specific growth rates of paid retirees reported by the Office of the DoD Actuary adjusted for regional migration patterns computed from historical DEERS data.

b. Estimates of the beneficiary population vary. The post headquarters estimates the total beneficiary population served by Blanchfield ACH to be approximately 162,000 (encl C). This service area includes the state of Tennessee and 23 counties in

Western Kentucky. Data provided by the Army's Office of the Surgeon General Medical Corps Optimization Study (OTSG, Nov 90), estimated the beneficiary population within the 40-mile inpatient catchment area to be 73,426. DMIS estimates that the total beneficiary population served within Blanchfield ACH's catchment area for 1991 is estimated to be 71,126. The small percentage of error appears to support the validity of DMIS data, at least for short term population projections. This analysis will use the beneficiary population provided by DMIS to maintain consistency when considering population projections.

c. The inpatient catchment area consists of the set of all zip codes whose centroids are within 40 miles of the hospital zip code centroid. The 40-mile circle population for a hospital represents an estimate of the number of beneficiaries within its 40-mile radius regardless of other hospitals in the area.

e. The total catchment population served by Blanchfield ACH in FY91 was first analyzed in terms of beneficiary status. Dependents (family members), of active duty members comprise the largest segment of the total beneficiary population. Active duty members are the next largest group. Dependents of retirees, retired members, and survivors of service members account for the remaining categories of the beneficiary population.

Blanchfield ACH FY91 Catchment Area Population

<u>Beneficiary Category</u>	<u>Population</u>	<u>Percent</u>
Active Duty	22,203	31.2
Dep of Active Duty	33,050	46.5
Retired	5,494	7.7
Dep of Retired	9,067	12.8
Surviving Spouse	<u>1,309</u>	1.8
Total	71,126	

f. The total population was broken down into four age categories. Those between the ages of 0 and 17 were placed in the first age category in an attempt to identify pediatric needs of the population. Ages 18-44 were grouped together to identify the majority of the active duty population and their adult family members. Those over 65 years old were placed in a separate age group to identify geriatric requirements. When analyzing the total population by age alone, without regard to gender or beneficiary status, two age groups (0-17 and 18-44), comprise a significant segment of the total population. A summary of the total population by age is listed below.

BACH FY 91 Beneficiary Population by Age

<u>Age</u>	<u>Population</u>	<u>Percent Population</u>
0-17	21,752	30.6
18-44	39,632	55.7
45-64	8,195	11.5
65+	<u>1,547</u>	2.2
Total	71,126	

g. When the total population was analyzed by gender and age, it was discovered that the beneficiary population is divided nearly equally between male and female beneficiaries. Males account for 38,298 and females for 32,828 members of the beneficiary population. A general summary of age categories by gender is presented below.

Males

<u>Age</u>	<u>Population</u>	<u>Percent Male Population</u>
0-17	11,009	28.8
18-44	22,427	58.6
45-64	4,077	10.6
65+	<u>785</u>	02.0
Total	38,298	

Females

<u>Age</u>	<u>Population</u>	<u>Percent Female Population</u>
0-17	10,743	32.7
18-44	17,205	52.4
45-64	4,118	12.6
65+	<u>762</u>	02.3
Total	32,828	

5. Demand.

a. In order to make the best estimate of inpatient clinical workload at Blanchfield ACH, Medical Expense and Performance Reporting System (MEPRS) reports and RAPS Utilization Projection Reports for FY89, RAPS Utilization Projection Reports for FY89 through FY91, and CHAMPUS Cost and Workload Reports and Patient Administration Services and Biostatistics Activity (PASBA) reports for FY89 and FY90 were analyzed. Several important conclusions were made from this analysis. PASBA reported 43,039 actual bed days in FY 89 and 42,412 bed days during FY90. RAPS projections were approximately 3,000 bed days below actual bed days reported by PASBA for FY89 and 2,400 bed days below actual bed days reported for FY90. RAPS projected the total inpatient workload for FY91, based on an FY88 base year, to be 40,032 bed days. This estimate is assumed to be low based on RAPS trend to

underestimate workload for FY89 and FY90. PASBA reports that the leading overall inpatient clinical areas in order of bed days utilization for FY89 and FY90 were Orthopedics, Psychiatry, General Surgery, Internal Medicine, and Obstetrics. RAPS projections for FY89 through FY95 identify these same clinical areas as having the greatest bed day utilization. RAPS projections of age specific data for FY91 indicate that the largest workload in terms of bed days will be concentrated in Orthopedics for active duty soldiers. This was followed by Psychiatry for active duty, Obstetrics for dependents of active duty, less than 65 years of age, Internal Medicine for retired, dependents of retired, and survivors under age 65; and General Surgery for active duty soldiers. (encl D)

b. PASBA reports indicate that 575,685 outpatient visits were conducted in FY89 and 669,079 outpatient visits during FY90. MEPRS data revealed leading areas for outpatient visits during FY89 were Family Practice, Emergency Medicine, Flight Medicine, and medical examinations. MEPRS reported that troop medical clinics accounted for 142,391 outpatient visits in FY89. RAPS projections are based on utilization of beneficiaries residing within the catchment area only. Projections of outpatient visits, totaled 476,915 for FY89 and 476,912 for FY90. Although the total number of visits are underestimated in the RAPS projections and the method of accounting outpatient visits by clinical area differ between the two system, the leading areas of outpatient visits projected by RAPS were similar to actual workload reported by MEPRS. RAPS projections for FY91 estimate the greatest areas of utilization will be Family Practice visits for active duty members, and Family Practice visits for dependents of active duty under age 65. This is followed by Pediatrics for dependents of active duty under age 65, and Emergency Medicine for dependents of active duty below age 65 (encl E). User Beneficiary analysis reveals that the active duty population accounts for the largest number of outpatient visits. The active duty component of the catchment area is responsible for approximately 49% of the total outpatient visits, followed by dependents of active duty below age 65 at about 36% (encl F).

c. An analysis of Blanchfield ACH's patient administration records and CHAMPUS Inpatient Non-Availability Statement (NAS) Reports for the two most current reporting periods (APR 88 - MAR 89, and APR 89 - MAR 90), revealed important information regarding care received outside Blanchfield ACH. Blanchfield ACH issued 1489 NAS during FY89. Obstetrics (676), Special Pediatrics (151), Ear, Nose and Throat (113), Gynecology (89), Internal Medicine (87), and Psychiatry (76), were the leading clinical areas for inpatient NAS in FY89. Blanchfield ACH issued 1560 NAS in FY 90; reflecting only a 5% increase from FY89. Obstetrics (787), Internal Medicine (174), Psychiatry II (130), Gynecology (86), and Orthopedics (84) were leading clinical areas

in FY 90. Of the 3,884 NAS issued for inpatient care during the period from APR 88 through MAR 90, dependents of active duty accounted for the greatest number of NAS (3,219), followed by dependents of retired or deceased members (558), and finally by military retirees (190) (encl G).

d. An analysis of hospital days reported in the CHAMPUS NAS Report indicates that NAS were required for 7,899 inpatient hospital days under CHAMPUS between APR 88 - MAR 89, and 9,953 hospital days between APR 89 - MAR 90. This is nearly a 21% increase in hospital days during APR 89 - MAR 90 when compared to the APR 88 - MAR 89 period. It is important to note that NAS were not required for an additional 25,290 hospital days under CHAMPUS during the same two periods (11,663 and 13,627 hospital days respectively for each period) (encl H). A NAS is not required for emergency medical treatment, care covered by other health insurance, care in a college infirmary, nursing facility, or residential treatment facility; care by a civilian physician in an inpatient military health services medical treatment facility, or care in an alcoholic treatment facility. Hospital days provided for Blanchfield ACH beneficiaries under CHAMPUS (both with and without a NAS issued), would have increased the demand for hospital days provided by Blanchfield ACH by 46% in FY89, and by 56% in FY90. Clinical areas of greatest bed day utilization under CHAMPUS from APR 88 - MAR 89 and from APR 89 to MAR 90 (with and without a NAS issued), were Psychiatry, Obstetrics, and Special Pediatrics (encls I & J). Dependents of active duty account for the greatest number of hospital days under CHAMPUS both with and without NAS issued. They are followed by dependents of retired or deceased service members, and finally by retirees (encl K).

e. A analysis of CHAMPUS Health Care Summary by Primary Diagnosis Report reveals that Blanchfield ACH beneficiaries were provided 27,569 outpatient visits for professional services under CHAMPUS during the period APR 88 - MAR 89, and 40,215 visits between APR 89 - MAR 90. This represents a 31% increase in the number of outpatient visits for professional services under CHAMPUS for APR 89 - MAR 90, over the period APR 88 - MAR 89. Of the 67,784 outpatient clinic visits under CHAMPUS during the entire period APR 88 - MAR 90, clinical areas accumulating the greatest number of visits were Psychiatry (11,641), Orthopedics (8,838), Ears, Nose and Throat (6,936), and Pulmonary/Respiratory (4,721). The additional 67,784 outpatient visits provided under CHAMPUS between APR 88-MAR 90, represents an additional 5.4% of the total outpatient visits received by Blanchfield ACH user beneficiaries during that period (encl L). An analysis of use by beneficiary category indicates an increase in all user beneficiaries during APR 89 - MAR 90, over APR 88 - MAR 89. Dependents of active duty comprise the greatest number of user beneficiaries and the greatest increase between the two reporting

periods. Grand totals for all clinical areas of outpatient visits for dependents of active duty increased by approximately 39%. The number of retiree-user beneficiaries also increased approximately 26%. Dependents of retired or deceased sponsors-user beneficiaries increased by 29% during this period. The total number of outpatient visits for all categories of user beneficiaries increased by 35% (encl M).

6. Needs.

a. An analysis of RAPS Population Projection Reports indicate a relatively stable population within the Blanchfield ACH catchment area over the next 3 to 5 years. Minimal growth (approximately 0.5%), is projected between FY91 (71,126), and FY93 (71,413), with no growth projected beyond FY93 for FY94 and FY95. Increases in the number of dependents of retired and dependents of deceased sponsors accounts for the only growth projected (encl N). The direct care inpatient workload and outpatient visits are also projected to remain relatively constant from FY91 to FY95 (encl O). CHAMPUS reports however indicate a growing user beneficiary population within and outside of the catchment area and a trend to shift workload to the civilian sector. This is supported by a 31% increase in outpatient visits for professional services under CHAMPUS, a 21% increase in CHAMPUS hospital days, and a 5% increase in non-availability statements issued from APR 88 - MAR 89, to APR 89 - MAR 90 (encl P).

b. The high percentage of beneficiaries between the ages 18-44 (55.72%), indicates a high need for orthopedic services. Orthopedics ranked first in inpatient occupied beds for FY89 and FY90, and is projected to remain first in FY91 through FY95. Orthopedics also ranked first in CHAMPUS outpatient visits in both reporting periods between APR 88 - MAR 89, and APR 89 - MAR 90. This age group also supports a high need for obstetric services. Obstetrics ranked third in inpatient occupied beds for both FY89 and FY90, and is projected to remain third through FY95. Obstetrics also accounted for nearly one half of all NAS issued in FY89 and FY90, and nearly 4,700 bed days under CHAMPUS from APR 89 to MAR 90.

c. The high percentage of beneficiaries between the ages of 0-17 (30.50%), indicates a great need for pediatric services. This need is clearly demonstrated in the significantly high numbers of Family Practice and Pediatric outpatient visits provided at Blanchfield ACH during FY89 and FY90. The number of Family Practice and Pediatric outpatient visits are projected to remain first and third respectively through FY95. NASS for Special Pediatric services under CHAMPUS ranked second only to Obstetrics in FY89. Special Pediatrics utilization also ranked

third under CHAMPUS with 6,936 outpatient visits and 1,086 inpatient bed days between APR 88 through MAR 90.

d. The number of beneficiaries over age 45 comprise 13.7% of the population within the catchment area and reflect the need to evaluate the Internal Medicine, General Surgery, a Family Practice services. Internal Medicine ranked fourth in inpatient occupied beds within Blanchfield ACH during FY89 (3,461), and second in FY90 (7,399). It is projected to rank second in inpatient occupied bed days in FY91 through FY95. Furthermore, Internal Medicine ranked second in NASS issued in FY90 (174); second only to Obstetrics.

e. The need for increased psychiatric services is obvious. Psychiatry ranks second in inpatient bed days provided at Blanchfield ACH and is by far the greatest clinical area of bed day utilization under CHAMPUS. Psychiatry also ranks first in outpatient visits under CHAMPUS and comprises a significant segment of the outpatient visits within Blanchfield ACH and its various clinics. Dependents of active duty utilize the greatest number of bed days and comprise the largest number of user beneficiaries of outpatient visits under CHAMPUS, followed by dependents of retired or deceased sponsors, and finally by retirees (encl Q).

f. Incidence rates for the military population is expected to be somewhat different than those provided by the Department of Health and Human Services (1987) due to the relatively youthful population when compared to the civilian sector, and the nature of the business that soldiers are typically involved. Soldiers of the 101st Airborne Division (Air Assault), may be expected to experience more trauma, requiring more orthopedic and surgical services than the population at large.

BACH PERSONNEL STATUS
(as of SEP 90)

	<u>Required</u>	<u>Authorized</u>	<u>Assigned</u>
Officer	209	162	192
Warrant Officer	8	4	7
Enlisted	349	307	354
Civilian	<u>638</u>	<u>597</u>	<u>655</u>
Total	1,204	1,070	1,208

Percent Authorized Strength

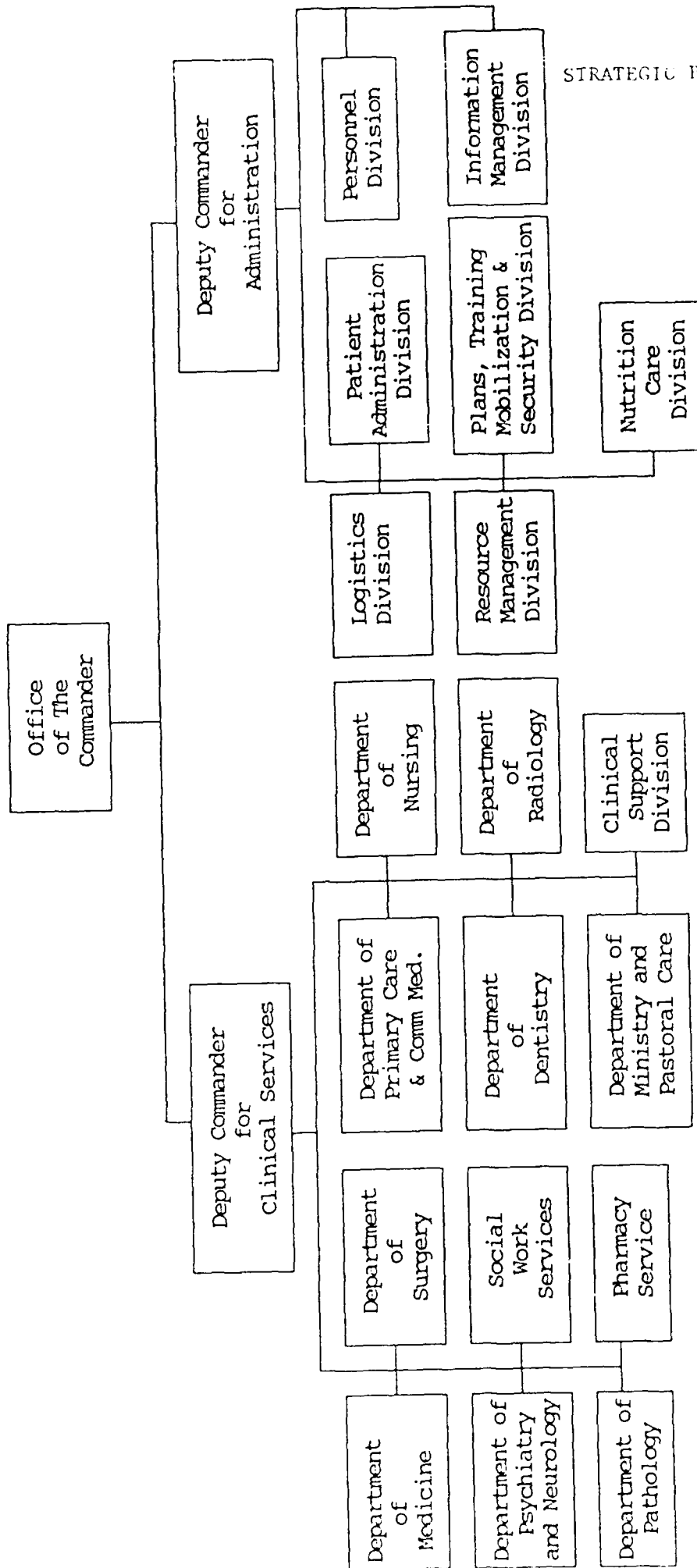
Officer	119%
Warrant Officer	175%
All Officers	120%
Enlisted	115%
All Military	117%
Civilian	110%
Total	113%

Commissioned Officer Personnel Status

<u>Branch</u>	<u>Required</u>	<u>Authorized</u>	<u>Assigned</u>
MC	72	60	66
MS	39	31	35
NC	83	59	76*
AMSC	10	8	10
CH	1	1	1
VC	<u>4</u>	<u>3</u>	<u>4</u>
Total	209	162	192

* Includes 21 assigned to the 86th Evacuation Hospital

COL Florence A. Blanchfield
 U.S. Army Community Hospital
 Fort Campbell, Kentucky



STRATEGIC PLANNING

ORGANIZATIONAL CHART

POST POPULATION PROFILE FY90

<u>Beneficiary Status</u>	<u>Population</u>
Military	23,692
Dependant	
On post	9,638
Off post	<u>23,647</u>
	33,285
Retirees	
Military	42,019
Dependant	<u>63,028</u>
	105,047
	<hr/>
Total	<u>162,024</u>

Based on an area of responsibility which includes the State of Tennessee and 23 counties in Western Kentucky as of AUG 90.

INPATIENT OCCUPIED BED DAYS

FY89 (PASBA)

Total Bed Days Reported 43,039

<u>Leading Clinincal Areas</u>	<u>Bed Days</u>
Orthopedics	8,604
Psychiatry	6,179
General Surgery	5,121
Internal Medicine	4,620
Obstetrics	4,527

FY90 (PASBA)

Total Bed Days Reported 42,412

<u>Leading Clinical Areas</u>	<u>Bed Days</u>
Orthopedics	8,669
Psychiatry	6,434
General Surgery	5,269
Internal Medicine	4,146
Obstetrics	4,097

FY91 (RAPS)

Total Bed Days Projected 40,028

<u>Leading Clinical Areas</u>	<u>Bed Days Projected</u>
Orthopedics	8,564
Internal Medicine	7,424
Obstetrics	5,712
Psychiatry	5,617
General Surgery	4,788

BACH OUTPATIENT VISITS

FY89 (PASBA)

Total Visits	575,685
* <u>Leading Clinical Areas</u>	<u>Percent Total</u>
Family Practice	7.9%
Emergency Medicine	7.2%
Flight Medicine	5.5%
Medical Exams	4.7%

FY90 (PASBA)

Total Visits	669,079
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FY91 (RAPS Projections)

Total Visits	476,911	
* <u>Leading Clinical Areas</u>	<u>Projected Visits</u>	<u>Percent Total</u>
Family Practice	251,699	53%
Emergency Medicine	45,468	10%
Pediatrics	37,256	8%
Orthopedics	28,228	6%
Psychiatry	18,999	4%

* Differences exist in the classification of outpatient visits by clinical area, but similarities exist in the five leading clinical areas between fiscal years.

BACH OUTPATIENT VISITS BY USER BENEFICIARY
(RAPS Projections)

<u>Beneficiary Category</u>	<u>FY90</u>	<u>FY91</u>	<u>FY95</u>
Active Duty	233,764	233,764	233,764
Dependant of Active Duty Under 65 Years	170,605	169,998	167,742
Others	62,778	63,293	65,206
Over 64 Years	<u>9,765</u>	<u>9,856</u>	<u>10,200</u>
Total	476,917	476,911	476,912

NASS ISSUED APR 88 - MAR 90

<u>Beneficiary Category</u>	<u>APR 88 - MAR 89</u>	<u>APR 89 - MAR 90</u>	<u>Total</u>	<u>Percent Change</u>
Dependant of Active Duty	1,423	1,796	3,219	+21%
Retirees	93	97	190	+04%
Dep of Retired or Deceased	<u>221</u>	<u>337</u>	<u>558</u>	+34%
Total All Categories of Beneficiaries	1,698	2,186	3,884	+22%

INPATIENT HOSPITAL DAYS

	<u>BACH</u>	CHAMPUS		Total	Grand	Percent
		<u>NAS REQ</u>	<u>NO NAS</u>	<u>CHAMPUS</u>	<u>Total</u>	<u>Increase*</u>
FY89	43,039	7,899	11,663	19,562	62,601	+46%
FY90	42,412	9,953	13,627	23,580	65,992	+56%

* Percent increase represents the increase in hospital days provided under CHAMPUS over those provided under BACH alone.

CHAMPUS BED DAY UTILIZATION
 BY CLINICAL AREA OF GREATEST UTILIZATION
 APR 88 - MAR 89

<u>Clinical Area</u>	<u>DEP AD</u>	<u>Retired</u>	<u>DEP RET/ Deceased</u>	<u>Total Bed Days</u>	<u>Percent Total</u>
Psychiatry	8,304	71	4,054	12,429	64%
(Group I)	(1,094)	38	(529)	(1,661)	
(Group II)	(7,210)	33	(3,525)	(10,768)	
Obstetrics	2,389	0	51	2,440	13%
Special Pediatrics	743	0	0	743	4%
Cardiology	189	222	141	552	3%
Neurology	120	16	268	404	2%
Total Bed Days = 19,562					

CHAMPUS BED DAY UTILIZATION
BY CLINICAL AREA OF GREATEST UTILIZATION
APR 89 - MAR 90

<u>Clinical Area</u>	<u>Bed Days</u>	<u>Percent Total</u>
Psychiatry	13,627	58%
(Group I)	(1,086)	
(Group II)	(12,113)	
Obstetrics	4,690	20%
Special Pediatrics	1,086	5%
Cardiology	578	3%
Neurology	538	2%
Total Bed Days	23,580	

CHAMPUS BED DAY UTILIZATION
BY BENEFICIARY STATUS

APR 88 - MAR 89

<u>Beneficiary Status</u>	<u>NO NAS</u>	<u>NAS REQ</u>	<u>Total Bed Days</u>
DEP of Active Duty	7,069	6,387	13,456
Retirees	345	429	774
DEP of Retired and Deceased	<u>4,048</u>	<u>1,083</u>	<u>5,332</u>
Total All Categories	11,663	7,899	19,562

APR 89 - MAR 90

<u>Beneficiary Status</u>	<u>NO NAS</u>	<u>NAS REQ</u>	<u>Total Bed Days</u>
DEP of Active Duty	9,871	7,899	17,770
Retirees	469	467	936
DEP of Retired and Deceased	<u>3,287</u>	<u>1,587</u>	<u>4,874</u>
Total All Categories	13,627	9,953	23,580

NAS not required for:

- Emergency medical care
- Care covered by other health insurance
- Care in a college infirmary, nursing facility, or residential treatment center
- Care given by a civilian physician in an inpatient military health services treatment facility
- Care in an alcoholic treatment facility

OUTPATIENT VISITS

By Source of Care Provided

<u>Source</u>	<u>88-89</u>	<u>89-90</u>	<u>Total</u>	<u>Percent Change</u>
BACH	575,685	669,079	1,244,764	+14%
CHAMPUS	<u>27,569</u>	<u>40,215</u>	<u>67,784</u>	+31%
Total	603,254	707,294	1,312,548	+15%

By Leading Clinical Area
(CHAMPUS Only)

<u>Clinical Area</u>	<u>88-89</u>	<u>89-90</u>	<u>Total</u>
Psychiatry	5,400	6,241	11,641
Orthopedics	3,226	5,612	8,838
Special Pediatrics	2,471	4,465	6,936
Pulmonary/ Respiratory	1,744	2,977	4,721

CHAMPUS OUTPATIENT USER BENEFICIARIES
(All Clinical Areas)

<u>Beneficiary Category</u>	<u>APR 88 - MAR 89</u>	<u>APR 89 - MAR 90</u>	<u>Percent Change</u>
Dependents of Active Duty	3,958	6,492	+39%
Retiree	795	1,081	+26%
Dependant of Retired/Deceased	<u>1,869</u>	<u>2,649</u>	+29%
Total	6,622	10,222	+35%

RAPS POPULATION PROJECTIONS

<u>FY</u>	<u>Active Duty</u>	<u>DEP of AD/RET</u>	<u>Retired</u>	<u>DEP of Retired</u>	<u>DEP of Deceased</u>	<u>Total</u>
90	22,263	33,132	5,436	8,970	1,296	71,097
91	22,206	33,050	5,494	9,067	1,309	71,126
92	22,206	33,050	5,546	9,154	1,318	71,274
93	22,206	33,050	5,594	9,233	1,330	71,413
94	22,206	33,050	5,594	9,233	1,330	71,413
95	22,206	33,050	5,594	9,233	1,330	71,413

Relative percentages by age and gender remain the same for projections through FY95.

RAPS PROJECTIONS

	<u>FY91</u>	<u>FY95</u>
Catchment Area Population	71,126	71,413
BACH Hospital Days	40,028	40,034
BACH Outpatient Visits	476,911	476,912

CHAMPUS WORKLOAD

	<u>APR 88 - MAR 89</u>	<u>APR 89 - MAR 90</u>	<u>Percent Change</u>
NAS	1,489	1,560	+15%
Hospital Days			
NAS Required	7,899	9,953	+21%
No NAS	<u>11,663</u>	<u>13,627</u>	+15%
Total	19,562	23,580	+17%
Outpatient Visits	27,569	40,215	+31%

Percent change represents the increase in only CHAMPUS workload between APR 89 and MAR 90.

CHAMPUS PSYCHIATRY WORKLOAD

Bed Day Utilization
By Beneficiary Category

<u>Beneficiary</u>	<u>APR 88 - MAR 89</u>	<u>APR 89 - MAR 90</u>
Dependant of Active Duty	8,304	10,413
Retirees	71	83
Dependant of Retired/Deceased	4,054	3,131
Total Bed Days	12,429	13,627

Outpatient Visits
By Number of Beneficiaries

<u>Beneficiary</u>	<u>APR 88 - MAR 89</u>	<u>APR 89 - MAR 90</u>	<u>Change</u>
Dependant of Active Duty	501	609	+18%
Retirees	61	65	+06%
Dependant of Retired/Deceased	231	280	+18%
Total Outpatient Visits	5,400	6,241	+14%

APPENIX D

Blanchfield Army Community Hospital StakeholdersInternal Stakeholders:

- * Commander BACH
- * Deputy Commander for Administration
- * Deputy Commander for Clinical Services
- * Department of Nursing personnel to include: Chief nurse, Army Nurse Corps Officers, nursing administrative support personnel, 91C Licensed Practical Nurses, nursing support staff (enlisted paraprofessionals), civilian registered nurses and licensed practical nurses, and civilian paraprofessionals.

* Military stakeholders include officers and enlisted professionals, paraprofessionals, technical, administrative, and general support personnel in each of the medical and surgical specialties of Allergy/Immunology, Dermatology, Internal Medicine, Ophthalmology/Optometry, Hearing Conservation and Audiology, Occupational and Physical Therapy, Orthopedics/Podiatry, Urology, General Surgery, Otolaryngology, Obstetrics and Gynecology, Pediatrics, Preventative Medicine, Neurology, Psychiatry, Social Work, Family Practice, Environmental Health, Community Health, Quality Assurance, Pharmacy Service, and Dentistry. Military stakeholders also include personnel in each of the administrative divisions to include: Information Management, Personnel Management, Patient Administration; Plans, Training, Mobilization, and Security; Logistics, Resource Management, and Nutrition Care.

* Civilian stakeholders include professional, paraprofessional, administrative, technical, and general support personnel in each of the clinical and administrative areas mentioned above.

External Stakeholders.

- * The active duty population served
- * Family members of the active duty population

- * Retired service members
- * Family members of retired service members
- * Parents and family members of those patients who are the direct recipients of medical care and services.
- * Reserve and National Guard members while on active duty for training
- * Congressional and other elected representatives within the local and state regions
- * Suppliers of goods and services who are financially dependant on contracts with BACH
- * Civilian hospitals and medical centers who provide medical services to CHAMPUS and supplemental care patients referred from BACH
- * Civilian hospitals which have sharing agreements with BACH for equipment, supplies, and educational services
- * Physicians who provide medical care and services to CHAMPUS and supplemental care patients including contract physicians and those under the CHAMPUS Partnership Program.
- * ALL 101st Airborne Division, supporting units, and installation and tenant activities, who rely on BACH to maintain their units at a high state of personnel readiness
- * Any military or civilian person who receives emergency medical care at BACH
- * Members of volunteer organizations such as the Red Cross, Officers Wives Auxiliary, and Noncommissioned Officers Wives Auxiliary
- * Other external stakeholders include Health Services Command, Army Office of the Surgeon General, Department of the Army, Department of Defense, Congress, the Commander and Chief of the Armed Forces, and the American public who depend on BACH to provide health services to members of the armed forces and their family members while serving at Fort Campbell

STRATEGIC PLANNING

APPENDIX E

Strategic Planning for U.S. Army
Health Services Command Workbook

STRATEGIC PLANNING

FOR STRATEGIC PLANNING

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U. S. ARMY

HEALTH SERVICES COMMAND



HSC 2000

HEALTH SERVICES
LONG - RANGE PLAN

THE HSC STRATEGIC PLAN

MEDCEN STRATEGIC PLANS

MEDDAC STRATEGIC
PLANS

U.S. ARMY MEDDAC

FORT CAMPBELL

STRATEGIC PLANNING CONFERENCE

INTRODUCTION

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Welcome to the Strategic Planning process. The U.S. Army Health Services Command Office of Strategic Planning is pleased to have the opportunity to work with you in the development of U.S. Army MEDDAC Fort Campbell's strategic plan.

By making the commitment to develop a strategic plan for your organization, you have demonstrated your dedication to the concept of consistently improving the quality of the work that you do and the care that you provide to your patients. U.S. Army MEDDAC, Fort Campbell has a reputation for outstanding performance, however, your command's key leadership wants to do even better.

The big innovation in strategic planning is having the organization's key decision makers talk with one another about what is truly important for MEDDAC Fort Campbell and the community which it serves. Strategic planning assists key decision makers to think and act strategically. It is not a substitute for the presence, participation, support, and commitment of key decision makers to raise and resolve the critical issues.

There are several important benefits which your organization can realize from employing the strategic planning process. MEDDAC, Fort Campbell, upon implementation of its plan should be better able to establish direction, focus attention, increase motivation, reduce costs, heighten communication and foster creativity. This sounds like a very full agenda, but remember, you are doing very well with many of these activities right now. Strategic planning will help you to improve upon them!

Finally, if you take away nothing else about strategic planning from this experience, try to remember what that great hockey player, Wayne Gretzky, said about the way he did his strategic planning:

"I skate to where I think the puck will be."

Good luck and have fun!

The HSC Office of Strategic Planning

STRATEGIC PLANNING DEFINED:

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Strategic planning is a disciplined effort to produce fundamental decisions and actions that shape and guide what an organization is, what it does, and why it does it.



"How's he feeling? I badly need a pair of kidneys."

SOME ADDITIONAL THOUGHTS:

Remember that it is strategic thinking and acting that are important, not strategic planning. In fact, if any particular approach to strategic planning gets in the way of strategic thought and action, the planning should be scrapped.

Strategic thinking and acting address such issues as how the organization is going to cope with dwindling or unpredictable resources, new public expectations, demographic changes, and new missions.

Strategic planning differs from long-range planning in that strategic planning attempts to identify and resolve issues. Long-range planning on the other hand focuses more on specifying goals and objectives and translating them into current budgets and work programs. Strategic planning attempts to design the future!

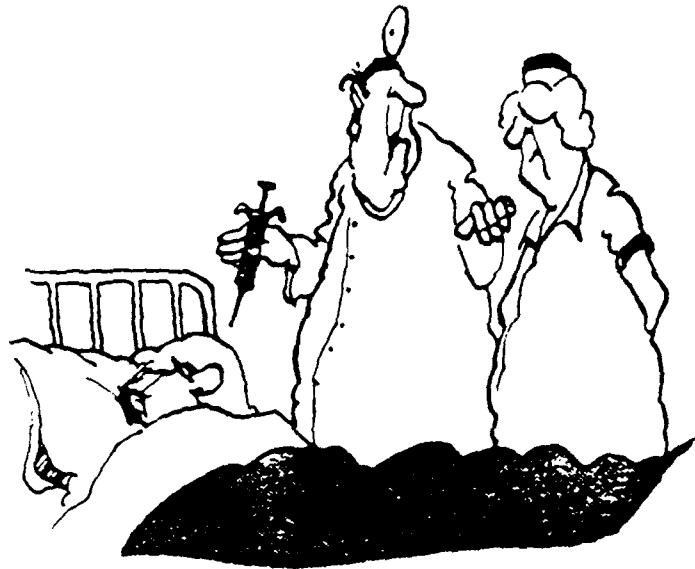
Question: Why plan strategically?

Answer: To take advantage of inevitable change.

Question: What type of organization is best able to take advantage of change?

Answer: A proactive organization.

- One that is able to predict the environment and prepare the organization's response.
- One that believes that the future is largely subject to creation.
- One that is committed to optimizing the future.



"I hate giving these injections. Look at my hands shaking."

JUST THINK FOR A MOMENT:

How is change affecting your organization today?

How do you see change affecting your organization in the future?

THE BENEFITS OF STRATEGIC PLANNING:

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- * Establishes Direction
- * Focuses Attention
- * Increases Motivation
- * Reduces Cost by Reducing Risk
- * Heightens Communication
- * Fosters Creativity

AN EXAMPLE OF STRATEGIC PLANNING:

Metro Health Center began in 1968 as a federally financed government clinic providing health services to the primarily low income residents in a central city neighborhood. Since then, its services and client base have expanded dramatically, while its legal and political status and funding sources have changed considerably. The center is now a free-standing non-profit organization.

By the mid 1980's, services included internal medicine, family practice, pediatrics, obstetrics and gynecology, podiatry, ophthalmology, minor surgery, laboratory and X-ray services, dental care, a pharmacy, health education, and transportation. The clinic's staff of nineteen (fifteen full-time equivalents) served approximately 5,000 community residents each year, with an annual budget of approximately \$600,000.

The federal Model Cities program provided most of Metro's initial funding. In 1972 the center became part of the city's department of public health. In 1975 Model Cities funding phased out, to be replaced by Community Development block grants and HEW grants as the major source of the center's funding. By 1980 the clinic's advisory board began to discuss whether the center might function more effectively as a free-standing nonprofit health center. In 1983 the advisory board and city officials decided to convert the center to nonprofit status.

When a new center director was hired in 1984, the center began strategic planning to manage the transition from city program to nonprofit agency. The issues to be addressed included the center's mission, target population, services, financing, staffing, structure, governance, marketing, and facilities, along with the necessary steps to implement the proposed changes. Metro Health Center now is a highly successful nonprofit agency and its strategic plan has been implemented almost in its entirety.

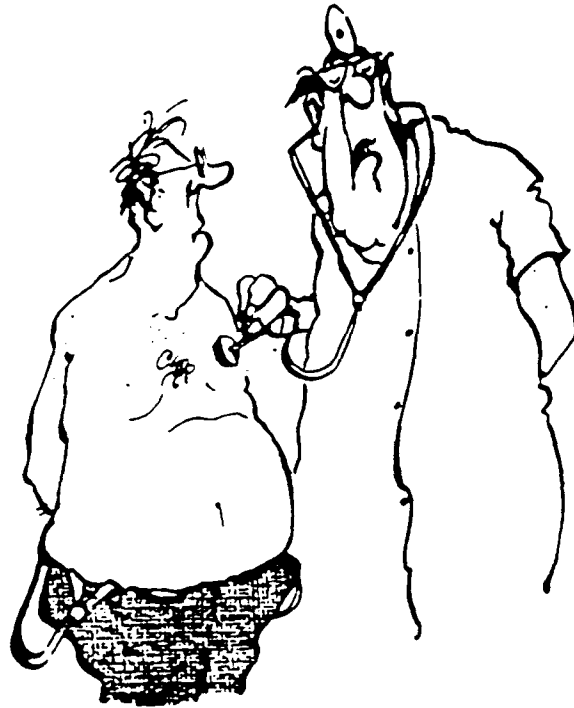
STRATEGIC PLANNING MUST:

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- * Determine What Courses Of Action Are Realistic.
- * Determine How Reasonable Attaining Each Is, Given Available Resources.
- * Select A Course Of Action Likely To Yield The Greatest Benefit.
- * Develop A Program To Realize The Selected Course.

...and address four fundamental questions:

1. Where are we going? (mission)
2. How do we get there? (strategies)
3. What is our blueprint for action? (budgets)
4. How do we know if we are on track? (control)



"It's stopped! But I think it'll start up again."

THE TWO PHASES OF THE STRATEGIC PLANNING PROCESS₁₂₈

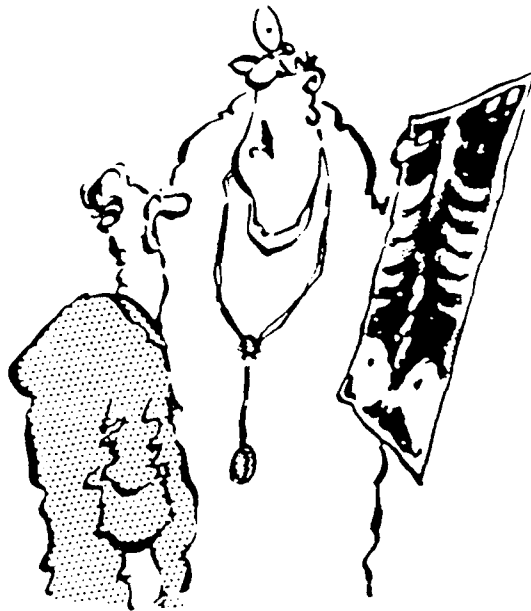
PHASE I:

1. Initiate and Agree on a Strategic Planning Process.
 2. Identify Organizational Mandates.
 3. Clarify Organizational Mission and Values -
 - * Develop a Mission Statement
-

PHASE II:

4. Assess the External Environment -
 - * Opportunities
 - * Threats
5. Assess the Internal Environment -
 - * Strengths
 - * Weaknesses
6. Identify the Strategic Issues Facing the Organization -
7. Formulate Strategies to Manage the Issues -
 - * Develop Goals
 - * Develop Objectives
 - * Develop Tasks
8. Establish an Effective Organizational Vision for the Future.

THE SPECIFICS
OF THE
STRATEGIC PLANNING PROCESS



"I think that dark shadow is where I spilled
some coffee."

1. INITIATE AND AGREE ON THE STRATEGIC PLANNING PROCESS:

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* The purpose of this first step in the process is to develop among the organization's key internal decision makers an initial agreement about the overall strategic planning effort and main planning steps.

* A good initial agreement guarantees the necessary resources. Money typically is not the most needed resource for strategic planning; the time and attention of key decision makers are needed more. In addition, staff time will be needed to gather information and provide logistical and clerical support.

* The First Step - Who Should Be Involved?

Some person (probably the Commander/CEO) or group must initiate and champion the strategic planning process. Strategic planning does not just happen; involved, committed people make it happen.

The CEO might also want to consider appointing a planning team. This team headed by the CEO should be made up of five to seven of the organization's key executives. For the purposes of the MEDDAC/MEDCEN planning process, the Commander should consider appointing the DCA, DCSCS, Chief Nurse, CSM, as well as a member from the civilian staff to the team. This team functions as an extension of the Commander/CEO and, as such, represents the total organization. They participate in many, if not all, of the planning activities of the organization. The team provides continuity to the process. This step is optional and depends mostly on the size and complexity of the organization.

A truly critical part of this first step is the formation of a group to carry out the actual work of developing the strategic plan. This team should include representatives from three levels of the organization: top leadership, middle management, and technical core or front line personnel. Top leadership's role is obvious. Middle management representation is important because of their vital role in translating policies and decisions into operations. Technical/front line staff are the ones who will most benefit or be hurt by change. Their early involvement and insight is key for any plan to succeed. This group also probably has the best perspective on the day to day problems confronting the organization from the customer's (patient) perspective. This team will be responsible for executing most of steps 2 through 7 in the strategic planning process.

2. Identify Organizational Mandates:

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* Before an organization can define its mission and values, it must know exactly what it is required to do by the external authorities (codified in laws, regulations, etc.) as well as by informal mandates. The purpose of this step is to clarify the nature and meaning of the externally imposed mandates, both formal and informal, affecting the organization.

* Stated simply, the questions that must be answered are:

- (1) What do we want to do?
- (2) What will we be allowed to do?
- (3) What will we have the resources to do?
- (4) What does our constituency (our customers) require of us?



"Here it is, 'Zebra Virus'!"

3. Develop a Mission Statement:

STRATEGIC PLANNING

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* The mission statement clarifies an organization's purpose, or why it should be doing what it does. It helps to focus the organization on what is truly important.

* Use the Mission Statement Worksheet in the back of this booklet to help you develop your draft mission statement. You should attempt to answer the questions:

- (1) Who are we?
- (2) What needs do we exist to fill?
- (3) What do we do to respond to these needs?
- (4) What is our philosophy and what are our core values?
- (5) What makes us distinctive or unique?



"In some parts of the world, whole villages could live on your food intake."

- * Guidelines for mission statement preparation:
 - Keep the formal and informal organizational mandates in mind.
 - The CEO might want to charge the small planning team with the responsibility of drafting the mission statement.
 - The mission statement should be no longer than one page.

4 & 5. Assess the Internal and External Environments:

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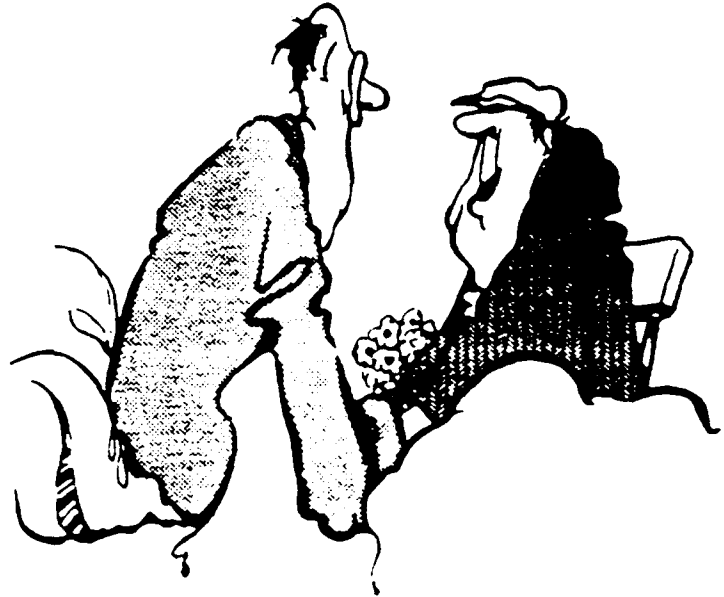
* Strategic issues typically concern how the organization (what is inside) relates to the larger environment (what is outside).

* Remember that a major purpose of strategic planning is to prepare an organization to respond effectively to the outside world before a crisis emerges.

* This environmental scan is a critical step in that it will help to identify the strategic issues that face the organization (step 6).

* One way to look at the forces and trends affecting your organization is to categorize them. You might want to consider the political, economic, social, technological, and for our purposes, patient-specific forces/trends.

* Refer to the Environmental Scan work sheets at the back of this booklet. Give careful thought to your organizations's Strengths, Weaknesses, Opportunities, and Threats as you complete the (SWOT) analysis.



"That guy who's filling in for you at the office is a real worker."

...and remember....

"You can observe an awful lot by just watching."

Yogi Berra

6. Identify the Strategic Issues Facing the Organization:

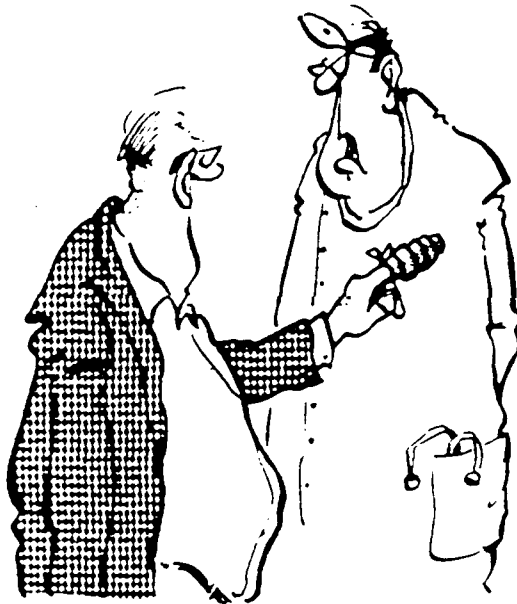
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* You are now ready to identify the strategic issues facing your organization. In doing so, you are getting at the heart of the strategic planning process.

* A strategic issue is defined as a fundamental policy choice affecting an organizations's mandates, mission, values, product or service level and mix, customers (patients), cost, financing, organization, or management.

* The purpose of this step therefore is to identify the fundamental policy choices facing the organization.

* Use the input developed from steps 2 through 5 to help you identify the strategic issues facing your organization. Develop your strategic issues list on the work sheet provided at the back of this booklet.



"Which finger is it?"

Process:

At this point all of the strategic issues will be batched and sorted according to some predetermined grouping. These lists will then be "purified" so that what remains are the issues, by category, which the planning groups will devise strategies for. These will appear in the form of Goals, Objectives, and Tasks.

7. Formulate Strategies:

* There are four basic components to formulating strategies: Developing Goals, Developing Objectives, Developing Tasks, and Developing Accountability.

* A Goal is a general statement of intent that specifies long-term achievements expected of the entire organization. A goal is consistent with the organization's environment and supports its mission. Goals normally do not specify time limits or assign responsibility for accomplishment. They do not require frequent change.

* An Objective is the desired outcome of the work efforts of individuals and groups in the organization. An objective is directly related to the realization of mission and goals. The objective statement will say what is to be accomplished. It will be measurable.

* A Task is a specific action in support of an objective. It can be measured, specifies time for starting and ending the action, and designates who is responsible and accountable.

* Developing Accountability requires that a responsible agency or person be identified to accomplish the task. It also requires that specific time lines be established for task accomplishment. Finally, it requires that a priority be assigned to each task based on the resources that will be allocated or time required for task completion.

Process:

This portion of the strategic plan can be free standing as an implementation document/action plan, or it may be included as a part of the strategic plan. Incorporating tasks, responsible agencies, milestones, and priorities into a separate action plan may be desirable due to the level of detail they will reflect. In this case, the objectives should be developed in narrative form so that they reflect the "will do" or "must do" element that make up the organization's strategy.

8. Establish a Vision for the Future:

STRATEGIC PLANNING

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* A Vision should be a clear, succinct description of what the organization (and the community) should look like as it successfully implements its strategies.

* This description should be the organization's vision of success.

* The vision statement is often written by the Commander/CEO.

* The guidance provided by the vision statement should be specific and reasonable.

* The vision statement should be relatively short - not more than several typed pages in length - and should be widely circulated among organizational members and other key supporters/users of the organization's services.



"How much do I owe you so far?"

STRATEGIC PLANNING

WORKSHEETS

STRATEGIC PLANNING
MISSION STATEMENT WORKSHEET

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WHO ARE WE?

WHAT ARE THE BASIC SOCIAL/COMMUNITY NEEDS WE EXIST TO MEET?

WHAT DO WE WANT TO DO TO RECOGNIZE, ANTICIPATE, AND RESPOND TO THOSE NEEDS/PROBLEMS?

WHAT IS OUR PHILOSOPHY AND WHAT ARE OUR CORE VALUES?

WHAT MAKES US DISTINCTIVE?

INTERNAL STRENGTHS WORKSHEET

STRENGTH # 1:

STRENGTH # 2:

STRENGTH # 3:

STRENGTH # 4:

STRENGTH # 5:

INTERNAL WEAKNESSES WORKSHEET

WEAKNESS # 1:

WEAKNESS # 2:

WEAKNESS # 3:

WEAKNESS # 4:

WEAKNESS # 5:

WEAKNESS # 6:

STRATEGIC PLANNING
EXTERNAL OPPORTUNITIES WORKSHEET

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OPPORTUNITY # 1:

OPPORTUNITY # 2:

OPPORTUNITY # 3:

OPPORTUNITY # 4:

OPPORTUNITY # 5:

OPPORTUNITY # 6:

EXTERNAL THREAT WORKSHEET

THREAT # 1:

THREAT # 2:

THREAT # 3:

THREAT # 4:

THREAT # 5:

THREAT # 6:

STRATEGIC PLANNING
STRATEGIC ISSUE IDENTIFICATION WORKSHEET

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ISSUE # 1:

ISSUE # 2:

ISSUE # 3:

ISSUE # 4:

ISSUE # 5:

ISSUE # 6:

SOME FINAL THOUGHTS

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"MANAGEMENT (LEADERSHIP) HAS NO CHOICE BUT TO
ANTICIPATE THE FUTURE"

Peter Drucker

"PREDICTIONS CONCERNING 5, 10 OR 15 YEARS AHEAD
ARE ALWAYS GUESSES...STILL, THERE IS A DIFFERENCE
BETWEEN AN EDUCATED GUESS AND A HUNCH"

Peter Drucker

"WHERE THERE IS NO VISION, THE PEOPLE PERISH"

Proverbs

"IF YOU DO NOT KNOW WHERE YOU ARE GOING, ANY ROAD
WILL GET YOU THERE"

The Koran

"I SKATE TO WHERE I THINK THE PUCK WILL BE"

Wayne Gretzky

APPENDIX F

Environmental Assessment and Strategic Issues

Internal Strengths

Facilities: Clean, modern and well maintained facility

Staff:

- * Excellent civilian staff who have a strong work ethic and who add stability to the organization
- * Highly motivated and dedicated military and civilian staff
- * Innovative, proactive, and forward-thinking philosophy
- * Well trained physicians and nurses
- * Outstanding professional staff

Teamwork:

- * Most people work well together
- * Excellent support from logistics, engineering, lab, and pharmacy
- * Excellent working relationship between clinical and admin staff
- * Excellent relationship with installation staff
- * Excellent support from installation staff
- * Relatively young military staff

Can-do Attitude: Willingness to complete the task

High Level of Concern for Patients:

- * High standards of patient service and continually work to improve service provided
- * Relationships with patients and staff

- * High level of concern for patients' welfare

Leadership:

- * Strong leadership, capable of creative management
- * Excellent Command and control system
- * Supervised training and education programs

Nonthreatening Environment: Nonthreatening environment to learn, grow, and be creative

Highly Automated:

- * Fully automated and integrated system for information management
- * Innovative plans in automation and techniques to accomplish our mission

Dedicated to Providing High Quality Health Care:

- * Well developed continuous care for chronic patients
- * Excellent somatic and psychotherapeutic treatment for active duty, adult dependants, retirees within all psychiatric diagnosis
- * Ability to provide psychiatric care at a relatively low cost as compared to civilian counterparts
- * State-of-the-art equipment in the Department of Pathology
- * Excellent quality assurance process
- * CHAMPUS partnership program is helping meet the needs of our patients

Internal Weaknesses

Staff:

- * Not enough medical or supporting staff to support the needs of the beneficiary population
- * Rapid turnover of military staff and loss of continuity

- * Mobilization for Operation Desert Shield/Desert Storm has significantly depleted the active duty, retired military and reservists who serve on the staff while work load has remained at the same level or increased
- * Shortages of physicians in Radiology; Ears, Nose, and throat; Pulmonary, Rheumatology, and Neurology specialities
- * Shortages of Nurses and Nurse Anesthetists

Facilities:

- * Lack of clinical and administrative space and facilities to allow for expansion
- * Physical space of outpatient pharmacy is inadequate

Communications:

- * Poor communication between departments
- * Hidden departmental agendas/power struggles/poor communication
- * Divisions and departments of the hospital function as separate entities rather than as an integrated whole
- * Too many layers of bureaucracy
- * Poor communication/appointment system
- * Failure to maximize the capabilities of existing automation in communicating and coordinating actions results in unnecessary paperwork, phone calls, and miscommunication
- * Resistance to change
- * Civilian-military conflicts

Access to Health Care:

- * Lack of programs for the retired community
- * Limited access to health care: lack of appointments

- * Waiting times for appointments, prescriptions, emergency room is excessive

- * Limited funding of pharmacy restricts the availability of some medications

Lack of Control:

- * Inability to influence how resources are spent

- * No incentive to increase productivity or improve customer service

- * Limited control over the organization's long-range agenda; limited discretionary money for long-term projects

Poor Support From Higher Headquarters:

- * Slow response time from higher headquarters regarding issues of concern or requirements

- * Lack of support from regional reference laboratory often results in lost lab requests which effects the quality of patient care

Equipment:

- * Lack of necessary equipment to provide angiographic services and intervention, nuclear medicine, or magnetic resonance imaging (MRI)

- * Lack of Magnetic Resonance Imaging and nuclear medicine equipment

Administrative vs. Clinical Duties: Competing demands between administrative and clinical duties

Troop Barracks: Inadequate enlisted barracks degrade the morale of our soldiers

Lack of Sensitivity for Patients: Lack of sensitivity and concern for patients needs by physicians, nurses, technicians, and receptionists

Short-Term Orientation: Lack of direction in long-term projects

EXTERNAL OPPORTUNITIES

Contract High-Cost/Low-Volume Care:

- * Excellent medical facilities in the local area make contracting high-cost, low-frequency services more cost effective
- * Economic pressures may persuade local health care providers to become involved in providing contract services under the Gateway to Care
- * Coordination of care with community facilities which would entail review of treatment, length of stay, and allow for better control of spending
- * Employment of civilian care providers in community as part of our care delivery system

Expansion of the Partnership Program: Increase access to care and reduce expenses through expansion of the partnership program and contract services

Recapture Supplemental Care and CHAMPUS Expenses:

- * Provide high quality health care to patients while reducing CHAMPUS expenses in high volume and high cost areas such as psychiatry and obstetrics
- * Greater control of resources at the local level through Gateway to Care
- * Gateway to Care initiatives provide the opportunity to transfer CHAMPUS funds to MEDDAC operating budgets if savings in CHAMPUS are demonstrated

Resource Sharing:

- * Resource sharing with local civilian and VA hospitals
- * VA sharing agreements for mail out prescription service
- * DOD Tri-service initiatives/regionalization could improve services, reduce expenses and improve sharing agreements

Wellness:

- * Capitalize on society's increasing awareness of wellness issues by providing timely health information that may lower health costs
- * Proactively support wellness of our beneficiary population

Information Management Systems:

- * Development of an information system that integrates all government hospital organizations would benefit the military health care community
- * Improved information management through implementation of Composite Health Care System (CHCS)
- * STAMIS automation

Improve Public Awareness and Public Image: Take advantage of increased media attention on Fort Campbell to improve public awareness of military policies and procedures

Reserve Forces: Take advantage of the strong relationship established between BACH and reserve components to improve utilization, training, and integration of reserve members at BACH

Improve Public Relations and Patient Satisfaction: Improved public relations and patient satisfaction through regular and mandatory training

Others:

- * Acquire equipment and personnel to improve laboratory services for the catchment area at a minimal expense
- * TQM should be institutionalized as a organizational philosophy and management practice to build teamwork, improve customer relations, and increase productivity
- * Improved training and staffing of clinical pharmacists through externship programs with the University of Kentucky and University of Tennessee
- * Improving communication with the installation staff by greater involvement in a social environment

External Threats

Reduced Resources:

- * Reduced resources may effect our ability to purchase equipment and supplies, and hire employees
- * There will be less money available to provide medical care. We will continue to be expected to do more with less
- * Capital financing to sustain program development, modernization, construction, and new technology will be increasing scarce
- * Limited funding may effect medical research and development
- * Limited resources may result in a cost shift to patients
- * Reduction of base operations support as a result of budget limitations and force structure reductions will directly effect services provided to BACH

Force Structure Reductions:

- * Programed reduction in the Army's force structure
- * Force structure reductions/down sizing
- * Shrinking military force combined with a stable beneficiary population will challenge our capabilities in terms of manpower and resources

Escalating Costs:

- * Escalation of costs for supplies and services
- * Increasing cost of medical technology and the decreasing military health care budget

Shortage of Professional Skills: Shortage of persons with professional skills within the area

Lack of Guidance and Support from Higher Headquarters:

- * Lack of guidance and support from higher headquarters
- * Loss of support provided by HSC upon its reorganization

Large Beneficiary Population:

- * A large beneficiary population whose demands greatly exceeds our capabilities to provide health care
- * The insatiable demand for health care will continue to grow as our beneficiaries increase their awareness of what is available within health care and in health care technology

Unreasonable ExpectationsIncreasing Administrative Burden:

- * Government regulations such as DRGs, third party payors, quality assurance, and other administrative changes cause physicians to spend more time on administrative tasks and less time providing health care
- * Slow procurement system for medical technology

Shortage of Ancillary Support Personnel: Manpower shortages in nursing and other ancillary support personnel will continue to prevent BACH from providing some levels of care

Mandated Programs:

- * DOD programs and projects are directed to be implemented at BACH without consideration of the beneficiaries needs, and without guidance by higher headquarters
- * Higher command dictates our future direction
- * Additional missions or increase in the scope of our current mission with appropriate increases in resources

Competition:

- * Ease of access to high quality care in the community

- * Competing for patients in a for-profit environment
- * Competition for dwindling resources
- * High quality marketing and public relations of other care providers
- * An inequality exists in pay scales between government and competitive markets which entice military professionals to leave military service
- * Government pay scales are not competitive to attract civilian employees
- * The rural setting makes heiring high quality, replacements for our medical technologists difficult.

Perceived Difference in the Quality of Care Provided in the Military Health Care System Compared to the Civilian Health Care System: Inability to market military health care services to our beneficiary population and the military senior leadership as being at least good as health care in the civilian market

Frequent Reorganization and Change in the Direction in the Army Medical Department and Department of Defense-Health Affairs

Aging Population: No Medicare or CHAMPUS coverage for prescription medications retirees over age 65

Desert Storm: Armed hostilities with Iraq may result in thousands of casualties, the expansion of BACH to its war-time configuration, limited services for family members and retirees, assignment and reassignment of reserve and regular Army personnel due to cross leveling and back fill of units in the theater of operation, near capacity or over capacity bed utilization, increased workload in all clinical and administrative areas, a 50 percent increase in hours worked per week, and greater physical and emotional stress on our staff.

- * Mobilization and deployment of physicians
- * Prolonged mobilization of active duty and reserve personnel may result in a wholesale exodus of physicians from military service

Others:

- * The Medical Care Composite Unit System upon which productivity and funding is based is inadequate and inequitable
- * Frequent reorganization and changes in direction in the Army Medical Department and Department of Defense-Health Affairs
- * Medical litigation
- * Clinical pharmacists roles mandated by review organizations
- * Threats that our personnel assigned to support Desert Storm may encounter include:
 - Naturally occurring diseases and non-battle injuries: Endemic diseases will continue to be a significant medical threat to the Army
 - Environmental extremes of heat, cold, and terrestrial altitude will degrade performance and continue to challenge our health care support
 - Battle injuries caused by small arms, artillery fragmentation, mines, high velocity weapons, and kinetic energy weapons will continue to complicate the management and treatment of medical casualties with traumatic wounds
 - Biological agents include microorganisms and toxins intended to incapacitate or kill. Genetic engineering will significantly increase the numbers and severity of biological agents which may be used on the battle field
 - The threat of chemical warfare significantly complicates the transfer and care of patients with traumatic and chemical injuries
 - Sustained or continuous operations add to the existing level of stress under combat
 - Fueled Air Explosives disperse an explosive cloud of fuel over the target. When ignited, the fuel consumes all available oxygen from the surrounding atmosphere

- The primary threat from directed energy weapons are lasers. The major health effects from laser radiation are eye injuries ranging from temporary flash blindness to permanent loss of vision

- Although Iraq is not known to possess nuclear weapons, tactical nuclear weapons may still be a threat in the near future as many third world countries attempt to obtain nuclear capability in the 21st century

Strategic Issues

Modern Equipment:

- * Ability modernize and acquire state-of-the-art medical technology
- * Maintain modern technologies and skills (MRI, Nuclear Medicine)
- * Pursuit of high technology equipment

State-of-the-art Medical Care: Expand the range of services to our patients through a greater number of speciality providers

Reduced resources and Manpower

Training, Education and Professional Development:

- * Appropriate training and education
- * Professional development of middle and lower-level leaders

Meeting the Needs of Our Beneficiary Population: Providing health services which meet the needs and demands of our beneficiary population

Reducing Bureaucracy and the Administrative Burden: Streamline the organization and reduce bureaucracy

Facilities Expansion and Modernization

Productivity Measurement and Funding Methods

Desert storm

Others:

- * Gateway to Care: Resources, personnel, beneficiaries, etc...
- * Marketing plan and Total Quality Management (TQM) integration
- * Recapturing CHAMPUS work load in child psychiatry
- * Expansion of child psychiatry inpatient unit
- * Improved public relations
- * Cost containment
- * Design methodologies for maintaining high standards for an increased workload with decreased staffing
- * Better utilization/staffing of the OR
- * Funding for facilities projects which will provide space for delivery of care
- * Improved interdepartmental communication
- * Drop-off center for pediatrics
- * Limited funds for required training and continuing professional education
- * CHCS
- * Drug utilization review of patient records outside the MEDDAC
- * Selection and training of PROFIS for war time manning
- * Installations support during war time mobilization
- * Preparation for expansion in support of BACH's war time mission

APPENDIX G

BLANCHFIELD ARMY COMMUNITY HOSPITAL

STRATEGIC PLAN

JANUARY 1991

BLANCHFIELD ARMY COMMUNITY HOSPITAL

VISION STATEMENT

Blanchfield Army Community Hospital is a premier health care facility, striving to surpass the standards of quality and the expectations of our patients.

MISSION STATEMENT

Our purpose is to provide total quality health care to each patient and strive to continuously improve the quality of life, productivity, and readiness of our soldiers, retirees, and family members in the Fort Campbell community.

VALUES

These shared organizational values reflect the guiding principles which bind us together and serve as the cornerstone of our organizational and individual actions in accomplishing our mission:

* **Integrity:** We exemplify sound moral principles, honesty, and sincerity which characterize our personal and professional actions.

* **Excellence:** We strive to surpass the established standards of performance and expectations of our patients, and continuously work toward incremental improvement in all our endeavors.

* **Loyalty:** We are loyal to our co-workers and patients; and to the values, principles, and ideals we are obligated to support.

* **Commitment:** We are highly motivated and dedicated to making a personal and professional contribution to the delivery of quality health care in both time of peace and war.

* **Professionalism:** We adhere to a professional code of ethics, strive for continued education and knowledge, obey and enforce the highest standards of health care delivery, and employ our skills and knowledge for the betterment of our community and the Army.

* **Innovation:** We are dedicated to creativity, flexibility, proactive behavior and strategic thought in both clinical and administrative areas which facilitate state-of-the-art patient care and services.

GOALS

Readiness: Maintain a high state of medical readiness to support Fort Campbell, mobilization and deployment, and other civilian and military emergencies.

Sustainment: Provide quality health care, based on fixed resources and assigned missions. Care must be provided by well trained, qualified, and caring health care providers.

Modernization: Continually explore, evaluate, and utilize creative and innovative methods to meet current and future missions and objectives.

READINESS OBJECTIVES

- Objective 1: Cross train medical personnel in both TOE and TDA settings.
- Objective 2: Conduct individual training of medical personnel in skills required in both TOE and TDA settings.
- Objective 3: Conduct collective training of medical personnel in both TOE and TDA settings.
- Objective 4: Emphasize health and well being of eligible beneficiaries through coordinated preventive medicine activities.
- Objective 5: Develop and establish varied expansion capabilities to support contingency operations for 200, 300, and 400 beds.
- Objective 6: Develop and implement a plan for accelerated access of all authorized health care providers on to the Fort Campbell installation.
- Objective 7: Establish a training program for clinical staff and health care providers which provides workload credit for attending required readiness training.
- Objective 8: Enhance the integration of CAPSTONE units, ready reserve, individual mobilization augmentees, and retired service members during mobilization and other contingency operations.

SUSTAINMENT OBJECTIVES

Objective 1: Maximize access to care within available resources.

Objective 2: Enhance health promotion and wellness of our staff and beneficiaries.

Objective 3: Ensure well trained, educated, and qualified providers deliver care that meets or exceeds the current standard of care.

Objective 4: Improve the accuracy of workload reporting.

Objective 5: Monitor state-of-the-art facilities, equipment, and technology to meet current and future requirements.

Objective 6: Improve communications between BACH and our beneficiaries.

Objective 7: Create and maintain a pleasant work environment.

MODERNIZATION OBJECTIVES

Objective 1: Develop and foster a command climate which provides an open and objective environment, receptive to change.

Objective 2: Improve patients' access to health care through enhancement of present systems.

Objective 3: Improve health care management through automated staff and patient feedback systems.

Objective 4: Enhance the present automation system to accommodate clinical and administrative needs.

Objective 5: Develop training programs to meet the needs of advanced technology. Ensure that training on all new equipment is completed within 90 days of installation.

Objective 6: Review and remove system obstacles which hinder productivity prior to the implementation of Gateway to Care.

Objective 7: Enhance the human resource program.

Objective 8: Develop innovative programs for the competitive acquisition of state-of-the-art equipment.

Objective 9: Efficiently use all space and accommodate expansion.

Objective 10: Improve documentation in medical records.

READINESS

Readiness Goal: Maintain a high state of medical readiness to support Fort Campbell, mobilization and deployment, and other civilian and military emergencies.

Objective: Cross train medical personnel in both TOE and TDA settings.

Strategy 1: Maintain the PROFIS system alignment for Fort Campbell units.

Milestone: One month after the return of the 101st Airborne Division.

Responsible Agency: Personnel Division.

Outcome Measure: 100% alignment of PROFIS to Fort Campbell units.

Strategy 2: Establish a training schedule for TOE and TDA personnel.

Milestone: Three to six months after the return of the 101st Airborne Division.

Responsible Agency: PTM&S.

Outcome Measure: Realistic training opportunities leading to proficiency in skills required in both TOE and TDA settings.

READINESS

Objective: Conduct individual training of medical personnel in skills required in both TOE and TDA settings.

Strategy 1: Maintain a high state of preparation of replacements for overseas movement (POR).

Milestone: Ongoing.

Responsible Agency: Personnel Division.

Outcome Measure: 100% POR ready.

Strategy 2: Develop and maintain a prioritized list of healthcare providers to attend training that increase their readiness. These courses would include the combat casualty care course (C4/C4A), chemical/biological/nuclear courses, expert field medical badge qualification training and testing, advanced trauma life support (ATLS) training, and the air assault course among others.

Milestone: Three months after the return of the 101st Airborne Division.

Responsible Agency: PTM&S.

Outcome Measure: Increased combat readiness and combat effectiveness of health care providers.

READINESS

Objective: Conduct collective training of medical personnel in both TOE and TDA settings.

Strategy: Identify and implement medical team collective training.

Milestone: Three months after the return of the 101st Airborne Division.

Responsible Agency: PTM&S.

Outcome Measure: Combat effective medical teams.

READINESS

Objective: Emphasize health and well being of eligible beneficiaries through coordinated preventive medicine activities.

Strategy: Enhance and coordinate mandated programs in preventive medicine.

Milestone: JAN 92.

Responsible Agency: DCCS.

Outcome Measures:

- * Improved health and well being of the beneficiary population.
- * Reduced need for MEDDAC resources during contingency operations due to the improved level of primary care and health of our beneficiaries.

READINESS

Objective: Develop and establish varied expansion capabilities to support contingency operations for 200, 300, and 400 beds.

Strategy 1: Identify personnel (to include civilian volunteers), equipment, and facilities resources requirements.

Milestone: 1 MAY 91.

Responsible Agency: PTM&S.

Strategy 2: Develop acquisition strategies.

Milestones:

- * 1 MAY 91 (200 beds expansion).
- * 1 JUN 91 (300 beds expansion).
- * 1 JUL 91 (400 beds expansion).

Responsible Agency: PTM&S.

Outcome Measure: An established contingency plan which facilitates our capability for rapid expansion and delivery of health care during contingency operations.

READINESS

Objective: Develop and implement a plan for accelerated access of all authorized health care providers on to the Fort Campbell installation.

Strategy 1: Develop a standing operating procedure.

Milestone: 1 MAY 1991.

Responsible Agency: PTM&S; coordination with DCCS and C, CSD.

Strategy 2: Establish a memorandum of understanding with the Fort Campbell installation commander.

Milestone: 1 July 1991.

Responsible Agency: PTM&S; coordination with DCCS and C, CSD.

Outcome Measures:

- * Health care providers have rapid access to the installation during emergencies.
- * Reduced confusion and frustration by the hospital and installation staff when health care providers must enter the installation when responding to medical emergencies.
- * Improved response time for providers.

READINESS

Objective: Establish a training program for clinical staff and health care providers which provides workload credit for attending required readiness training.

Strategy: Develop a proposal for submission to HSC.

Milestone: 1 June 1991.

Responsible Agency: C, RMD; coordination with DCCS & C, CSD.

Outcome Measures:

- * An equitable system which recognizes required training of clinical staff in readiness skills.
- * More health care providers receive readiness training.
- * BACH receives workload credit for providing health care providers with required readiness training.
- * Clinical staff is better trained and prepared to perform contingency mission.

READINESS

Objective: Enhance the integration of CAPSTONE units, ready reserve, individual mobilization augmentees, and retired service members during mobilization and other contingency operations.

Strategy 1: Identify PROFIS losses.

Milestone: Ongoing/Continuous.

Responsible Agency: C, PER.

Strategy 2: Evaluate CAPSTONE unit's and IMA's capability to fill anticipated losses.

Milestone: Ongoing/Continuous.

Responsible Agency: C, PTM&S.

Strategy 3: Prioritize IMA requirements and request IMAs needed to meet anticipated vacancies created by PROFIS mobilization.

Milestone: 1 June 1991.

Responsible Agency: C, PTM&S; coordination with DCCS & DCA.

Outcome Measures:

* Rapid transition to war time mission of PROFIS personnel.

* Rapid transition and integration of reserve personnel into BACH upon mobilization.

* Reduced disruption in patient care upon mobilization and deployment of PROFIS staff.

SUSTAINMENT

Sustainment Goal: Provide quality health care, based on fixed resources and assigned missions. Care must be provided by well trained, qualified, and caring health care providers.

Objective: Maximize access to care within available resources.

Strategy 1: Utilize capabilities under the Gateway to Care system to provide care after duty hours.

Milestone: Ongoing.

Responsible Agency: DCCS.

Outcome Measures:

- * Reduced waiting times.
- * Increased patient satisfaction.

Strategy 2: Develop sharing agreements.

Milestones: Ongoing.

Responsible Agency: DCCS.

Outcome Measure: Reduced expenses for supplemental care.

Strategy 3: Develop and Implement Gateway to Care.

Milestones: 1st QTR FY92.

Responsible Agency: Commander.

Outcome Measures:

- * Reduced CHAMPUS expenses.
- * Increased enrollees.
- * Improved services.

SUSTAINMENT

Strategy 4: Expand triage services in pediatrics and the outpatient clinic.

Milestone: 4th QTR FY91.

Responsible Agency: DCCS.

Outcome Measure: Increased patient satisfaction.

Strategy 5: Provide an outreach mobile health van.

Milestone: 1st QTR FY92.

Responsible Agency: Chief, Preventive Medicine.

Outcome Measures:

- * Increased number of patients visited.
- * Increased number of immunizations.

Strategy 6: Expand services provided after duty hours.

Milestone: Ongoing.

Responsible Agency: DCCS.

Outcome Measures:

- * Greater ability to meet patient demand.
- * Reduced emergency room visits.
- * Reduced waiting time for clinic appointments.

SUSTAINMENT

Objective: Enhance health promotion and wellness of staff and beneficiaries.

Strategy 1: Complete a needs survey.

Milestone: 1st QTR FY92.

Responsible Agency: Chief, Preventive Medicine.

Outcome Measure: Identification and analysis of wellness and health promotion needs.

Strategy 2: Develop a tailored education program to meet the identified needs of our staff and beneficiary population.

Milestone: 2nd QTR FY92.

Responsible Agency: Chief, Preventive Medicine.

Outcome Measures:

- * Level of staff/beneficiary participation in the program.
- * Patient/staff feedback.

Strategy 3: Increase use of in-house televisions to educate patients/consumers on wellness programs.

Milestone: 3rd QTR FY92.

Responsible Agency: Chief, Preventive Medicine.

Outcome Measures:

- * Patient feedback.
- * Increased patient awareness and use of wellness programs.

SUSTAINMENT

Strategy 4: Increase the frequency and comprehensiveness of BACH health fairs.

Milestone: 3rd QTR FY91.

Responsible Agency: Chief, Preventive Medicine.

Outcome Measures:

- * Increased patient participation.
- * Increased patient awareness of primary care services.

Strategy 5: Case find.

Milestone: Ongoing.

Responsible Agency: Chief, Preventive Medicine.

Outcome Measure: Increased number of positive findings.

Strategy 6: Increase safety education and awareness.

Milestone: Ongoing.

Responsible Agency: Safety Office.

Outcome Measures:

- * Reduced accidents.
- * Reduced compensation dollars.
- * Meet HSC objectives/limits.

SUSTAINMENT

Objective: Ensure well trained, educated, and qualified providers deliver care that meets or exceeds the current standard of care.

Strategy 1: Maintain a quality assurance program which ensures high quality care through monitoring and evaluation.

Milestone: Ongoing.

Responsible Agency: DCCS, DCA; C, DON; QA.

Outcome Measures:

- * Reduced number of adverse outcomes.
- * Reduced number of abeyances.
- * Reduced number risk management issues.

Strategy 2: Expand continuing medical education and officer professional development programs to maximize TDY funds and staff knowledge.

Milestone: 4th QTR FY92.

Responsible Agency: DCA, DCCS; C, DON.

Outcome Measures:

- * Increased continuing medical education available each quarter.
- * Increased number of health care providers attending continuing medical education per FY.

SUSTAINMENT

Objective: Improve the accuracy of workload reporting.

Strategy 1: Ensure inservice training on workload reporting is ongoing.

Milestone: Ongoing.

Responsible Agency: C, PAD; C, CSD; C, IMD; C, RMD; C, NEDS.

Outcome Measure: Increased number of personnel trained. (Work toward 100% trained)

Strategy 2: Establish a schedule of periodic internal audits of workload.

Milestone: 4th QTR FY91.

Responsible Agency: DCA, Internal Auditor.

Outcome Measure: Timely data for workload measurement.

Strategy 3: Hire a DRG coordinator.

Milestone: 1st QTR FY92.

Responsible Agency: C, PAD.

Outcome Measures:

- * More accurate workload reporting.
- * Increased third party reimbursements.

Strategy 4: Train the hospital medical, nursing, and administrative staff on DRGs.

Milestone: 2nd QTR FY92-FY95.

Responsible Agency: C, PAD; DRG coordinator.

Outcome Measure: A more accurate workload report resulting in an increase in funds provided by HSC for BACH's operating and supply budget.

SUSTAINMENT

Objective: Monitor state-of-the-art facilities, equipment, and technology to meet current and future requirements.

Strategy 1: Acquire funds to maintain MEDCASE and CEEP programs.

Milestone: Ongoing.

Responsible Agency: DCA; C, LOG (bio-medical).

Outcome Measures:

- * Increased funds received.
- * Greater percentage of funds obligated.
- * More equipment received.
- * Supply dollars saved.

Strategy 2: Obtain funds to construct a consolidated troop medical clinic.

Milestones: Ongoing.

Responsible Agency: RMD.

Outcome Measures:

- * Increased patient satisfaction.
- * Improved utilization of personnel.

Strategy 3: Make certain that the five year equipment plan results in timely acquisitions.

Milestones:

- * Ongoing.
- * Professional staff education on a quarterly or semiannual basis (FY91-FY96).

Responsible Agency: DCCS; C, LOG; C, RMD.

Outcome Measures: State-of-the-art equipment.

SUSTAINMENT

Strategy 4: Conduct a space utilization study for the purpose of relocating non-clinical services outside of the main hospital facility.

Milestone: 4th QTR FY91.

Responsible Agency: C, RMD; C, LOG.

Outcome Measures: Improved space utilization for all clinical and administrative areas.

SUSTAINMENT

Objective: Improve communications between BACH and our beneficiaries.

Strategy 1: Hire a public affairs officer (PAO).

Milestone: 2nd QTR FY91.

Responsible Agency: DCA.

Outcome Measure: Full-time PAO.

Strategy 2: Increase communication with the beneficiary population through greater media coverage of BACH.

Milestone: 3rd QTR FY91.

Responsible Agency: PAO.

Outcome Measure:

- * Increased patient awareness.
- * Increased patient satisfaction.
- * Better utilization of existing programs.

Strategy 3: Establish quarterly meetings with local physicians and hospitals.

Milestone: 4th QTR FY91.

Responsible Agency: DCCS.

Outcome Measures:

- * Improved communications with local health care providers and health care organizations.
- * Contract for possible health care provider board.

SUSTAINMENT

Strategy 4: Increase use of the health consumer council.

Milestone: 2nd QTR FY92.

Responsible Agency: Commander.

Outcome Measures:

- * Increased awareness of beneficiary needs and demands.
- * More accurate and timely information regarding beneficiary concerns and desires.
- * A highly visible, service-oriented leadership and staff.
- * Improved patient satisfaction.

Strategy 5: Train and educate the hospital staff on methods to improve communications.

Milestone: 4th QTR FY91.

Responsible Agency: IMD, PAO.

Outcome Measure: Maximize health care providers' time.

SUSTAINMENT

Objective: Create and maintain a pleasant work environment.

Strategy 1: Organize a task force to identify organizational features which contribute to staff dissatisfaction, develop alternative courses of action, and recommend possible solutions.

Milestone: 4th QTR FY91.

Responsible Agency: C, PER.

Outcome Measure: Improved employee morale.

Strategy 2: Highlight the features of working at BACH.

Milestones: 4th QTR FY91.

Responsible Agency: PAO.

Outcome Measures:

- * Improved employee morale.
- * Increased employee awareness.

Strategy 3: Improve living conditions for junior enlisted personnel.

Milestone: Ongoing.

Responsible Agency: Troop Commander.

Outcome Measure: Improved morale.

MODERNIZATION

Modernization Goal: Continually explore, evaluate, and utilize creative and innovative methods to meet current and future missions and objectives.

Objective: Develop and foster a command climate which provides an open and objective environment, receptive to change.

Strategy 1: Develop working committees for personnel, equipment, and facilities utilization (request to be a test site).

Milestone: 3rd QTR FY 91.

Responsible Agency: Commander.

Strategy 2: Implement total quality management in all areas.

Milestone: 3rd QTR FY91.

Responsible Agency: Quality management board.

Outcome Measures:

- * Reduction of patient complaints.
- * Increased staff satisfaction.
- * Increased number of personnel trained in TQM.
- * Successful influence with higher headquarters.
- * Increased productivity.

MODERNIZATION

Objective: Improve patient's access to health care through enhancement of present systems.

Strategy 1: Develop and install an automated patient appointment system in which all departments and divisions can obtain essential information from the data base in order to improve the present communications system (implement the Composite Health Care System).

Milestone: 2nd QTR FY92.

Responsible Agency: IMD.

Outcome Measures:

- * Improved productivity.
- * Increased savings.
- * Improved staff satisfaction.
- * Improved patient satisfaction.

Strategy 2: Implement Gateway to Care.

Milestone: 3rd QTR FY91.

Responsible Agency: Gateway to Care steering committee.

Outcome Measures:

- * Containment of CHAMPUS costs.
- * Improved access to care.

MODERNIZATION

Objective: Improve health care management through automated staff and patient feedback system.

Strategy 1: Obtain an interactive automated system that provides timely, high quality feedback.

Milestone: 2nd QTR FY92.

Responsible Agency: C, IMD.

Strategy 2: Develop and support a proactive patient relations representative.

Milestone: 3rd QTR FY91.

Responsible Agency: C, CSD.

Outcome Measures:

- * Improved statistical accuracy.
- * Improved responsiveness from staff members.
- * Decreased patient complaints and encouragement of positive and constructive comments.
- * Improved community and volunteer relationships.

MODERNIZATION

Objective: Enhance the present automation system to accommodate clinical and administrative needs.

Strategy 1: Develop an automation upgrade plan which emphasizes support for the clinical areas.

Milestone: 3rd QTR FY91.

Responsible Agency: C, IMD.

Strategy 2: Develop a summary sheet explaining automation systems and services available.

Milestone: 3rd QTR FY91.

Responsible Agency: C, IMD.

Strategy 3: Revise the Automation Guidance Council so that it is proactive.

Milestone: 3rd QTR FY91.

Responsible Agency: C, IMD.

Strategy 4: Conduct a clinical systems analysis.

Milestone: 3rd QTR FY91.

Responsible Agency: C, IMD.

Outcome Measures:

- * Increased staff satisfaction.
- * Increased productivity.
- * Increased level of automation knowledge.
- * Improved internal/external communications.

MODERNIZATION

Objective: Develop training programs to meet the needs of advanced technology to ensure that training on all new equipment is complete not later than 90 days of installation.

Strategy 1: Implement a teleconference training program.

Milestone: 3rd QTR FY91.

Responsible Agency: DCCS.

Strategy 2: Develop a physician continuing education program.

Milestone: Three months after Desert Storm.

Responsible Agency: DCCS.

Outcome Measures:

- * Increased staff satisfaction.
- * Increased attendance in training.
- * Improved patient care.
- * Increased requests for state-of-the-art equipment and technology.

MODERNIZATION

Objective: Review and remove system obstacles which hinder productivity prior to the implementation of Gateway to Care.

Strategy 1: Revise the consumer advisory council and be proactive in the intervention of potential problems.

Milestone: 3rd QTR FY91.

Responsible Agency: Commander.

Strategy 2: Develop a productivity-weighted workload accountability system.

Milestone: 3rd QTR FY91.

Responsible Agency: C, PAD; Gateway to Care Committee.

Strategy 3: Develop a staff and community awareness program.

Milestone: 3rd QTR FY91.

Responsible Agency: PAO.

Outcome Measures:

- * Increased staff retention.
- * Improve efficiency.
- * Increased awareness.
- * Increased patient education.

MODERNIZATION

Objective: Enhance the human resource program.

Strategy 1: Improve the relationship with the hospital and post civilian personnel office.

Milestone: 3rd QTR FY91.

Responsible Agency: C, RMD.

Strategy 2: Develop an innovative program to attract individuals in critically short skills, by enhancing salaries and incentives using managed care resources.

Milestones: 2nd QTR FY92.

Responsible Agency: C, RMD.

Strategy 3: Develop a summary sheet explaining the process to follow for elimination of personnel.

Milestone: 3rd QTR FY91.

Responsible Agency: C, RMD.

Outcome Measures:

- * Reduced time spent on adverse personnel management issues.
- * Reduced CPO conflicts.
- * Adequate staffing.
- * Improved quality of applicants selected for employment.
- * Improved retention of civilian workers.

MODERNIZATION

Objective: Develop innovative programs for the competitive acquisition of state-of-the-art equipment.

Strategy 1: Develop a summary sheet explaining all methods available for equipment acquisition.

Milestone: 3rd QTR FY91.

Responsible Agency: C, LOG.

Strategy 2: Explore non-traditional methods of equipment acquisition.

Milestone: 3rd QTR FY91.

Responsible Agency: C, LOG.

Outcome Measures:

- * Increased user involvement.
- * Reduced acquisition time.
- * An improved and flexible system.
- * Increased utilization of appropriate equipment.
- * Improved productivity and patient care.

MODERNIZATION

Objective: Efficiently use all space and accommodate expansion.

Strategy 1: Conduct an analysis of space utilization within the BACH facility.

Milestone: Post Desert Storm.

Responsible Agency: C, RMD.

Strategy 2: Relocate services, which are not essential to patient care in BACH's main facility, to areas outside the main hospital.

Milestone: 3rd QTR FY91.

Responsible Agency: Facilities steering committee.

Strategy 3: Obtain regionalized mobile care.

Milestone: 3rd QTR FY91.

Responsible Agency: DCCS, DCA.

Outcome Measures:

- * Greater access to specialty services.
- * More responsive patient care.
- * Increased patient and staff satisfaction.
- * Increased use of the hospital.
- * Increased savings.

MODERNIZATION

Objective: Improve documentation in medical records.

Strategy 1: Develop an automated inpatient transcription system.

Milestone: 1st QTR FY 92.

Responsible Agency: C, IMD.

Strategy 2: Obtain a voice activated, outpatient transcription service which is compatible with the inpatient system.

Milestone: 1st QTR FY92.

Responsible Agency: C, IMD.

Outcome Measures:

- * Increased productivity.
- * Improved health care communication.
- * Reduced backlog.
- * Reduced number of incomplete medical records.
- * Standardized medical reports.